CHAPTER I

INTRODUCTION

1.1 Background & Rationale

With the aging of the world population, more than one-quarter of the world's population will be over the age of 60 by the year 2100 (World Health Organization, [WHO], 2004). As in most other countries, the proportion of elderly people is increasing every year in Thailand due to decreasing birth rates and increasing longevity. The proportion of those 60 years and older in Thailand was approximately 9.2% in 2000, and it is expected to be 15.3% in 2020 (Thailand Ministry of Interior, 2003). The average life expectancy at birth increased from 68.55 years in 2000 to 71.57 in 2005 (Thailand Life Expectancy at Birth, 2005).

Tae Wha Lee et al., (2005) stated that "as individuals live longer, health promoting behaviors become even more important, particularly with regard to maintaining function and independence and improving quality of life. Issues in health promotion for older persons are related to their independence in every day life, high cognitive and physical function, and active engagement with life. There is considerable evidence that health promoting behaviors of older adults offer the potential for improving health status and quality of life (QOL) as well as reducing the cost of health care."

QOL is considered to be the key goal for health promotion in older people, and knowledge about the factors that influence QOL in old age is of major importance as aging population becomes a reality world-wide. However empirical knowledge about QOL in this population is limited (Huppert et al., 2000; Mowad, 2004).

In addition, the direction of the Thailand Health Development Plan under the Ninth National Economics and Social Development Plan focuses on human-centered

development within holistic approach strategies for sustainable development. The main strategies are to improve the quality of life of the Thai people (Thailand Health Profile 2001-2004, 2006). Since there are only a few health promoting programs for Thai elderly, little is known about how health promoting behaviors eventually contribute to the quality of life.

Then, it is significant to note that the study in the area of active aging and QOL of the aging population by using strategies to empower the elderly, family, and community should strongly support the aging policy of Thailand.

1.2 Expected Benefits & Application

Outcomes from this research/study about the quality of life and health promoting behaviors of the elderly people in Srisamrong District, Sukhothai Province will provide useful recommendations for stakeholders and health policymakers, research, and decision making on important aspects of health and social services. Findings from this study will be useful for Thai elderlyin particular. Even though recommendations are offered on the basis of results form the study in the elderly from a rural community, the findings are important for strategic planning and delivery of appropriate and effective support for the elderly people living similar areas. Thus, it will be affective for the elderly people because most of them live in rural areas in Thailand.

1.3 Research Questions

1.3.1 What is the quality of life among the elderly in Srisamrong District, Sukhothai Province?

1.3.2 What are the relationships between health promoting behaviors and quality of life of the elderly in Srisamrong District, Sukhothai Province?

1.3.3 What are the factors (socio-demographic, predisposing, enabling, and reinforcing factors) related to health promoting behaviors among the elderly in Srisamrong District, Sukhothai Province?

1.4 Research Objectives

1.4.1 General Objective

The general objective of this study was to assess the quality of life and the important factors of the elderly in Srisamrong District, Sukhothai Province.

1.4.2 Specific Objectives

1.4.2.1 To explore the relationships between health promoting behaviors and the quality of life of the elderly in Srisamrong District, Sukhothai Province.

1.4.2.2 To explore the relationships between the specific factors (socio-demographic factors, predisposing factors, enabling factors, and reinforcing factors) and health promoting behaviors among the elderly in Srisamrong District, Sukhothai Province.

1.5 Operational Definitions

In this study, there were both independent and dependent variables.

1.5.1 Independent variables:

Gender refered to male and female.

Marital status refered to the current marital status of the elderly. It was classified into married, single, widowed, and divorced/separated.

Education level refered to the highest year of education of the elderly. It was divided into no education, primary education, secondary education, and higher than secondary education.

Occupation refered to the current working status from which the elderly earned an income. It was be divided into no occupation, retired, government official, trader, agriculturist, employee, and others.

Current income refered to an amount of money that the elderly received in return of their work or from other sources such as children, savings, salary, spouse, parent and others.

Living arrangement refered to the family member who lived with the elderly in the same house.

Illness condition refered to the illness condition which was diagnosed by the doctor.

Health status perception refered to the level of the elderly's confidence in their own ability to perform any health promoting behavior.

The availability of community elderly club refered to the existence of organization, which offered activities to the elderly and accessibility for the elderly to join the club.

The accessibility to health services refered to the elderly's ability to gain access to health services in the community such as hospital, primary health care center, and clinic.

The satisfaction with health services refered to an opinion and satisfying of the elderly in use of health services.

Social support refered to the perception of the elderly towards the emotional support, information and material support and the feeling of being admired from others.

Access to health promotion information refered to receiving information about the nine aspects of health promotion for on nutritional practice, exercise,
non-smoking, non-alcohol drinking, safety practice, housing sanitation, annual physical examination, social interaction, and stress management from mass media such as the radio, television, and newspaper.

Nutrition practice refered to behaviors of the elderly in selecting (healthy) food. Healthy eating behaviors were as the following : eating vegetables and fruit, eating protein from fish, eating food which is prepared from vegetable oil, and clean water at least six to eight glasses a day. The elderly should avoid fatty food, salty food, and food with high sugar content.

Exercise refered to an activity to generate movements of various body parts, leading to change in various systems of the body, with an aim to improve individual health. Exercises for the elderly were walking, doing work, or doing hobbies for 20-30 minutes until sweating at least three times per week.

Non-alcohol drinking refered to the elderly : behavior of not drinking alcoholic beverages at least in the past six months.

Non-smoking refered to non-smoking behavior of the elderly at least in the past six months.

Safety practice refered to the activity to prevent oneself from daily accidents. The awareness would help the elderly avoid the accident. This could be practiced, for example, by walking carefully and wearing low-heel shoes with straps.

Housing sanitation refered to the activities of managing and maintaining the house and housing compound to be clean and tidy. This included the ventilation of wind and air in the house and the sufficiency of light to help see everything clearly.

Annual physical examination refered to behaviors of the elderly in having a medical check-up once a year such as taking blood pressure, having blood chemistry and cholesterol checked, having urine examination, having chest x-ray, and getting EKG for heart check.

Social interactions refered to the actions or practices to express the ability to build relations with family and social members, talking, consulting and exchanging the problems and ideas and helping each other.

Stress management refered to the practice of the elderly to release the stress and improper emotional expression to feel relaxed. These practices were, for example, the acceptance of the changes and loss, the flexibility to respond to conditions and environmental situations with proper behavior.

1.5.2 Independent variables

Quality of life (QOL) was defined as individuals' perception of their position in life in the context of the culture and value systems in which they lived and in relation to their goals, expectations, standards, and concerns. It was a broad ranging concept affected in a complex way by the persons' physical health, psychological state, personal beliefs, social relationships, and their relationship to salient features of their environment (WHO, 1996).

In this study, (WHO, 1996). QOL was measured by WHOQOL-BREF, which contained four domains, totaling 24 topics, and two topics for overall quality of life and general health facet as follows:

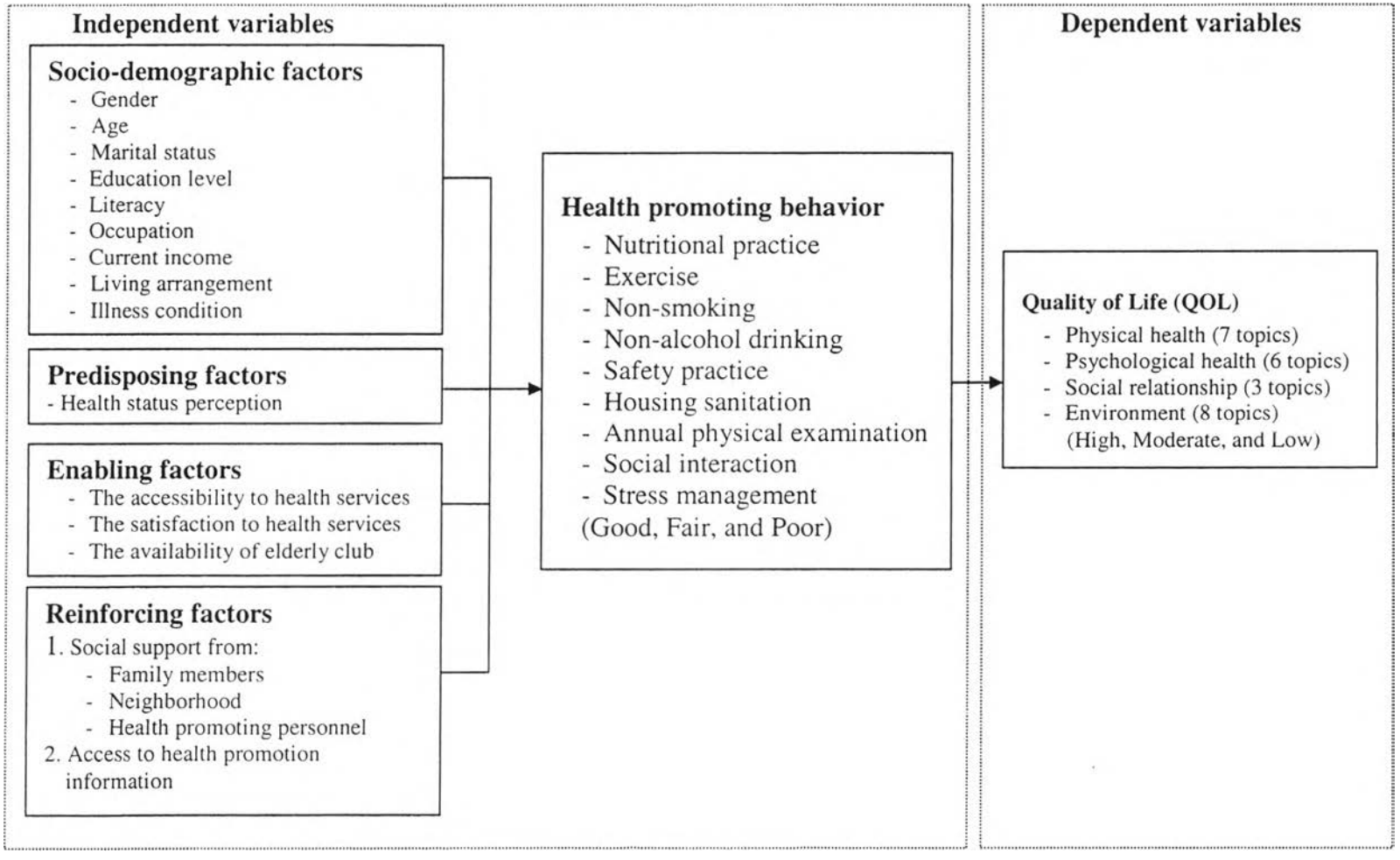
Physical health factors contained facets incorporated within seven topics: activity of daily living, dependence on medical substance and medical aids, mobility, energy and fatigue, plain and discomfort, sleep and rest, and work capacity.

Psychological factors contained facets incorporated within six topics: bodily image and appearance, negative feelings, positive feelings, self-esteem, spiritual/religion/personal beliefs, and thinking (learning, memory, and concentration).

Social relationship factors contained facets incorporated within three topics: personal relationship, social support, and sexual activity.

Environment factors contained facets incorporated within eight topics: financial resource, freedom (physical safety and security), health and social care, home environment, opportunity to acquire new information and skills, participation in and opportunity for recreation, physical environment, and transport.

1.6 Conceptual Framework



Figures 1: Conceptual framework of the study