การผลิตผลงานวิชาการที่มีคุณภาพ

ลือชัย ศรีเงินยวง
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ประกอบการบรรยายโครงการอบรมการผลิตผลงานทางวิชาการอย่างมีคุณภาพ คณะศิลปศาสตร์ มหาวิทยาลัยแม่โจ้ 20 พฤษภาคม 2568

วัตถุดิบ

ผลงาน

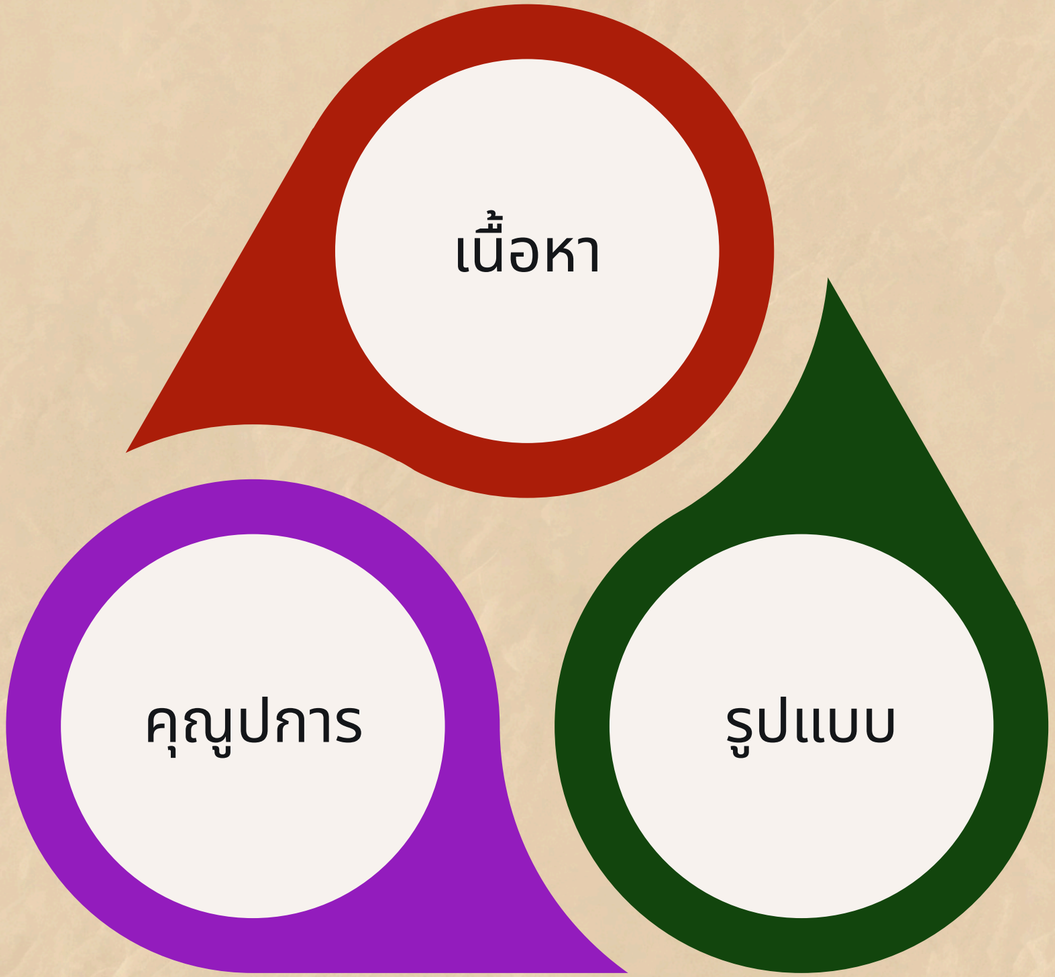
วิจัย

การสอน

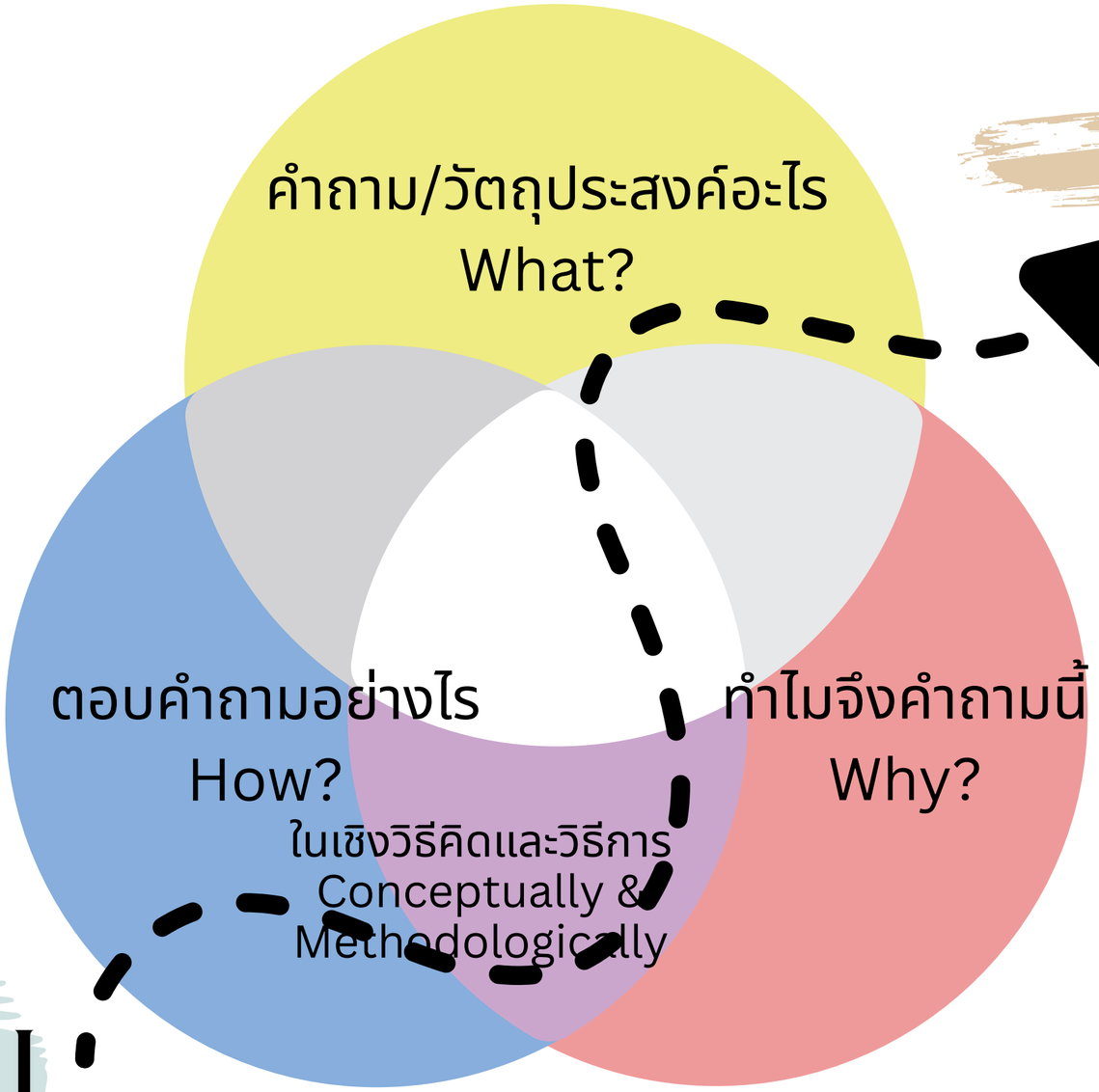
บริการวิชาการและอื่นๆ

รายงาน
ตำรา/เอกสารวิชาการ
บทความ

ผลงานวิชาการคุณภาพคือ อย่างไร?



REPORT



PROPOSAL

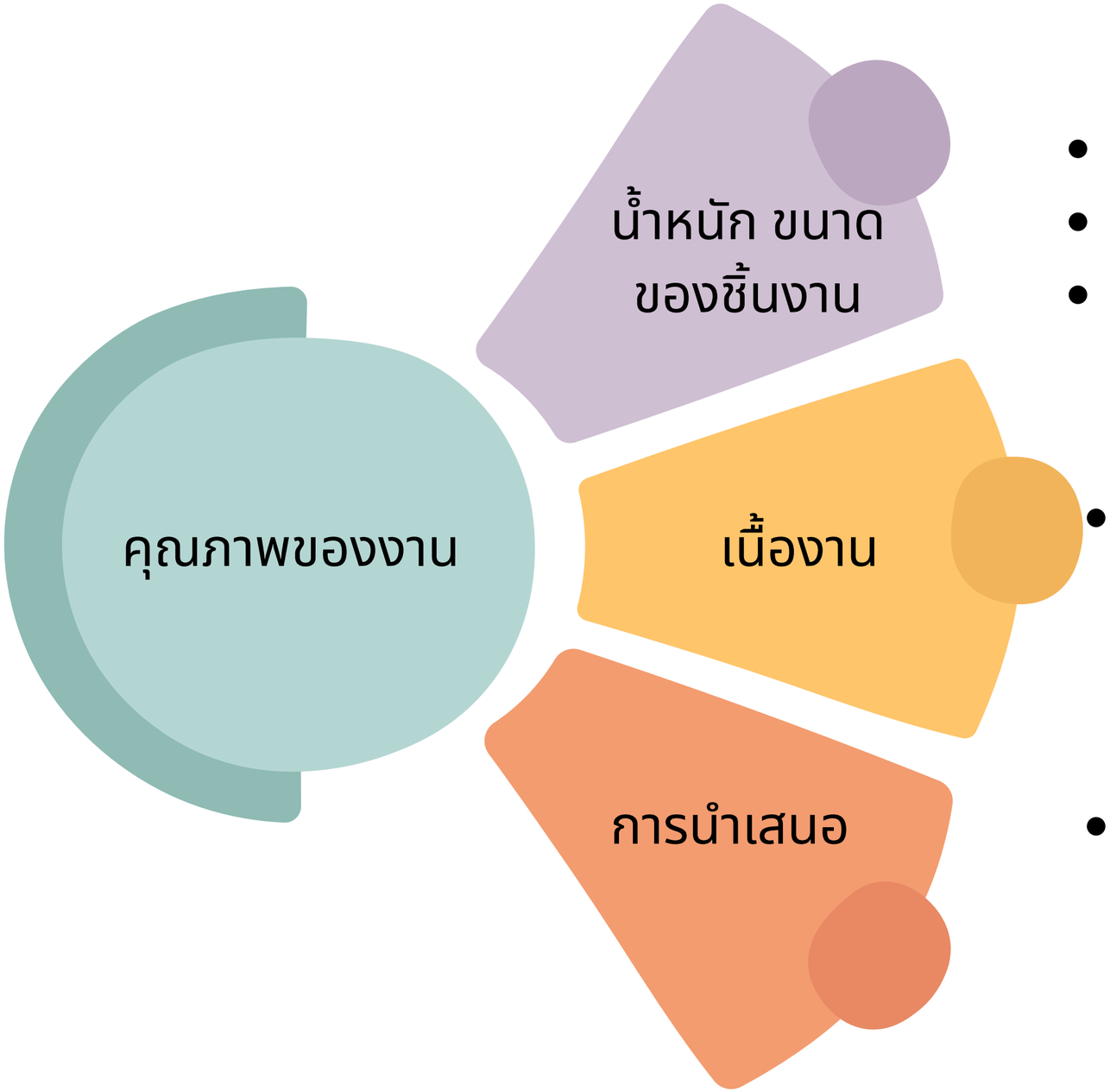
วัตถุดิบ (วิกฤติ/ปัญหา) ในสังคมมีมากมาย แต่หาโจทย์ไม่ได้ ทำให้การวิจัยห่างไกลจากชีวิตผู้คนและสังคม (และแหล่งทุน)

โจทย์เล็กและธรรมดาเกินไป
(ทำเพียงเพื่อให้มีผลงาน/ มักน้อย ทำเล็กๆ คนเดียว/ เป็นทีมแต่เพียงชื่อ งานธรรมดาเกินไป ที่ทำหรือไม่ทำก็ไม่มีผลต่อการพัฒนาวิชาการ/องค์ความรู้ หรือ นโยบาย ฯลฯ)

ตรรกะและระดับการคิดวิเคราะห์ต่ำกว่ามาตรฐาน
(ทำตามๆกัน ติดรูปแบบ ติดคำภีร์/ตำรา จำนนต่อวิชาการฝรั่ง)

“มักน้อยสันโดษ” แบบผิดทาง
(ติดใน Comfort Zone กลัวการออกไปสนามใหญ่
แหล่งทุน เวทีวิชาการระดับชาติ/นานาชาติ ความร่วมมือข้ามสาขา/สถาบันฯ)
ความเชี่ยวชาญเฉพาะกลายเป็นกับดัก)

หลงติดในกับดักฐานคิด
“วิจัยเพื่อไต่เต้า” (ขอให้มีชิ้นงาน)
“วิจัยเพื่อการค้า” (รับจ้าง ซื้อ Authorship)



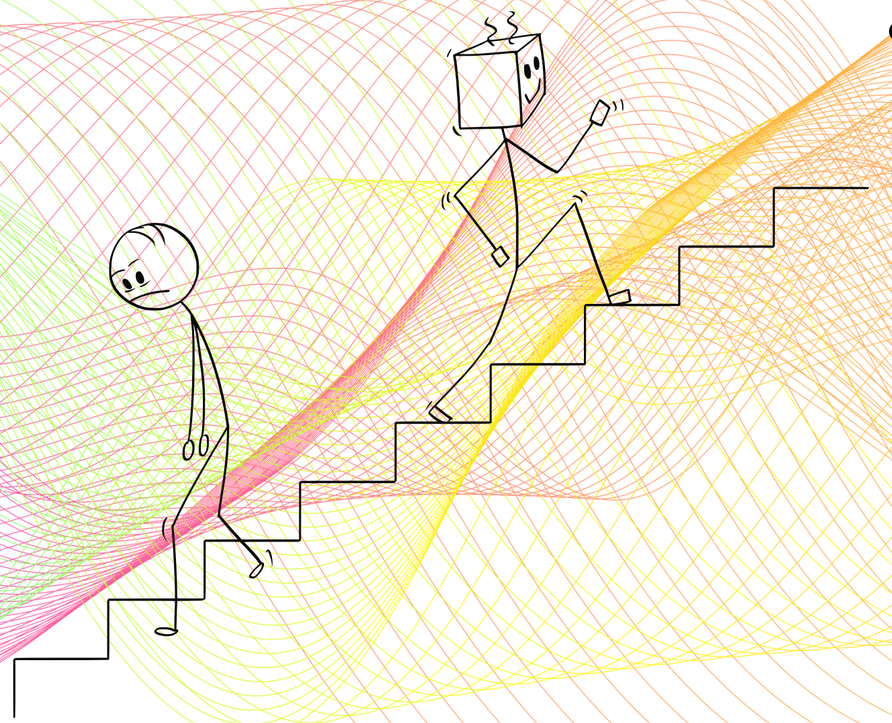
- ท้องถิ่น สู่ ภูมิภาค และ สากล
- กรณีศึกษา สู่ การเปรียบเทียบกรณีศึกษา
- เชิงประจักษ์/วิจัยสนาม (Empirical) กับการยกระดับสู่ทฤษฎี (Theoretical)

- ความประณีตตั้งแต่การตั้งคำถามวิจัย การออกแบบ/เก็บข้อมูล ตรรกะในการวิเคราะห์ ตีความและนำเสนอ

- ประเด็นลึกซึ้ง คม ชัดเจน ภาษาประณีต ชี้มุมมอง/ประเด็นที่ผู้อ่านมองไม่เห็น ได้ฉุกคิด

โอกาส

- Ranking / ตัวชี้วัดของทุกสถาบันการศึกษา
- แหล่งทุนไม่ใช่ปัญหา
- ระบบสนับสนุน (เงินสนับสนุนการจัดทำต้นฉบับ ค่าตีพิมพ์ รางวัลผลงานวิชาการ)



ผลกระทบ/ผลเสีย

- เน้นที่รางวัล ตอบเกณฑ์ประเมิน แต่คุณภาพต่ำลง ละเลยการสอนและสังคม
- ผู้ได้ประโยชน์คือ คนแปล/edit ภาษา ธุรกิจวารสาร สถาบันต้องจ่ายรางวัล/ค่าผลงานเพิ่มขึ้น)
- ธุรกิจการตีพิมพ์ วารสาร และบทความ ที่มีผลถึงค่าใช้จ่าย
- สังคมไม่ได้ประโยชน์

บริบทการทำงานวิชาการปัจจุบัน

เทคนิค ทำอย่างไรให้ได้ตีพิมพ์

- คุณภาพงานคือหัวใจ
- จริยธรรมการวิจัย
  - IRB รัดกุม ชัดเจน มีหลักฐาน ทำจริง
  - COA/ Tools- IG/ Consent Form/ transcripts ต้องพร้อม
- Authorships
  - Contribution จริง
  - ความร่วมมือ (สหสาขา) (Inter-collabs/ world class schorlars)
- Methodology and analysis
  - บรรยายสิ่งที่ทำจริง
- ความสอดคล้องกับลักษณะวารสาร
  - เนื้อหา ความยาว
  - สไตล์การรีวิวของ reviewer
  - ภาษา (ด้านมานุษยวิทยา ต้องการความช่วยเหลือจากเจ้าของภาษา)

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journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Microbes and marginalisation: 'Facing' antimicrobial resistance in bedridden patients in a peri-urban area of Thailand

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Contents lists available at ScienceDirect

One Health

journal homepage: www.elsevier.com/locate/onehlt

One Health drivers of antibacterial resistance: Quantifying the relative impacts of human, animal and environmental use and transmission

Ross D. Booton [a], Aronrag Meeyai [b,c], Nour Alhusein [d], Henry Buller [e], Edward Feil [f], Helen Lambert [d], Skorn Mongkolsuk [g], Emma Pitchforth [h], Kristen K. Reyher [a], Walasinee Sakcamduang [i], Jutamaad Satayavivad [j], Andrew C. Singer [k], Luechai Sringernyuang [l], Visanu Thamlikitkul [m], Lucy Vass [a], OH-DART Study Group, Matthew B. Avison [n], Katherine M. E. Turner [a,*]

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Authors' contribution statement

Conception and design of the study: RDB, KMET. Acquisition of data: RDB, MBA, KMET. Mathematical modelling: RDB, AM, KKR, ACS, LV, MBA, KMET. Coding and simulations: RDB. Analysis and interpretation of results: RDB, AM, NA, HB, EF, HL, SM, EP, KKR, WS, JS, ACS, LS, VT, LV, OH-DART study group, MBS, KMET. Writing and drafting of the manuscript: RDB, AM, NA, HB, EF, HL, SM, EP, KKR, WS, JS, ACS, LS, VT, LV, OH-DART study group, MBS, KMET. Approval of the submitted manuscript: RDB, AM, NA, HB, EF, HL, SM, EP, KKR, WS, JS, ACS, LS, VT, LV, OH-DART study group, MBS, KMET.

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Antimicrobial Resistance

The social burden of antimicrobial resistance: what is it, how can we measure it, and why does it matter?

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Antimicrobial resistance (AMR) is a growing global health threat, which is increasingly quantified in terms of its human health and economic burden. In this article, we highlight that for policy and planning purposes the social burden of AMR is as important to attend to as health and economic burdens, requiring systematic consideration and measurement of multiple dimensions. We provide a conceptual and empirical overview of four dimensions of the social burden of AMR: the distribution of AMR among and between populations; the lived experiences of AMR by patients and carers; how and by whom AMR interventions are shouldered; and how AMR can change society. We illustrate these dimensions through five case studies drawn from research projects in the UK, East Africa, Thailand and Brazil. Drawing on these insights, we discuss challenges and opportunities for documentation and measurement of AMR's social burden going forward. Taking this seriously aligns with the consensus observation that to address AMR requires moving away from pathogen-based and siloed disciplinary perspectives and means embracing different forms of data and evidence from around the world. We propose an interdisciplinary engagement across researchers, policy makers and community stakeholders to arrive at agreed principles and metrics for future monitoring of the social burden. We need to tackle invisibility through lack of data by considering the social burden in design of AMR surveillance and research, includes mainstreaming social science

with serious intent the impactful artistic and journalistic approaches to communicate about AMR (e.g. Figure 2) to diverse audiences. This raises a third challenge, to work together across disciplines to embrace skillsets not just as translational but as foundational to our understanding—not just communication—of the AMR problem. Such approaches have the potential to bring

Ethical approval

The five case studies in this article draw on already published research, which have their own ethical clearances. Case study 2: Ethical approval was obtained from Mahidol University, Thailand (Ref. 159.1807) and the London School of Hygiene and Tropical Medicine Ethics Committee (Ref. 15481). Case study 3: ethics approval for the study was obtained

from the School of Biomedical Sciences Research and Ethics Committee, Makerere University College of Health of Sciences (SBSREC REF no.562), the Uganda National Council for Science and Technology (SS 4679) and the London School of Hygiene and Tropical Medicine Ethics Committee (LSHTM Ethics Ref: 15244). Case study 4: This study was approved by the Ethics Review Committee of the School of Nursing at the University of São Paulo and the National Commission on Ethics in Research (CONEP) in Brazil, under number 42442921.7.0000.5392. Case study 5: The study received ethical approval from the University of St Andrews, UK (number MD14548, 10/09/19); National Institute for Medical Research, Tanzania (number 2831, updated 26/07/19); CUHAS/BMC Research Ethics and Review Committee (number CREC/266/2018, updated on 02/2019); Mbeya Medical Research and Ethics Committee (number SZEC-2439/R.A/V.1/303030); Kilimanjaro Christian Medical College, Tanzania (number 2293, updated 14/08/19); Uganda National Council for Science and Technology (number HS2406, 18/06/18); Makerere University, Uganda (number 514, 25/04/18); and Kenya Medical Research Institute (04/06/19, Scientific and Ethics Review Committee (SERU) number KEMRI/SERU/CMR/P00112/3865V.1.2).

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Routledge
Taylor & Francis Group

The unseen use of antimicrobials: Drivers of human antibiotic use in a community in Thailand and implications for surveillance

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ABSTRACT

We investigated sociocultural and economic drivers of human antimicrobial use (AMU) in Thailand through ethnographic research, interviews, focus groups and a cross-sectional survey. This community-based study generated findings clustered around three key themes: treatment-seeking practices, medicine use, and interpretation of biomedical constructs. Participants sought care from public health facilities for chronic conditions, but medicines from the private sector were considered more powerful and were preferred for acute complaints. Many antibiotics were unrecognised as such by consumers

ARTICLE HISTORY
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KEYWORDS
Antimicrobial use; Antimicrobial consumption; Thailand; Antimicrobial resistance; AMR national action plan; Antibiotic use

Interviews and focus groups

Participants, recruitment and sampling

Data collection took place between June 2020 and December 2021. Initially researchers contacted local village health volunteers (Kauffman & Myers, 1997) and explained the study. Contact with households was then made by the village health volunteers who purposively selected households based on health status (including households known to have had contact with healthcare services due to ongoing health problems), geographical area (representation from both rural and semi-urban areas) and socio-economic diversity (variety of occupations and economic positions). Households who were happy to participate were introduced to the researchers. In total, 40 households were recruited in which three social science researchers (KW, KP, NC) conducted participant observation and completed interviews with family members. Participant observation took place during repeated field visits to each household by three researchers that included participating in and recording (through note-taking and photographs) various household activities including domestic tasks, food cultivation in home gardens, and livelihood generation, as well as household use of medicines, characteristics of the surrounding environment and proximity to health care facilities. Interviewees were in effect self-selected from among family members according to availability, but efforts were made to ensure a representative spread of occupations and household types across the overall sample. Other adult family members contributed to interviews if they were present. Only adults participated in the study, but some informants spoke of their experiences handling younger household members' illnesses during interviews. The total number of household members was 216, among whom 60 (28%) were elders (60 years old and over), 114 (53%) were adults (19–59 years old) and 42 (19%) were 18 years old or younger. Households' sizes ranged between 2 to 13 members with an average of 5 members. Occupation varied but were mostly related to traditional agriculture, factory manufacturing or food industry. Households' demographics can be viewed in (Supplementary data: Table 1). Additionally, two focus groups were conducted by (LS, VM, KW, KP). Focus group participants were recruited from two geographical areas (rural vs semi-urban) and included a combination of village health volunteers and lay people. The participants' age ranged between 30 and 60 years and occupations included government employment, running private businesses or farming (Supplementary data: Table 2: Focus groups' demographics).


Q
A


THANK YOU