Factors Influencing Quality of Life Among Older Adults Residing in Rural Communities Along the Thai-Cambodian Border: A Cross-Sectional Study

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ABSTRACT:

Introduction: The rapid increase in the elderly population has become a significant global challenge, particularly in ensuring the effective management and provision of care to promote a good quality of life for older adults.

Objectives: This study aims to explore the quality of life and identify the factors that predict it among the elderly living in rural communities along the Thai-Cambodian border.

Methods: This cross-sectional study, based on the ecological model, will collect data from 400 elderly individuals in LahanSai District, Buriram Province, Thailand, along the Thai-Cambodian border. Data collection is scheduled from January to April 2024.

Results: The quality of life of the elderly in the sample group was found to be moderate in both overall and individual aspects. Nine independent variables were identified as predictors of quality of life, explaining 62.6% of the variance ($R^2 = 0.626$), with statistical significance ($F = 72.893$, $p < .001$). Positive predictors included the ability to perform activities of daily living (ADL) ($B = 0.674$, $p < .001$), cognitive score ($B = 3.381$, $p < .001$), and social support ($B = 0.138$, $p = .018$). In contrast, variables with negative influences included the number of medications received ($B = -3.994$, $p = .020$), vulnerability score ($B = -1.649$, $p < .001$), age group ($B = -1.244$, $p = .008$), and fall risk score ($B = -0.836$, $p < .001$).

Conclusions: The results of this study suggest that a multifaceted approach, addressing both personal and social factors, is crucial for improving outcomes in rural and underserved communities.

1. Introduction

The world is currently becoming an aging society with the older adult population numbering 651 million people in 2022 or 14% of the entire population. This number is expected to increase to one-fourth or 22% of the entire population by 2050 (World Health Organization, 2024). Thailand fully become an aging society in 2023 (Department of Administrative Affairs, 2024). The ratio of Thai older adults increased rapidly to become the third highest in the world after Singapore (Department of Elderly Affairs, 2024). In addition, Buriram Province has become a fully aging society with 17.25% of the population being older adults (4. Department of Health, Ministry of Public Health, 2024). Rapid increases in the older adult population have created challenges in managing and providing care for older adults to have a good quality of life.

Care for older adults in a long-term care system has become more important in line with the growth of the older adult population worldwide. Therefore, improving quality of life among older adults in this system is a significant challenge for the personnel involved because older adults have to cope with deteriorative physical and psychological changes including increases in chronic diseases (Khan et al., 2024). Furthermore, many

older adults are socially isolated. This has effects on overall quality of life. Therefore, older adults need care strategies with coverage of and focus on community participation and service technology modifications (Wang et al., 2023). At the same time, the government has to cope with challenges in funding long-term care, causing effects on service access and quality of services received by older adults (Ozobokeme et al., 2022). Thus, policies must be consistent with local needs while supporting active aging, engagement in society, and emphasizing sustainable good quality of life for older adults (Simard et al., 2020).

Based on the literature review, the following factors categorized according to a bio-ecological model were found to have effects on quality of life among older adults: 1) Intrapersonal factors such as gender, marital status, age, income sufficiency, chronic diseases, exercise, nutrition, sleep, ability to perform activities in daily living, physical disability, psychological factors, and depression (Vilasri et al., 2020; Kaewsingam et al., 2021; Nopour et al., 2022; Prithiba et al., 20023); 2) Interpersonal factors such as family characteristics, social support, caregiver roles, and neighbors were significant in determining quality of life and social support networks (Vilasri et al., 2020; López et al., 2023); 3) Organizational factors covered quality of care at home and health services important for maintaining quality of life such as care services at home provided by older adults' caregivers, healthcare networks, and satisfaction in services (Vilasri et al., 2020; Kaewsingam et al., 2021); 4) Community factors consisted of social engagement, access to community resources such as care facilities and social services (Moon & Cha, 2022) and differences between urban and rural environments (Lee , 2022); and 5) Public policies which determine overall frameworks of care for older adults.

Nong Wang Sub-district, LahanSai District, Buriram Province is a rural area located on the Thai-Cambodia border. The area's remote geography affects access to health services and resources necessary for the care of older adults' health. Although the area has six Tambon health promotion hospitals and health station, older adults' healthcare has to cope with many limitations. Currently, 2,244 older adults are in the area (Health Data Center, 2023). Of this number, 2,169 older adults are society-bound, 59 older adults are house-bound, and 32 older adults are bedridden. The top three chronic diseases found among older adults were hypertension, diabetes, and asthma (LahanSai District Public Health Office , 2023). Most older adults in the area had a main income from agriculture and government benefits, which affected lifestyles, health and income in general. However, behavioral factors, health literacy, and environmental conditions remain significant components unlinked to quality of life among older adults in the area. Furthermore, no holistic studies were found to have been conducted using a systemic conceptual framework, such as an ecological model, to understand factors affecting older adults' quality of life at every level from the intrapersonal level and the community level to the societal level. Therefore, the researcher was interested in studying factors affecting quality of life among older adults in the aforementioned area by using the ecological model as a guideline in the study to create understanding of systemically associated factors with coverage in order to lead to policy developments and effective guidelines for improving quality of life among older adults in rural areas on the Thai-Cambodia border with sustainability.

2. Objectives

To study quality of life and factors predicting quality of life among older adults in rural communities on the Thai-Cambodia border.

3. Methods

This cross-sectional study implemented an ecological model at the personal, interpersonal, organizational, and community levels to provide a framework for the study. Data were collected by surveying primary data such as older adults' data using the following assessment forms and questionnaires: 1) the form for collecting data on older adults and family primary caregivers; 2) Mini-Cog test form; 3) ADL assessment form; 4) WHOQOL assessment form; and 5) the self-care behavior knowledge questionnaire.

Research Methodology

This study was conducted in Nong Wang Sub-district, Buriram Province, which had 13 villages (LahanSai District Public Health Office , 2023). Data were collected in January to April 2024.

Population and Sample

This study had a population and sample of 2,244 older adult subjects aged 60 years and up

who were living in Nong Wang Sub-district, LahanSai District, Buriram.

Sample

The researcher specified inclusion and exclusion criteria to obtain a quantitative and qualitative sample. Sample size was determined using the formula of Taro Yamane from statistical data on 2,244 older adults in Nong Wang Sub-district (LahanSai District Public Health Office , 2023).Calculations using Taro Yamane's formula resulted in 400 subjects. The researcher used the method of quota sampling by conducting simple random sampling from a randomized numerical table with consideration given to the population in each village. Inclusion criteria were as follows: Older adults who are able to communicate and willing to participate in the study. Exclusion criteria consisted of refusal to consent to participate in the study.

Study instruments

The following instruments were used in this study:

1. The Mini-Cog assessment form developed by Borson et al. and translated into Thai by Trongsakul et al. (Trongsakul et al., 2015) was used to assess cognitive impairment. This assessment form reported an interrater reliability score of 0.80 and a concurrent validity score with a positive correlation of 0.47 with MMSE-Thai 2002. Out of a full score of five points, a score of < 3 points is considered as cognitive impairment. Patients with scores of three points and up were assigned to the experimental group and the control group during trial use of the model.

2. The FRAIL Scale of Sriwong et al. (Sriwong et al., 2019) was a short screening form which used five questions. Each question represented key components of frailty, namely, fatigue, resistance, ambulation, illness, and loss of weight. The assessment criteria was for scores of three points and up to be considered as an indication of frailty.

3. The form for collecting data on older adults consisted of demographic data, family data, and health data was created by the researcher from the literature review.

4. The form for assessing the ability to perform basic activities in daily living among older adults created by Mahoney & Barthel in 1965 was translated into Thai and modified by SuttichaiJitapankun et al. (1998) with a total of ten questions. The form was used to assess older adults' real ability by awarding scores based on the ability to perform each activity and had a score range of 0 – 20 points. Scores of > 12 points meant no dependence.

5. The form for assessing self-care behaviors of older adults created by the researcher from the literature review was as follows:

5.1 The form had eight questions on older adults' self-care knowledge. "Yes" earned 1 point, "No" earned 0 points, and "Unknown" earned 0 points. Negative questions awarded scores opposite to positive questions. This area used the criteria of assessing mean scores with a score range of 0-8 points. Mean scores were in three levels consisting of low knowledge (0-2.67 points), middling knowledge (2.68-5.35 points), and high knowledge (5.36-8.00 points).

5.2 The form contained seven questions on older adults' self-care behaviors with responses on a 5-level rating scale. Respondents were able to select only one response. Scores were considered based on positive and

negative questions. The scoring criteria were as follows: For positive questions, "Highest" earned 5 points, "High" earned 4 points, "Medium" earned 3 points, "Low" earned 2 points, and "Never" earned 1 point. Responses to negative questions were in reverse order. Mean scores were interpreted using the following criteria: "Lowest" (7-12.6 points), "Low" (12.7-18.3 points), "Medium" (18.4-24 points), "High" (24.1 – 29.7 points), and "Highest" (29.8-35 points).

6. The World Health Organization's Quality of Life Brief – Thai (WHOQOL-BREF-THAI) with 26 questions was an instrument developed from the World Health Organization's instrument for indicating quality of life by Mahatnirankun et al. (Mahatnirandkulet al., 2015). The instrument contained 26 questions on four areas of quality of life consisting of physical health, mental health, social relationships, and environment. The instrument was tested and found to be accurate with a content validity index of 0.65 and good reliability. Internal consistency shown with Cronbach's alpha coefficient was at 0.84. Responses were on a 5-level rating scale. Respondents were able to select only one response. Scores were awarded by considering positive and negative questions with the following criteria: For positive questions, "Highest" earned 5 points, "High" earned 4 points, "Medium" earned 3 points, "Low" earned 2 points, and "Never" earned 1 point. Responses to negative questions were in reverse order. Mean scores were interpreted using the criteria of assessing mean scores for overall quality of life. The instrument had a score range of 26-130 points and scoring criteria were as follows: 26-60 points indicated poor quality of life, 61-95 points indicated middling quality of life, and 96-130 points indicated good quality of life. Quality of life scores for separate components were as follows:

	Level Quality of Life		
Components	**Poor**	**Middling**	**Good**
1. Physical Health	7 – 16	17 – 26	27 - 35
2.Psychological Health	6 – 14	15 – 22	23 - 30
3. Social Relationships	3 – 7	8 – 11	12 - 15
4. Environment	8 – 18	19 – 29	30 – 40
Overall Quality of Life	26 – 60	61 – 95	96 - 130

7. The form for assessing likelihood of falling in older adults (Thai FRAT) was an assessment form for risk of falling among Thai older adults living in a community developed by Thiamwong, et al. (Thiamwon et al., 2004). The form consisted of the following six risk factors: 1) gender (Female = 1 point and Male = 2 points); 2) visual impairment with inability to read more than half of numbers at a range of 6/12 meters = 1 point and ability to read more than of half numbers at a range of 6/12 meters = 0 points; 3) poor balance where inability to line feet up or stand for ten seconds = 2 points and ability to line feet up and stand for ten seconds = 0 points; 4) medication use by taking more than one type of medications such as sleep medications, sedatives, hypertension medications, diuretics, and four or more types of medications = 1 points and medication non-adherence by not taking sleep medications, sedatives, hypertension medications, diuretics, or fewer than four types of medications = 0 points; 5) record of falling (fewer than two falls in the past six months) where any record of falling = 5 points and no record of falling = 0 points; 6) housing conditions where older adults living in houses raised two meters from the floor and need a stair to move up-down = 1 point and older adults who did not live in housing of the aforementioned type = 0 points. Scores of 4-11 points were analyzed as a risk of falling and scores of 0-3 points were analyzed as no risk of falling.

8. The social support assessment form developed by Cheun-im (Chuen-im, 2007) [23]using the Rankford and House social support concept had reliability with a Cronbach's alpha coefficient of 0.83. Responses were on a 3-level rating scale. "Low" earned 1 point, "Medium" earned 2 points, and "High" earned 3 points. Interpretation used the following mean scores: 1.0-1.6 points meant low social support, 1.7-2.3 points meant medium social support, and 2.4-3.0 points meant high social support.

Instrument Quality Testing

The researcher presented the form for assessing older adults' self-care behavior and knowledge developed from the literature review to five qualified experts consisting of a doctor of family medicine, a nursing professor with expertise in community nursing, a nurse with expertise in community nursing, a public health academic, and a social worker to determine an Index of Item – Objective Congruence (IOC). An IOC of 0.91 (0.6-1 was obtained. The question concerning older adults' bedrooms on the first floor and lighting sufficiency was excluded because IOC = 0.2. The researcher tried out the revised questionnaire with a group of 30 people who had the same characteristics as the sample in the study to determine reliability using alpha coefficients, from which a reliability score of .897 was obtained.

Data Analysis

Quantitative Data Analysis – Data from questionnaires were analyzed according to specified objectives by using a mathematical statistical program (SPSS Version 29) as follows: descriptive statistics such as frequency, percentage, mean scores, and standard deviation (SD). Analysis of factors predicting overall quality of life used multiple linear regression analysis.

4. Results

Data from 400 subjects were divided into data on intrapersonal and interpersonal factors as follows: Intrapersonal Factors – A majority of the sample was female (54.0%) with an age range of 60-97 years at a mean of 69.85 (S.D. = 7.5) years. Most of the sample had an age range of 60-79 years (60%). Most of the samples were married (65.3%). The highest education level for most of the sample was elementary education (96.0%). Most of the samples had chronic diseases (68%) with hypertension as the most encountered disease (20.8%). Most of the samples had cognitive impairment (Mini-Cog < 3 points) (85.5%). Most of the sample had sufficient income for savings (98.5%), low risk of falling (< 4 points) (57.8%), no smoking (96%), no alcohol consumption (66.0%), no regular medications (71.8%), < 5 types of medications (97%), and had medication adherence (68.3%). Some of the samples were frail (1.5%). Older adults' self-care knowledge was at the High and Highest levels (95.3%). Low self-care behaviors were the most encountered level of self-care behaviors among older adults (54.5%).

Interpersonal Factors: Most of the older adults lived with a spouse and children (97.5%). In the area of social support, the sample had a medium mean score of 2.25 (0.44) for emotional social support, a medium mean score of 2.14 (0.50) for material and service social support, a medium mean score of 2.32 (0.53) for valuation, and a high mean score of 2.57 (0.47) for information social support. Most of the older adults' caregivers were neighbors (50.7%). Caregivers' activities in caring for older adults were mostly material and financial care (94.8%), followed by healthcare (72%), and helped with activities in daily living (65%). Most of the sample had membership in clubs (80%).

Organizational and Community Factors: From a focus group meeting of 16 people involved in the care of older adults in Nong Wang Sub-district, problems of older adults in the community were found to be: 1) access to service systems such as health benefits and traveling; 2) healthcare knowledge: caregivers and older adults; 3) income and occupation; 4) caregivers; 5) purchases of medications to take independently such as sets of medications; 6) alcoholism; and 7) other problems: substance abuse and murder. Factors associated

with care for older adults in the community consisted of: 1) lack of income, supplementary occupations, and having a main income from living allowances; 2) older adults had to care for grandchildren, preventing older adults from working and causing older adults to lose income; 3) older adults lived alone without caregivers because children and grandchildren went to work in cities; 4) ability to perform activities in daily living; 5) lack of reinforcement in care; 7) depression and chronic diseases. Activities or projects that should be prepared to care for older adults were as follows: 1) schools should be established for older adults; 2) projects should be created to promote older adult health; 3) training should be provided on healthcare knowledge such as medication use, dietary intake, and exercise activities; 4) vocational support activities should be organized for older adults; and 5) equipment should be provided to help older adults in basic self-care such as wheelchairs, canes or beds.

In the area of quality of life among older adults in the sample, overall and separate quality of life were found to be at a medium level. (Table 1)

Table 1: Average Quality of Life of the Sample Overall and by Specific Aspects

	$\bar{x}$	S.D.	Quality of life level
The Overall Quality of Life	89.27	9.30	moderate
- Physicalhealth	23.75	3.07	moderate
- Psychology	21.98	2.52	moderate
- Socialrelationships	9.44	1.89	moderate
- Environmental	27.28	2.88	moderate

Factors Predicting Overall Quality of Life among Older Adults in the Sample

The factors used to predict overall quality of life among older adults were intrapersonal factors and interpersonal factors. Intrapersonal factors consisted of gender, age, marital status, highest level of education, chronic diseases, cognitive impairment, income sufficiency, risk of falling, smoking, alcohol consumption, amount of medications, frailty, older adults' self-care knowledge, and older adults' self-care behaviors. Interpersonal factors consisted of family characteristics, caregiver status, club membership, and social support.

Analysis of factors predicting quality of life among older adults using multiple regression found this regression model was able to predict fluctuations in quality of life among older adults at 62.6% ($R^2 = 0.626$) with statistical significance ($F = 72.893$, $p < .001$). Furthermore, the Durbin-Watson score of 1.631 showed no autocorrelation problems. Multiple regression analysis found this model to be suitable and statistically significant with $F = 72.428$ and Sig. $< .001$, indicating all seven independent variables were able to significantly describe fluctuations in overall quality of life.

From the analysis, the following can be explained: 1) On the number of medications received, higher numbers of medications received caused overall quality of life to decline by 3.994 units; 2) On frailty, one extra unit of frailty score caused overall quality of life to decline by 1.649 units; 3) On ADL, better ability to perform activities in daily living improved overall quality by 0.734 units; 4) On age, overall quality of life declined by 1.244 units when age is higher; 5) On cognition scores, better cognition scores caused overall quality of life to

increase by 3.381 units; 6) On fall risk scores, overall quality of life declined by 0.836 units when scores for risk of falling were higher; 7) On self-care knowledge, self-care knowledge helped to improve overall quality of life by 11.348 units; 8) On self-care behaviors, more good self-care behaviors increased overall quality of life by 0.719 units; and 9) On social support, higher social support increased overall quality of life by 0.138 units.

The findings can be written in a regressive equation as follows: Overall Quality of Life = 39.431 – 3.994 (number of medications received) – 1.649 (frailty score) + 0.674 (ADL score) – 1,244 (age group) + 3.381 (cognition score) – 0.836 (risk of falling score) + 11.348 (self-care knowledge score) + 0.719 (self-care behavior) + .138 (social support score). Table 2

Table 2: Factors Predicting the Overall Quality of Life of the Elderly Using Multiple Regression Analysis

Prediction Variables	B	S.E.	Beta	t	P value	95%CI	
						lower	upper
Constant	39.431	4.839		8.149	<.001	29.918	48.944
- Number of medications	-3.994	1.713	.-073	-2.332	.020	-7.362	.-626
- FRAIL scale	-1.649	.337	.-175	-4.895	<.001	-2.311	.-987
- ADL	.674	.164	.136	4.107	<.001	.351	.996
- Age	-1.244	.470	.-089	-2.646	.008	-2.169	.-320
- Cognitivefunction	3.381	.920	.128	3.677	<.001	1.573	5.189
- Risk of Falling	.-836	.227	.-137	-3.677	<.001	-1.283	.-389
- Knowledge of self-care	11.348	1.272	.280	8.922	<.001	8.847	13.849
- Self-care behavior	.719	.057	.450	12.519	<.001	.606	.832
- Social Support	.138	.058	.080	2.375	.018	.024	.252

($F = 72.893$, $p < .001$, $R^2 = 0.626$, Durbin-Watson = 1.631)

5. Discussion

This study analyzed factors affecting overall quality of life among older adults using multiple regression. According to the findings, the regression model developed was able to explain fluctuations in quality of life among older adults at 62.6% ($R^2 = 0.626$) with statistical significance ($F = 72.893$, $p < .001$), indicating the studied factors had significant influence over overall quality of life among older adults.

The intrapersonal factors with influence over quality of life consisted of age, cognitive impairment, frailty, number of medications received, and ability to perform activities in daily living (ADL), risk of falling, self-care knowledge, and self-care behaviors. The findings can be discussed as follows: Older age caused older

adults' quality of life to decline. This may be because older adults have deteriorative physical and memory changes with advancing age. In addition, older adults may have multiple chronic diseases, causing lower quality of life (Newman-Norlundet al., 2022; Liu et al., 2024) and leading to loneliness, which further reduced satisfaction in life (Terzieva et al., 2024). The findings revealed older age was correlated with reductions in health-related quality of life (HRQOL) among older adults, which was influenced by impairments, disability, and chronic diseases, particularly effects on the physical domain. Scores were lower in women when compared to men (Suryadi et al., 2024). The findings were consistent with a study conducted by Zhao & Wan (Zhao & Wan, 2024) who conducted a cross-temporal meta-analysis and found older age to have caused quality of life to be lower by 7.94 points.

Normal cognitive functions increase quality of life. The findings from this study showed that cognitive functions play a significant role in health-related quality of life (HRQOL), particularly among older adults with mild cognitive impairment (MCI). This is consistent with a study conducted by Su et al.(Su et al., 2022), which indicated that people with cognitive impairment (CI) generally have a lower quality of life compared to those with normal cognitive health. The factors influencing the correlation between cognitive functions and HRQOL include age, gender, and comorbidities, highlighting the complexity of factors associated with quality of life in older adults. Furthermore, a longitudinal study by Keramat et al. (Keramat et al., 2023) confirmed that more severe cognitive impairment is clearly and negatively correlated with HRQOL. These findings support the idea that mental health promotion is crucial for the treatment and long-term improvement of quality of life.

Higher FRAIL scale among older adults significantly worsened quality of life because frailty covered fatigue, mobility problems, chronic diseases, and loss of weight with effects on older adults' ability to perform activities (Veronese et al., 2022; Valvani et al., 2024) leading to health risks and more deaths. This was consistent with a study conducted by Bhattarai et al. (Bhattarai et al., 2024), which indicated frailty was linked to reductions in physical ability and co-morbidities. The study consistently showed higher frailty scores were associated with lower quality of life in various dimensions including physical and psychological health (Zúñiga et al., 2019; Souza Júnior et al., 2021). The findings were also consistent with Li et al. (Li et al., 2020) who found frail older adults had significantly lower assessed quality of life than strong older adults while associated factors such as age, marital status, and co-morbidities had influence on more severe frailty (Suryadi et al., 2024). Furthermore, frail older adults were found to be at risk of reduced mobility and frail older adults used health services more frequently (Limpawattana et al., 2022), indicating higher health problems reduced quality of life.

The number of medications received by older adults negatively affected quality of life. With higher numbers of medications received, overall quality of life declined among older adults with polypharmacy, which may be correlated with chronic diseases or multiple health problems which affected older adults' living conditions and happiness(Khezrianet al., 2020). This was consistent with a study conducted by Montiel-Luque et al. (Montiel-Luque et al. 2017) who found adherence to more than ten types of medications were correlated with lower quality of life. Polypharmacy led to side-effects or medication reactions, which may lead to negative health outcomes such as cognitive impairment, reduced ability to perform activities in daily living, and lower quality of life (Nagarajaet al., 2019; Yoshida et al., 2024).

Ability to perform activities in daily living (ADLs) significantly increased quality of life among older adults. This study revealed most of the samples were active older adults with ADL scores of more than 12 points, indicating older adults were independent. The findings were consistent with a previous study conducted by Dadson and Ball (Dadson and Ball, 2023) which stated the ability to perform activities in daily living increased value and happiness in the lives of older adults. Ability to perform activities in daily living were also correlated with reductions in depression and loneliness (Nejadsadeghi et al., 2022). This was consistent

with studies conducted by Rajan et al. (Rajan et al. 2024) andMohammed Ragab Eid et al. (Mohammed Ragab Eid et al., 2024) which indicated ADL was positively correlated with quality of life in many dimensions and better ability to perform activities in daily living helped to improve overall quality of life outcomes.Higher risk of falling causes older adults to have lower quality of life. The aforementioned risks were associated with many factors including age-related physical changes such as muscle fatigue, imbalance, and fear of falling. Furthermore, external factors such as unsafe environments significantly increased risk of falling (Mahmutovićet al., 2024; Nascimento et al., 2024). The effects of fall risks were not limited to physical effects such as injuries and include psychological and social effects. Fear of falling may lead to reductions or avoidance of daily activities, causing older adults to feel socially isolated and increasing likelihood of depression (Camp et al., 2024). A study conducted by Kandeel et al. (Kandeel et al., 2024) also indicated the importance of knowledge and perceptions concerning risk of falling among older adults, which can reduce anxiety and cause older adults to have appropriate behavioral adjustments.

Good self-care knowledge and self-care behaviors helped to significantly improved overall quality of life. Self-care knowledge and practices played significant roles in effective health management and increasing quality of life for older adults. Self-care ability was directly correlated with effective health management, which reduced risk of chronic diseases and promoted better long-term well-being, particularly among older adults who had to cope with many chronic diseases. Self-care knowledge helped older adults to manage chronic conditions appropriately and reduced risk of disease (Togatorop et al., 2024). Furthermore, self-care was closely linked to the ability to perform the activities in daily living, which was a significant factor in maintaining older adults' independence. Ability to perform activities independently increased confidence and reduced dependence, causing older adults to be happier. When older adults participated in self-care, this also promoted good emotional and social well-being, which is a significant component of quality of life (Fatukaloba&Salim, 2023).

Interpersonal factors affected good quality of life among older adults. Social support played a significant role in promoting quality of life among older adults. Support from friends, families, or communities had positive effects on mental health and activities in daily living. Not only did social support help older adults to better manage chronic diseases, social support also increased health knowledge and promoted self-esteem (Dinh&Bonner, 2023). A study conducted by Rahsyani&Purwanti (Rahsyani&Purwanti, 2024) showed family support was a significant variable capable of clearly predicting happiness and quality of life among older adults. In particular, emotional support and care from family members helped to reduce loneliness and risk of depression, leading to more positive mental health outcomes (Salvador, 2023). Furthermore, support from communities and friends played significant roles in giving necessary emotional support to help older adults manage stress inherent in the aging process effectively (Zu et al., 2024). Participation in community activities was also linked with better physical health and feelings of value in society, causing older adults to have higher quality of life.

Limitations

This study had a sample limited to older adults living in urban or community areas with good access to health and social services, which may be unable to reflect older adults in remote or rural areas who may have problems of limited access to healthcare and social support, which may affect the findings on quality of life. This cross-sectional study may be unable to reflect changes in quality of life among older adults in the long term.

CONCLUSIONS

The findings showed the significance of personal and interpersonal factors for the quality of life of older adults such as age, cognitive impairment, frailty, ability to perform activities in daily living (ADL), number of medications, and risk of falling. Therefore, long-term studies should be conducted to survey the long-term effects of factors affecting the quality of life of older adults. In addition, studies should be conducted to develop a model for promoting self-care and self-care behavior adjustment among older adults along with developing activities that stimulate and enhance brain functions. Studies should be conducted on the effects of polypharmacy and multiple health conditions among older adults to reduce negative effects from excessive medication use and management of multiple health problems, the creation of strong support systems from families, friends, and communities. Studies should be conducted in larger samples with coverage of older adults in many regions of Thailand.

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