CHAPTER II

LITERATURE REVIEW

2.1 Definition of term "elderly"

Most developed countries have accepted the chronological age of 65 as the definition of elderly or old person. However, the situation is different from the developing countries because it is many times associated with the age at which one begins to receive pension benefit. At present, there is not United Nations standard numerical criterion, but the UN agreed that the age of elderly population is 60 and over (WHO, 2006).

In 2002, WHO also defined that the people who are sixty or older than sixty years old are older adults or older population. However, the definition of old age is varied over time, depending on culture and situation. For example, in USA the age of sixty-five or over is old, whereas two hundred year ago, the age of fifty might have been considered to be old. Americans believe that old age begins at sixty three for men, and sixty two for women. Younger people usually think the old age begins when the individual stops working or stops contributing to society, or when the family is raised for women. But the older respondents are more likely to respond that the old age depends on attitudes, good health, or activity level (Chasteen, 2000). The age at which one is consider old may depend on its definition. A child may

consider someone over twenty be old, a teenager may think forty be old and the sixty years old people may consider seventy as elderly people. In essence, old is generally the though of age beyond one's own. Most elders do not consider themselves old until they become sick or dependent upon others (Ferrini & Ferrini, 2000). In addition, the study by Orimo et al. (2006) revealed that many Japanese believed that the elderly person should be characterized by losing of functional independence or defined as a person who is over 70 or 75 years old.

However, in some developing countries, especially in Africa, elderly person should be either 50 or 55 years of age, depending on definition, region and country. Somehow it is quite difficult to define the elderly age since African people do not have official records of their actual dates of birth (WHO, 2006).

In Thailand, Thai government enacted National Elderly Plan II which was defined elderly population as 60 and over, and achieve the pension's scheme (MOPH, 2001b).

In global aspect, there is not any accepted definition, in many instances the age at which a person became eligible for statutory and occupational retirement pensions has become the default definitions in each country. Therefore, the ages of 60 and 65 years are often used.

2.1.1 Classification of the elderly person

There are several ways to classify people by age. The reasons should be:

(1) to predict significant attribute of specific to individuals,

(2) to select a specific target for social action or policy,

(3) to define a subject study.

Selecting age categories, it needs to be considered the underlying purpose and selected the definition accordingly. Age of people can be classified by using criteria as follows;

(1) Life stage

Aging is a life long process that punctuated by period of changes (Moritz & Stein, 1999). It's continuous process that begins at maturity and continues until death (Ferrini & Ferrini, 2000). People can be categorized as being in roughly comparable stage of life, such as adolescence, young adulthood, middle age and later maturity. Using life stage to determine old age, is difficult to pinpoint exactly when one stage begins and another ends.

(2) Functional age

The functional age defined as the physiological capacity of the body changes. It is useful for the policy programs and services, to increase common services to the target specific groups of people in need of certain kind of assistance (Morkan & Kunkel, 2001). For instance, the people who have physical limitations that need assistance from another person, the measures of functional need are Activities of Daily Living (ADLs), a generic term for several scales that measure an individual's ability to accomplish, without assistance, routine personal care activities such as bathing, eating, dressing and getting in and out of bed (Morkan & Kunkel, 2001).

(3) Chronological age

Morkan & Kunkel (2001) stated that using chronological age is a simply ways to classify work's life stage. As mentioned earlier, in the United State of America, age of sixty-five is defined as the beginning of the older age because it is

the age of the full retirement benefits from social security. Researchers often use age of sixty-five as a cut off point of old age, many businesses use this age to define "senior citizen discounts" and even older themselves look as thus age as the beginning of their later year (Ferrini & Ferrini, 2000).

Some gerontologists make distinction between the young-old (sixty-five to seventy four) and the old-old (seventy five and above) because there are significant differences between these two groups. Generally the young-old is more vigorous, has higher income and is more likely to be married and has fewer health problems than the old-old. But this distinction is not absolute.

Using chronological age to determine old age is limited in obvious ways;

(1) there is no abrupt change occurs on the eve of one's sixty fifth birthdays that automatically transforms a person from middle age to elderly age

(2) There are profound differences among individuals at the same age that make generalizations problematic. Some elders have extremely good health, while some in middle age exhibit disabilities and illness.

However, chronological age of sixty and over is often used as criteria to determine the old age according to the Thai National Elderly Plan II 2002-2021, the age of full retirement benefits from social security of Thailand, and UN's definition (WHO, 2006) as mentioned earlier.

2.2 Social Support Definitions

Social support has been defined and measured in numerous ways;

Cohen et al. (2000) stated that social support is often used in a broad sense, referring to any process which social relations might promote health and well being and the social resources that persons perceive to be available or are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relation.

Cobb (1979) defined social support as the perceived belonging to a social network of communication and mutual obligation.

Caplan (1974) defined social support as attachment, which promote mastery, offer guidance and practice identify-validating feedback about behavior.

House (1981) identified four independent types of social supportive behaviors ;

1) Emotional support involves the provision of empathy, love, trust and carries,
2) Instrument support involves the provision of tangible aid and services that directly assist a person in need,
3) Information support is the provision of advice, suggestions and information that a person can use to address problems, and
4) Appraisal support is the provision of information that is for self-evaluation purpose that is constructive feedback, affirmation and social comparison.

Barrera & Ainley (1983) identified six function attributed to social support;

1) Directive guidance such as providing information, instruction and advice,

2) Intimate interaction such as expressing, intimacy, esteem, physical affirmation and trust,
3) Positive social interaction such as discussing interest, involving in recreational activities, joking,
4) Material aid such as loaning money,
5) Behavior assistance such as sharing of task, and
6) Feed back.

Tolsdolf (1976) conceived social support as the product of all social bonds providing an individual with;

1) goods and services such as financial aid or help with housework,
2) information and guidance such as suggestion about where and how to consult about health
3) psychosocial backing such as encouragement, emotional comfort and intimacy.

In conclusion, social support definitions begin with social relationship or social interaction between giver and receiver and also divided into two categories;

(1) functional definitions or objective definitions which indicate what people has actually received or reported to be received,
(2) perception definitions or subjective definitions which are capturing an individual's belief of the available support.

Faber & Wasserman (2002) revealed that subjective assessments of social support are more persistently and more powerfully, related to health and well being, than objective measures. For instance, Lyyra & Heikkinen (2006) indicated by theoretical framework that perceived social support is divided into assistance related

and non assistance related supports. This study found that the risk of death in woman in the lowest tertile of non assistance related to support was almost 2.5 times higher than that of in women in the highest tertile. The risk remained strong even when the indicators of baseline socio-demographic, psychological and physiological health and functioning are controlled. Elkan et al. (2001) also found that home visit was associated with a significant reduction of mortality. Five studies of home visiting to frail elderly people who were at risk of adverse outcome showed a significant reduction of mortality (0.72: 0.46 to 0.91). Therefore, this study will focus on definition of perceived social support among elderly people which refers to the elders' perception of availability of support from others in times of need, i.e., the extent to which the elder's believes he/she can find the kind of support he/she wants.

2.3 A Concept Model Link Social Support to Health

This study is applied the concept model of how social network impact to health which is divided into two ways (Berkman et al. 2000).

(1) upstream level which describes social network as a larger social and culture context that affect to the condition of social network structures. In this upstream, the macro social forces related to the political economy can be integrated to the social network as mediating structures between the largest and smallest scale of social forms. Labors markets, economics pressures and organizational relations influence the structure of the network.

(2) downstream level which influences network structure and function on social and interpersonal behavior. Berkman et al. (2000) also indicated that the

networks operate at the behavioral level through four primary pathways; 1) provision of support, 2) social influence, 3) social engagement or social integration, and 4) access to resources and material goods.

Those kinds of interpersonal interaction influence even more proximate pathways to health status including (1) direct physiological stress response, (2) psychological states and traits including self-esteem, self efficacy and security, (3) health damaging behaviors such as tobacco consumption or high risk sexual activity, health promoting behavior such as appropriate health service utilization, medical adherence, and exercise, and finally to (4) exposure to infectious diseases agents such as HIV, other sexually transmitted diseases or tuberculosis.

Detail as shown in figure 3 follow;

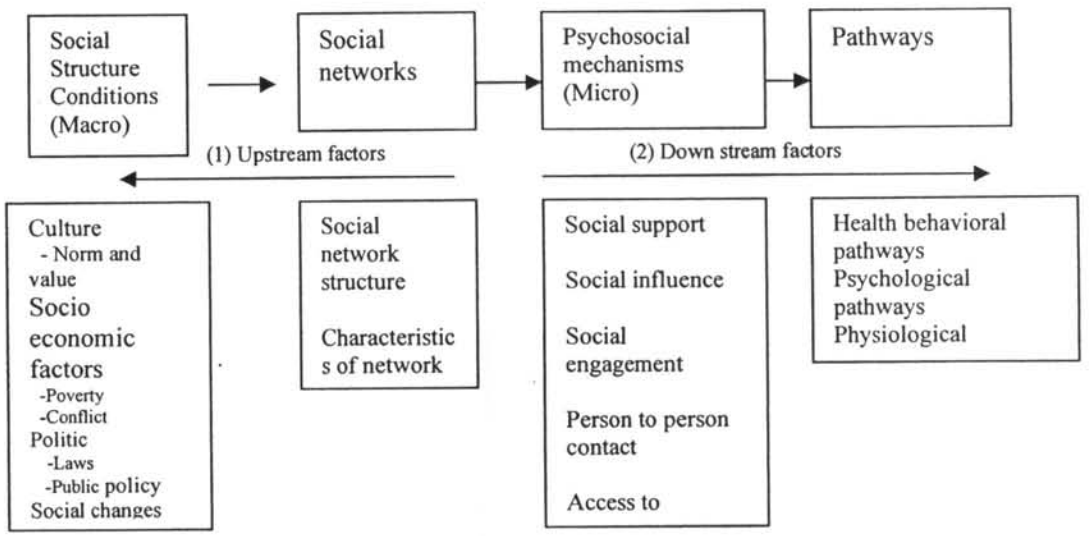


Figure 3: A Concept Model of How Social Network Impact Health

Source: Berkman, L.F., Glass, T., Brissette, I., & Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. **Social Science & Medicine.** 51(6), 843-857.

Berkman et al. (2000) model illustrated the whole picture of social network system influence on health which social support is the one factor involved. However, there are two related models explaining how social support influence on health: Stress Buffering Model, and Main Effect Model.

2.3.1 Stress Buffering Model

This model proposes that support is related to well-being only for persons under stress. Cohen et al. (2000) described the roles of social support by determining individual response to potential stressful events. Support presumably operated by preventing responses to stressful events is inimical to health.

Support may play a role in several different points in the causal linking stressors to illness. Firstly, the belief that others will provide necessary resources may redefine the potential for harm posed by a situation and bolster one's perceived ability to cope with imposed demand, thereby preventing a particular situation from being appraised as highly stressful (Thoits, 1985). Secondly, support beliefs may reduce or eliminate the effective reaction to stressful event, dampen physiologic response to the event, or prevent or alter maladaptive behavior responses. The availability of persons to talk about problems has also been found to reduce the intrusive thoughts that act maintain chronic maladaptive response stressful events (Lepore at el., 1996).

The actual receipt of support could play a role here. Support may alleviate the impact of stress appraisal by providing a solution to the problem, by reducing the perceived importance of the problem, or by providing a distraction from the problem. It might also tranquilize the neuroendocrine system so that people are less reactive to perceived stress or facilitate healthful behaviors such as exercise,

personal hygiene, proper nutrition and rest (Cohen et al., 2000). Pathway through which social support influence response to stressful life events is illustrated in figure 4 below

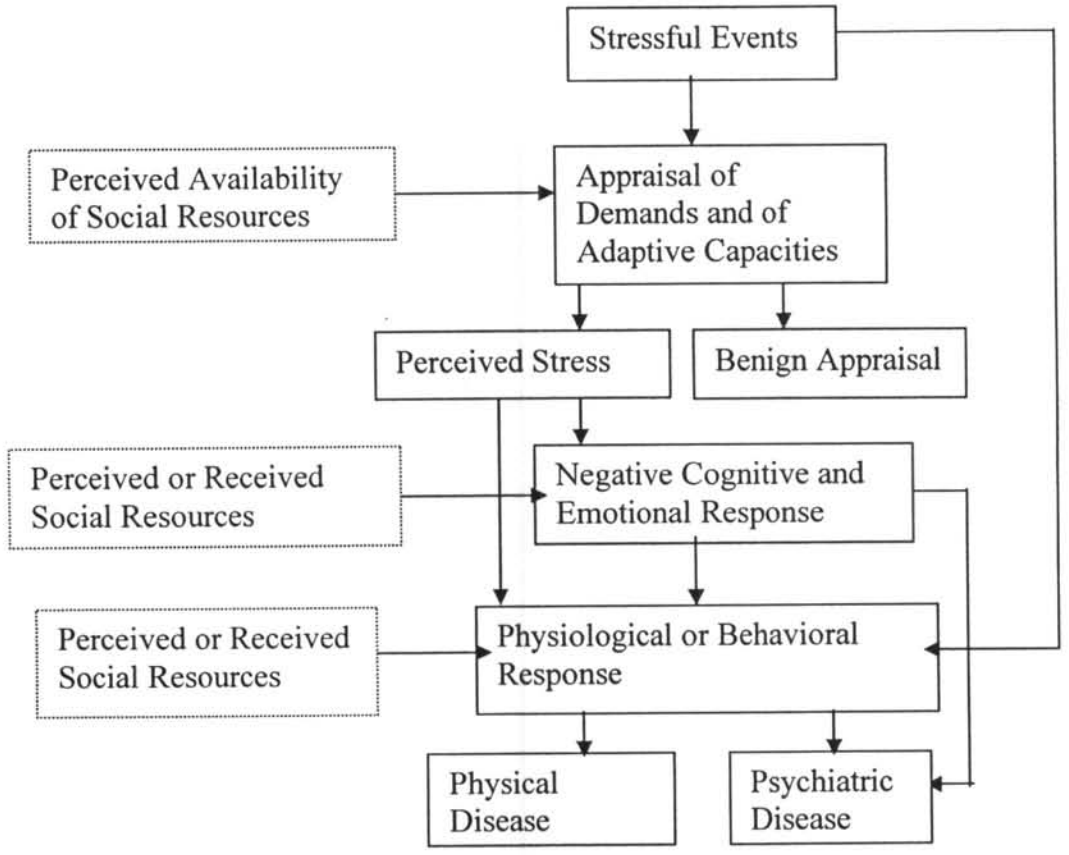


Figure 4: Pathways through which Social Support Influences Responses to Stressful Life Events

Sources: Cohen, S., Underwood, L., & Gottlieb, B. (Eds.). (2000). **Social support measurement and interventions: a guide for health and social scientists.** New York : Oxford University Press., pp.13

2.3.2 Main Effect Model

Cohen et al. (2000) described the mechanism through which social relationships can have main effect on psychological and physical health. Those who

participate in a social network are subject to social controls and peer pressures that influence normative health behaviors. For example, their networks might influence whether they exercise, eat low fat diets, or smoke. Integration in social network is also presumed to provide a source of generalized positive affect; sense of predictability and stability, purpose of belonging and security, and recognition of self worth because of demonstrated ability to meet normative role expectations (Cohen & Wills, 1985). These positive psychological states are presumed to be beneficial because they reduce psychological despair (Thoits, 1985), results in greater motivation to care for oneself, or results in suppressed neuro-endocrine response and enhances immune function (Uchino et al., 1996).

Moreover, Cohen et al. (2000) indicated that having a wide range of network ties also provides multiple sources of information and thereby increases the probability of having access to an appropriate information source. Information could influence health relevant behaviors or help one to avoid or minimize stressful or other high-risk situation. For example, network members could provide information regarding access to medical services or regarding the benefits of behaviors that positively influence health and well being. A network may operate to prevent disease by providing tangible and economic services that results health and better health care for network members. For example, network could provide food, clothing and housing to prevent disease and limit exposure to risk factors. Network also provides information health care that prevents minor illness from developing into more serious diseases.

Cohen et al. (2000) postulated that isolation is a possible cause of disease rather than social integration protecting or enhancing health. Cohen et al. (2000) assumed that isolation increases negative affect and a sense of alienation and decreases feeling of control and self esteem. Alternatively, one can merely view isolation as a stressor. In any case, these negative psychological states could induce increase on neuroendocrine response, suppress immune function, and interfere with performance of health behavior. Detail is shown in figure 5 as follow: Pathways through which social relationship can have direct (main) effect on psychological and physical health shown as figure 5 below;

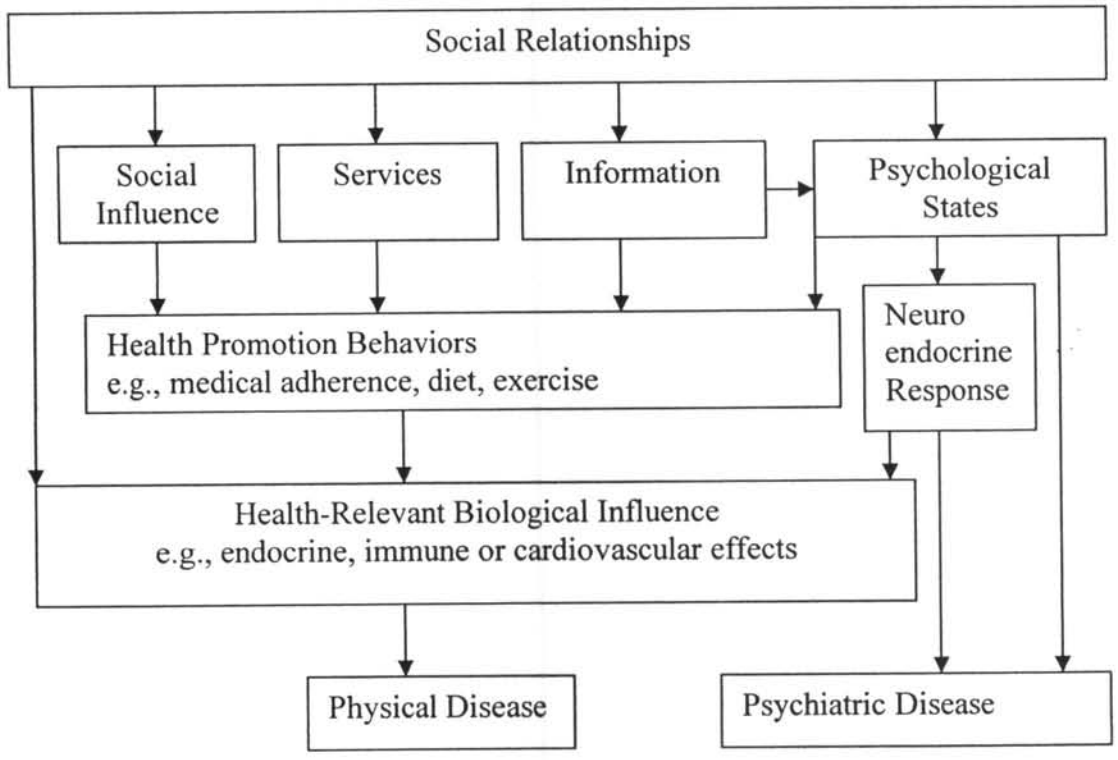


Figure 5: Pathways through which Social Relationship can have direct (main) Effects on Psychological and Physical Health

Sources: Cohen, S., Underwood, L., & Gottlieb, B. (Eds.). (2000). **Social support measurement and interventions: A guide for health and social scientists.** New York : Oxford University Press., pp 12.

2.4 Factors Related Social Support

Following concept model of Berkman et al. (2000) indicated factors related to social network condition are social structure (culture, socioeconomic structure, politics, and social change), social network characteristic, and psychosocial mechanism (social influence, social engagement and person to person contact). Moreover, a study among the Taiwanese by Cornman et al. (2001) revealed social support determinants among the elderly people are (1) socio demographic factors, (2) social network factors, (3) social integration factors and (4) personal health characteristics factors. Those mentioned factors were related when social structure is controlled (macro or upstream level).

Under the Thai condition of culture, socioeconomic structure, politics, and society, this study focus on four aspects of factors related social support, which are (1) socio demographic factors, (2) social network factors, (3)social integration factors and (4) personal health characteristics factors.

2.4.1 Socio Demographic Factors

(1) Gender

Gender related to perceived social support is inconsistent. Von Dras et al. (2000) hypothesized and found that women have greater perceived social support than men. Antonucci (1985) speculated that women may have a higher sense of available support because they are generally embedded in more varied social networks than men who tend to rely primary on wives or partners for support. She also noted that women tend to be both kin keepers and keepers of family obligations. This more central role that women play in the family may make social support more

available to them. Others studies, however, found women are less satisfied with social support (Vaux, 1985). Moreover, Okamoto & Tanaka (2004) found that emotional support was related to self rate in health of men only, but not women, after controlling chronic illness, somatic symptoms, depression, loneliness, age and living arrangement.

Vaux (1985) attributed some of this variation in gender differences in social support perceptions to difference in methods, particularly in relation to the samples and measures used. Also Liang et al. (1992) indicated that gender influence interposal exchange directly and indirectly which affect to perceived social support.

(2) Age

Social support in older aged tends to decrease with advancing age (Due et al., 1999). In a large sample of a longitudinal study (N=2,011), Due et al. (1999) divided random samples into different age groups and found that advancing age was negatively associated with social network and instrument support. The pattern of social contacts among the 25 years old and among the 70 years old were different. The 25 years old tended to have contact with friends, while the 70 years old had more contact with children, friends and people they knew from formal associations. In addition, Tagaya et al. (2000) stated that social support and social network tended to decrease with age. Moreover, the relationship between social support and age in each gender, and the decline in social support with age was observed only for men: about 30% of women of all age groups responded that every kind of social support was available to them.

Similar to a longitudinal study, McCamish-Svensson et al. (1999) found that the number of friends of people in a single cohort of 80 years olds decreased significantly when the subjects were well integrated with family and friends. The number of people who reported no close friends at all approximately doubles between the ages of 80 and 83. These findings showed that advancing age may be associated with fewer social networks, which in turn, results in less social support (Malathum, 2001).

(3) Education

The elderly people who are higher educated are more perceived social support. Cornman et al. (2001) found that Taiwanese elders hold positive perceptions about availability of social support, and these perceptions are fairly stable over the 10 year period under review. Elderly people have a secondary school education, are more likely than respective counter parts to have consistency positive perception about the availability of social support Liang et al. (1992) also found education influence interposal exchange directly and indirectly which affect to perceived social support.

(4) Income

Financial support in old age tends to be decreased in advancing age. Von Dras & Siegler (1997) hypothesized that individuals of higher socio-economic status (measured by education, income and employment status) would report greater perceived social support.

2.4.2 Social Network

Social network is defined as the web of social relationships that surround an individual and characteristics of those ties (Berkman et al., 2000). Social networks are linkages between people that may or may not interpersonal relation. Social networks play an essential role in people's health and well being in later life (Seeman & Berkman, 1988 ; Turner & Marino, 1994). It has been found, for instance, that being able to maintain close contact with kin or close friend is conductive to life satisfaction of older persons (Silverman et al., 2000), and that happiness among older age group is positively related to available support from close social partner (Baldassare et al., 1984). It could be that personal social network can provide social companionship, instrument aid as well as emotional comfort to the elderly people, helping to release pressure, to reduce depressive feelings and to buffer the ill effects of stressful life events on health (Silverman et al., 2000). Supportive relationships within social network are hence essential for enhancing life quality and ensuring happiness in later life.

2.4.2.1 Social Network Structure

Berkman et al. (2000) described social network characteristics which includes 4 characteristics as follows:

(a) Range or size which refers to number of network member,

(b) Density refers to which the members are connected to each other,

(c) Boundedness refers to the degree to which they are defined in the basis of traditional group structures such as kin, work, and neighborhood,

(d) Homogeneity refers to the extent to which individuals are similar to each other in a network.

In addition, Berkman et al. (2000) described the characteristics of individual social network structure tie include:

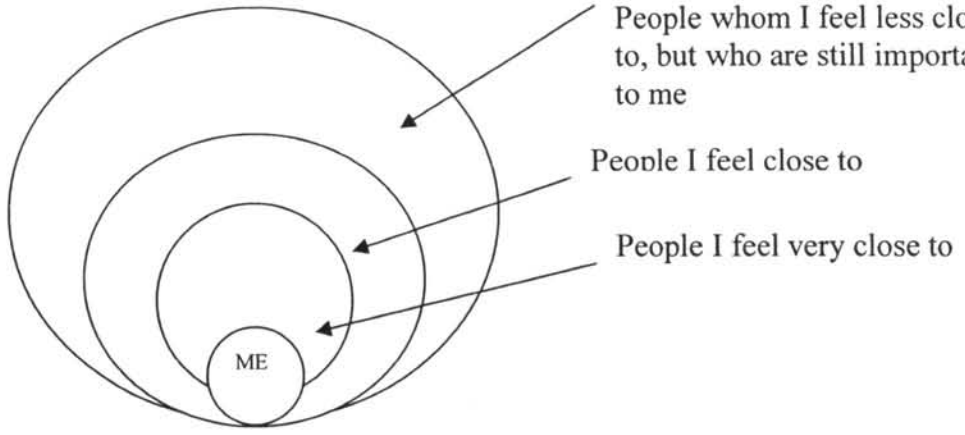
(a) Frequency of contact (number of face to face contacts, or contact by phone or mail),

(b) Multiplicity (the number of types of transactions or support flowing through a set of ties),

(c) Duration (the length of time an individual knows another), and

(d) Reciprocity (the extent to which exchange or transactions are even or reciprocal).

Moreover, psychologists are interested not only in whom older adults include in their networks, but also in how close they feel to these individuals. The social convoy model is used for closeness of network members, which reflects the notion that the network comprises people who are close to and trust each other, through part or all of life (Morkan & Kunkel, 2001). The convoy model is illustrated in Figure 6.



People who are not close = supporters not placed in the circle diagram

Figure 6: Social Network Measurements with the Convoy Circle Diagram

Source: Morkan, L.A. & Kunkel, S.R. (2001). **Aging: the social context**. (2nd Ed.). Thousand Oaks, CA : Pine Forge Press.

In this model, the innermost circle represents the person or persons deemed so important that you could not imagine life without them. The middle circle includes other close network members who are important to you. The outer circle is for others who are less close but still important in your network. Together they provide an estimate of the number of ties in your network as well as their relative closeness.

When the number of important network members for younger is compared to that of older adults, most researches indicated that older adults reported overall fewer important others than younger adults do (Morkan & Kunkel, 2001). A recent review of the literature on social relations in late life summarized the findings on the size of individual social networks. This study indicated that older adults generally report a total of 5 to 15 important persons, whereas younger adults generally report between 15 and 35. This comparison is particular striking in that the

high end of the range of older adults is equal to the low end for younger adults (Morkan & Kunkel, 2001).

Research on social networks of adults further suggests that their networks show a high concentration of very important others. Antonucci & Akiyama (1987) examined social network characteristics and psychological closeness in a national sample of adults aged 50 and older. For those older adults, the average size of the network was 8.9, consisting of 3.5 very close members. A high proportion of social contacts reported to be important actors across all age groups consist of family ties and most of the individuals deemed very close are family members.

2.4.2.2 The elderly social network

In Thailand, the social convoy model had been explored by Yodpech et al. (1997) which revealed the innermost of support are family, friend and community respectively. Thus, this study emphasizes on the function of those networks related to perceived social support, which are family, friend, neighborhood and community, community staff.

(1) Family

Family means a group of individuals (two or more) and the pattern of membership between them. Patterson (1999) described the function of the family as reproduction, care and nurturance of children, socialization, meeting economic needs, intergenerational and kinship, regulation of sexual behavior and social placement.

Family has a major impact on the formation of lifestyles in older age. It is the most significant support group in times of crisis regardless of

access to public social programs. The family can be the source of great joy and satisfaction (such as wedding, births, anniversaries, holidays and cerebration) but can be filled with sorrow and disappointment in the down times (such as funerals, accidents, illness, and economic hardship, etc). If the family is stable and serves the social support function, older member are likely to receive support throughout their live. (Lassey & Lassey, 2001) However, not only happiness happens in the family, but also negative emotions. Some families do not provide supportive environment and may not fulfill the needs of members when they are in crisis. Conflict between adult children and their older parents usually involves one or both issues;

1) Disagreement over perceived more favorable treatment of other family members

2) Different point of views about life style choice and preferred habits

A parent may be critical of the choices an adult makes and vice versa. However, even when conflicts arise the relationship usually persists and solidarity of the family continues .When the family fails to fulfill the proper role, there is often a problem in older individuals who have poor relationship skills and who lack the ability to form and sustain other intimate relationships. Fortunately, a high proportion without good family situation learn to develop other positive friendships and may still achieve a strong self confidence and optimal older age (Lassey & Lassey 2001).

The family social support functions

In times of crisis or disability, older adults receive both emotional and instrumental assistance from kin. Turning to close others for this support can be thought of as a means of compensating for functional losses. Older adults who lack supportive ties on whom they can rely for assistance are at greatest risk of institutionalization when they can no longer care for themselves. It is estimated that 80 percent of informal care for frail and disable elders is provided by kin acting as family caregivers (Dwyer, 1995).

The family provides a wide array of assistance to kin with health limitations, most of it routine aid in tasks of everyday living that may be so normalized as not to be thought of as assistance by family members (Chappell, 1990). Although sometimes limited in their health care skills, there are pressures toward placing more responsibility for sophisticated procedure in the hands of relatives to minimize health care costs in insurance and medicine (Glazer, 1993).

The elderly who care? : Family Caregivers

Morkan & Kunkel (2001) described family caregivers as family members who undertaking responsibilities for the elders care. In addition, the person most responsible for the care of an impaired person is the primary caregiver while the other network members are referred to as secondary caregivers.

The provision of care to older adults has been shown to follow a hierarchical pattern (Cantor, 1983). Caregivers are selected from available kin (Allen et al., 1999). Causes of male partners are generally older, more wives than husbands face the duties of care giving (Chappell, 1990). If a spouse is unavailable or

unable to provide the needed assistance, they turn to next adult children. Among adult children, gender, proximity, marital status and the prior quality of the relationship can all contribute to the selection of an adult child as primary caregiver (Allen et al., 1999). Daughters are three times as likely as sons to assume the role of primary caregivers. Among the most impaired parents, the disparity between daughters and sons increases such those daughters are four times as likely to assume the primary caregiver role (Stone & Kemper, 1989).

Horowitz (1985) found notable differences in how sons and daughters performed the caregiver role. Although both groups were highly involved in providing care, they differed in the type of care they provided. Aside from the emotional support commonly provided by both sons and daughters, more of the hands-on care of transportation, household chores, meal preparation, and personal care fell to daughters. Sons involved themselves in male gender-specific tasks (financial management, dealing with bureaucracies) or gender-neutral tasks, spending less time and doing a smaller number of tasks overall than their female counterparts. Most married sons involved their spouses in the care giving, whereas fewer than half of daughters did so.

However, daughters experienced more stress in association with their care-giving duties, largely because of their greater commitment in time and task responsibility. Sons appear to be more motivated by norms of obligation and feminism, whereas daughters are more often motivated by the affection of the relationship, confirming the kin keeping role of women in the family system.

Family support and perceived social support

Several studies reveal that family is the major source of support among the elderly people. Koyano et al. (1994) indicated that family–centrality in social support system of the Japanese elders. Similar to Thailand, Yodpech et al. (1997) revealed that the family is the major support for Thai elders. Litwin & Landau (2000) found that the kin network was found to offer the greatest degree of support, and the family-intensive type. Zimmer & Kwong (2004) found having more children increases the chances of receiving support from children and decrease chance of receiving from others in Chinese elders. Liang et al. (1992) found Wuhan Chinese elders were active engaged in exchange of social support with family and kin. The elders not only receive but also provide a substantial amount of health to others. Social support for the elders in Wuhan was almost provided by members of the immediate and extended family, with their children and spouses being the primary source.

The support that the elders perceived affected to the elderly health and well being. Yoon & Kropf (2004) found that older Korean and older Korean American have support from family rather than friends. While respondents with more support from family and significant others (god, partner, and grandchild) are less likely to report depressive symptoms, but support from friend does not impact on health outcome. Chow et al. (2004) revealed that the social network intervention was increased sense of belonging, collecting power and self esteems score among the Chinese elders. Ross & Mirowsky (2002) found that having adult children and surviving parent increased the length of life one expects. Also, people expect to live

longer when they report high level of emotional support, and that association is mediated entirely by the perception that one has someone to call on when one is sick. People with information support expect to live longer than those without it, and this is especially true for persons with physical impairments. Chan & Lee (2006) found that Chinese people happiness in later life is associated with the size of network and the perceived available support from network. The people with large social network tend to be generally more satisfied with recent life.

(2) Friend

Friendships are optimal self chosen and can be easily broken if not satisfactory. Ability to select and sustain friendships outside the family is an important part of maintaining personal autonomy because friends can also provide affection, affirmation and assistance in times of needs (Lassey & Lassey, 2001). The contradiction is explained between family relationships and friends, as family relationship are obligatory while friendships are voluntary. The elders cannot terminate a stressful family relationship but they can end a friendship (Antonucci & Akiyama, 1995 ; Siebert et al., 1999).

Attributes of close friendship include a feeling of belonging, integration into a social group, intimate experiences, and reassurance of self-worth, assistance with need, open communication and information sharing. Older people achieve great satisfaction from good friendship and experience a sense of loneliness when friends are not available for regular interaction. The attachment to friends means that a move from home and neighborhood to a new location, a required move

to institutional setting away from home, or the death of a close friend can be profoundly up setting (Lassey & Lassey, 2001).

Friend support

As elders have a decrease in social role, their social network will be limited. The elders' friends tend to be long term friends and clearly prefer familiar friends to acquaintances they do not know well. The elder's friendship accepted each other as friends over quite some time, sharing historical context and exchanging positive support during their most productive years. Emotional support is important in friendships (Siebert et al., 1999), and reciprocal affective support is one of the few variables uniquely contributing to well being (Antonucci & Akiyama, 1995). Elders seek friends who can reduce the discrepancy between their perception of who they are and the negative identify meaning they might receive from family and others. Friends can offer the positive identify that support only such peers can provide, and elders are committed to the role. With friends, they can shift from a less positive identity to the reassuring identity of a friend, exchanging meaningful feedback and having their positive self perception legitimized.

Friend support is related to perceived social support. Okabayashi et al. (2004) revealed the Japanese elders who have higher instrument support, such as helping chores and higher emotional support from friends, showed higher life satisfactions. In the other hand, Fiori et al. (2006) found individuals in non-friends restricted network had significantly higher depressive symptomatology than did those in non-family restricted network.

(3) Neighborhood and community

Older individuals in a strong and well-developed neighborhood and community usually receive ongoing support from a variety of sources. Activities and services available in the community are provided meaning and stimulation to daily life while fulfilling basic personal and household needs. On the other hand, a poorly developed community can be socially frustrating, short of needed services, dangerous to health and security, and may sharply curtail freedom, autonomy and overall life quality for its older citizens (Forschner, 1992).

2.4.3 Social Integration

Social integration is extent to which an individual participate in a broad rang of social relationships (Brissette et al., 2000). Liang et al. (1992) described social integration as the connections that individual maintains with others which are often measured by enumerating the number of social relationship (e.g. marital status, employment, number of children) possessed and the amount of social contacts (e.g. visitation with children, organizational participation) made by an individual. It is assumed that support is being provided. Although measures of social integration are useful for specifying the condition under which support might be provided, there is no way to determine whether support was actually furnished.

Cohen & Will (1985) also suggested that social relationship have an impact on health through social and informational influence. Integrated individual are subject to social controls that may influence the enactment of health behaviors and prevent risky behaviors. Social network members may also act as sources of information regarding appropriate medical care. Moreover, the feedback an individual

receives from network members may influence symptom reporting compliance with medical regimens (Brissette et al., 2000). Thus, the more integration would benefit for the social support perceived. However, some study revealed that the more integration, the more social role, somehow occurs of conflict. Among the elderly people, social integration benefited to the elders in many results: increased feelings of self worth and control over one's environment which may influence health through a variety of pathways (Cohen et al., 2000).

In this chapter, this study focuses on the social environment among the elderly integrated which include family, non family, non-organization and organization participation as detail follow:

(1) Family relation

There are two components of family status, i.e. marital status and living arrangement.

Marital status: Marriage is generally very beneficial for both partners in later life (Ferrini & Ferrini, 2000). It can provide companionship, helping with daily living and personal care when a partner needs assistance, and a higher household income compared to those who are single. Most elders are married during the early part of their later year. However, with advancing age, frail health and death of companions, they more become widowed. Because women live longer than men and they have tendency to marry men older than themselves, women are more likely to become widowed. In USA, older men are nearly twice as likely to be marrying older women. For example in 1997, almost haft of older American women were widows, and almost four times more than the number of widowers. Two thirds of

women age seventy-five and older were widowed and two thirds of men this age were married (Schoen & Weineck, 1993).

Living arrangement: Living arrangements generally reflects marital status- those who are married are more likely to live with families (Ferrini & Ferrini, 2000). However, the number of the elderly living with the elderly member decreases with advancing age. Older women are less likely to live with family than older men, mostly because older men are married and older women are widowed. In USA, 80 percent of elderly men lived with their families compared to 57 percent of women that age. After age 85, only 47 percent of elders lived in a family setting. About 13 percent (8 percent of men and 17 percent of women) were not living with spouses, but instead lived with children, siblings, or the relatives, while another 2 percent lived with non-relatives.

However, the population of elders living alone is increasing. In USA, almost one third of older people live alone (41 percent of older women and 17 percent of men). Yeh & Lo (2004) found that living alone is related to the decreased level of perceived social support and feeling lonely after adjusted for potential confounders.

Marital status, living arrangement and the availability of children play a major role in determining whether an older person needs formal care. When a spouse or child does not present, the elderly are more likely to be institutionalized. Currently trends, such as the increase of divorce rate, tendency to have fewer children, more women entering in the work force, child migration searching for a job, will likely affect the living arrangements of the future elders.

(2) Non Family Relation

Working status : Working is generally very beneficial for the elders in self esteem and self reliance. Aquino et al. (1996) found number of working hours at a paying job, lower level of depression and greater perceived social support were directly related to satisfaction in life among the elders.

(3) Non-organization and organization integration

Religious activities: Religious activities benefit for social support among the elders. Krause et al. (1999) found greater involvement in religion is associated with providing help to others, but these effects emerge for older men only. Regardless of gender, elders who provide assistance to others more often rate their health more favorable than older adults who are less involved in helping others. In addition, Krause (2006) indicated that greater involvement in religion is associated with a lower mortality risk. Providing emotional support to fellow member tends to lessen the deleterious effect of social support provider's own economic problems and mortality.

2.4.4 Personal Health Characteristics

Perceptions about social support are influenced by personality health characteristics (Cornman et al., 2001). It may be important in understanding perceived availability of social support because of the ways in which they may affect a person's evaluation of supportive behaviors as well as his ability to mobilize support (Cornman et al., 2001). For instance, people with low self esteem or with depression may be more likely to assess negatively or misremember supportive interactions, leading to an overall low perception of available support (Lakey et al.,

1996). In a similar vein, Von Dras et al. (2000) hypothesized that those with high self-esteem would have higher perceived support. People with high self-esteem tend to be more gregarious and involve in more social activities leading them to have a higher perceived availability of support. Of all variables they examined, which included gender, income, education, marital status, family roles and social activities, self-esteem explained the most variance in perceptions about support availability. Lakey et al. (1996) also found self esteem as well as locus of control to be highly correlated with support perceptions (Pearson correlation of 0.40) and further suggested that perceived support may be influenced by one's personality.

In addition, Zunzunegui (2003) found when controlling for age, gender, education and functional status, low emotional support and reception of instrument support aid were significantly associated with poor self related health. Being a widower and sharing living arrangement with children was associated with good self related health. Depression symptoms were associated with low emotional support and reception of instrumental.

2.5 Social Support Measurement

There were several social support instruments that have been published over the past 20 years. The measurement can be divided into three main categories including (1) Briefs uni-dimensional scales, (2) Broad-based scales of close and diffuse support, and (3) Multidimensional inventories. Most of all perceived social support instruments were assess the perceived social support rather than received social support. However, Antonucci et al. (1997) emphasized that the discussions

concerning social support tend to focus on positive support interactions, but social interactions can also be negative or conflict. Antonucci et al. (1997) illustrated that people who had conflict or negative relationship are often the people whom feel close, on the other hand a conflict with stranger has less impact than conflict with a spouse or child. Thus, Antonucci et al. (1997) recommended that any assessment of the positive aspects of social support also assess the possible existence of negative aspects of these same social relationships.

2.5.1 The Personal Resource Questionnaire (PRQ 85)

Personal Resource Questionnaire (PRQ) was de veloped in the late 1970's by Patricia Brandt and Clarann Weinert, who were at that time doctoral students at the University of Washington.

The PRQ85 is beneficial for the test of perceived social support degree and also reveals the problem and needs of the respondents in time of crisis in last three months. It measures perceived social support in two parts:

1) Exploring social network information when the elderly in needs and problems in 10 life crisis situations

2) Perceived social support 25 items which including five dimension: (1) attachment/intimacy, (2) social interaction, (3) nurturance, (4) reassurance of worth, and (5) availability of assistance. In this part, this tool assessed by 7 points of Likert scale designed to assess the perceived level of social support. It is important to note that the Cronbach's alpha for the PRO 85 of the sample was 0.92, which is consistent with alphas reported across multiple studies (Weinert & Brandt, 1987). Thus, the strength of this tool is highly reliability.

In addition, the PRQ85 instrument had been translated into Thai and used to explore perceived social support in several studies among Thai elders with very high reliability. Thus, the language and content validity had been approved and accepted in Thailand. To follow the research objective, this study uses the PRQ85.

2.6 Thai Elderly People

For more understanding of Thai elders, this chapter describes the Thai elders in 3 parts including (1) Thai elders' socio demographic characteristics, (2) Thai elders' health status, and (3) Thai elders' social support.

2.6.1 Thai Elderly Socio Demographic Characteristics

(a) Gender and age

Thai population aging trend differs little in gender (Sobieszczyk et al., 2002). UN estimates women at a modestly high proportion from 1980 to 2040, and the 2000 census found 10.3 percent of women compared to 8.7 percent of men at the age of 60 or over. Thongkrajai & Wapatanawong (2004) revealed that compared to Thai elderly population structure, elderly women was greater than elderly men. The older women are, the larger proportion of them is.

(b) Marital status

Chayovan (1999) indicated that 98 percent of Thai elders were married, Kanchanakijsakul (2002) revealed that the proportion of single or unmarried elders was not large, but it has increased over time. The number of married males was greater than married females, while female elders were widows. The number of married elders in rural areas is greater than that in urban areas (Jitapunkul et al., 2000;

Chayovan, 1999). The projection in the next 10 years reveals that the number of single elders will increase to 3 percent with dramatically getting older. This proportion will increase in females rather than males (Jitapunkul et al., 2000). In addition, marital status among Thai elders relies on the age, also married status decline with age while the more age the more widows. Chayovan & Knodel (1997) indicated that widowhood was far more prevalent among Thai elderly women than men nearly 42 percent compared to about 15 percent, and a far higher proportion of Thai elderly men than women were married. These two complementary patterns were large part due to the tendency of Thai men than older women to remarry. Therefore, single and widow elders were mostly female (Chayovan, 1999).

(c) Education

Before 1990, the proportion of elders with no schooling was large. From 1990 to 2000, it declined dramatically from almost two-fifth of the elders to less than one-fourth. This reflects the absence of universal education in Thailand when the elderly studied were young. The elders with schooling were a large proportion in 1990s to present. They were educated at primary level or grade 4 which was compulsory educational level at that time (Kanchanakijsakul, 2002). Similarly, Thai elderly long term plan 2545-2564 reveals that the most of Thai elderly education was primary school level (59.5 percent), while 24.6 percent of all haven't attended school. It is important to note that, the proportion of the elders who haven't attended school and illiterate was one of the problems that made the elderly inaccessibility of the health and important information.

(d) Income and source of income

Chayowan (1999) found yearly income level of Thai elders was relative low with mean and median at about 29,000 Baht and 10,000 Baht respectively. Major source of income of Thai elders was child and spouse. More than haft of the elders have no money saving. Of those, the proportion of rural elders was higher than urban elders (Sritanyarat et al., 2002).

2.6.2 Thai Elders' Health

Thai elders perceived their health status as moderate level (Sritanyarat at el., 2002) while Thai socio economic change produces advantage in both public health and medical technology which can control the communicable diseases (except: AIDS, Tuberculosis and Malaria). The study of Disability Adjusted Life Years (DALYs) among Thai elderly revealed that health problems among the elders were non communicable diseases (especially chronics diseases) and accidents. There were cancer, stroke, accident, diabetes mellitus, hypertension, dementia, and depression disorder (Jitapunkul et al., 2000).

The national study revealed that one-fourth of the elders fell in these health problems which made the elders difficult to carry out the activities they used to do before. About 18.9 percent of them fell in these problems for more than 6 months. It is important to note that there were 1.6 percent of the elders who cannot walk across the room and 3.1 percent cannot go outside their places. The likely hood of experience major disabilities dramatically increases in very old age. Chuprapawan (2000) stated that 19 percent of the elders in Thailand were disabled by major causes

of accidents, stroke and blindness. 2.1 percent of Thai elders were dependent on their families. The older they are, the more dependent they are.

In addition, Jitapunkul & Bunnag (1999) found that Thai elders had illness without hospitalization during the last month, 93% had sought treatment and 7% did nothing. Just over a haft (52.8%) used health services. Subjects who had self imitating symptoms or disease tend to not use health services, while subject with chronic condition did. Independent determinants of health services used are living in rural areas, being well educated and better off, not drinking alcohol and severity of illness identified. As these results, Jitapunkul & Bunnag (1999) concluded that there was a low rate of health service used and children had an important role in taking care of parents.

The mental health problems among the elders were lonely and depression (Chayovan & Knodel, 1997 ; Jitapunkul & Bunnag, 1999). Loneliness is increasing by age. Females were prone to lonely higher than males, while childless elders were lonely higher than the elders living with their child. Noticeably, urban elders were lonely higher than rural elders. Chayovan & Knodel (1997) also revealed that factors that affect the elderly mental health were income, social network size, number of family member, health status, social support, working status and occupation.

The elderly health problems produce considerable health care demands, particular when health problems of the elders become serious. The elders used around 28 percent of total hospital beds (Jitapunkul & Bunnag, 199 9) and

projected that the ratio of Thai elders using hospital bed will increase to three times of the youths using (Knodel et al., 1992).

2.6.3 Thai Elderly Social Support

Thai elderly social support can be described into three parts including; Thai elderly perceived social support, Thai elderly social network, and Thai elderly social integration.

2.6.3.1 Thai elderly perceived social support

Thai elders perceived social support at high level. Noisuk (2002) revealed that the elderly clients in NaKhon-SaWan Hospital perceived social support and all aspects of social support at high level. Similarly, Phokruprasert (2002) also found NaKhon SaWan elders perceived high level of social support and found significant statistics of marital status, income, and elderly club membership among perceived social supports. Whilst, Polinn et al. (2005) found the elders in Thong Chai sub-district, Pech Buri Province perceived social support at high level. Lortrakul (2004) indicated that the overall score for the social support of the elders with coronary heart disease were at a high level and also found positive significant relationships between the overall score and subscale score for social support and health promoting behaviors.

2.6.3.2 Thai elderly social network

Thai elders can be described in two parts: network size and network sources;

Social network size; Thai elderly social network size was small. Yodpech et al. (1997) found social network size of Thai elders were 2 or 3 persons. The important network of the elders was their families.

Social network sources: **Family support;** as mentioned in chapter I, the major source of social support to Thai elders is family; Thai elders receive support from their children, spouse, relatives and friends (Yodpech et al., 1997). The responsible people who care for the elders are "family caregiver". In Thailand, family caregivers were child or spouse. Preparing meals is one major activity that caregiver provide for the elders. Others include providing medicine and assisting with daily activities. The duration of care-giving depends on such factors as the elderly person's health status, self-help ability, the caregiver's employment status and living arrangement (Sritanyarat et al., 2002)

Choowattanapakorn (1999) revealed that daughters usually play the role of caregiver for elderly parents. The youngest daughter is most common favored for this role. If the elderly people have no daughter, the youngest son will stay and provide assistance. There are many reasons why the elders generally prefer to living with daughter, for example, daughter is typically perceived to be emotionally closer to parent, more dependable, and better caregiver. Thais believe that sons and daughters are socialized into different roles, and the role of daughters in Thai society is the best suited to provide personal care for parents.

In addition, Sritanyarat et al. (2002) found that Co-residing child took care of the female elders more than males while daughters supported the elders more than sons. Also, non co-resident child provided material support higher

than co-reside child. Childless elders were less support than elders living with children, and the elders in extended family received support higher than single family.

Friend support: Thai elders received emotional and informal support from their friends (Knodel & Chayovan, 1997 ; Yodpech et al., 1997).

It is important to noted that Thai elders are not only the receivers, but also they take a role as providers. Some elders were family caregivers and take responsibility in their families. Chayovan (1999) revealed that 19.6 percent of elderly caregivers were at the age of 60-80. Also, half of the female elders spent their money for miscellaneous expenses in their houses (Sritanyarat et al., 2002), and others help their families taking care of their grandchildren.

2.6.3.3 Thai elderly social integration

Thai elderly social integration can be described in terms of living arrangement, working status, religion activities, elderly club joining and community participation.

Thai elderly living arrangements: Most Thai elders were co-resident with at least one child (Kanchanakijsakul, 2002), however the study by Chayovan & Knodel (1997) showed that among Thai elders with a living child but not co-residing with a child, almost 40 percent lived adjacent to a child. Such arrangements may be seen as providing greater privacy for both parties. Knodel et al. (1995) indicated that some elders prefer to this arrangement type, especially if they are in good health.

The Thai family size becomes small; it is largely possible for an increasing proportion of living with a spouse only among Thai elders to exist. Due largely to modernization leading to a decline in mortality and altering lifestyles, Kanchanakijsakul (2002) revealed the proportion of the elders living with spouse only has greatly increased. The projection revealed that the number of child living with will decrease to 2 and the proportion of elders with no child were 5.6 (Chayovan & Knodel, 1997). In addition, the proportion of the elders living alone has been increased. Chayovan (1999) indicated that there were 6% of the elders living alone and in this proportion, females are greater than males. The likelihood of living alone increase with advancing age.

Working status: Elderly males currently work higher than females two times. In 1997, the elders entering to work force were 32.0%, while others did housework or not working because of age. Young elders (60-69 years old) still worked higher than the old-old (70 years old and over) and rural elders (both male and female) worked higher than urban ones (Chayovan & Knodel, 1997). Kanchanakijsakul (2002) indicated that in 2001, nearly haft of Thai elders worked. Of those a large number worked in less modern occupations (such as agriculture workers, miners, quarrymen, equipment workers, craftsmen, laborers and services). Only the small proportion of the elders worked in more modern occupations (such as Profession, technical, administrative, executive, clerical and sales). The majority of Thai elders lived in rural areas, particularly in the northeast region.

The elderly club: In 1996, there were 3,487 elderly clubs in Thailand. Among these, 1,042 clubs (30.0%) has been worked. Siripanich et al.

(1996) revealed that the elderly club was relevance for the elderly. Most of the members were the elders at the age of 60 and over, some clubs were eligible to the elders at the age of 50 and over. The elderly clubs were set up in the government office (Hospital, Health Center) 34.9%, in Wat 32.9% and in the elderly home 27.3% respectively. The members prioritized and selected activities, such as religious activities, entertainment activities, health promotion and prevention activities, physical exercise, working activities, art and culture activities, tourism, moral activities, and funeral support fund. Some elderly supports were from MOPH staff, Ministry of Social Development and Human Security, and the community.

Jittrasirinuwat (2001) postulated that elderly club is the mechanism to provide activities and also beneficial for elderly groups to decrease stress. Jittrasirinuwat (2001) found that the elderly club membership and non membership in Sountang sub-district, Lamae district, Chumporn province, Thailand depressive score in a group club may help to decrease depressive disorder in the elders.

Religion activities: Buddhism is the national religion of Thailand. Ninety-five percent of Thais are Buddhists (Choowattanapakorn, 1999) Similarly, Wongsith & Siriboon (1996) found that 90.1% of Thai elders was Buddhists, 8.9% was Islamic, 0.8% was others, and 0.2% no answer respectively. Among Buddhists, there was 35% of the elders regularly go to temple on important Buddhism days, 50% occasionally and 15% never. The young elders went to temple more frequent than the old-old elders did, and the number of rural elders generally

going to temple was greater than that of urban elders. However, there were a few different proportion among elderly males and females.

Choowattanapakorn (1999) indicated that because of Buddhist belief, the tradition of repayment of parents' goodness is perceived as of value for everyone. Individually, Thais perceive that adherence to this custom brings merit. As well as repayment of the dept of gratitude by caring for parents or financial support, doing good acts for other people in general is believed to bring merit. Villagers hope such merit mean better life in the future. A better life may mean rich, power, prestige, good health, beauty and good employments. Conversely, doing more evil acts than good acts leads to a life of poverty and hardship.

Merit making is generally performed at a temple or Wat. Wat is the moral, social and symbolic of community. The most institutionalized merit making is by the elderly people. The elders do not go to temple for loneliness to enjoy the company with other. Burr (1978) found that Thai elders went to temple not for companionship, but for accumulate merit.

Thai Elderly Community participation; Generally, Thai elders joined the community activities such as temple activities, wedding ceremony, new house cerebration and so on. Wongsith & Siriboon (1996) revealed that potential of Thai elders to participate activities depended on the status of the elders, namely being a house hold head, a house owner, a breadwinner, a decision maker or a consultant. It differed between elderly males and females and changed with age.

2.7 Why does this study emphasize the strengthening of social support among the elders?

Even through previous studies in Thai elders revealed that Thai elders fulfill high level of social support, it was effected by factors in both macro and micro levels. The factors in macro level include social structure conditions, socio economic conditions, politics and social change, while factors in micro level are the social network structure, social influence or even the elderly health characteristics (Berkman et al., 2000).

In Thailand, due to the demographic change, the number of elderly people has been increased, while the number of caregivers of Thai elderly decreased. The elderly health problems, which were non communicable diseases and disability, made social support more important to improve health and well being among the elders as mentioned in Chapter I.

In addition, there are several organizations in Thailand responsible for the elders. However, those organizations work depending on their own policies. For example, there are six divisions in Ministry of public health responsible for the elders, namely Division of Medicine for curative, Division of Health for health promotion, Division of Mental Health for mental health, Division of Traditional Medicine for health promotion, Division of Health and Services Support for services and research among the elders, and The Policy and Planning Office for co-ordination (Chaunprasert, 2007). Some activities that implemented were related, fragmented, redundancy and uncovered in rural areas (Chaunprasert, 2007).

Even through the Second National Long-term Plan for Older Persons in Thailand, Thailand Health Development Plan under the 9th National Economic and Social Development Plan (2002-2006), and the Plan of Family Development have been enacted to strengthen the potential of family care for the elders, most of Thai elders were inaccessible to social services (Yodpech, 2007), due to limitation of health and social services, lack of well train staffs, potential caregiver and community concerned for the elderly. There was no project implemented successfully (Yodpech, 2007) for solving this problem. Jitapunkul et al. (200 0) postulated that it needs comprehensive and effective strategy to strengthen social support among the elders.

2.8 Empowering Community: Approach for Strengthening Social Support among the Elders

2.8.1 Community empowerment definitions

Fetterman et al. (1996) defined community empowerment as a mechanism set up by people, organizations and community to gain mastery over the affair. WHO (2003) defined community empowerment as a process where by individuals and communities are involved in planning and conducting local activities to meet the community needs and promote community's self reliance in respect to development.

WHO (2003) indicated that the process of community empowerment is roots of community requirement at all levels, with the understanding that community is the best judge of it own problems and possesses the ability to undertake appropriate

action for their solution. This can be facilitated by capacity buildings and imparting skills for decision making, planning, implementation and resource management.

2.8.2 Why does this study emphasize on community empowerment?

Current top down and bureaucratic in social and health services among the elderly approaches is based on centralized government intervention. It is unable to address most of confronting issues including health problems, lack of family caregiver, resolving in youth and elderly relation conflicts. It calls for a new management philosophy which can balance the needs of sustainable resource management against those of sustainable livelihoods. Participatory approaches offer methods which attempt to tackle these challenges to certain context. Co-management promote the resource users to acts as co-managers whereby sharing power and balancing community will perceived their mutual interests in sustaining elderly social support resources and will pay a proactive in regulating elderly support themselves. However, it is ensured that elderly community support organizations which are co management are considerably strengthened and their capacity adequately enhanced to play the role of partners of the community social support for the elderly resources. Thus, community empowerment was employed. The expected outcomes of this approach are:

(1) to extent coverage program the whole community awareness

(2) to make the program more efficient with the greater coordination of resource, activities and efforts pooled by the community

(3) to make a program more effective trough joint community efforts to set goals, objective and strategy for action

(4) to promote self reliance among the community members and increase their sense of control over their own problems.

In this study, stakeholders in community accessed elderly social support. They were; (1) provider (family members, friends, community and related organization staff who are responsible for the health/social services for the elders) and (2) user (the elderly people). All these stakeholders were involved to strengthen community's capacity and confidence. These will lead to succeed in development by using their own resources and helping other organizations to accomplish higher perceived social support and well being among the elders.

2.8.3 Community Empowering Approach

Kumar (2005) revealed that empower is hard to visualize and even harder to achieve. It is a process and not a blue prints. It grows over time and it has several dimensions which mutually reinforces each other. Increasing the number of dimensions increases the chances of success of empowerment. Kumar (2005) postulated that empowerment requires a holistic approach to empower involving two approaches: intervention as community level as well as outside the community to promote an enabling environment. Figure 7 show community empowerment approach.

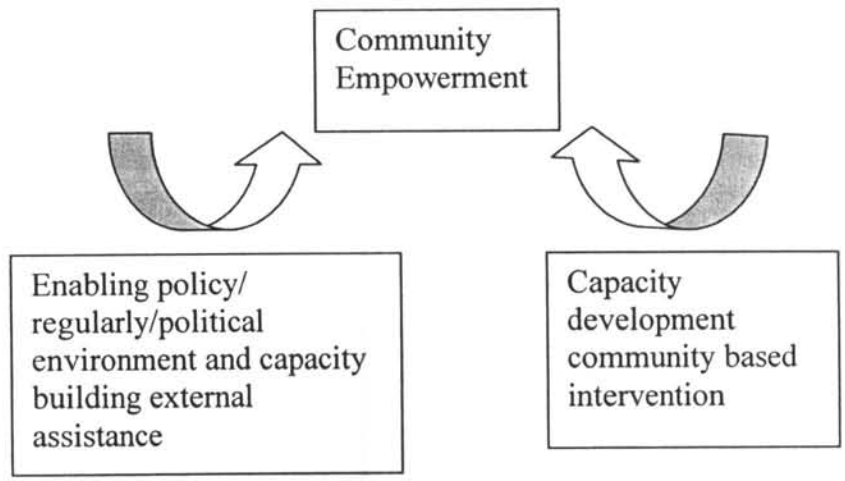


Figure 7: Community Empowerment Approach (Kumar, 2005).

2.8.4 Community empowerment based intervention

There were seven steps of community empowerment. Scott & Jaffe (1991) described that the steps of community empowerment are testing the climate for empowerment, moving attitude, moving through self-esteem, developing collaborative relationships, building empowered teams and decision making – the core process of empowered teams.

(1) Testing the climate for empowerment

Empowerment starts by testing climate of empowerment. There are 8 parts;

- ***Clarity of purpose***: people know where they stand
- ***Morale:*** people are trusted, I feel respected as a person, and individual differences in life style and value are respected.

- ***Fairness:*** I approve of the things that go on here, people are treated fairly, I trust when community team says.
- ***Recognition:*** the community teams expects the best for elders
- ***Teamwork:*** people help each others, people work together to solve difficult problems, people care for each other and people here are out for the group not themselves.
- ***Participation:*** people have voice in decision, problems are shared and people get resources they need to do their jobs.
- ***Communication:*** I am kept informed what going on in the elderly community social supports, communication is clear and prompt between groups and I understand why things are asked to me.
- ***Healthy environment:*** people are able to manage the pressure of their problems, I am able to grow and learn and there are opportunities for community development.

The test would be explored the climate of empowerment, which needs to concerned each part before entering the community empowerment to the next step.

(2) Moving attitude

Community empowerment involves a series of a shift mind or attitudinal change. For example:

Powerless ⟶ empowered

Wait for activities ⟶ taking action

Reactive ⟶ creative and proactive

Blame placing ⟶ problem solving

Empowerment involves three major shifts of attitude in organization:

Towards process: to reach the goal, a work group must look at how it gets here. It must be reached the goal again and do things better next time. It must develop self awareness of how it does things and this understanding must be shared.

Towards responsibility: in the empowered work team, everyone has the responsibility that was traditionally given to the leaders. If anyone sees a problem or has an idea, they are responsible for raising it to the group. The idea must be respected and everyone should be engaged in looking for ways to grow and develop.

Towards learning: in the empowerment group, people are in the process of learning. They are willing to take action, to find out and solve problems, to take risks, to speak out and work together.

(3) Change to create empowerment

The process of empowerment works in three levels:

- Attitude: stakeholders take on self managing, accountable, and responsible for their works.
- Relationship: team relationships become vital and they focus on process as well as content. They are involved communication giving and receiving feedback.
- Organization structure: policies, practices and incentives are adopted to match the value of empowerment.

The changing in attitude, relationship and organization structure is dynamic while empowered process illustrated as shown in the following figure:

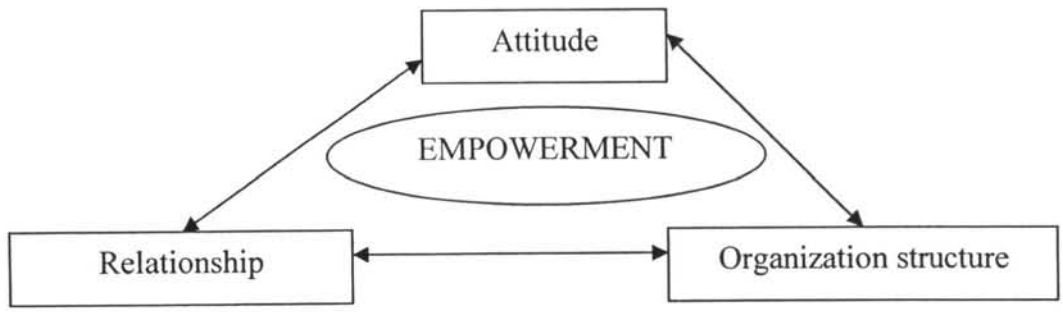


Figure 8 : Pyramid of Change to Create Empowerment

Source: Scott, C.D. & Jaffe, D.T. (1991). **Empowerment: building a committed workforce.** London: Kogan Page.

(4) Moving through self-esteem

There is a set of effective motivators of the empowered teams that call VIP motivators which are; Validation, Information and Participation.

- ***Validation***: the team/people would be empowered to respect as people flexible to meet a person need, encouraged to learn development and new skills.
- ***Information***: the team/people should know things being done, getting inside information about the community
- ***Participation***: the team/people are involved in decision making that affects them.

The VIP motivators help the team/people to be encouraged to their satisfaction in how well they do jobs. The key of motivation in an empowered environment is to understand what makes people most satisfied doing a good job. When people are given information, skills, tools and responsibility, they thrive. Self esteem is enhanced when people are allowed to exercise judgments in their works.

(5) Developing Collaborative Relationships

Collaboration is where a group of people share planning, implementing and fruits of activities. It is a full partnership. There are several steps represent moves in the direction of real collaboration:

- Step 1: Paternalism - taking care of people without telling them
- Step 2: Communication - telling people why things are done and keeping them informed
- Step 3: Participation - asking people for ideas and input.
- Step 4: Collaboration- sharing, planning, implementation, accountability and rewards.

(6) Building Empowered Teams

The team is where empowered grows. The most important ingredient of empowerment is the direct relationships between people in the team. Things needed to be synergy when building empowered teams are ownership, responsibility, authority, power, rewards and energy. Moreover, the facilitators are responsible for setting the process for expanding responsibility for the team including (1) creating mission and vision, (2) offering guidance and support, and coaching and assessing performance as it happens.

The action ideas for team empowerments are as follows;

- Present a challenge and have the team nominate a group to work together to solve the problem. Set time for the group to produce a result, but do not interfere. When they come back with the solution, engage the dialogue to select an option.

- Establish a clear mission together: Set aside some time to talk about the reasons your team exists. Encourage everyone to give ideas. Write down one or two sentences that describe your team's purpose.
- Teach people the skills of solving problems and brainstorming, and choose a member to facilitate these techniques. Do not interrupt or take back control.
- Provide time and place for meeting: Train your group to facilitate meetings. Take it in turns to run your meetings with these techniques. Learn from each others.
- Give clear feedback about performance. Establish some guideline for how give feedback: no attacks, criticism or non changeable elements. As a team, pick one area of solving and have everyone give feedback to others about that area.
- Focus on the positive and celebrate the successful rewards.

(7) Decision making – the core process of Empowered Teams

By attitude changing, relationship and organization structure, the goal of empowerment, building a committed workforce, is collaboration to work and make their own decision. Figure 9 presents the decision making levels:

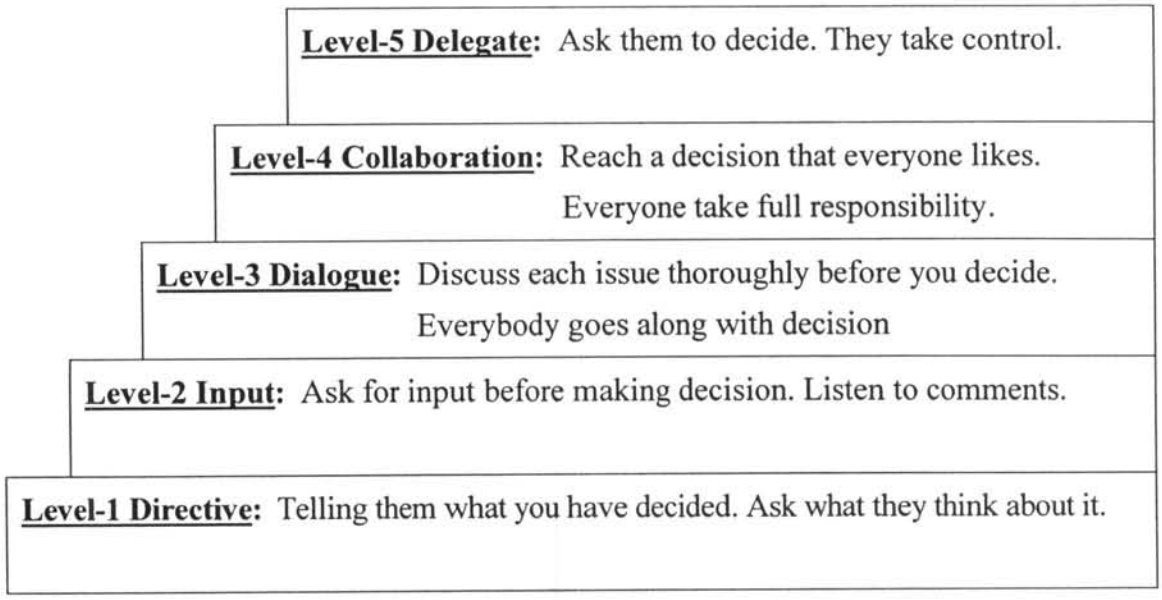


Figure 9: Decision Making Level

Source: Scott, C.D. & Jaffe, D.T. (1991). **Empowerment: building a committed workforce.** London: Kogan Page.

Empowered decision making can be happened at all levels. There are times when level-1 is appropriated. What importance of how to do it, with explanation and consideration, or as an edict handed down. The level at which the decision is made should be clear to the team.

It is important to note that the more people are involved in decision making, the more committed they will implement. It takes more time to get more commitment. Thus, the consideration of more information, flexibility, and knowledge to handle unexpected outcome and unpredictable difficulties without confused would help the team to make decisions.

2.8.5 Empowerment Strategies Strengthening Social Support among the Elders

This study aims to strengthening social support among the elderly where as strengthening means community empowers. To initiate the community

empowerment in strengthening social support among the elderly, Scott & Jaffe (1991) state that there were 2 components:

(1) Priority of the social support of the elderly problems and development of the solution plan

(2) Changing the attitude for working together between the elderly social supports stakeholders.

Community Empowerment strategy

The strategies for community empowering using various instruments community forum, case study, field trip, community forum, group process.

The strategy that this study used are:

1. Community forum: by researcher presentation the research findings
2. Group process by Appreciation influence control (AIC) technique to explore the stakholders expectation, the elderly problems and the community plan.

AIC philosophy is based on the principle that power relationships are central to the process of organization. It was translated into a model for organizing development work in the late 1970s and early 1980s by William E. Smith (MacNeil, 2007). The process has been implemented in a variety of sectors and settings, including local, regional, and national. AIC is a workshop-based technique that encourages stakeholders to consider social, political, and cultural factors along with technical and economic aspects that influence a given project or policy. AIC helps workshop participants identify a common purpose, encourages participants to

recognize the range of stakeholders relevant to that purpose, and creates an enabling forum for stakeholders to pursue that purpose collaboratively. A typical workshop includes:

- Inviting relevant stakeholders to design a plan with a clear goal
- "Appreciative phase" with group reporting back
- People are encouraged to envision clear outcomes, to make recommendations and commitments to transfer plan to action

Community Empowerment Process

There were 2 process of the community empowerment to strengthening social support among the elderly:

1. Identifying stakeholders and developing the community forum regard to listening the community in the elderly social support problems, comments and suggestions.
2. Community participation in planning process using AIC technique which aims to identify the elderly social support problems, analysis and priority problems, and develop the community action plan.

2.8.6 Empowering evaluation

Fetterman et al. (1996) indicated that empowering evaluation is the use of evaluation concepts, technique and findings to foster improvement and self determination. It employs both qualitative and qualitative methodologies. It can be applied to individuals, groups, organizations, communities, societies or culture. The focus is on the programs. It is attentive to empower process and outcomes.

2.8.6.1 Process of Empowerment Evaluation

Fetterman et al. (1996) postulated the process of empowerment evaluation into six elements: (a) assessing community concerns and resources, (b) setting a mission and objectives, (c) developing strategies and action plan, (d) monitoring process and outcome, (e) communicating information to relevance audience, and (f) promoting adaptation, renewal, and institutionalization.

This process is an interactive and iterative process, by which the community, in collaboration with support team, identifies its own health issues, decides how to address them, monitors progress toward its goals, and uses the information to adapt and sustain the initiatives. Each aspect is described as follow.

(1) Assessing community concern and resources

In empowerment evaluation; the support teams assist local initiatives in the initiatives in the initial and ongoing task of assessing local concerns and resources for change. Listening to the community concerns; securing community input, ownership and involvement, is critical to sustaining initiatives. Support teams provide workshop sessions and on site consultation to build the capacity of staff, leadership and volunteers. Support teams also provide assistance with formal needs assessment and inventories of community strength and resources.

This study aims to strengthen social support among the elders, therefore, each local coalition for community dwelling elders conducted listening sessions to access community concerns and resources for addressing their missions. The listening sessions consisted of informal public meetings in which participant identified (a) problems or issue, (b) barriers or resistance to addressing the

problems, (c) resources for the change, and (d) potential solutions. The listening sessions were designed to involve key leaders, people affected by problems, and people who contribute to address the problems throughout all sectors of the community. Listening sessions continued to be held throughout the initiative to meet empowerment aims of (a) maintaining community involvement in setting the goal and objectives, and (b) attracting volunteers to help the action plan.

(2) Setting a mission and objectives

Although the mission of community initiative may be largely defined by the granting agency, it should be tailored to the community's own unique vision and circumstances. The support team assists community initiatives in identifying or adapting the mission and objectives. In this case, to strengthen social support among the elderly, initiative modifies its mission and objectives to include social support activities. Support teams facilitate workshop sessions with staff and membership of initiatives and provide on-site consultation to review and, if necessary, adapt these aspects of the strategic plan.

(3) Developing Strategies and Action Plan

Fawcett et al., 1996 stated that an important task for a community initiative is to develop strategies, the general approach, such as coalition building or advocacy, by which it achieves its mission. Action planning, that is, identifying specific community changes to be sought in each relevant sector of the community, may be particularly clinical to success.

(4) Monitoring Process and Outcome

This step is important to evaluate the empowerment system. Fetterman et al. (1996) postulated that core components of the measurement system were (a) monitoring system to assess process and intermediate outcome, (b) constituent survey of process and outcome, (c) behavioral survey, (d) measures of community – level indicators, (e) interviews with participants to obtain qualitative information about critical events. All measure are refined, collected and interpreted in collaboration with staff and leadership of participation community initiative.

(5) Communication Information and Relevant Audience

Regularly sharing accomplishments and keeping constituents informed of progress are important to maintain community support, obtaining additional resource, and ensuring accountability. Support team provide data reports and training to enable coalition leadership and staff to communicate their data to coalition membership, boards of directors, current and prospectus funding agents and other important constituents.

(6) Promoting Adaptation, Renewal and Institutionalization

In the life span of community initiatives, adaptation and renewal may be necessary to address a variety of predicable changes, including those in leadership, goals, and objectives and community conditions and concerns. Institutionalization of valued components is initiative, including evaluation may also be important to community initiatives. Support teams facilitate training and provide regular consultation to this end, but ultimate success may be unknown for years after the evaluation.

The process of empowerment evaluation is dynamic, each aspect illustrated in figure 10.

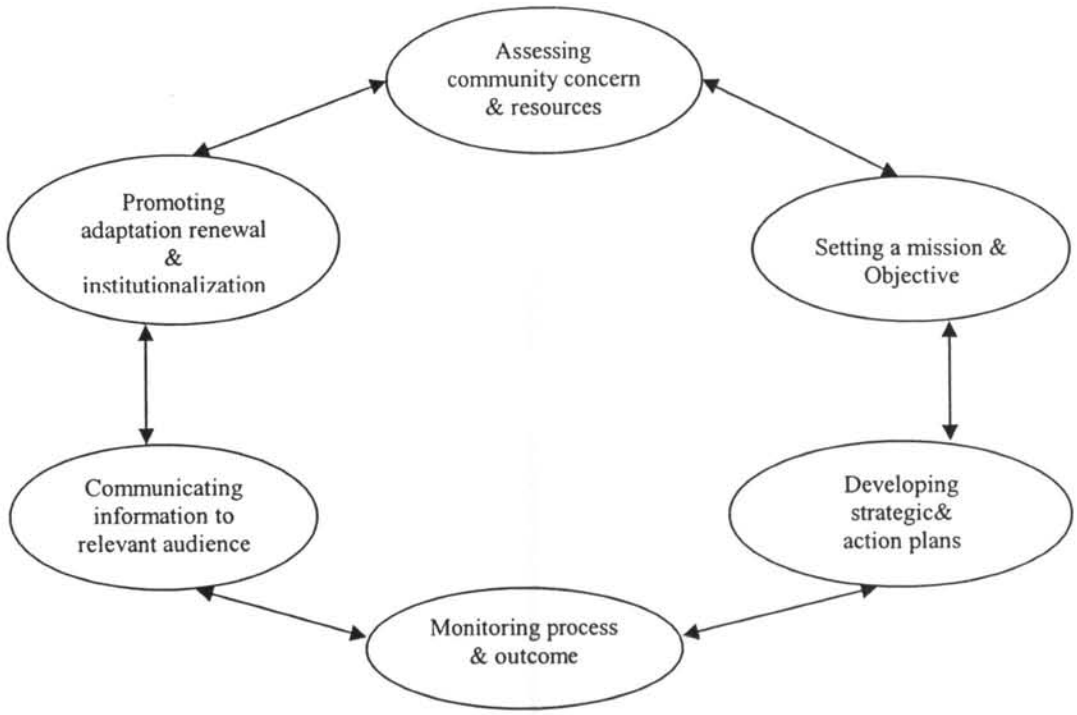


Figure 10: Process of Empowerment Evaluation

Source: Fetterman, D.M., Kaftarian, S., & Wandersman, A. (Eds.). (1996). **Empowerment evaluation: Knowledge and tools for self-assessment and accountability.** Thousand Oaks, Calif. : Sage Publications.

In sum, empowerment evaluation aims to build community competence, optimize community outcome, and promote adaptation, renewal and institutionalization of community health initiatives. This study, by the community forum and group process, there were 2 steps of the indicators of the empowerment evaluation;

1. Stakeholders: understand the elderly problem and needs, cause of the elderly problems, problems solving skills, analysis skills and self determinants. Consequently develop their positives self esteem, self and other acceptance and self confidence. Most of all they become aware of listening to the people, getting people to participate in the elderly problems and led to understand their role and functions as call partnership.
2. Community action plan according to strengthening social support among the elderly which are supported by community, sustainability and community participation.

In conclusion, the literature review illustrated that there were the elderly social support problems by the activities that fragmented, redundancy and found some gaps of the elderly social support provisions. Thus, eliminate that problems, empowerment approach were used aims to community participation to develop the strengthening social support among the elderly action plan. The approaches of this study are as figure 11.

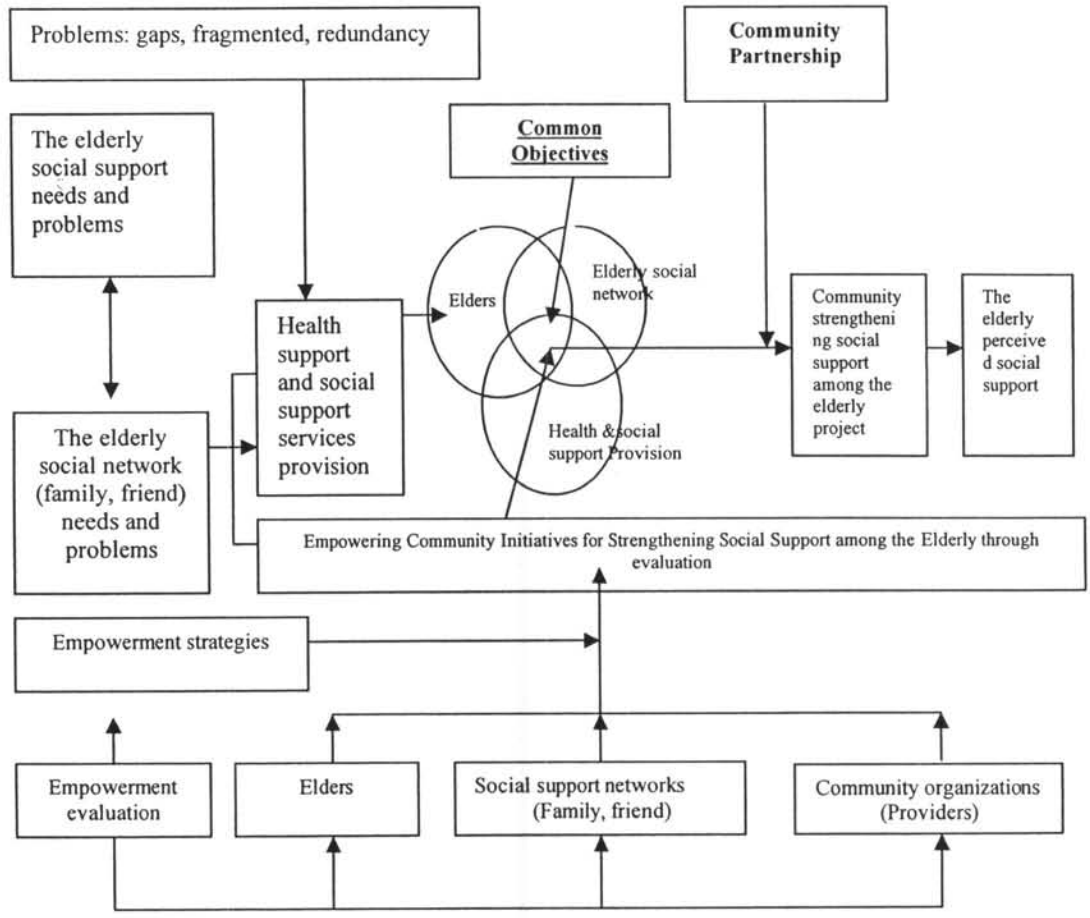


Figure 11: Study Approach