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The Dimensions of Community-based Programs in Kahrizak[1] (According to Anderson's Health Behavior Model)

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Abstract: *The older population in the world especially in Iran is growing. According to census the number of individuals aged is approaching5/07 million In 2006 the nation is bracing for the aging of baby boom generation in 20 next year, which will swell the 65 and older population to10 million By 2020 and 26 million by 2050. (Iran census, 2006) this population trends ported increased demand for health care. This study examined community-based programs dimensions that performed in Kahrizak (Iran). The method was survey. The data were collected by questionnaire. 50 older adults that participated in these programs due to old age were interviewed. The data were analyzed by SPSS 11. For the theoretical framework we used Anderson health behavior model. The results showed that according this model financial factors; income, housing, receiving financial help and health insurance help older adults to use community-based programs. 62 percent of participants evaluated the programs good and they reported good mental and physical status. Because there is a bit literature in theoretical and practical field of that in Iran the study suggested more research about this subject in future.*

Keywords: *Community-based programs, older adults, Kahrizak, Anderson health behavior model.*

Introduction and Background

The older population in the world especially in Iran is growing. According to census the number of individuals aged is approaching5/07 million In2006 the nation is bracing for the aging of baby boom generation in 20 next year, which will swell the 65 and older population to10 million By 2020 and26 million by 2050. (Iran census, 2006) this population trends ported increased demand for health care. One of the new ways of keeping older people in the society and increasing their independency is community-based programs. These programs have emerged in the past decade as an alternative way, which integrates education and social action to improve health and reduce health disparities especially among older people.(Nina b, Wallerstein, bonnie Duran; 2006) it focuses on relationship between academic and community programs and allow older adults to age in community.

These programs provide more professional healthcare in community rather than only in institutional facilities. Need for CBP will therefore increasing greatly (Chen, 2010) It seems that participation in the CBP affects older adults' health status. This study sought to show dimensions of CBP in Iran performed for older adults in Kahrizak. For the theatrical framework we use the Anderson behavior model of health services and Chen's model for understanding factors that influence success of CBP services for enhancing older adults' health during old age. Modern medical care has increase life expectancy; it has also prolonged the length of time that older adults are likely to require long-term care. Building an effective care system that allows older adults to remain in community, increasing their independency and improving health status has become a critical task for policy makers, and service developer and government. Most of older adults have preferred to age at home or in communities (Chen, 2010)

[1] For designing this article we got help from the Chen's study about Understanding Factors Success of Home- and Community- Based Services in Keeping Older Adults in Community Settings

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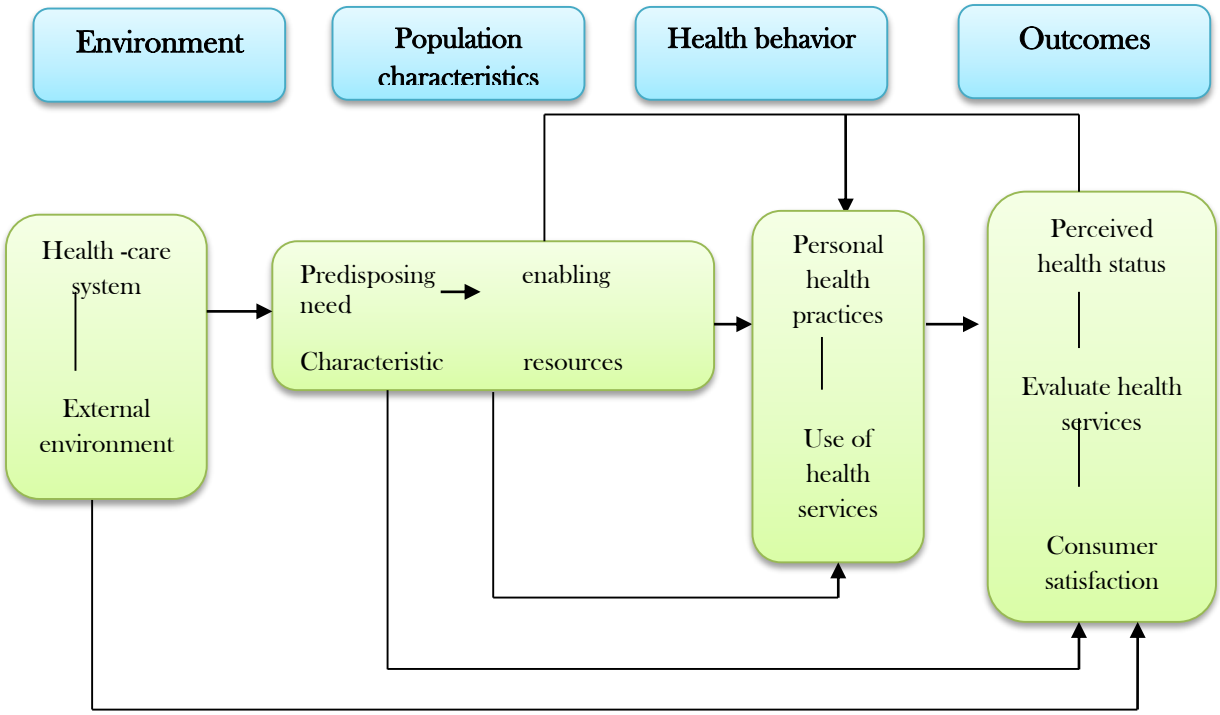
how to support older home or in communities has been a challenge for the government. In response CBP are services that have been develop to support older adults and provide their needs. In the past, the term long-term care was synonymous with nursing home care. Overtime, the definition has been broadened to include all health and health-related services, provided formally or informally, in an institution or at home, to functionally impair or chronically ill individuals. A wide range of formal, home- and community-based programs—such as personal care, homecare, adult day care services—have developed to replace care provided primarily by families in the past (Schwab, Meng: 2003).

The delivery and financing of long-term care affects older people, their caregivers, and a society at large. For older persons, their health, quality of life, and economic security are shaped by whether services are available and how they are delivered (Kane, 2001). Several sets of challenge within the CBP deserve further exploration: issues of participation and community consent, issues of power and privilege issues of racism and ethnic discrimination, and issues of research for social change (Nina B. wallerstein, bonnie duran: 2006)CBP intervention is based on two primary assumptions for improving life satisfaction and reducing disparities. One of, that intervention can be strengthened if they benefit from community insight and incorporate community theories of etiology and change into the empirical science base; and two, that there is an added value to participation itself for enhancing health. (Nina B. Wallenstein, bonnie Duran: 2006).

The purpose of these programs is to reduce dependency of health professionals, to ensure cultural and local sensitivity, to facilitate sustainability, to enhance producing of programs. One of the most effectiveness empowerment of older adults has identified that CBP improving older adults' health and therefore they can live independent also these programs allow the older person to be cared for at a relatively low-cost and, most importantly, in the preferred, familiar surroundings of his or her home. Anderson (1995) has developed a relatively different model of health behavior. Initially devised in the latter 1960s, the model has undergone considerable reformulation since then. Anderson began with a relatively simple explanation of health service usage at the family level of analysis that has evolved into an increasingly complex interpretation of health-service utilization at individual level. As Anderson (1995) points out, the "model portrays the multiple influences on health services use and, subsequently, on health status. Although not an alternative to the HBM, the model of health services offers an increased number of variables associated with potential outcomes. And, according to Anderson (1995) the model also includes feedback loops showing that outcomes, in turn, affects subsequent predisposing factors and perceived need for services as well as health behavior. Only time and continued investigation will determine the value of the model as an explanation of health outcomes.

As suggested earlier, models of health behavior provide the medical sociologist with a powerful analytic tool that has cross-cultural relevance. Although deceptively simple, these models allow medical sociologist and others (e.g., health psychologists) to engage in efforts to predict health behaviors. Thus, it is becoming increasingly important for individuals as well as various social institutions to differentiate between those behaviors that are indicate of health versus behaviors resulting in illness or disability. The outcomes associated with such decisions have significant consequences not only for the individual, but for society as well. (Matcha: 2000). Anderson (1968) defined health services as a function of three components: predisposing, enabling and need. People are predisposed to illness due to different factors such as demographic characteristic, social structure and health benefits. However, people rely on enabling factors to provide the means for individuals to use services. In addition, people may not seek help until they feel the need (Tsuannkuo, 2001)

The research shows that these programs effects older adults' people health state. Finding has shown that older people were less satisfied because they were on happy with their unfulfilled lives as they reached the endlessness of old age. (Brain scotten rlich and derrek mlsascowitz)



Research Method

The empirical basis of this research is a survey conducted in 2012 with persons aged 50 years and older participated in community- based programs performed in Kahrizak. The survey, based on random sample and data was collected by questionnaire and due to the age of respondents, the questionnaire was filled by interview. The study examined CBP components that divided into three components according to Anderson's framework: predisposing, enabling and needs variables.

The model's' predisposing component in the current CBP included; age, gender and level of education… even for individuals predisposed to use CBP, some means must be available for them to do so. A condition that permits an individual to act on a value or to satisfy a need is defined as an enabling condition (Chen, 2010). Because older adults' social environmental support and financial status were a determinant for older adult's ability to participate CBP therefore improving their health status these current study defined this factor both social enabling and financial enabling factors. Social enabling factors are: Living arrangement, the most frequents contact with, the most intimate contact with Frequent of visited, satisfaction of relationship with people, receiving help, membership in social, cultural, religious group, participate in religious ceremonies, participate in congregation prayer.

Financial enabling included Income, housing, having health insurance, types of health insurance, satisfaction of health insurance, providing of rehabilitation tools of health insurance, receiving financial help. Finally, although predisposing and enabling factors are necessary conditions for the CBP to increase health status among older adults, they are not sufficient. For these programs, older adults must perceive some needs. Need may result from illness or from aging related functional disabilities. Older adults can perceive a need for assistant with the particular activity in the past. We defined needs in this study as self-reported disability that included, heart problem, diabetes, hypertension, mouth and teeth problem and other disease.

Community- based programs components	**Indicators**	
Predisposing factors	Age Gender Level of education	
Enabling factors	**financial**	Income Housing Health insurance
	social	Living arrangement The most frequents contact with The most intimate contact with Frequent of visited Satisfaction of relationship with people
Disability and needs factors	-	Arteries Heart problem Diabetes Mouth &teeth problem hypertension

Results

Predisposing factor: The results have shown that 70 percent of participants in CBP of Kahrizak were women, 30 percent just be men. The mean age of the two groups (men and women) was 69.22 years. The mean level of education was 1.92 that shown the most of older adults had elementary school literacy.

predisposing	**frequently**	**percent**	**Means deviation**	**Mean**
gender				
men	15	30	-	-
women	35	70		
total	50	100		
age				
60-66	17	34	0.81	69.22
67-73	20	40		
74-82	13	26		
total	50	100		
Level of education				
0	29	58	0.3	1.92
Less than 5	16	32		
Above 5	5	10		
total	50	100	-	-

Financial enabling factor: 48 percent of participants had less than 1660000 Rials income in month. The mean of income was 2240000 Rials this result has shown that most of the older adults participated in CBP of Kahrizak class in low income….60 percent of persons have received financial help that 43.3 percent of them receiving financial help of relief committee of imam Khomeini and 33.3 percent had family financial support.78 percent of participants have personal housing and health insurance. 59 percent use social security health insurance and 30/8 percent use….. 33.3 percent was satisfied health insurance services in low level. 94.9 percent of health insurance users respond that the companies provide the rehabilitation tools.

Financial enabling	frequently	percent	Means deviation	Mean
Income				
• **Less than166000**	24	48	25033	224400
• **166000-333000**	6	12		
• **Above 334000**	20	40		
✓ **Total**	50	100		
Housing				
• **Personal housing**	39	78		
• **Leased housing**	5	10		
• **Children housing**	6	12		
• **State housing**	0	0		
✓ **total**	50	100		
Having health insurance				
• **yes**	39	78		
• **no**	11	22		
✓ **total**	50	100		
Types of health insurance				
• **social security health insurance**	23	59		
• **Health insurance**	12	30.8		
• **Complementary health insurance**	1	2.6		
• **other**	3	7.7		
✓ **total**	39	100		
Satisfaction of health insurance				
• **low**	13	33.3	0.15	2.6
• **somewhat**	20	51.3		
• **high**	6	15.4		
✓ **total**	50	100		
Providing of rehabilitation tools of health insurance				
• **yes**	37	94.9		
• **no**	13	5.1		
✓ **total**	39	100		
Receiving financial help				
• **yes**	30	60		
• **no**	20	40		
✓ **total**	50	100		
financial help resources				
• **Family**	10	33.3		
• **Relief committee of imam Khomeini**	13	43.3		
• **Behzisti- welfare organization**	4	13.3		
• **Shahid foundation**	3	10		
✓ **total**	30	100		

Social enabling: 32 percent of persons live with spouse only. 62 percent had the most contact with children. 40 percent had the most intimidate contact with their spouses. 34 percent of older adults visited their family minimum once a week. 42 percent receiving people help (family, children, neighbors…) for doing daily activity in high level.52 percent of persons had high satisfaction of relationship with people and the mean of that was 4/4. 94 percent of participants are membership of any social, cultural, religious group. 70 percent had high participation in religious ceremony and 54 percent of them had low participation in congregation prayer (Namaz-e Jamaa't) due to old age.

Social enabling	frequently	percent	Means deviation	Mean
Living arrangement				
✓ **alone**	10	20		
✓ **with spouse only**	16	32		
✓ **With children only**	14	28		
✓ **With spouse & children**	10	20		
• **total**	50	100		
The most frequents contact with				
✓ **sister**	1	2		
✓ **brother**	2	4		
✓ **children**	31	62		
✓ **relative**	3	4		
✓ **neighbors**	10	20		
✓ **friends**	1	2		
✓ **other**	3	6		
• **total**	50	100		
The most intimate contact with				
✓ **spouse**	20	40		
✓ **daughter**	16	32		
✓ **sun**	2	4		
✓ **sister**	0	0		
✓ **brother**	1	2		
✓ **relative**	1	2		
✓ **other**	10	20		
• **total**	50	100		
Frequent of visited				
✓ **Every day**	14	28		
✓ **Once a week**	17	34		
✓ **Once a month**	12	24		
✓ **Once a year**	4	8		
✓ **Rarely**	3	6		
• **total**	50	100		
Satisfaction of relationship with people				
✓ **low**	17	14	0.12	4.4
✓ **somewhat**	17	34		
✓ **high**	26	52		
• **total**	50	100		
Receiving help				
✓ **low**	16	32	0.25	3.6
✓ **somewhat**	11	22		
✓ **high**	23	46		
• **total**	50	100		
Membership in social, cultural, religious group				
✓ **Yes**	3	47		
✓ **No**	6	94		
• **total**	50	100		
Participate in religious ceremonies				
✓ **low**	8	16		
✓ **somewhat**	7	14		
✓ **high**	35	70		
• **total**	50	100		
Participate in congregation prayer				
✓ **low**	29	54		
✓ **somewhat**	8	16		
✓ **high**	13	26		
• **total**	50	100		

Needs and disabilities: 13 percent of individuals suffer from heart problem, 52 percent arteries, 22 percent hypertension, 8 percent mouth and teeth problem and 42 percent other diseases.

Needs and disabilities		frequently	percent
Heart problem	yes	8	16
	no	42	84
Arteries	yes	26	52
	no	24	48
Diabetes	yes	12	24
	no	38	76
hypertension	yes	11	22
	no	39	78
Mouth &teeth problem	yes	4	8
	no	46	92
others	yes	21	42
	no	29	58

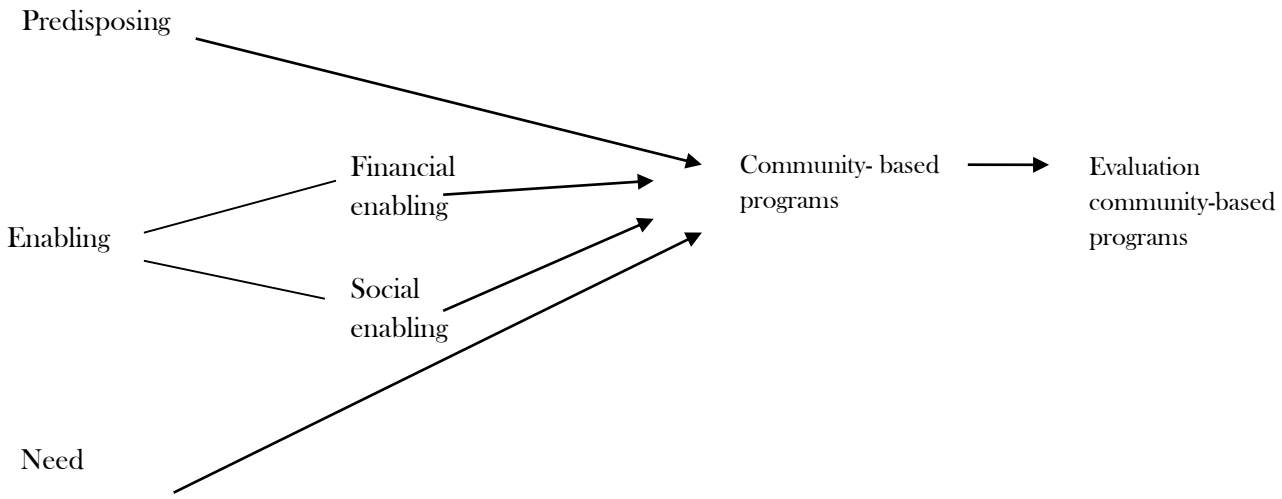
Self-reported evaluation of health status: at the CBP evaluation, the participants' self-reported; 40 percent evaluate their health status good. 44 percent had used CBP for 1-2 years. 38 percent was using the services above 2+ years. 46 percent was feeling better when they enrolled the programs. 64 percent gave high feedback respective behavior. 42 percent doing their daily activity better than pervious. 50 percent had better high health status and 44 percent have high rehabilitation and therapy status. In addition, participants reported their health status both physical and mental better than pervious.

self-reported evaluation of health status	frequently	percent
• **poor**	9	18
• **fair**	21	42
• **good**	20	40
• **total**	50	100
Time of using CBP		
• **Less than a year**	9	18
• **1-2 years**	22	44
• **2+ years**	19	38
Better feeling		
• **low**	6	12
• **somewhat**	21	42
• **high**	23	46
Better respective behavior from others		
• **low**	4	8
• **somehow**	14	28
• **high**	32	64
Satisfaction of giving services		
• **low**	2	4
• **somewhat**	17	34
• **high**	31	62
Doing daily activity		
• **low**	13	26
• **somewhat**	15	30
• **high**	21	42
Health status		
• **low**	11	22
• **somewhat**	22	44
• **high**	17	34
Social relationship with people		

• **low**	7	14
• **somewhat**	30	60
• **high**	13	26
Mental status		
• **low**	7	14
• **somewhat**	18	36
• **high**	25	50
Financial status		
• **low**	18	36
• **somehow**	18	36
• **high**	14	28
Rehabilitation & therapy status		
• **low**	9	18
• **somewhat**	19	38
• **high**	22	44

Discussion

The main purpose of this study is to examine the dimensions of community-based programs that performed in Kahrizak for 3 years. Aging is being a series problem in Iran in next 15 years. Growing population enters retirement and the demand for supportive services to elders increase (J. Kevin Eckert, Leslie Morgan, namratta swamy, 2004). It is clear that neither formal services nor informal can meet the health care needs of those. Thus the policy maker should develop the new ways of keeping older adults that meet their needs, secure welfare, avoid of isolation and exclusion and give them independency for doing daily activity, keeping fund, and expanding social networks and so . According to results, it seems that the CBP is the new trend of long term care system and the best alternative way of keeping older adults in the society. Although it is a short time that these programs performed in Kahrizak but older adults are so satisfied due to keeping their independency. According to Anderson behavior model financial factors; income, housing, receiving financial help and health insurance help older adults to use community-based programs. 62 percent of participants evaluated the programs good and they reported good mental and physical status. Using these programs can help older people to keep their independency and regaining identity. It can use aging as an opportunity and older adult as a social and cultural capital. Because there is a bit literature in theatrical and practical field of that in Iran the study suggested more research about this subject in future.



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