CHAPTER VI

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The main purpose of this thesis is to gather all the findings of survey data and literature reviewed to develop a program to strengthen social support among the elderly. This chapter returns to the research questions, to explain how the study results provide answers to them. The relationships between results of this study are compared to other related studies and reports. In addition this chapter describes limitations, conclusion and recommendations.

6.2 Discussion of Findings

Data was collected from eight communities by the research team gathering data in face to face interviews with a structured questionnaire and in depth interview about the elderly and their social network. The response rate was 97.08 percent which was 756 persons. This study attempted to gather data from all elderly in each community. However, this study had some limitations as (1) some elderly people had acute or current medical or psychiatric problems that might interfere with memory or judgment and (2) limitations of the definition of elderly, for as time passed (the dissertation plan used the KK PHO data in July 2004, the data collection begun in July 2005) people who were initially 59 became elderly (according to the definition of

elderly) and some elderly passed away. Therefore, it was difficult to achieve as many elderly as the total number in the first plan.

However, all elderly who were active and well enough to join the study were interviewed.

The findings of this study will be discussed in 4 main sections being: characteristics of the elderly, perceived social support, social support determinants and the elderly and elderly social network perspectives.

6.2.1 Characteristics of the elderly

6.2.1.1 Socio demographic characteristics

Most of the Thai elderly were female. Thai life expectancy at birth was 72 years in 2002, while female life expectancy at birth was 75 years and that for males was 70 years (Chayovan, 1999). The proportion of females is higher than males in each age group of 60 years and over. The proportion is 1.2:1 while in the group of 80 years and over, the proportion is 1.6:1 (Survey of population change, population gazette, 2001). Thus most of the Thai elderly population are female. This study found that 65% of the old-old sample were female while 34.5% were male.

Jitapunkul et al. (2000) reports that one third of Thai elderly had no schooling and this proportion was higher among female elderly and the old-old. The findings of this study also found a similar pattern: 20.2% of female elderly had no schooling while only 4.2% of male elderly had no schooling. By comparing age group, this study also found that more of the old-old had no schooling than the young old (24.2% old-old, 5.4% young old).

Most of sample elderly were poor. This study found that 64% of the sample had a monthly income. However, it was low with a median of 1,000

baht. This was similar to the study of Chayovan (1999) which indicated that Thai elderly received a monthly income of 800 baht or 10,000 baht per year. This study also found that the proportion of female and old elderly who had no income was higher than male and young elderly, which is similar to the features of Thai elderly with old female elderly poorer than males (Sritanyarat et al., 2002).

In terms of the number of sources of income, this study also found that among the elderly who had income, more than half had only one source of income. The important sources of income for the group were their children, and the elderly themselves.

6.2.1.2 Social network characteristic

Social network characteristics of the elderly means the web of social relationships for the elderly, and it is discussed in terms of four main social networks: (1) family (2) friends (3) community health staff and (4) community staff.

1) Family

This study found that important social networks among elderly were children, spouse, grandchildren and others. This was similar to the findings of Sritanyarat et al. (2002) which indicates that important social networks for Thai elderly are family, friends, neighbors and relatives.

Family size

This study found more than half of the respondents lived in small families (1-3 members). The Thailand Elderly Plan (2002-2021) indicated that as the Thai population structure has changed, it is reflected in family size, delayed marriage, declining rate of population growth, and life style change (agricultural to industrial

and service) which made the family size decline. It is also reflected in the ability of the family to support the elderly.

There were different family sizes by gender and place. While 6% of respondents lived alone, more females lived alone than males. This is similar to the study by Chayovan (1999) which indicated that 6% of the Thai elderly lived alone and that proportion will increase.

Interestingly, there were 53.3% of rural respondents who lived with 1-3 family members which is higher than for the urban elderly (48.7%). It suggests that the sons and daughters migrate to towns and cities, which makes the family size smaller.

Family caregiver

There were 94.0% of the sample elderly who had a family caregiver while the proportion among male elderly was higher than among female elderly (99.3% male, 90.6% female). Comparing gender, this can be explained by most female elderly being widows, thus the proportion of child caregivers among females is higher than among male, while spouse care giver is higher among males than females.

Interestingly, this study found that male and young elderly had more family care givers than female and old elderly. It could be that male and young elderly were active and remarried while female and old elderly were widows. Therefore, the female elderly would be an important group to care for and support as a first priority.

Who is the family caregiver?

This study found that 51.9% of the elderly reported their children were family caregivers (daughter or son or both), 32.2 % spouse, and 8.2% grandchildren (male or female or both). Among child care givers, daughters were the highest proportion (75.1%) while sons were 24.9%. These results correspond to the findings of the

Thailand Elderly Plan (2002-2021) which reported that two thirds of family care givers were daughters (64%) and 27% were spouses. Choowattanapakorn (1999) indicates that daughters usually play the role of caregiver for elderly parents. Daughters are typically perceived to be emotionally closer to parents, more dependable, and better caregivers. Thais believe that sons and daughters are socialized into different roles and that the role of daughter in Thai society is best suited to providing personal care (Knodel et al., 1995).

When looking for more detail among the important family caregivers of spouses, children and grandchildren, this study found that female caregivers are the important group for the elderly with wives, daughters and granddaughters having a higher percentage in all elderly gender, age and living area groups. Noticeably, among the spouse group, this age group was 45-86 year olds which includes adults and the elderly. It is possible that the older spouse caregiver has a heavy burden to care for others. Among the child caregivers, they were adults while grandchildren were adolescents. They had less time to give the elderly since it had to be after work or after school. Including the social perspective, therefore, the elderly and their kin adapt their time and habits to each other.

This study also found that most family care givers (spouse, child and grandchild) completed primary school which is lower education for Thais. This would be reflected in their ability to care for the elderly. Almost all family care givers care for the elderly through obligation. However, since family caregivers normally have a low educational background they are unsure of what care to give and the correct way to give that care, and so the potential of this group needs to be developed.

Family caregiver tie

Qualitative data reveals that the family caregiver contacts the elderly all the time, and is responsible for all tasks. Preparation of meals is one major task, as well as providing medicine and assisting with daily living activities. Duration of care giving depends on the elders' health status and self-help ability. These finding are similar to the study of Azn & Roungsopahkul (1999) that concluded that the majority of caregivers are either their children and/or their spouses. The caregiver performs all tasks for the elderly depending on the elder's capability.

2) Friends

There are several definitions of friendship. However, attributes of close friendship include a feeling of belonging, integration into a social group, intimate experiences, reassurance of self-worth, assistance with need, open communication and information sharing (Lassey & Lassey, 2001). The difference is explained between family relationships and friends as being that family relationships are obligatory while friendships are voluntary; the elderly cannot terminate a stressful family relationship although they can end a friendship (Antonucci & Akiyama, 1995). Elders seek friends who can reduce the discrepancy between their perception of who they are and the negative meaning they might receive from family and others. Friends can offer the positive identity support that 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.

This study found that 20.6 % of respondents had no close friends, with female and old elderly having a higher proportion than male and young elderly. This study

also found statistical significance amongst the close friends by gender ($p<0.05$). Thus, female and old elderly will be an important group to care and support as a first priority as mentioned earlier. Sritanyarat et al. (2002) reveal that Thai elders perceive emotional support from friends while qualitative data of this study found that elderly received information, financial and emotional support from their old-old friends.

Elderly close friends were mostly of opposite gender, with mean age 65.1 SD 8.5. Almost all were agriculture workers, who usually came to visit the elderly, or regularly contacted them, and 99.7% were from the neighborhood. Forschner (1992) indicated that older individuals in a strong and well-developed neighborhood and community usually received ongoing support from a variety of sources. Activities and services available in the community provide meaning and stimulation to daily life while fulfilling basic personal and household needs.

Number of close friends

Half of the sampled elderly have only one close friend (58.5%), while others (28.1%) have two close friends or three close friends (13.4%). This study found statistical significance between the number of elderly close friends and gender at the significance level of 0.05 also. In a large sample of a longitudinal study (N=2,011), Due et al. (1999) divided a random sample 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 year olds and among the 70 year olds was different. The 25 year olds tended to have contact with friends, while the 70 year olds had more contact with children, friends and people they knew from formal associations.

In a similar way, in a longitudinal study, McCamish-Svensson et al. (1999) found that the number of friends of people in a single cohort of 80 year olds decreased significantly from 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.

Type and frequency of contact of elderly close friends

This study found that most elderly contacted close friends via visits (99.0%). There was only 1.0% who contacted via telephone. Regular contact was highest (67.1%) followed by occasionally. Almost 100% of the elderly had direct contact with their friends. The reason was that the elderly friend was mostly the elder who lived next door, and so was very easy to contact. It was possible to contact them any time they wanted. Therefore, this study found a high proportion of regular contact with friends.

3) Community Health Staff

This study found that half of the respondents did not know community health staff (such as health center staff, community hospital nurse). Interestingly, the proportion of female and old elderly was higher than male and young elderly. This would imply that half of the elderly possibly receive service by health center or community hospital, but they did not recognize the staffs' names and their work place or maybe some the elderly had declining cognition which made them forget community health staff and their work place.

Number of known health personnel

When asking about the range of community health network, when comparing by gender, age group and living areas, the elderly had few community health staff

networks. There were 83.1% of all respondents who knew only one community health staff while 10.4% knew two.

4) Knowing community staff (SDAO)

There were 51.8% of respondents who knew community staff (sub district organization staffs or sub district municipality staff who are responsible for the elderly). Interestingly, the proportion there was little difference among gender and age group.

Number of known community staff

The social network range of community staff was wider than community health staff. Among the elderly who knew community staff, the social network range for community staff was 1-4. Most elderly knew 1-2 people (94.2%) while some knew 3-4 people (5.8%). However, in general, one sub-district administration organization or sub district municipality had only one staff member responsible for the health of the elderly. Therefore, it would possible that the elderly knew only 1-2 people.

Type of frequency of contact by community health staff and community staff

Qualitative data reveals that community health staff regularly visit the community elderly once a month. However, it was hard to visit all community dwelling elderly under their responsibility. It was dependent on the elderly health status and job related factors. However, the database of community elderly was collected and analyzed to identify elderly cases at risk to start home visits later.

Among the community staff, qualitative data also supported that the elderly knew only one or two staff since in the last year they came and gave them blankets

and presents which was formal contact. The social contact was during festivals or community ceremonies.

6.2.1.3 Social Integration

Social integration characteristics of this study refer to a group of activities of the elderly which will be discussed in four parts: family relations, non family relations, formal social interactions, and non-formal social interaction.

1) Family relations

Marital status

More than half of the sample were married (54.1%) whereas 44.6% were widows. More male elderly were married than female elderly (74.4% female, 40.9% male) while more female elderly were widowed than males (57.3% female, 24.9% male). In addition, there were 1.8% of female elderly who were still single. Statistical testing found that there was statistical significance between marital status and gender ($p<0.05$). This contrasts the work of Kanchanakijsakul (2002) which explains that most elderly have been married at least once and three fifths are currently married. However, the proportion of widows has increased.

Looking at age group, this study found that more of the young old were married than the old-old (67.6% young old, 37.6% old-old) while the old-old group contained more widows than the younger group. In addition, there was statistical significance between marital status and the elderly age group ($p<0.05$). This point reveals that the older have a greater likelihood of living alone or living with children than the younger but live with their spouse less often. This may be largely due to older spouse mortality.

Living arrangements

This study found that 6.0% of the sample lived alone, 47.4% lived with spouse, 39.1% lived with their child and 7.5% lived with their grandchild.

Who lives alone?

Despite the small proportion of elderly living alone as mentioned earlier, there are important issues that all elderly need to be supported in. Regarding age group and gender, older elderly have a greater likelihood of living alone than younger but living with a spouse less often, and females live longer than males. This may be largely due to older spousal mortality.

Living with spouse

Noticeably, this study found 47.4% of the sample elderly living with spouse (spouse only, spouse and child, and spouse and child's family). Among this group, this study found 23.0% living with spouse only. A previous study among Thai elderly reveals that the proportion of the elderly living with a spouse only has greatly increased. This may be due to modernization leading to a decline in mortality and altering lifestyles. Modernization accompanying industrial growth may also create greater physical separation between generations (Kanchanakijsakul, 2002). A study by Chayovan & Knodel (1997) shows that among Thai elderly with a living child almost 40% lived adjacent to a child. As mentioned earlier, an improving economic situation in recent years has facilitated construction of separate dwelling units for married children near their old parents. Such arrangements may be seen as providing greater privacy for both parties. Indeed, focus group discussions have revealed that some elderly prefer this type of arrangement, especially if they are in good health (Knodel et al., 1995). With improvements in mortality and socioeconomic

development, therefore, it is likely for an increasing proportion of living with a spouse only among Thai elderly to exist.

Focusing on gender, the proportion of elderly living with spouse only is higher for males than female. Meanwhile, the proportion of elderly living alone is higher for females than males, possibly because females have longer life expectancy than males and males may die before they are alone.

Living with their child

In case of the elderly who live with their child, more than eighty percent were living with a child's family which is the highest in each gender and age group. There were 13.2% living with a child only.

There was a higher proportion of the elderly living with child in females, and older age than those for male and younger. Kanchanakijsakul (2002) reveal that the proportion of elderly living with children declines with age, possibly due to child migration or child marriage. The phenomenon is greater when the elderly are aging and their children are adults, later in their life course. That is, children may migrate to more urban areas, or they may move to dwellings separate from their aging parents when they get married.

Living with a grandchild

This study found 7.5% of the elderly who lived with a grandchild. The percentage living with a grandchild only (90%) was higher in each gender and age group. This study also found statistical significance amongst living arrangement by gender and age group.

As noted, female elderly live longer. Female and older elder had a high proportion living with children and grandchildren. However, possibly due to child

migration or child marriage, there was high proportion of the elderly living with a grandchild only.

2) Non-family relations

Working status

More than half of the elderly do not work. There were 44.1% of the total sample working. This study also reveals that more male elderly work than female, while more younger work than older. This study also found statistical significance amongst working status by gender and age group ($p<0.05$).

Among the elderly working group, 80.9% perform agriculture labor; such as farming and animal raising, and being a farmer also has a higher percentage in each gender and age group.

This study supports the study by Kanchanakijsakul (2002) which indicates that nearly half of all elderly were working in the previous year. Of those, a large number worked in less modern occupations (agriculture workers, miners, quarrymen, equipment workers, craftsmen, laborers and services). Only a small proportion of the elderly worked in more modern occupations (professional, technical, administrative, executive, clerical and sales).

There is no previous study comparing working status by comparing gender and age group. However, it is possible that male elderly were younger and healthier and more able to work in the rice field or others than older, female elderly.

3) Formal social interactions

Preliminary in-depth interviews reveal that there were 8 community organizations that the elderly were involved in. These included elderly club, health volunteer club, community school committee, community temple committee, and

housewife club. Concerning community organization involvement, 34.1% of the sample were elderly club members, 12.9% were community temple committee members, 11.2% were health volunteer club members, 10.9% were housewife club members and 9.0% were community school committee members. The young elderly were more involved in community organizations than the older. This is contrary to a study by Yodpech et al. (1997) which indicates that 6.4% of all elderly are involved in community elderly clubs.

However, when focusing on frequency of contact, this study found that more than 80% of the elderly members joined activities sometimes and regularly while the others joined activities less than regularly. This can be explained perhaps by saying that the elderly club and its activities are provided for them, rather than the elderly being the instigators of the activities. Only the elderly are invited to the meetings and some activities are not attractive to the elderly, so they do not attend regularly, which causes the club to fail in its goal of developing social interaction.

4) Informal social interactions

Visits with children

This study found that 48.1% of respondents visit their children occasionally, 31.7% never and 20.2% visit with children regularly. Females and the older visit their children less than males and younger. However, these results relate to the elderly living arrangements, with more than eighty percent living with their child's family which is higher in each gender and age group. Among the elderly who live with their child, there was no need to come to visit their children, except the go to visit other kin who live next door or in another place.

Visits with friends

There were 54.4% of the sample elderly who regularly visited with friends, 30% who occasionally visited, and 15.7% never. As mentioned above concerning the characteristics of elderly friends, almost all elderly friends were in the neighborhood, and thus they were convenient to visit. Noticeably, females had less contact with their friends than males, while older regularly visited their friends more than younger. It is possible that females normally stay in their house and are unlikely to go outside while their friends come to see them instead. Older elderly who are not working usually come to visit their friends while their children go to work.

The in-depth interview reveals that the elderly in the rural areas normally have lunch with their neighbors. They exchange their meals, talk and laugh with each other. When the elderly are in trouble such as having health problems, family problems or financial problems, their friends help them by listening, problem solving and making suggestions.

Religious activities

Almost all of this sample were Buddhist, while Wongsith & Siriboon (1996) found that 90.1% of Thai elderly were Buddhist, 8.9% Islamic, others 0.8% and no answer 0.2%.

More than 80% of the sample used to present food to Buddhist monks while 11.7% never did. Females and the older presented food less often to a Buddhist monk than males and younger.

In addition, 69.6% of the sample used to go the temple to make merit, and this study also found that older and rural elderly regularly go the temple for this purpose more than younger elderly. While 88% of the sample go to temples on important

Buddhist Days. Females, older elderly go less to temple on important Buddhist Days than males and younger elderly. This proportion was different from Wongsith & Siriboon (1996) who found that 35% of the elderly regularly go to temple on important Buddhist days, 50% occasionally and 15% never. Wongsith & Siriboon (1996) also found the proportion of young elders who go to the temple was higher than old elders.

Joining community activities

Community activities refers to activities such as wedding ceremonies, new house celebrations, Song Kran festival, New year's celebration or funeral ceremonies.

This study found 70.0% of respondents regularly join community activities, 18.9% occasionally and only 11.4% never. This study also found that the proportion of male and young elderly joining community activities was higher than female and old elderly at a statistically significant level ($p=0.05$).

6.2.1.4 Personal health characteristics

Perceived health status

This study found that 53.1% of the sample perceived their health status as moderate, 28.3% poor and 18.5% good which was similar to Jitapunkul et al. (2000) who noted that two-thirds of Thai elderly perceived their health status as moderate and good. The moderate and good health of the elderly means independence and good mood. This study also found no statistical significance between perceived health status when comparing by gender and age group ($p>0.05$) which differs from a previous study that a higher proportion of females perceived their health status as poor than male elders (Jitapunkul et al., 2000).

Chronic diseases

In Thailand, hypertension, diabetes mellitus, stroke, and accidents are the most important chronic diseases that cause the elderly disability. There were 69.3% of Thai elders who 60-90 years old have chronic diseases. This study also found a similar pattern that 64.7% of the sample elderly have chronic diseases with a high proportion in each gender and age group, while there is no statistical significance between currently having a chronic disease of respondents against gender and age group ($p>0.05$).

Stress

There were 88.6% of respondents who reported 0-250 in a stress test which corresponds to a normal level of stress for the elderly, whereas there is little difference between elderly gender and age groups. These findings are similar to Polinn et al. (2005) who indicate that the mental health of the elderly in Thongchai sub-district, Petch Buri Province was good and similar to the findings of Sitthiwong et al. (1996) who found that the elderly who were cared for by their family were less stressed compared to elderly who live alone.

6.2.2 Perceived Social Support Level

In total score of perceived social support (75), the elderly respondents' perceived social support score was 70.12 which is 93.94% of the perceived social support total score (75.0). This finding is similar to the study of Phokruprasert (2002) which reveals that the elderly in Surat Thani had perceived social support score at a high level. This was also similar to Polinn et al. (2005) who indicated that the elderly in Thongchai sub-district in Petch Buri province had perceived social support at a high level.

When comparing perceived social support dimensions, this study found that respondents' perceived social support score was close to 15 for each item, which means that the sample elderly had a high level of perceived social support for each dimension. The highest scores were in the dimensions of opportunity for nurturance (Nurturance) (means 14.20 SD 1.60), provision for attachment/intimacy (means 14.11 SD 1.80), and the availability of information, emotional and material help (means 14.08 SD 1.59), whereas the smallest perceived social support score was for the dimension of being an integral part of a group (mean 13.64 SD 1.68). This is similar to the findings of Noisuk (2002) which reveal that elder clients at the Psychiatric Clinic in Nakhon SaWan province had a high mean score in the dimension of provision of attachment/intimacy, provision of nurturance but the smallest perceived social support dimension was social integration. Phokruprasert (2002) found that almost all elderly in Surat Thani Province perceived social support from those valued at high level, the available emotional/information and material help at medium level and less perceived social support in social integration.

According to Thai culture, Choowattanapakorn (1999) indicated that social support among the elderly and their families is an obligation; social support occurs in terms of caring for parents and supports all kinds of family activities. Jitapunkul et al. (2000) have revealed that young Thais generally have a positive attitude towards elderly care, recognizing that care for the elderly is one of the greatest duties that they have to do. However, cause of the Thailand population structure and Thai socio economic had been changed impact to a large number of unskilled agricultural workers moved into the manufacturing and service sectors. Both male and female laborers migrated from rural areas. They wanted high incomes to

support their families back home. As a result, many old people were left at home alone with their grandchildren (Caffrey, 1992). While, mostly of the Thai elderly had no job, as a results the elderly had opportunity for nurturing in term of look after and caring their grandchild.

6.2.2.1 Perceived social support compared by gender and age group

When comparing social support by gender, this study found that female respondents had less perception about social support than male elderly which was statistically significant at the level 0.05. However, gender relation to perceived social support is inconsistent. Von Dras et al. (2000) hypothesize and find that women have greater perceived social support than men. Antonucci (1985) speculates that women may have a higher sense of available support because they are generally embedded in more varied social networks than are men who tend to rely primarily on wives or partners for support. She also notes 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, find that women are less satisfied with social support (Vaux, 1985). Vaux (1985) attributes some of this variation in gender differences in social support perceptions to difference in methods, particularly in relation to the samples and measures used.

When comparing social support by age group, this study found old elders (70 and over) had less perception of social support than young elders (60-69 year old) which was statistically significant at the level 0.05. Cornman et al. (2001) reveals that there was a decline in positive perceived social support among elderly Taiwanese about availability of social support over time. More over, Due et al.

(1999) indicate that social support in older ages tends to decrease with advancing age. In a large sample of a longitudinal study (N=2,011), Due et al. (1999) divided a random sample 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 olds and among the 70 years old was different. The 25 years olds tends to have contact with friends, while the 70 years old had more contact with children, friends and people they knew from formal associations.

In a similar way, in a longitudinal study, McCamish-Svensson et al. (1999) found that the number of friends of people in a single cohort of 80 year olds decreased significantly from 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 show that advancing age may be associated with fewer social networks, which in turn, results in less social support (Malathum, 2001).

6.2.3 Perceived Social Support Determinants

Multivariate analysis on several important models of perceived social support determinants was performed. For all sample elderly, this study found educational level, close friends, knowing the OBT staff, working status, joining elderly club activities and joining community activities were significant in the positive direction.

This model reveals that elderly socio demographic (education level), social network characteristics (close friends, knowing the OBT staff) and social integration characteristics (working status, joining elderly club activities and joining community activities) related to the elderly perceived social support.

However, as mentioned earlier, the proportion of elderly with no schooling was large (Kanchanakijsakul, 2002), the Second National Long-term Plan for Older Persons Thailand 2002-2021 also reveals that 59.5 % of Thai elderly had completed a primary school or higher while 24.6 percent had received no schooling at all (Jitapunkul et al., 2002). It is important to note that the sizeable proportion of the elderly who had had no schooling and were illiterate was correlated problems that the elderly had in accessing health services and important information. In addition, Cornman et al. (2001) reveal that the elderly with a higher education are more likely to have consistently positive perception about available support. Similar to the study of Suwonnaroop (2002) using PRQ85 found education, were direct influences on health-promoting behaviors, through social support among American Older Adults.

Social networking plays an essential role in people's health and wellbeing in later life (Turner & Marino, 1994). It can provide social companionship, instrumental aid, as well as emotional comfort to the elderly, 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 networks are hence essential for enhancing life quality and ensuring happiness in later life (Chan & Lee, 2006). Even through, this study found the elderly perceived social support at high level. Interestingly, this study did not find that the social network of the family was related to perceived social support; instead, this study found the number of close friends and knowing community staff to be statistically significant at level 0.05. It is known that family members are the most important source of help and support from informal networks. However, given the demographic changes in Thai society, which have affected the population structure, those elderly who have no or

very few kin to count on would turn to close friends or community staff for support. Elderly people also tend to replace missing kin by converting close friends into quasi kin or fictive kin (MacRae, 1992). Chan & Lee (2006) indicated that friends and relatives constitute a dominant part of social networks and are oftentimes important source of support for the aged. Slater (1995) indicated that companionship provides information support, sharing knowledge or skills, offering advices and giving others forums of assistance to other who needs health. Apart to knowing community health staff, Forschner (1992) indicate that 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. A study by Sritanyarat et al. (2002) confirm the findings that neighborhood has become the important social support source among Thai elderly when there are care givers working or living apart; most of the day time the elderly spend with their friends, social support occurs in term of information support, emotional support.

In terms of social integration factors, this study found working status, being an elderly club member, and joining community activities to be associated with perceived social support. Social integration factors related to perceived social support would be explained by Cohen et al. (2000) which described an identity and esteem model of the psychological influence of social relationships, which suggested that the ability to meet role expectation may result in cognitive benefits such as increased feelings of self worth and control over one's environment, which may influence health through a variety of pathways. Activities that elders integrated were means to possess and the amount of social contacts made by each elder. It is assumed that the

presence of extensive social ties and interactions ensures that support is being provided.

In terms of working status, this study found working status strongly related to perceived social support. Hargrave & Hanna (1997) stated that working is the degree to which the elderly has come to terms with his or her contribution to the family and society; those elderly who are still working are more likely to have more social interaction and more perceived social support. Aquino et al. (1996) also revealed that a larger number of hours worked at a paying job, lower levels of depression, and greater perceived social support were directly related to higher levels of life satisfaction.

Elderly club membership is associated with perceived social support. In Thailand, elderly clubs give members an opportunity for social interaction that consequently affects the social relationships which ultimately influence the flow of resources to each member. Siripanich et al. (1996) revealed that the Thai 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 education activities, physical exercise, working activities, art and culture activities, tourism, moral activities, and funeral support fund. Jittrasirinuwat (2001) postulated that elderly club is the mechanism to provide activities and also beneficial for elderly groups to decrease stress resulting of social support.

Similar to joining community activities results to the elderly had more opportunity in social integration. In this study, community activities include wedding ceremonies, new house celebrations, community meetings and so on. Two main kinds of activities related to perceived social support can be explained by social integration theories that give people several roles, and having social interaction. However, conflicts happen when there is unmet need for interaction, but social integration gives the elderly more self esteem and development in good social relations. Cohen & Wills (1985) postulated that social integration has an impact on health through social and informational influence. Social networks may also act as sources of information.

6.2.3.1 Social support determinants compared by gender

This study found different factors related to perceived social support among male and female elderly. Model 2 reveals educational level, knowing community staff, working status, visits with children and joining community activities were statistically significant in a positive direction to male elderly while model 3 reveals that having close friends, knowing the health staff, elderly club membership, and joining religion activities were statistically significant in a positive direction to female elderly.

Among sample male elderly this study found socio demographic (education level), social network (knowing community staff), and social integration (working status, visits with children and joining community activities) indicating that male elderly were still active. The qualitative data indicates that male elders need to continue working to give them self esteem and self worth. Among males who remarried, working status means earning a living and education means access to new information. Cornman et al. (2001) reveals that Taiwanese elderly with

more education tend to have more consistently positive perceptions about the availability of social support. Moreover, when considering gender specific tasks, male elderly work included financial work and dealing with bureaucracies which affected their perceived social support. Qualitative data explains that male elders normally contact with community staff for community development or talking Thai politics. For male elders visiting children who live next door or live apart were means to keep them still active. Also concerning joining the community, qualitative data reveals that male elderly join in as leaders of ceremonies and prayers.

With respect to female elders, the important social networks of the female elderly were friends and community health staff. As mentioned earlier, more than half the sample elders were female, and also more than half of these were widows. While the number of family members of Thai elderly has decreased and because of Thai economics changes, some family members have moved to search for jobs in towns, and therefore the Thai family has become smaller in size with fewer children to take the role of caregiver for elderly parents (Choowattanapakorn, 1999). Cornman et al. (2001) indicate that social and economic development in Taiwan is providing adult children with social and economic opportunities outside the family as well as the means of greater geographic mobility, making the elderly less reliable as a source of social support. Such a shift towards relying on friends for support may be particularly important for future cohorts of the elderly who have fewer children. Therefore, having close friends related to perceived social support for female elderly, which affected the flow of resources. Yodpech 2007 reveals that Thai elderly perceived their friends as the source of emotional support. In this research, female elderly and friends interact in all kinds of support and take on roles as providers and

receivers. Qualitative data revels that information exchange takes place by visiting and talking about looking after their children, grandchildren, health, and sometimes star gossip. Koyano et al. (1994) revealed that women were more likely than men to have neighbors and friends as available source of support, but men were more likely to have family members as the available source of long term care giving.

Choowattanapakorn (1999) reports that Thai female elders appeared to have a higher incidence of illness than the elderly males. In line with the findings of this study, knowing community health staff affects perceived social support. Qualitative data reveals that receiving knowledge from community health staff made the elderly confident about telling health information to their friends. Also, the elderly are prompt to believe and change their behavior, because of trust and familiarity as well.

The elderly club was related to perceived social support among female elderly. Most of the elderly club were female elderly, thus there is no doubt that more female elderly join elderly clubs than males. The elderly club provides activities such as meetings, health education by community health staff, and special activities such as exercise. Moreover, the elderly club gave the elderly the opportunity for social interaction that affects social relations and the flow of resources in the end.

All of the sample is Buddhist and in this study the male elderly joined in more religious activities than female elderly. However, this study found that joining religious activities related to perceived social support among female elders. Qualitative data reveals that females go to temple to perform ceremonies and make merit, which agrees with similar findings of Choowattanapakorn (1999) which indicates that the elderly do not go to the temple because of loneliness or to enjoy the

company of other people. Also Burr found that the Thai elderly did not go to the temple for companionship but to accumulate merit.

6.2.3.2 Social support determinants compared by age group

When controlling other factors, this study found different factors relating to perceived social support in young elderly and old elderly. Factors in the young elderly related to perceived social support were having close friends and social working status, while education level and living arrangement related to old elderly perceived social support. This study found that religious activities and joining community activities related to both young and old elderly.

Among young elderly (60-69 years old) in developed countries who are active, the social network is important as friends affect perceived social support. As mentioned above, as family size become smaller, friends become important persons who care for the elderly. Moreover, qualitative data reveals that visits with friends and contact with friends made the elderly have more social interaction and demonstrate that they are still active. Similarly, young elderly need to continue working, which means to they still have worth and are active. The elderly reply that they have no need to wait for financial support from their children, because of the hardships of the economy. Thus, some elderly ask for a job to earn a living. Moreover, working helps the elderly integrate into the social community, which gives them more connections that affect sources of support.

Among the old-old group, education level was related to perceived social support. Univariate analysis reveals that educational level among young and old elderly differed and was statistically significant, with old elders less educated than young elders. Qualitative data reveals that the old elders asked for

information, especially health information. They believe that if they had higher learning they would find it easier to access health information. The old elders feel that they have no need to depend and wait for help from others.

With regard to living arrangements, as mentioned earlier, most old elders were female and widows, and therefore living arrangements for old elderly were with their children, and grandchildren. Ferrini & Ferrini (2000) indicate that older women are less likely to live with their family than older men, mostly because older men are married and older women are widowed. Caffrey (1992) reveals that old people can expect to be valued and honored by their children. In Thai culture, children do not leave their parents alone because they have a sense of obligation. Therefore, under Thai living arrangements, most Thais refuse to let their parents move into an institution for elderly people. Living arrangements are important to the elderly as a source of support: the social interaction results in social relationships which affect perceived social support.

6.2.4 The Elderly and Elderly Social Network Perspectives: Needs and Problems in Addressing Social Support for the Elderly

6.2.4.1 Elderly perspectives;

Social support provision

This study found that the elderly play an important role in providing support. The support provided were financial support and information to their family, friends and community. Also the elderly provide emotional support to their children and friends. Qualitative findings reveal that the support that the elderly provide differed in each network. The close contacts of the elderly are the family, which children and their grandchildren inherit. Some elderly prepare money and land for the children,

while some elderly provide some of their money for their grandchildren to go to school. Giving money gave the elderly a powerful role and made their children obedient and have respect for them. For financial support to their friends, the elderly provide this kind of support in two ways, firstly by giving and secondly by lending. Friends lent the elderly money when they had an economic crisis, and thus this kind of providing support made the elderly feel self worth and giving nurturance. Concerning financial support for the community, the elderly mainly donated their money to a temple, believing that every good word or good act brings good return.

Information support that the elderly provided were normally sharing life experiences, work skills and legends of the community. The information that the elderly provide made the elderly feel self esteem and being accepted as people who are knowledgeable. Interestingly, the elderly love to tell their past experiences that impress others, somehow making their family, especially their children, listen attentively to their story. The information that the female elderly provide to friends is health issues such as about curative herbs or well known doctors. Among male elderly, the information issue was Thai politics, community development and places to work.

Most elderly provided emotional support to their friends. Kanayo (1990) reported neighbors and friends were more dependable for less burdensome instrumental support, such as a grocery shopping, than for care-related support in the case of the Japanese elderly living alone. Ferrini & Ferrini (2000) reported that elderly friends could be an important source of emotional support. Because the elders' friends were elderly themselves, the companionship let them share their experiences, help solve problems, and be a friend when others are feeling lonely. On the other hand, the

elderly provide emotional support to their children by giving them advice and consultation. The elderly did not share their experiences; the emotional support that they provided was to be the one who loves and cares.

Concerning the role of elderly provider, Ferrini & Ferrini (2000) revealed it may be more beneficial than receiving. Results from logistic regression analysis indicate that mortality was significantly reduced for individuals who reported providing instrumental support to their friends, relatives, and neighbors, and individuals who reported providing emotional support to their spouses. In this study providing support made the elderly contact their social network and integrate with their society, causing them to have self worth, self esteem, and more opportunity for nurturance which gave them the opportunity to be a source of support.

Social support received

The elderly received financial, information, instrumental and emotional support through their network such as from spouse, children, grandchildren, community health and community staff. Received support made the elderly feel loved and cared for. Even through their children live apart, the financial support and telephone calls made the elderly happy. Among the elderly who were less supported by their family, government support in terms of monthly allowance was given. However, this did not cover all, and some elderly need to be supported.

Regarding information and instrumental support, the family plays the major role in support. Either in times of happiness, sorrow, health or illness, children are the most important persons in the life of the elderly. The elderly perceived that there were obligations that good children have to perform.

6.2.4.2 Family caregiver perspectives

Family caregivers are family members who undertake responsibilities for the care of the elderly (Morkan & Kunkel, 2001). This study found several types of family caregiver: spouse, child (daughter, son), grandchild (granddaughter, grandson) and daughter in law. Perspectives of the key informant care givers depend on their age, capabilities, experience and relation. Spouse or daughter or son care for the elderly by doing everything that they can, which is better than the care by grandchildren and daughters in law because of their age and lack of life experience. However, under the perspective of family care giver, a strong culture and obligation made the family care givers willing to care and support their own elderly and keep respect to the senior population. The support that family care givers provided was financial support, daily life activities support, health support and emotional support.

6.2.4.3 Friend perspectives

This study did not find differences across gender between elderly friends. Friend supports were voluntary support, because companionship and neighborliness made relationships between elderly and their friends close and dependent on each criterion when needed.

6.2.4.4 Community health staff and Sub District Administration Organization staff perspectives:

This study found that community leaders had not much idea about care for the elderly. Community activities was practiced in line with culture and government policy. Therefore, community elderly activities held depended on important Thai days and other organizations that arrange elderly activities in the

community. Therefore, the community supports program intervention by other related organizations for the elderly in the community.

Community heath staff and community staff were official government officers working close to the community. Through providing coordination, health staff work to support the health of the elderly and community staff work to provide social support. However, some activities work well together while some projects stand alone depending on the timeframe of each project. Young staff who are active made projects for the elderly successful in the areas of information support, material support and instrumental support.

6.2.5 Social support needs/problems

To explore the elderly social network concerning needs/problems in addressing perceived social support for the elderly, questions directed at the elderly, family care giver, friends, community leaders, and community staff were asked to encompass both the real and felt needs of the subjects. The findings differed in each subject.

6.2.5.1 Elderly needs/problems

The most important elderly needs were financial support, as found by Yodpech et al. (1997) who revealed that the Thai elders' needs were social support because of being poor. This study also found that the elderly needs to work and help their children, and don't want to rely on their care givers. The important issue that this study found as being a need of the elderly was the need to have someone who cares when they are ill. It was seen there was a lack of care givers or care givers who had no time to care. Some elderly expressed the feeling that they miss

their children who live apart. At present, technology such as mobile phones has been introduced to the elderly.

6.2.5.2 Family caregiver needs/problems

There were two types of people who care for the elderly. The first type is people who do not work outside, and so there were no needs and no problems. The second type was family caregivers who still work or students who revealed that they have not enough time to care. This reflects the economic status and the small size of families in which there are few people for elderly care. In addition, some family care givers ask for knowledge about elderly care.

6.2.5.3 Elderly friends' needs/problems

Because of companionship relations there were less needs/problems with social support provided to the elderly by friends. Some elderly friends requested community activities, to make the elderly and their friends healthy, such as exercise and home visits by a nurse.

6.2.5.4 Community leaders' needs/problems

Most of these were native to the community and so knew the people under their responsibility well. However, because the community had no funding the activities were only religious activities that the temple committee organized in coordination with the community. Therefore, needs/problems in addressing social support under the aspect of community leaders were community activities such as exercise programs and elderly care training programs which need related organizations to operate. Also, community leaders request financial support and material support for poor elderly.

6.2.5.5 Community health staff and Sub District Administrative Organization staff needs/problems

As mentioned earlier, community health staff work for elderly health by visiting, providing home health care and implementing some health promotion programs, while community staff work for social security which is related to health. This study found the same needs/problems in addressing social support for the elderly in the areas of lack of personnel and elderly care-support training. However, the Thai government has implemented several projects which support elderly people (MOPH, 2001b). It has begun a social security scheme for the elderly, comprising a health card that entitles the holder free medical treatment in public hospitals belonging to the Ministry of Public Health. The program intervention regarding non-community diseases and communicable disease control were implemented for all Thai elderly. In addition, a geriatric health service was established in Bangkok in 1980 to train people to care for older patients (Warnes, 1992). However, geriatric specialists or trained nurses were still inadequate in remote areas.

6.2.5.6 Strategy that combines quantitative and qualitative information in the development of intervention to strengthen social support among the elderly

This study combined methodology of quantitative and qualitative techniques regarding understanding the perceived social support among the elderly. For this study qualitative techniques were introduced in order to gain better and deeper understanding of the elderly and their social network perspectives, as well as needs/problems in addressing perceived social support for the elderly.

While quantitative techniques provided the knowledge on perceived social support and its determinants as a whole. Clark (2000) revealed that in conducting health services research, multiple methodologies are required because the health care environment is complex and changing. Moreover, Sitthi-amorn & Somrongthong (2000) stated that a combination of methods using multi disciplinary approaches should better reflect the true nature of the public health situation. This study aims to fill the knowledge gap. Findings were provided to the community stakeholders to identify ways and means of strengthening social support among the elderly. It aimed to disseminate research findings to stakeholders, and then asked for feedback and suggestions.

For sustainable development, this study used community empowerment as an approach to develop social support for elderly intervention. Community forums and group processes (AIC) were held with the aims of raising awareness and sharing information of the current study to stakeholders. Several issues were discussed, including how to reduce gaps, fragmentation and redundancy of existing services, and understanding each other. Finally, the stakeholders agreed to develop and join the project regarding strengthening social support for the elderly.

With good cooperation, the findings indicate that almost all stakeholders perceived community participation as a key to success of social support improvement among the elderly. The indicators of project success were perceived satisfaction of the elderly for social support, improving elderly health behavior, and finally improving elderly health and well being.

Concerning strengthening social support among the elderly, the project followed research findings which revealed that elderly who had higher social

network and social integration were likely to perceive higher social support. Similarly to the study among the elderly in Beijing and Hong Kong, the elderly who had better social networks were more likely to perceive higher social support than elderly who had less networks and social integration (Chan & Lee, 2006).

However, the empowerment process in this study was only the first round. There is no empowerment process to fit all situations. Thus, in the intervention project, feedback from the community forum will determine what is required for the next step, and whether any changes are necessary to the elderly social support programs. Further action is required to maintain community participation. In addition, the stakeholders that have been empowered need to have their skills developed concerning program implementation, monitoring and evaluating the plan.

6.3 Conclusions

6.3.1 Elderly characteristics

6.3.1.1 The elderly socio demographic characteristics

More than half of the sample were female. Interestingly, female mean age was higher than male elderly with statistical significance at level 0.05. This study also found 83.2% of the sample completed primary school, while the proportion of female and the old elderly who had no schooling was higher than for male and young elderly. This study also reveals that the sample elderly were poor; only 64.1% of the sample had monthly income while the income median was 1,000 baht. Female and old elderly received less income than male and the young elderly.

6.3.1.2 The elderly social network characteristics

This study found that 5.9% of the sample elderly lived alone, while most of the elderly who lived with a family having a family care giver were male and young elderly. Most family caregivers were spouses and children among male elderly while care givers among female elderly were children. This study also found half of the sample elderly lived in families with 1-3 members.

There were 79.4% of sample elderly who had close friends of the same sex and age. This study also found that elderly had close friends in the neighborhood and regular contact by visit. Half of the sample elderly had only one close friend.

This study also found that nearly half of the elderly did not know community health staff and community staff. Among the elderly who knew, there was only one staff member of community health staff that they knew while they knew 1-2 members of community staff.

6.3.1.3 Elderly social integration characteristics

Half of the sample elderly were married; others were widowed and single. There were more males and young elders who were married while female and old elders included many widows. Therefore, more male elders lived with their spouse than female elders, while there were few different living arrangements when compared to the elderly age group. This study also found that male and young elderly still worked while their occupation was mostly agricultural worker.

Concerning community organization involvement, 34.1% of the sample was an elderly club member, 12.9% on the community temple committee, 11.2% a health volunteer club member, 10.9% a housewife club member and 9.0% on

the community school committee. However, among these members, frequencies of contact with these organizations differed by gender and age group. In addition, there were less than half of the members who joined in group/organization activities.

With regard to community involvement, more male elderly regularly visited their children than female, while male old-old visit their friends more than female and young.

In the area of joining religious activities, there was 68.9% of the sample who regularly went to the temple, 19.1% occasionally and 12.0% never. This study found that the proportion of male and younger going to the temple was higher than female and older elderly.

Lastly, this study found that more than 88.9% of respondents joined in community activities whereas the proportion of male and young elderly who joined in with community activities was higher than female and old elderly.

6.3.1.4 Elderly personal health characteristics

This study found that half of the respondents perceived their health status as moderate, 28.3% as poor and only 18.5% as good, with small difference in proportions in each gender, age group and place of living. There were 64.7% of the sample who had a chronic disease. This study also found no statistical significance between current chronic disease of respondents by gender and age group. This study also found 11.4% of respondents had a high stress score with no statistical difference by gender and age group but statistical difference by the elders' place of residence.

6.3.2 Elderly Perceived social support

6.3.2.1 Elderly personal resources

There were 1-2 personal resources that the elderly perceived could help them when they were in a situation of need. This study found that daughters were more important caregivers than sons. The neighborhoods become important when the elderly felt lonely and needed someone to talk to.

6.3.2.2 Social support needs in the last six months

Social support needs in the last six months were (1) financial support, (2) needing someone to care when the elderly were sick and not being able to carry out your usual activities for a week, (3) emotional support (when they felt lonely), (4) needing someone to talk to and (5) needing help for an extended period of time in caring for a family member who is sick or handicapped.

6.3.2.3 Elderly perceived social support level

This study found that the sample elderly perceived social support at a high level. Sample elderly perceived a high score for opportunity for nurturance (Nurturance) dimension, provision for attachment/intimacy dimension, and the availability of information, emotional and material help while a lower perceived social support score was for the dimension of being an integral part of a group.

This study found that male and young elderly perceived higher social support than female and old elderly which was statistically different at the level 0.05.

This study also found perceived social support of male elderly for provision for attachment/intimacy (Intimacy), indication that one is valued (Worth), and the opportunity for nurturance (Nurturance) which were higher than for

female elderly with statistical difference of 0.05. While young elderly perceived a social support mean higher than old elderly in the dimension of an indication that one is valued (Worth) and the opportunity for nurturance (Nurturance) with statistical difference at 0.05.

6.3.3 Perceived social support determinants

6.3.3.1 Bi-variate analysis

This study found similar and different factors influencing perceived social support in each elderly gender and age group. These were having close friends and elderly club membership which had the most responses in each elderly gender and age group.

When comparing elderly gender, variables that influenced both male and female elders were monthly income, having close friends, elderly club membership, and joining community activities, while other factors influencing male elderly were educational level, knowing community staff, marital status, working status, visits with children. Factors influencing only female elderly were knowing health staff, health volunteer club membership, housewife club membership, and religious activities.

When looking at the elderly age group, variables that influenced both young and old elders was having a family caregiver, having close friends, working status, elderly club membership, religious activities and joining the community activities. Factors that influenced perceived social support only among young elderly were knowing community staff, current chronic diseases and stress while factors influencing perceived social support only among old elderly were educational level, living arrangement, community school committee membership,

community temple committee membership, house wife club membership, visiting children and visiting friends.

6.3.3.2 Multi Variate analysis

In conclusion, this study found factors that related to perceived social support and developed **five models** relevant to the best prediction of perceived social support among the elderly.

Social support determinants among elders were educational level, number of elderly close friends, knowing the OBT staff, elderly club membership and joining community activities.

When compared by gender, this study found perceived social support determinants among male elderly were educational level, knowing community staff, working status, visiting children and joining community activities while perceived social support determinants among male elderly were number of elderly close friends, knowing the health staff, elderly club membership, and joining religious activities.

This study found that joining religious activities related to perceived social support in both young and old elderly. Other perceived social support determinants of young elderly were number of elderly close friends, working status, and joining community activities. Perceived social support determinants amongst old elderly were educational level, living arrangements, and joining community activities.

6.3.4 Elderly and their Social Networks Perspectives, Needs in Addressing Social Support for the Elderly

The qualitative data confirm that the family is the major support among Thai elderly. However, the elderly, family care givers and elderly friends did

not know the meaning of social support. Social support among the elderly and their families is an obligation, thus social support occurs in terms of caring for parents and supports all kinds of family activities. The neighborhood has become the important social support source when there are care givers working or living apart. Most of the day time the elderly spend with their friends, thus friends' support influences health behavior, attitude and information.

Community leaders and community staff (both community health staff and sub-district organization administration staff) social support provision were top down activities and cultural activities such as home visits and social activities such as Family Day on April 13th (Song Kran Day) or New Year when the elderly were invited to join activities. Even through in all areas of the study, elderly clubs were held, the activities were monthly meetings by the community health staff with few elders joining the club. Some of the elderly did not join because of their health problems, family duties and some activities not being appropriate for them such as aerobic exercise and dancing which some elders refused to do.

This study also found that there were no integrated community programs initiated for elderly health and social support. All activities that were running in the community were policy implementations and this study also found that all staff need elderly care and social support training.

6.3.5 The strategy that combines quantitative and qualitative information in the development of intervention to strengthen social support among the elderly

The approach that this study used is community empowerment using community forum and group process in exploring the social support community

stakeholder perspectives, opinions and experiences to prioritize elderly social support problems and initiate a strengthening social support program for community elderly.

This study found multiple dimensions of social support problems by the results of the group process which need to be empowered as follows:

The elderly: elderly education, working status, financial problems, few networks, little social integration, loneliness,

The family caregiver: more family caregivers, education level, and understanding the capacity of the elderly,

The elderly friend: education level, community leaders (no community activities), community staff, need for more knowledge for elderly social support and care.

Interestingly, by priority setting this study found the vision and objectives of the strengthening social support program among the elderly should be:

Vision:

"Khon Kaen elderly want social support at a high level by sustaining and continuing support from the elderly themselves, their family, and the community which affects the elders' behavioral health and well being",

Objectives:

- to strengthen the capacity of the elderly according to education, working status and financial status,
- to expand the social network of the elderly and
- to develop strategies for the elderly community social integration.

In all of the activities, community health staff and chiefs of the elderly club were secretaries of the program. The evaluation of the plan was based on the

intervention goal, including three levels: Process, alter the social environment's structure or supportive transactions; Proximal effects, demonstrate desired level of change in social support perceived/received; and Distal effects, demonstrate desired level of change in health status behavior and well being.

6.4 Recommendations

The purpose of this study was to provide recommendations to concerned people related to strengthening social support among the elderly, with regard to elderly health, health behavior and well being. This study used both quantitative and qualitative methods, and findings will be one of the best references for local policy makers, local community organizations and other relevant people. A set of recommendations will be distributed to all stakeholders. The following are recommendation drawn from research findings.

6.4.1 Recommendation for policy makers

This study found there were no integrated programs for the community elderly. To strengthen social support community participation is the one best approach recommended to make the program more efficient, with the greater coordination of resources, activities and efforts pooled by the community, and to promote self reliance among the community members and increase their sense of control over problems of the elderly. Community empowerment involves creating a partnership atmosphere among stakeholders (government, private and local organizations) and identifying possible interventions with regard to this study's findings (perceived social support determinants are educational level, number of elderly close friends, knowing OBT

staff, elderly club membership and joining community activities). Feasibility studies of advantages and disadvantages of the model are needed.

1. Apart from elderly not knowing the community health staff or sub district organization staff, this study also found lack of staff and requests for training programs in community care. With regard to the trend in Thailand for more elderly, human resources development in the areas of elderly health and social support are urgently needed.

2. There were no program implementations for the elderly who live alone with lack of the opportunity for support from family and the community. This target population requires policies and programs. Funding support are needed.

6.4.2 Recommendation for stakeholders

1. This study found social support was run by family obligation. However, there were a variety of family caregivers (spouse, daughter, son, grandson, granddaughter etc.) and quality of social support and this study found a gap between lifestyle of each generation. Thus, strengthening caregivers through social support and care for the elderly programs are needed by empowering family caregivers such as elderly social support and care training, health education, consultation, etc. In addition, repayment campaigns and gratitude of children should be recognized as having good children in the community initiates a positive attitude to the elderly and senior citizens in the community.

2. This study found that friends are an important source of social support among the elderly when they are lonely and need someone to talk to. Companionship provides information support, emotional support and evaluation support. Therefore, to strengthen social support and to promote elderly health

behavior and health education, peers or self help groups are recommended as a channel for the elderly.

3. This study found that female and old elderly are the groups that perceive less social support: they are often widowed, less educated, poor, and have less social integration than male and young elderly. The prioritized target population among the elderly should be this group.

4. Nearly half of the elderly do not work. In-depth interview reveals that the elderly need to work and need to understand their capacity. Linkages should be created with related organizations, the community and community clubs to initiate jobs for community elderly.

5. Social support needs among the elderly are financial support, recommendation to discourage the elderly or their families from taking loans from private money lenders, assisting with small credit from community savings, or initiating community funding, creating linkage with related organizations for the elderly for funding, strengthening family support especially financial support for the elderly, strengthening jobs for the community elderly, assisting in taking up income generating activities, providing skill development training, market support and mobilizing funds.

6. Most of the elderly perceived their health status as moderate, while more than 50% of the elderly had chronic diseases and around 10% of the elderly had stress. To promote elderly health, information support by friends were recommended and quality of health education program by related organizations needs to be considered and implemented.

7. Half of the elderly were elderly club members, but some of them join club activities irregularly or occasionally. The in depth interview reveals that the elderly club was run by the community staff, and some of the activities did not match the elders' needs and problems. The community leaders also revealed that the community needs sustainable projects and the staff responsible. To expand the elderly club membership and persuade more elderly to join club activities, community participation and empowering the elderly to initiate elderly club activities were recommended to strengthen the elderly club which affects the elders' opportunity for more social interaction and social support.

6.4.3 Recommendation for further study

1. Further study to explore relationships between social support and quality of life of the elderly or the elders' well being with regard to evaluate the strengthening of the social support intervention program among the elderly. According to the objectives of this study, the tools have been developed to only explore the situation.

2. This study used the PRQ85 international standard tools to assess elderly social support, but some parts of these tools rely on Western elderly social, culture and living styles. It would be better to develop the perceived social support questionnaire for Thai elderly in which society, culture and lifestyle are definitely compatible.

3. This study focuses on exploring perceived social support and micro mechanisms (social environment and social network such as family, friends, community). The social structure at the macro level was not considered such as culture (norms and values), socio-economic structure (poverty), conflict, politics, law

and social changes which affect social support. For further study the macro level needs exploring.

4. This study attempts to explore perceived social support and social interaction between the elderly and their social network and the social environment. However, this study only focuses on the positive aspects. Further study is needed in the elderly concerning their network conflicts and negative social interactions and to look for strategies to eliminate the problems.

5. This study has emphasized important social networks among the elderly such as families, friends and the community. More understanding is needed of the social support role of these networks, social network range, social network structure and social network ties. The recommendation is to focus on each network related to the elders' perceived social support.

6. This study did not cover assessing perceived social support among frail elderly, elderly who had serious health problems and their care givers. The suggestion of this study is to explore the populations mentioned because these groups need more support than any other group.

7. Community empowerment used in this study only approaches stakeholders in learning and sharing experience to develop the intervention programs. For program implementation, a participatory research study is suggested. The concept of participatory research study is to bring in stakeholders to work together to identify the elderly social support problems in the community through collecting and analyzing information to identify and quantify gaps, fragmentation, and redundancies in the existing social support services. In addition the findings from research and

evidence should be disseminated to all concerned people to find solutions to strengthen social support among the elderly.

8. This study used both qualitative and quantitative studies. For qualitative study, in depth interview and focus group discussion were formulated. As time was limited for qualitative data collection, the interviewer seemed to be a stranger to the respondents. To create rapport more time is needed. Although every possible effort was made to make respondents feel comfortable and relaxed, in some sensitive issues such as social support needs/problems, the female elderly in particular were reluctant to disclose their personal information. To solve this problems the next study should spend more time in the community with respondents to create rapport before conducting the qualitative study

6.5 Study Limitations

1. Perceived social support assessment of this study is a subjective evaluation; it relies on the elders' perception, mood and attitude which change over time. Therefore, the measurement only depends on the elderly perception. However, because major support of the elderly comes from the family, some elderly over presented because of child image protection while some under perceived social support from family because they need more support from others.

2. The quantitative study used in this study is a cross sectional descriptive study. The limitation of this design is that it studies at a single point of time. Results of this study must be used with caution when applied to other periods of time.