



ภาพสุขภาพของผู้สูงอายุที่พักอาศัยในชุมชนนันทนเหมียน เมืองนันทนิง มลฑลกวาสี สาธารณรัฐประชาชนจีน

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บทคัดย่อ

การศึกษาเชิงสำรวจแบบภาคตัดขวางนี้มีวัตถุประสงค์เพื่ออธิบายภาพสุขภาพของผู้สูงอายุชาวจีนในชุมชนนันทนเหมียน เมืองนันทนิง มลฑลกวาสี สาธารณรัฐประชาชนจีน ใช้การสุ่มตัวอย่างแบบหลายขั้นตอนได้ผู้สูงอายุจำนวน 201 คน เก็บข้อมูลโดยใช้แบบสัมภาษณ์และเครื่องมือประเมินมาตรฐาน วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา

ผลการวิจัย พบว่า 1) ลักษณะประชากรจากผู้สูงอายุ 201 คนพบว่าส่วนใหญ่เป็นหญิง (ร้อยละ 53.7) อายุ 60-69 ปี (ร้อยละ 53.2) จบการศึกษาระดับมัธยมต้น (ร้อยละ 28.9) เคยมีอาชีพทำงานในโรงงานอุตสาหกรรม (ร้อยละ 48.8) และไม่ได้ทำงานหลังเกษียณอายุ (ร้อยละ 53.2) 2) สุขภาพกาย ผู้สูงอายุส่วนใหญ่รับรู้สุขภาพตนเองว่าอยู่ในระดับปานกลาง (ร้อยละ 48.3) และรับรู้ว่าสุขภาพตนเองเหมือนกับคนอื่นในวัยเดียวกัน (ร้อยละ 50.7) ผู้สูงอายุเป็นโรคเฉลี่ย 1.36 โรคต่อคน โรคที่พบบ่อย คือ ความดันโลหิตสูง เบาหวาน และข้ออักเสบหรือรูมาตอยด์ ความเจ็บป่วยที่พบ คือ อาการปวด อ่อนเพลีย/อ่อนล้า และหน้ามืด/เป็นลม ปัญหาสำคัญในผู้สูงอายุที่พบบ่อย คือ การมองเห็น การนอนหลับ การสูญเสียความทรงจำ การได้ยิน และอาการกลืนปีสภาวะไม่อยู่ ด้านพฤติกรรมสุขภาพ ส่วนใหญ่รับประทานอาหารวันละสามครั้ง (ร้อยละ 89.6) ไม่สูบบุหรี่ (ร้อยละ 88.6) ไม่ดื่มสุรา (ร้อยละ 81.1) และออกกำลังกายอย่างน้อย 3 ครั้งต่อสัปดาห์ (ร้อยละ 64.2) การทำหน้าที่ด้านร่างกาย ผลการประเมิน BAI พบว่า ร้อยละ 29.9 มีภาวะพึ่งพาในการทำกิจวัตรประจำวัน ผลการประเมิน IADL พบว่าผู้สูงอายุมีภาวะพึ่งพา เรื่อง การซักรีดเสื้อผ้า การจัดการเรื่องเงิน และการใช้โทรศัพท์ 3) สุขภาพจิต ผู้สูงอายुर้อยละ 30.9 มีภาวะซึมเศร้า และร้อยละ 23.5 มีภาวะการรู้คิดบกพร่อง 4) สุขภาพสังคม ผู้สูงอายุส่วนใหญ่ มีสถานภาพสมรสคู่ (ร้อยละ 70.1) อาศัยอยู่กับครอบครัวในอาคารพักแบบสองห้อง (ร้อยละ 80.1) โดยอยู่กับสมาชิกของครอบครัว (ร้อยละ 34.8) และผู้สูงอายุส่วนใหญ่ไม่ชอบเข้าร่วมกิจกรรมทางสังคม (ร้อยละ 76.6) และพบว่าครอบครัวเป็นแหล่งสนับสนุนที่สำคัญของผู้สูงอายุ โดยส่วนใหญ่ได้รับการสนับสนุนหลักด้านอุปกรณ์-สิ่งของเครื่องใช้ในชีวิตประจำวันจากบุตรชายมากกว่าบุตรสาว แต่จะได้รับการสนับสนุนด้านการเงินจากบุตรสาวมากกว่าบุตรชาย การศึกษานี้ทำให้ได้ข้อมูลพื้นฐานที่เป็นประโยชน์ในการวางแผนการดูแลแบบเป็นองค์รวมและในการจัดบริการผู้สูงอายุในชุมชนเพื่อตอบสนองความต้องการของผู้สูงอายุในชุมชนเมืองนันทนิง มลฑลกวาสี สาธารณรัฐประชาชนจีน

คำสำคัญ: ภาพสุขภาพ ผู้สูงอายุ ชุมชน ประเทศจีน

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Rationale and Background

China has become an aging society. Older people (60 years and over) increased from 145.09 million (11.1%) in 2005 to 159.89 million (12.0%) in 2008¹. In comparison the Guangxi Zhuang Autonomous Region, at the end of 2007, had 6.35 million of older people which accounted for 13.31% of the total population². Data showed that the ratio of older people in Guangxi was higher than the national average.

The increasing numbers of older people leads to a growing need for care. Three types of care are presently available for older people in China: community-based care, familial care, and institutional care³. Most older Chinese people still live with family members in various arrangements within the community.

Community-based long-term care for older people in China, supported by local governments, had emerged especially in urban areas⁴. Older people are encouraged to remain living in their own homes as long as possible, assisted by community support services when the need arises⁴. Hence, it offers a unique challenge for the Chinese health care system to pay more attention to the health of older Chinese people in the community.

The Ministry of Health established a health record, which has been chiefly used in the township health centers, village clinics, and community health service units and centers⁵. The record pays attention to physical health, rather than the holistic health of older people. It does not indicate information of functional ability, mobility, depressive symptoms, cognition, or social function. Therefore, data on the holistic health of older people in the community is needed in order to reflect the overall health profile of older people.

To date, the health profile of older Chinese people has been studied in two different settings: in a hospital and in a residential apartment^{3,6}. There is limited data on the health profile of older Chinese people living

in community. Thus, there is a need to address the lack of information on the health profile of older Chinese population in community settings.

Older people in the community tend to be affected adversely by health inequalities and poverty due to their physical and mental health deterioration, functional decline and social adversity⁷. Thus, this study aims to describe the health profile of older people living in Nanmian community, Nanning, Guangxi, and People's Republic of China.

Conceptual Framework

This study employs the conceptual framework from Aroonsang et al.⁸ which was based on the World Health Organization's definition of health, and the comprehensive assessment of the Australian Health Minister's Advisory Council (AHMAC). The researcher modified the conceptual framework to fit with the context of Chinese urban communities comprised of four dimensions: **demographic characteristics, physical health, mental health and social health**⁹.

Methodology

A cross-sectional descriptive survey study was used to describe the health profile of older Chinese people living in Nanmian community, Nanning, Guanxi, Peoples' Republic of China.

Subjects: Multistage sampling was used to obtain the 201 older people as subjects for the study. The study was conducted during February and March, 2011.

Instruments: Health profile questionnaires developed by Aroonsang et al.⁷, Shi⁶, and Wang et al.³ were modified by the researcher for use in this study. There were 4 sections: 1) **demographic characteristics:** age, gender, educational level, occupation, and income; 2) **physical health:** health perception, diseases and illnesses, geriatric problems, health behaviors, and physical function; 3) **mental health:** mood status



and cognition; and 4) **social health**: perceived social support, received sources of support, and social network. The five standard scales used were: the Barthel ADL Index (BAI)¹⁰, Instrumental Activity of Daily Living Scale (IADLs)¹¹, the Geriatric Depression Scale-15 items (GDS-15), Mini-Mental State Examination (MMSE)¹² and Perceived Social Support Scale (PSSS).¹³

Validity and Reliability: The questionnaire was checked for content validity by five experts, and the Content Validity Index (CVI) of 0.904 was calculated¹⁴. Based on Cronbach's alpha, the internal consistency reliabilities of the BAI, IADLs, MMSE and PSSS were 0.95, 0.92, 0.76, and 0.86, respectively. Based on the Kuder Richardson 21 (KR-21), the reliability for the GDS-15 was 0.75. The validity and reliability for all scales were within acceptable levels.

Data collection procedures: Permission for obtaining data was approved by the KhonKaen University Ethics Committee for Human Subjects, the Beihu street office of Xi Xiangtang district, and the office of Nanmian community neighborhood committee.

Officers of the Nanmian community neighborhood committee contacted and informed the eligible older people who verbally agreed to participate. The subjects selected the time, date and place for the interviews. Face to face interviews based on questionnaires and standard scales were used to collect data.

Data Analysis: The Statistical Package for the Social Sciences (SPSS) was used for analyzing descriptive statistics.

Results

The health profile of older people comprised of 4 sections

1. Demographic characteristics: Of the 201 older people, 53.7% were females and 46.3% were males. Age ranged from 60 to 89 years (mean

= 69.78). The largest age group was the young old group, 60-69 years old (53.2%). Most of them were educated (86.1%), and had middle school education (28.9%). The major ethnicity was Han (80.1%). The major occupation before 60 years of age was industrial worker (48.8%) and the major current occupation was housework (48.1%).

2. Physical health: For **health perception**, most of the sample perceived their health as fair (48.2%), and as the same as others of the same age (50.7%). Data concerning diseases and illnesses was collected from the subjects' perceptions, with no official medical diagnosis. The most prevalent **diseases** found were hypertension (38.3%), diabetes mellitus (15.9%), rheumatoid arthritis or osteoporosis (15.4%), cardiovascular disease (10.9%), gastro-duodenal ulcer (8.5%) and hyperlipidemia (8.5%). On average the sample suffered from 1.36 diseases during the 6 months prior to data collection.

The most common illnesses found were pain (38.3%), weakness/fatigue (13.4%), vertigo or syncope (10.0%), and cough (6.5%). Most subjects (92%) reported that they had at least one geriatric problem within the past 6 month. The top five geriatric problems were vision problems (76.1%), sleep problems (62.7%), memory loss (40.8%), hearing problems (26.9%), and urinary incontinence (17.9%). The health behaviors reported were: 88.6% did not smoke at all, 81.1% did not drink at all, 64.2% exercised more than three times per week, and 89.6% had three meals per day. Physical function was assessed by the Barthel ADL Index and IADL Index. Most subjects (70.1%) were physically independent, 24.4% had mild physical dependence, and 5.5% had moderate to very severe dependence on ADLs. The most dependent of the IADLs were: dependence on laundry (10.0%), followed by money management (9.5%), then telephone (8.5%).



3. Mental health: Older people's mental health was measured by mood status and cognition. The mood status assessed by GDS-15 showed that most of the older people (69.1%) had normal mood status, 21.9% had mild depression, and 9% had moderate to severe depression. Cognition, assessed by the MMSE, showed that of 183 older people, 23.5% were identified as having cognitive impairments.

4. Social health: Social health was measured by social support and social network. Social support involved perceived social support and received sources of social support. Perceived social support was measured by PSSS. Older people had support from family (mean: 5.65–5.82), followed by friends (mean: 3.40–3.89), and significant others (mean: 2.70–2.72). Received sources of support: Subjects obtained material support mostly from sons (63.2%), followed by daughters (61.7%), then by spouse (34.3%). Of the total subject, 70.6% had financial support from the government (pension or insurance), 44.8% from daughters, 43.8% from sons, and 13.4% from spouse. The majority of older people received instrumental support from sons (51.7%), followed by daughters (43.8%), then spouse (34.8%). Social network: Most subjects (70.1%) were married; (80.1%) lived in a two-room apartment; (34.8%) lived with children, grandchildren and spouse; (26.4%) lived with spouse; and (11.4%) lived alone. For the social contact, 51.7% reported that they had visits from children or grandchildren, and 23.9% were visited by relatives. For the telephone contact, most subjects (54.2%) had occasional contact with children, relatives, friends & neighbors, and co-workers; 27.4% reported frequent telephone contacts; and only 18.4% of them reported that they did not have any contacts at all. Most (76.6%) did not participate in any social activities and 11% participated in social activities regularly.

Discussion

Demographic data showed that there were more females than males in the studied urban community group, and most were in the young-old age group (60–69 years). This finding is similar to the Chinese national study conducted by Wan et al.¹⁵

Physical health profile: Over one-fourth of the subjects perceived their health to be poor or very bad. Similar results were found by Li et al.¹⁶ in urban cities of Guangxi. However, nearly one-half of the subjects perceived their health as fair. This perception may be influenced by Asian culture and Confucianism by which people tend to express their ideas of moderation, rectitude, and lack of prejudice that would conceal their real feelings.

On average the subjects suffered from 1.36 diseases during the 6 months prior to data collection. The findings reported that most (74.6%) had at least one disease. These results were consistent with Cheng et al.¹⁷ who reported that older people in the community had an average of 1.24 diseases. The most prevalent diseases of older people were hypertension, diabetes mellitus, rheumatoid arthritis or osteoporosis and cardiovascular disease. The disease with the highest incidence in the present study was hypertension (38.3%). This result was lower than a national survey among older Chinese people in cities which showed dramatically higher prevalence rates of hypertension (42%) among older adults aged 60 years and over. The most common illnesses of our older people were pain, weakness/fatigue and vertigo/syncope. Sha et al.¹⁸, Mitprasart U, Surit P¹⁹, Nadee S, Teeranute A, Boonsawat W²⁰ also reported the most common symptoms in older people were musculoskeletal pain, fatigue and shortness of breath. In this study, 38.3% of older people had pain. Pain was the most common illness reported among older people.



For geriatric problems, the majority of older people (92%) reported that they had at least one geriatric problem within the past 6 months. The high prevalence of geriatric symptoms indicates that older people need appropriate health care to deal with these conditions.

For health behaviors, the study found that most subjects exercised, had regular diet habits and ate healthy foods. Only a small group of older people had the negative health behaviors of smoking and drinking. Data from the current study indicates that most older people in Nanmian community live with good health habits. Lee et al.²¹ suggested that a potential benefit of engaging in multiple healthy lifestyle habits is for maintaining cognitive health.

Physical function: For the BAI, 29.9% of older people were dependent for all or some ADLs. It indicates that older people need assistance in performing ADLs. A higher prevalence of ADL dependence was reported in Spain by Milla' n-Calenti et al.²² that 36.35% of older people were dependent for all or some ADLs in the community. The different results could be due to cultural differences and using different ADL items in the studies. A study by Shi et al,⁶ reported up to 58.7% of older patients in the hospital were dependent for all or some ADLs during hospitalization. These results might indicate that older people in the community are more independent with ADLs than those in the hospital settings. The reasons for these differences may be due to the patterns of diseases and illnesses, variations in life styles, and the setting or environment.

From the IADLs of our subjects, we found that they were most dependent on laundry (10.0%), followed by money management (9.5%), then telephone (8.5%). A study done in African showed that older people in their community are more likely to report dependence on IADL tasks like transferring and getting to places outside the home²³. These varied results might be related to cultural differences.

The mental health profile was measured by mood status and cognition. For mood status, one-third (30.9%) of older people had depression. This was slightly higher than that found by Katona et al.²⁴ who reported a 22% prevalence of depression in the baseline population of community-dwelling older people with ADL limitations in Islington. However, our findings were lower than who reported the prevalence of depression of older people in Korea to be at 63%. These differences might be explained by the prevalence of depression in different regions influenced by cultural factors and state of health, as well as the methods and instruments used. It indicates that depression in older people is a widespread problem²⁵.

The current study found that 23.5% were identified as having cognitive impairment or dementia. A previous study done in the city of Changsha, China reported a dementia rate of 27.5%²⁶. The slightly differences among MMSE results may be due to socio-cultural differences and the method used.

The social health profile (PSSS) was used to assess the perceptions of older people regarding social support from family, friends and significant others in the community. This study presents that older people have support from family, followed by friends and significant others, respectively. The study also showed the majority of older people received instrumental, material, and financial support from sons, daughters, and spouses.

Traditionally family members, especially adult children, have been expected to be the main source of support for older people. Adult children are the primary source of support for older people in China. It was also found that sons provided instrumental support more than daughters, while daughters provided more financial support than sons. However, findings from Lecovich & Lankri²⁷ indicated that sons tended to be perceived as more responsible for providing financial



assistance to their parents, while daughters were more likely to be expected to provide care and instrumental assistance.

For the social network, most of the subjects were married and lived in the two-room apartment. However, 37.8% of older people lived in an "empty-nest family". The study showed that the "empty nest family" in China accounted for almost 25% of elderly households, and the proportion of "empty nest families" in Beijing was over 35%²⁸. However, 59.7% of older people lived with children or others in intergenerational households. The results reflect Chinese culture, where family is an important source of support for older Chinese people in the community.

Limitations of the study

Data collection for the present study was carried out in winter when weather was cold, moist and rainy. Older people tend to report more health problems during winter months than during other seasons. Seasonal influence may be a relevant factor for older people carrying out the IADLs and participating in social activities. The seasonal limitations may have influenced the responses in some parts of the health profile of community-dwelling older people.

Implications

The health profile provides baseline information on the minimum dataset of the holistic health of older people in community. Community health nurses need to be trained to assess and monitor the health profile, as well as to develop the complete holistic health records of older people in the community. Nursing administrators should provide support for setting up community aged care services that are specific to the health care demands of community older people. Nursing education or training in gerontological or geriatric care for older people in community should be provided.

Recommendations

A longitudinal study should be conducted in order to explore the changes in the dimensions of health profile of older Chinese people in the community.

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Health Profile of Older Chinese People in Nanmian Community, Nanning, Guangxi, People's Republic of China

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Abstract

This cross-sectional survey study aimed to describe the health profile of older Chinese people in Nanmian community, Nanning, Guangxi, People's Republic of China. Multistage sampling was used to obtain 201 older subjects from Nanmain community. Data were collected by using questionnaire and standard assessment tools. Descriptive statistics was used for data analysis.

Results: 1) Demographic characteristics: Most of the 201 older people were females (53.7%), aged 60-69 years (53.2%), had middle school education (28.9%), were industrial workers (48.8%), and had no work after retirement (53.2%); 2) Physical health: Most of older people perceived their health as fair (48.2%), and as the same as others of the same age (50.7%). Older people had an average of 1.36 diseases. The most prevalent diseases found were: hypertension, diabetes mellitus, and rheumatoid arthritis or osteoporosis. The most common illnesses found were: pain, weakness/fatigue and vertigo/syncope. The top five geriatric problems reported were vision problems, sleep problems, memory loss, hearing problems, and urinary incontinence. Health behaviors: Most of the subjects ate three meals per day (89.6%), did not smoke (88.6%), did not drink (81.1%), and did exercise more than three times per week (64.2%). Physical function: The Barthel ADL Index (BAI) showed 29.9% were dependent in ADLs. The most dependence in IADLs were: laundry, money management and telephone, respectively; 3) Mental health: 30.9% had depression and 23.5% were identified as having cognitive impairments; 4) Social health: Most of the subjects were married (70.1%), lived in a 2-room apartment (80.1%), lived with family members (34.8%), and did not participate in any social activities (76.6%). Family was the main source of social support of older people. Most of them got material and instrumental support more from sons than daughters, but got financial support more from daughters than sons. This study provides baseline information which is beneficial for planning holistic health care and community aged care to meet the demands of older persons in Nanning, Guangxi, People's Republic of China.

Keywords: Health profile, older people, community, China

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