COVID-19 and older persons:

Evidence from the survey in Thailand

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Preface

Thailand has transitioned to an aged society in which 12 million people, or 19.2 per cent of Thailand's population – almost one out of every five – are aged over 60 years and 1 out of 10 people are aged over 80 years. Almost 2 million older persons are not in good physical health, with some 250,000 being in an extremely poor condition. That was the picture before the coronavirus disease 2019 (COVID-19) pandemic.

The COVID-19 crisis has come at a time when Thai society itself is going through a significant transition, moving quickly away from a traditional, nuclear family-oriented pattern and towards a far more fluid and fragmented structure, to which mass migration from the country's rural areas to Bangkok and a handful of other urban centres with grandparents and children left in the countryside while parents work in the cities have contributed.

This report is written based on a survey conducted by the College of Population Studies that was commissioned by United Nations Population Fund (UNFPA) Thailand. The objective of the survey was to provide evidence to decision makers to inform responses to older persons' needs during the COVID-19 lockdown period. Although the evidence from the survey provides a partial view of the situation, it is recognized as being a pioneering piece of work assessing the impact of COVID-19 on older persons. It may be premature to conclude on the extent of the impact of the COVID-19 crisis on older persons in this report, because the crisis is ongoing and some consequences will take time to emerge. Further investigation will be needed to learn more about how older persons' livelihoods will have been affected by the old-age population after the lengthy period of the COVID-19 pandemic, which started in March 2020.

The COVID-19 pandemic has shone a light on the fact that older persons need special attention, as they are particularly affected, and not just in terms of physical health. There are older persons who are poor, many of whom live alone, lacking family and other socioeconomic support. Almost 90 per cent of them do not have a caregiver; they must take care of themselves. With minimal safety nets, the risks to them are obvious.

At a time of crisis, especially one of this unprecedented magnitude, UNFPA is clear that the voices of older persons, their opinions and concerns, must be heard. The survey findings reveal that up to 81 per cent of the respondents face barriers to earning an income because of the pandemic. Up to 58 per cent say that the pandemic has affected their income. Almost one in three indicate that they do not have sufficient income for basic subsistence amid the pandemic.

A key aspect of leaving no one behind is the continuum of practical and emotional support that older people consistently need through families and other informal networks, or intergenerational support, as younger relatives are taking care of older ones all the more and are thereby renewing the sense of family and the solidarity that this can bring about.

Along with this, we need better safety nets for older persons. Only 4 per cent of them receive an income from their savings or assets, with their main source of income being their children. The survey findings indicate that only one in five older persons have earned an income from employment during the pandemic. This rising level of unemployment and other damaging economic impacts of COVID-19 are being witnessed in Thailand and beyond. This situation for older people may be more severe than ever.

Social protection systems and measures should be put in place to address the issue of abuse over the course of the outbreak, just as greater attention is being paid at present to the rising number of incidents of domestic violence under lockdowns and quarantine.

The pandemic is actually an opportunity for the government and citizens of Thailand, and indeed people globally, to pause and take stock of how we can rearrange our lives as individuals, as family units and as entire nations. This introspection should also help to better ensure that the most vulnerable members of society are not left behind – not only in the context of COVID-19 but also going forward under the vision of the Sustainable Development Goals.

Ultimately, all of this requires a life-cycle approach to population ageing – with gender equality and human rights at its core – that recognizes that the foundation of healthy ageing is established at the very beginning of life itself, including a strong focus on ensuring that girls and women have the opportunity to thrive in every way.

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Abbreviations

CCSA	Centre for COVID-19 Situation Administration
COVID-19	Coronavirus 2019
OAA	Old Age Allowance
NSO	National Statistical Office
TPMAP	Thai People Map and Analytics Platform
UNFPA	United Nations Population Fund
WHO	World Health Organization

Photos: UNFPA/ Chalit Saphaphak

Executive summary


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The coronavirus disease 2019 (COVID-19) pandemic has disrupted people's lives, families and communities, and, more broadly, the economies and sustainability of the world's nations. Although the virus can be transmitted to any person of any age, considerable evidence shows that the risk of more severe illnesses and mortality increases sharply with age. Countries with older populations are therefore more likely to experience greater levels of infections and deaths.

Thailand has one of the oldest populations in South-East Asia, with 19.2 per cent of the total population aged 60 years and over in 2020. The Thai government has given serious attention to controlling the pandemic situation. A state of emergency was declared on 26 March 2020, right after new COVID-19 cases spiked to 111 in one day. This was followed by curfews and various public health measures to contain the spread of the virus. These measures have proven successful; the death toll as at 23 April 2020 was 50, and the total number of confirmed COVID-19 cases among Thai citizens was 2,521, of which 10.1 per cent were older persons aged 60 years and over.

However, great success comes at a high cost. The COVID-19 crisis seems to be worsening the already weak economy of Thailand. As a result of effective lockdown measures, economic activities have declined. Job and income losses have been increasing, worsening household welfare. None have suffered more than those already living in vulnerability and insecurity. Among them, older persons have been recognized as one of the populations most severely affected by the COVID-19 pandemic.

Before the COVID-19 crisis, evidence shows that the well-being of Thai older persons had continually improved over the past decade because of the government's efforts to develop policies and measures to support these people. Many older Thais have continued to work and increasingly live independently, on their own or with their spouse only. Despite this improved situation, many remain vulnerable and depend on the government's Old Age Allowance (OAA). As a result of the COVID-19 crisis, those who were working have often lost their jobs, and those who were already vulnerable are likely to struggle even more. This emphasizes the specific challenges and needs faced by older persons, as well as the need to plan and implement responses specifically targeting older persons. To effectively support responses to older persons' needs, the government and non-governmental agencies need an evidence-based assessment of older persons' situation during the COVID-19 outbreak and lockdown period.

The Impact of COVID-19 on Older Persons in Thailand survey, conducted in July 2020, was the very first COVID-19 survey directly focusing on older persons. It aimed to provide a unique source of information based on systematically collected data. The survey targeted individuals aged 60 years and over, collecting information on economic status, living arrangements, and the physical and psychological health of respondents before and during the COVID-19 outbreak. It also assessed their knowledge, practices and sources of information regarding COVID-19. Although the lockdown measures had been relaxed at the time of the survey, avoiding face-to-face interactions was still recommended. The advantages and disadvantages of other data collection modes were considered, and it was finally decided that an online survey would be created using the Google Forms tool. The survey employed a multistage sampling technique. The questionnaires were sent out to all older persons living in the sampled communities and villages via the messaging application Line. When a survey participant lived alone, was vulnerable, dependent or illiterate, or had no smartphone or Internet access, a local intermediary served as an interviewer. A total of 1,230 interviews were completed in both urban and rural areas located in nine provinces and five regions across Thailand.

Overall, the mean age of the respondents was 69.7 years (standard deviation = 7.4 years); 55.4 per cent were women, 68.7 per cent had completed basic or compulsory education (4–6 years), and 63.7 per cent were married. The average number of living children per respondent was 2.8. With regard to socioeconomic status, 47.2 per cent had worked in the past 12 months, 94 per cent received the government's OAA, 45 per cent had an annual income of less than 20,000 Thai baht (B), and 46.6 per cent reported that their income was either sometimes or always inadequate before the COVID-19 outbreak. In terms of living arrangements, 67 per cent coresided with at least one child, whereas 5.5 per cent lived alone and 12 per cent lived with their spouse only.

Key Findings

- During the COVID-19 outbreak and lockdown period, virtually all the older persons surveyed remained at their usual residence. Less than 2 per cent had someone move into their household, and only 1 per cent reported relocation.

- Of the older persons who had worked in the past 12 months, 81 per cent experienced work-related difficulties during the COVID-19 pandemic, and 36 per cent of these older persons had become unemployed, had lost vendor spaces or had been forced to accept a lower salary. Older persons in urban areas were more likely to experience difficulties than those in rural areas.

- The percentages of older persons who received income from work, children and interest decreased during the COVID-19 outbreak. The percentage of respondents citing the OAA as their main income source increased significantly, from 40 per cent to 56 per cent. At the same time, the percentage of older persons who reported work as their main income source decreased substantially, from 40 per cent to 22 per cent.

- Income was affected by the COVID-19 outbreak for 58 per cent of respondents, of whom 60 per cent relied mainly on income from work. Older persons living in urban areas were more likely to experience low income than those living in rural areas.

- The percentage of older persons who indicated that their income was at least adequate decreased substantially, from 54 per cent to 37 per cent. One third of the respondents with adequate income indicated that their income was no longer adequate during COVID-19. Among those whose income was sometimes inadequate, one quarter indicated that their financial status had worsened during COVID-19.

- Overall, 80 per cent indicated that their health was about the same as before COVID-19. About one fifth felt that their health was worse than before; this proportion was higher in urban areas than in rural areas. Only small percentages (4–8 per cent) reported that their health problems became worse during the COVID-19 pandemic.

- One quarter of older persons experienced one of the selected psychological symptoms either sometimes or always during the COVID-19 pandemic. The most common symptom was feeling worried (57.2 per cent), followed by loss of appetite (47.3 per cent), loneliness (25.0 per cent) and unhappiness (23.3 per cent). The percentages varied little by gender but were significantly higher in urban areas than in rural areas. Older persons living alone were more likely to feel lonely than those in other living arrangements.

- The issues that most commonly worried older persons were their personal and family financial status, worse health due to missed medical appointments, and fear that they and their family members would contract the coronavirus.

- About half experienced difficulties in maintaining each of the selected routine activities. The percentages varied by gender and area of residence. Older men and rural residents were more likely than their counterparts to experience difficulties in their routine activities.

- One quarter of older persons reported that their life satisfaction was lower during the COVID-19 outbreak. Older persons in urban areas were twice as likely as their rural counterparts to report lower life satisfaction.

- Virtually all respondents indicated that they received information regarding the COVID-19 outbreak from at least one of the selected sources. Television or radio and family were the two primary information sources for older persons.

- Nearly all of the older persons were aware of their own risk of developing a more serious illness if they contracted the coronavirus, and they also knew about the transmission and prevention of viral infections. Fewer than half knew about the length of the incubation period and the appropriate duration of quarantine. The majority of older persons complied with health recommendations, including wearing a face mask, avoiding leaving the house, and socially distancing from others.

- Overall, 75 per cent received the government's cash support of B5,000 for three months through one of the three cash transfer programmes for farmers, low-income people and older persons.

At this point, it may be premature to conclude on the extent of the negative impact of the COVID-19 crisis on older persons, particularly the economic consequences, which usually take some time to fully unfold. The findings in this report show that many Thai older persons are experiencing a higher level of economic insecurity in their later life. One out of four Thai older persons reported experiencing at least one psychological symptom, indicating a higher risk of new or worsening mental health problems. A particularly striking result is that those in urban areas are more vulnerable than their rural counterparts in relation to many aspects of well-being.

The COVID-19 crisis shows that the government's OAA programme serves as the foundation of economic security for older adults, but the benefit is relatively small, and it is insufficient even in normal times. As Thailand continues through the COVID-19 crisis, safeguarding the economic security of older persons requires policy efforts at many levels. Policies and measures to support people and businesses affected by the COVID-19 outbreak must take into account the older population that wants to work and that relies on income from work.

Section I

Introduction

The outbreak of the novel COVID-19 began in China around the end of 2019 and quickly spread to other parts of the world, bringing about alarming infection figures and death tolls. On 11 March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic.[1] COVID-19 has not only caused illness and death but also affected all individuals' lifestyles, in terms of both protecting themselves and containing the outbreak. The public sector is faced with challenges in designing and implementing public health measures to cope with a wide range of problems due to the outbreak.

Although everyone is at risk of contracting COVID-19 if they are exposed to the virus, older persons are at a higher risk of severe disease and mortality following infection. Empirical data from various countries around the world have shown the tendency of older persons to experience more severe side effects because of COVID-19 than other age groups, which may lead to even more critical and life-threatening symptoms. The morbidity rate of older persons aged 80 years and over is five times the average.[2] WHO has reported that over 95 per cent of fatalities due to COVID-19 in Europe have been those aged 60 years and over (United Nations Department of Economic and Social Affairs, 2020). China reported that, as at 7 February 2020, 3.6 per cent of COVID-19 confirmed cases aged 60–69 years had died. This increased to 8.0 per cent among those in their 70s and 14.8 per cent among those in their 80s. Italy, as at 17 March, reported around the same case fatality rate for older persons aged 60–69 years, at 3.5 per cent, but a much higher rate of 20.2 per cent for those aged 80 years and over.[3,4] The global death toll for all age groups reported on 26 April 2020 was as high as 193,710 (United Nations, 2020). As at 20 October, at the time of writing this final report, the global total number of confirmed deaths had reached 1.12 million.[5] If the situation continues as public health and social service resources have been exhausted as a result of fighting COVID-19, the number of infections and deaths are likely to become even higher.

According to the policy recommendations published by the United Nations (2020) on the impact of COVID-19 on older persons, in addition to a higher risk of death compared with other age groups, older persons may face additional vulnerability from being left alone, not being treated equally or even being mistreated. In some countries where lockdown measures have been in place, older persons locked down with their families or caregivers have been more prone to higher risks of violence, abuse or neglect. Those residing in crowded housing, such as slums and prisons, have been not only at a higher risk of exposure to the coronavirus (Lloyd-Sherlock et al., 2020) but also more likely to have had limited access to food, clean water, health services and essential assistance. In countries where limited or no long-term care systems are available, older persons tended to be cared for by family members, mostly wives who are also around the same age, which increased the risk of interpersonal transmission (United Nations, 2020).

In addition, the COVID-19 crisis has affected older persons' socioeconomic well-being. Social distancing has a profound impact on social support (e.g. the number of visits made by their children and community members), which can make older persons, particularly those who live by themselves, feel isolated and lonely. Sustaining this measure may negatively affect the mental health of older persons in the long term. These symptoms tend to be more severe for those with limited or no access to information technology. In terms of the government scheme to promote employment among older persons, the spread of COVID-19 has inevitably affected their potential employment and income. This problem will have been aggravated in the absence of other sources of income, such as support from children, government pensions, allowances and income protection.

COVID-19 situation prior to the survey

In Thailand, the Ministry of Public Health reported 2,839 COVID-19 confirmed cases as at 23 April 2020, of which 2,521 cases were Thai citizens. Of these confirmed cases, 10.1 per cent were persons aged 60 years and over, with 40 per cent in the youngest age group of 60–64 years.[6] According to WHO Thailand's situation report on COVID-19, as at 17 April, 3.7 per cent of the population aged 60–69 years had died because of COVID-19, compared with less than 1 per cent of the population aged 40 years and under. The mortality rate increased almost three-fold to 12.1 per cent for those aged 70 years and over (WHO Thailand, 2020).

The Thai government has given serious attention to controlling the pandemic situation. A state of emergency was declared on 26 March 2020, right after new COVID-19 cases spiked to 111 in one day. This was followed by curfews and various public health measures to contain the spread of the virus. Although the COVID-19 pandemic in Thailand has subsided, as reflected by the first and second stages of the relaxation of the lockdown measures on economic, health and leisure activities on 3 May 2020 and 17 May 2020, respectively, the impact of the COVID-19 crisis seems to be worsening the already weak economy of Thailand. As a result of the effective lockdown measures, economic activities have declined. The number of job and income losses has been increasing, worsening household welfare. None have suffered more than those already living in vulnerability and insecurity. Among them, older persons have been recognized as one of the populations most severely affected by the COVID-19 pandemic.

During the COVID-19 outbreak, various government agencies and academic institutions have attempted to collect information to assess the consequences for the general population as well as specific groups, such as farmers and ethnic youths. However, no survey had collected information directly from populations aged 60 years and over at the time of this survey's inception. The data obtained through this survey are extremely important for policymakers and related governmental and non-governmental agencies in effectively addressing the needs of older persons.

Situation of older persons in Thailand prior to COVID-19

The number of older persons in Thailand has increased rapidly and will continue to do so in future decades. This section gives a brief overview of the trends in population ageing and the demographic and socioeconomic situation of older persons in Thailand prior to the COVID-19 outbreak.

[1] Data obtained from the Department of Disease Control, Ministry of Public Health. Available at https://ddc.moph.go.th/viralpneumonia/ind_world.php (accessed in May 2020).

[2] United Nations Population Fund Thailand. Available at https://thailand.unfpa.org/th/elderly-COVID19 (accessed in May 2020).

[3] Our World in Data, "Mortality risk of COVID-19". Available at https://ourworldindata.org/mortality-risk-covid (accessed in October 2020).

[4] Caution is needed in interpreting the case fatality rates, because many cases in the population have not been confirmed owing to a lack of COVID-19 tests, and many infected people who would eventually die may have been alive at the time of recording.

[5] Our World in Data, "Mortality risk of COVID-19". Available at https://ourworldindata.org/mortality-risk-covid (accessed in October 2020).

[6] Data on the number of confirmed cases were taken from COVID-19 Daily, Thailand. Available at https://data.go.th/dataset/covid-19-daily.

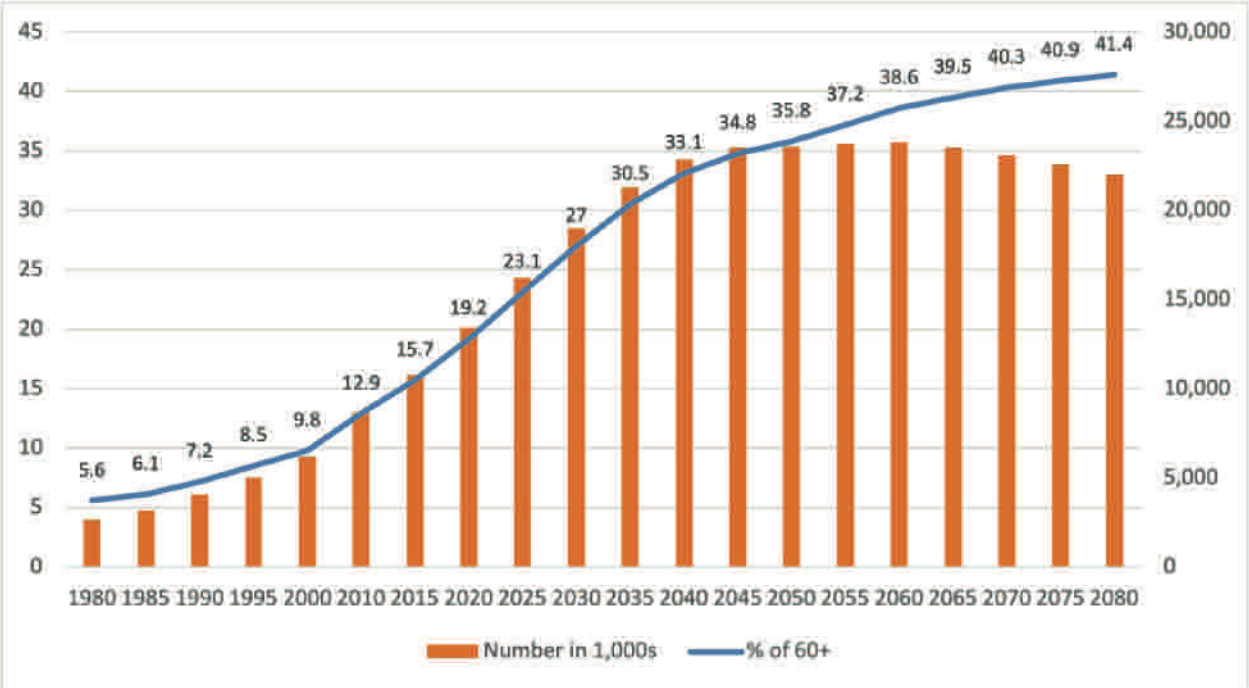
Trends in population ageing

Thailand's population is ageing rapidly. The country is the second most aged country in South-East Asia. Only in Singapore is the percentage of older persons higher than in Thailand. The rapidly increasing ageing population has resulted from a combination of a fertility decline, from 6 children per woman to only 1.5, and an increasing level of survivorship at an older age. According to the most recent United Nations population projection for Thailand (2019), the population aged 60 years and over has increased around fivefold between 1980 and 2020, rising from 2.6 million to 13.4 million. In the same period, the percentage of the population represented by persons aged 60 years and over increased from 5.6 per cent to 19.2 per cent (Figure 1.1).

Figure 1.1 also shows the future growth of the ageing population in Thailand. The Thai population aged 60 years and over is expected to almost double between 2020 and 2050, rising from 13.4 million to 23.5 million. The percentage of the older population will depend on the future trend in fertility. According to the medium fertility variant – the most commonly used – the percentage of the older population will almost double from 19.2 per cent in 2020 to 35.8 per cent in 2050.

Figure 1.1

Number and percentage of the population aged 60 years and over, medium fertility variant of the United Nations, Thailand, 1980–2080



Source: 2019 United Nations Population Division population estimates and projection (United Nations, 2019).
Note: Results shown are based on medium fertility.

Socioeconomic and health characteristics of older persons

Information in this section heavily relies on the report Thailand's Older Persons and Their Well-Being: An Update Based on the 2017 Survey of Older Persons in Thailand, which was authored by Dr Bussarawan Teerawitchitchainan and colleagues (2019). The report was largely based on the most recent and available national survey of older persons conducted by the National Statistics Office of Thailand (NSO) in 2017.

Women make up a disproportionate share of the Thai older population, constituting 55.1 per cent of all older people, and 81 per cent of older men are married, compared with 48 per cent of older women. In contrast, 42 per cent of older women are widowed, compared with only 14 per cent of older men. The average number of living children is 2.9. The great majority of Thai older people have a basic primary education, with about 10 per cent having no education.

Co-residence with one or more adult children is the most common living arrangement among Thai older persons, even though there was a steady decline from 71 per cent in 1995 to only 52 per cent in 2017. The continued decline in coresidence with children is a result of the fertility trend of fewer children, combined with greater dispersion of children owing to migration. Living alone accounts for 11 per cent of older persons. However, 28 per cent of older persons who live alone and almost one quarter of those who live with only a spouse have at least one child living adjacent. Moreover, 28 per cent of older persons live in households of three or more generations, with 37 per cent living with at least one grandchild.

According to the "2017 Survey of Older Persons" (NSO, 2017), 38 per cent of all persons aged 60 years or over reported that they worked during the past 12 months. The percentages of those who worked are significantly higher among older men than among older women and among rural residents than among urban residents. Work is a possible source of income for older persons. Other significant sources include the government's OAA scheme and children. In 2017, 86 per cent of persons aged 60 years and over received the OAA. Around the same percentage received at least some income in the past year from their children. The percentage of respondents reporting children as their main source of income was 35 per cent in 2017. Around one fifth reported the OAA as their main income source. Women generally reported lower incomes than men. Rural respondents reported considerably lower incomes and viewed their economic situations as less favourable than those of respondents living in urban areas. Around 56 per cent of older adults believed that their income was adequate. By 2017, virtually all older persons lived in a household with a television, and 95 per cent lived in a household with a refrigerator. One third of older Thais lived in a household with Internet access.

Two fifths of older Thais assessed their health during the past week as good or very good; 16 per cent reported that they could see clearly and 13 per cent reported that they could not hear clearly. These percentages were higher in urban areas than in rural areas. At least one difficulty in functional limitations or activities of daily living was experienced by 37 per cent. Around one third of older adults reported that they received a physical check-up (free of charge or with minimal fees) during the past year, primarily from government health facilities.

Section II

Data and Measures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Data

This report relies on data from the Impact of COVID-19 on Older Persons in Thailand survey conducted in July 2020 by Chulalongkorn University's College of Population Studies. This survey was the first to specifically focus on the impact of the COVID-19 outbreak and lockdown measures on older persons. The survey inquired about socioeconomic status, living arrangements, physical and psychological health, and daily activities of older persons before and during the COVID-19 outbreak. It also inquired about older persons' sources of information, knowledge and preventive practices regarding COVID-19, as well as the assistance and support they had received to alleviate its impact.

The survey covered individuals aged 60 years and over who resided in urban and rural sites in the selected nine provinces located in five regions (including Bangkok) across Thailand. In each region, two provinces were chosen. One province was randomly selected from the top three provinces with the largest proportions of older persons. Since vulnerable people often face greater challenges in times of crisis and tend to be excluded if the data collection involves modern technology, the other province was randomly selected from the top three provinces with the highest percentages of vulnerable older persons, as reflected by two indicators: having no job or income and being deserted by their family, the community and the government. Carrying out the survey in all the chosen provinces enabled us to cover older persons living in various socioeconomic conditions. More details of the survey methodology are provided in Annex I.

Table 2.1 presents a total of 1,230 complete interviews by area of residence, province and region. Consistent with Thailand's geographical distribution of older persons, the number of interviews was highest for the north-east region and lowest for Bangkok, and higher for rural areas than for urban areas.

Table 2.1

Number of respondents in the survey by area of residence, province and region

Region	Province	Area of residence		Number of respondents
		Urban	Rural	
Bangkok	Bangkok	131	-	131
Central	Samut Songkram	67	87	154
	Ayuddhaya	67	90	157
Northern	Lampang	43	80	123
	Chiang Rai	45	83	128
North-East	Nakon Ratchasima	59	134	193
	Buriram	55	135	190
Southern	Songkla	27	53	80
	Phang Nga	24	50	74
Total		**518**	**712**	**1,230**

Owing to the COVID-19 pandemic, several surveys, particularly those using face-to-face interviews, were postponed or redesigned. As our survey aimed to assess the impact of the COVID-19 crisis and lockdown measures, it was vital to obtain responses from older persons regarding how they were affected as soon as the pandemic subsided and the lockdown measures were eased. Given the government's health recommendations on social distancing and interprovincial travel, our survey was initially designed to rely primarily on a self-administered online questionnaire. Under this approach, a questionnaire created in Google Docs was distributed directly to individuals aged 60 years and over who resided in the sampled communities and villages by our local intermediaries via a messaging application called Line. The local intermediaries comprised local administrative officers, health staff at the subdistrict health-promoting hospital or municipal health service centre, and various volunteer groups, such as village health volunteers and older person volunteers. However, this approach has some limitations: many Thai older persons have limited literacy or poor eyesight, do not own a smartphone, or live alone or in a household without a smartphone. Therefore, another mode of data collection – a face-to-face interview – was arranged to assist respondents in completing the survey and to increase the coverage of these older people. The project's intermediaries conducted face-to-face interviews and completed the survey on their own mobile phone on behalf of these older persons. More details of how data were collected from different groups of older persons are included in Annex I.

Virtually all of the respondents completed the survey with assistance from the local intermediaries. The self-administered online survey proved unsuccessful from the first week of fieldwork commencement, because the team did not receive any questionnaire responses from the group of older persons who were initially intended to complete the survey by themselves. The response rate was relatively high for face-to-face interviews, because older persons were more receptive to social interactions with the survey team, following the lockdown situation. Very few older adults refused to participate in the survey. Therefore, the survey's overall response rate varied greatly between 0 per cent and 93 per cent.

Measures

The survey's questionnaire solicited detailed information on various aspects of the well-being of older persons before and during the COVID-19 and lockdown measure period. The content of the questionnaire was drawn from the research team's previous reports on the situation of older persons in Thailand, available evidence on related issues regarding older persons and COVID-19, and questionnaires used in previous surveys conducted in Thailand and elsewhere to assess the impact of COVID-19 on the general population and specific groups, such as youths and labourers. The draft versions of the questionnaire were reviewed by several national and international experts and pre-tested with a sample of 10 older adults.

The survey included both objective and subjective information to assess older people's well-being. The objective measures of material well-being were income level, sources of monetary support, expenses and debts, whereas the subjective measure was drawn from a single questionnaire item asking respondents to assess their income adequacy. Similarly, both objective and subjective questions were used to assess health status. Notably, attempts to obtain more objective measures (for example, blood tests and biomarkers) were outside the scope of the survey. Objective health measures were self-reported health and functional problems, whereas subjective health measures were assessed through a self-reported question relating to health status before the COVID-19 crisis and health status during the COVID-19 crisis compared with before.

Psychological health was measured through self-reported psychological symptoms and life satisfaction. Psychological symptoms included loss of appetite, no hope in life, and feeling unhappy, sad, worried and lonely. The response categories were "never", "sometimes" and "always". Life satisfaction was measured by a single-item question with a 5-point scale ranging from 1 (very satisfied) to 5 (very dissatisfied).

The survey also inquired about daily activities undertaken before and during the COVID-19 crisis and lockdown measures, as well as sources of information on the COVID-19 situation. The questionnaire included true/false (correct/incorrect) questions that tested respondents' basic knowledge regarding COVID-19. The full questionnaire is provided in Annex II.

Section III

Basic Characteristics of Respondents

The basic sociodemographic characteristics of the respondents are presented in Table 3.1. Women modestly outnumbered men. Slightly more than half of the respondents lived in rural areas, and almost one third was married at the time. Gender and area of residence did not differ substantially among age groups. However, the percentage of the respondents who were married at the time decreased considerably as age increased. Although approximately two thirds of respondents aged 60–69 years were married at the time, this was the case for half of those aged 80 years and over.

Table 3.1

Basic demographic and social characteristics of respondents by age cohort

	Total	Age group		
		60–69	70–79	80+
Percentage of respondents who were:		57.4	30.6	12.0
Women	55.4	57.0	54.5	50.3
Rural residents	57.9	52.9	65.4	62.6
Married	63.7	68.7	59.6	50.3
Education (percentage distribution)				
None	7.4	4.1	8.0	21.8
1–3 years	8.5	5.4	11.2	17.0
4–6 years	68.7	70.0	69.7	59.9
Lower secondary	6.0	8.2	4.0	0.7
Upper secondary or beyond				
9.3	12.3	7.2	0.7	
Total	100	100	100	100
Region (percentage distribution)				
Bangkok	11.2	12.5	9.4	9.4
Central	26.6	24.6	29.4	29.0
North	21.4	22.2	19.4	23.2
North-east	27.7	28.3	27.4	25.4
South	13.2	12.5	14.4	13.0
Total	100	100	100	100
Number of respondents	**1,230**	**707**	**376**	**147**

The results in Table 3.1 show that, overall, around 7.4 per cent of respondents had no formal education, whereas two thirds had completed at least the basic compulsory level that prevailed at the time when they were of primary school age. Those with a lower secondary or upper secondary or beyond education level constituted a smaller proportion of around 15.3 per cent of the older population. The

educational distribution of the current cohort of older Thais varied substantially by age group. The lower percentage of no education and less than basic compulsory education among younger cohorts reflects the expansion of public education over the period when different cohorts were of school age. In contrast, the percentage of lower secondary and upper secondary or beyond declined with age.

Among those aged 60–69 years, approximately 20 per cent had at least some secondary schooling, compared with only 1 per cent of those aged 80 years and over. The results show that the basic compulsory schooling of 4–6 years was by far the most frequent level of schooling for the respondents in all three cohorts and sampled provinces.

Figure 3.1

Number of living children (percentage distribution) by age cohort

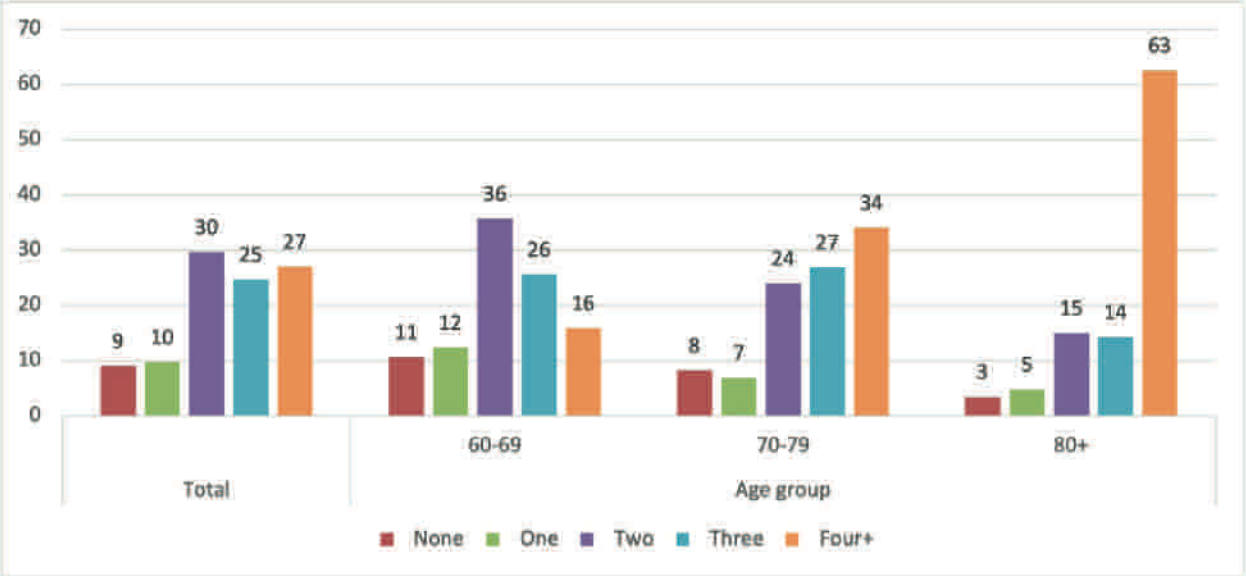


Figure 3.1 shows the mean number of living children overall and with respect to the respondents' age. The number of living children refers to the count of reported surviving biological children or stepchildren, as well as adopted children. The overall mean number of living children was 2.8. As anticipated by Thailand's demographic structure shift, the three cohorts differed considerably with respect to family size. The mean number of living children was 2.3, 3.0 and 4.1 for respondents aged 60–69 years, 70–79 years and 80 years and over, respectively. Less than one fifth of the respondents aged 60–69 years had four or more children, compared with almost two thirds of those aged 80 years and over. Conversely, three fifths of those aged 60–69 years had two or fewer children, compared with only 23 per cent of those in their 80s. Still, childlessness and one-child families were fairly uncommon overall and among all three cohorts.

To explore the economic impact of COVID-19, the survey collected both objective and subjective information regarding material well-being before the COVID-19 outbreak. As Table 3.2 shows, almost half of the respondents (47 per cent) were economically active before the COVID-19 outbreak. This is modestly higher than the corresponding figure based on the "2017 Survey of Older Persons in Thailand" (NSO, 2017) (38 per cent). This suggests that the Thai government's efforts in promoting old-age employment have been fruitful. Table 3.2 also shows that the percentage of respondents working declined rapidly as age increased: 63 per cent of those aged 60–69 years reported that they worked in the past 12 months, as did 32 per cent of those aged 70–79 years and 9 per cent of those aged 80 years and over.

Table 3.2

Economic status before the COVID-19 outbreak by age group

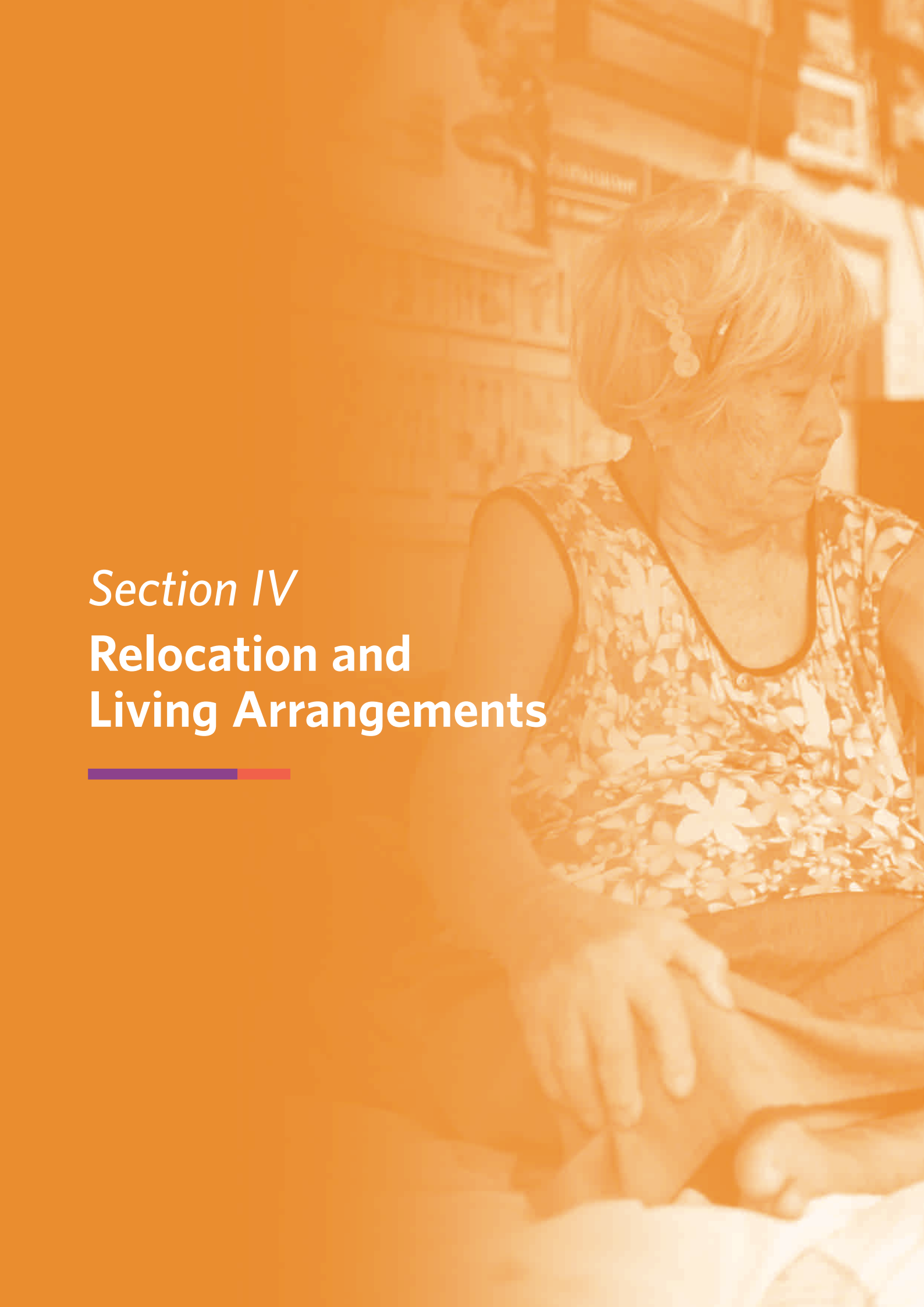
	Total	Age group		
		60–69	70–79	80+
Percentage of those who had worked in the past 12 months	47.2	63.2	32.2	8.8
Average annual income (percentage distribution)				
<10,000	28.2	20.8	35.6	44.9
10,000–19,900	16.9	15.7	18.4	19.0
20,000–29,999	11.8	11.3	13.6	9.5
30,000–39,999	7.2	7.5	6.1	8.2
40,000–49,999	5.3	5.8	5.6	2.0
50,000–99,999	17.6	21.8	12.8	9.5
100,000 or higher	10.6	14.9	6.4	0.7
Do not know	2.5	2.3	1.6	6.1
Total	100	100	100	100
Percentage of those whose household had:				
Radio	59.3	59.0	59.8	59.2
Television	97.5	97.9	97.9	94.6
Cellphone (including a smartphone)				
80.7	86.3	75.0	68.0	
Computer (desktop, laptop or tablet)	25.6	26.2	24.5	25.9
Internet	45.6	47.9	42.0	43.5
Self-reported income adequacy (percentage distribution)				
Adequate or more than adequate	53.4	53.2	52.4	57.1
Sometimes inadequate	32.2	32.0	33.0	31.3
Always inadequate	14.4	14.9	14.6	14.1
Total	**100**	**100**	**100**	**100**

The survey included a question asking respondents to estimate their average annual personal income. The results show that almost half of the respondents (45 per cent) were concentrated in the two lowest income categories. The percentage of respondents in the two highest categories constituted a considerably smaller proportion of around 28 per cent.

Another objective piece of information on economic well-being was household possession. Although the presence of household items does not necessarily mean that such items belong to the respondent, it can serve as an indicator of the economic status of their household (Knodel et al., 2006). As Table 3.2 shows, the most common household possession was a television (98 per cent), followed by a cellphone (81 per cent). Almost half of the respondents lived in households with Internet access, and one quarter (25.6 per cent) lived in households in which at least one member had a computer. The differences in possession of household items were modest among age groups, except those relating to cellphones. Although the percentage of respondents living in households with a cellphone was highest for those aged 60–69 years, it was distinctively low for the oldest respondents.

The survey also included a subjective question asking respondents to assess whether their overall income before the COVID-19 outbreak was adequate. Slightly more than half of the respondents (53.3 per cent) indicated that their income was adequate or more than adequate, with around 14 per cent indicating that their income was always inadequate. The differences in self-assessed income adequacy were very small among age groups. Interestingly, those aged 80 years and over assessed their income more positively than those in their 60s (Table 3.2).

It should be noted here that some of the characteristics of the respondents in this survey may not be directly comparable to those in earlier national surveys of older persons. Although this survey was based on national probability sampling, it covered only 9 provinces out of 77 countrywide, whereas earlier national surveys, such as the surveys of older persons in Thailand of the NSO, included almost all provinces in Thailand. Nonetheless, the primary aim of this survey was not to be nationally representative but to cover vulnerable older persons.



Section IV

Relocation and Living Arrangements

One of the leading concerns regarding the well-being of older persons in the COVID-19 pandemic is its potential impact on the relocation of either the older persons or their family members that will inevitably change the older persons' living arrangements. However, because of the government's travel restrictions and lockdown measures, the other concern is the possibility that old-age parents are abandoned, particularly those who live completely on their own without a spouse or any children nearby.

To assess the impact of the COVID-19 pandemic on living arrangements, the survey asked respondents if they had moved out of their usual residence or if someone who is not a usual resident (such as adult migrant children) had moved into their household because of the COVID-19 pandemic. The results shown in Table 4.1 indicate that virtually all respondents did not relocate during the COVID-19 pandemic. Less than 2 per cent of all respondents had someone move into their household during the pandemic, and only around 1 per cent reported relocation. The same was reported by Cohn (2020), who found that only 1 per cent of US adults aged 65 years and over had relocated during the COVID-19 pandemic.

The small percentage of adult migrant children returning to their homes was, nonetheless, contrary to our expectation. This may be partly because our sampled provinces were not major sources of migrant labourers. In addition, although the lockdown measures were in place, several businesses were still operating. Given this, fewer migrants than anticipated returned to their hometowns during the COVID-19 pandemic and lockdown period.

Overall, very few differences were found in age and gender among older persons who reported relocating. However, urban respondents were more likely than their rural counterparts to relocate during the pandemic (Table 4.1). With respect to the destination of relocation, the majority of older persons (62.5 per cent) indicated that they moved outside the province where they lived before the outbreak of COVID-19 (result not shown).

Table 4.1

Older persons' experience of relocation because of the COVID-19 crisis by age, gender and area of residence

	Total	Age group			Gender		Area of residence	
		60–69	70–79	80+	Men	Women	Urban	Rural
Moved to live elsewhere	0.7	0.7	0.5	0.7	0.7	0.6	1.2	0.3
Did not move but had someone move in	1.7	1.0	2.1	4.1	1.5	1.9	0.8	2.4
Did not move and had no one move in	97.6	98.3	97.3	95.2	97.8	97.5	98.1	97.3

Table 4.2 describes respondents' living arrangements during the COVID-19 pandemic. Living with a spouse and children and living with children only were the most common forms of living arrangement. Overall, 70 per cent of the respondents coresided with at least one of their children during the COVID-19 outbreak. Of those who lived independently during the pandemic, most lived with a spouse. Those who lived alone accounted for only 5.5 per cent of all respondents. The results further show that respondents aged 80 years and over were more likely to live with at least one child and less likely to live alone or with a spouse only. There were also gender differences in the pattern of living arrangements. Older women were more likely to live alone and less likely to live with a spouse only than their male counterparts. This, as suggested in other reports (Teerawitchitchainan et al., 2019), reflects the higher levels of widowhood among older women. Urban respondents were more likely than their rural counterparts to live independently, either alone or with a spouse only. The percentage of respondents who lived with a spouse and others but no children was also higher in urban areas than in rural areas. In contrast, living with a spouse and children was more common among rural respondents than among urban respondents.

Living with at least one grandchild of any age was fairly common among respondents during the COVID-19 pandemic. About one third lived with at least one grandchild aged 15 years or under regardless of whether the household contained any other members. Under 1 per cent lived with at least one young grandchild in a household in which no one else resided. This form of living is often referred to as a skipped-generation household. The percentage of respondents who lived with only a caretaker, housekeeper or servant in the absence of anyone else was negligible during the COVID-19 pandemic.

Table 4.2

Living arrangements during the COVID-19 pandemic

Percentage distribution of living arrangements	Total	Age group			Gender		Area of	
		60–69	70–79	80+	Men	Women	Urban	Rural
Alone	5.5	4.7	7.4	4.8	3.6	7.0	6.4	4.9
Spouse only	12.0	15.0	9.0	4.8	14.8	9.7	12.9	11.2
Spouse and others but no children	6.1	6.6	6.6	2.0	7.1	5.3	6.6	5.8
At least one child but no spouse	24.6	20.4	26.9	39.5	14.4	32.8	26.6	23.2
With spouse and children	43.3	45.1	40.7	41.5	54.7	34.2	39.6	46.1
With others only	8.5	8.2	9.3	7.5	5.3	11.0	7.9	8.8
Total	100	100	100	100	100	100	100	100
Percentage of those with any grandchild	52.5	50.4	52.9	61.9	52.7	52.3	50.6	53.9
Percentage of those with a grandchild aged ≤15 years	34.6	37.5	32.7	25.2	36.1	33.3	32.8	35.8
Percentage of those with a grandchild aged ≤15 years only	0.8	1.1	0.5	0.0	0.2	1.3	0.8	0.8
Percentage of those with relatives only	5.0	5.1	6.1	2.0	3.3	6.5	4.1	5.8
Percentage of those with housekeeper/ caretaker only	0.1	0.0	0.3	0.0	0.2	0.0	0.0	0.1

The survey did not inquire about who the respondents lived with in the same household before the COVID-19 situation. However, our results reveal that a minimal number of respondents relocated or had others move into their households. We can therefore assume that the pattern of living arrangements during the COVID-19 pandemic and lockdown period is likely to be the same as that before the pandemic.

Section V

Economic Activity and Income

Economic security and material well-being have been among the most pressing issues related to older persons (United Nations, 2002; UNFPA and HelpAge International, 2012). Many older people have been struggling to live, even in normal times. As a result of COVID-19, we are likely to see an aggravated impact on them and other socioeconomic subgroups. This section assesses the implications of the COVID-19 pandemic on older persons' economic well-being by focusing on how the economic resources they had before the pandemic have changed. At the time of writing this report, the economic consequences of the pandemic and responses to it may have just been starting to unfold (Li and Mutchler, 2020). Particular implications of the current economic downturn for older adults may have also begun to emerge. Since the COVID-19 pandemic seems far from over, the assessment of the current economic impact has certain limitations. Therefore, caution is required when interpreting the results.

Work and employment

As indicated in Section 3, 47.2 per cent of respondents reported that they had worked in the past 12 months, before the COVID-19 pandemic. Of these respondents, the great majority (81 per cent) reported experiencing some difficulties in relation to their work because of the government's measures to contain the spread of COVID-19. As shown in Figure 5.1, the percentage of respondents reporting work-related difficulties increased with age. All respondents aged 80 years and over who had worked during the past year reported encountering difficulties in relation to work. Older men and women differed very little in their experience of work-related difficulties. In addition, urban respondents were more likely to report work-related difficulties than rural respondents.

Respondents who had worked in the past year were further asked how their work and employment had been affected by the COVID-19 crisis. As shown in Figure 5.2, 4 per cent reported that they had been laid off, whereas 7 per cent had lost their job because businesses had been shut down. At the same time, 16 per cent indicated that they had lost their vendor space. Although many respondents had continued to be employed and paid, they were at risk of losing their job in the future. One fifth had faced decreasing sales, whereas 9 per cent had experienced a salary cut. Moreover, for those who still had a job, one fifth had been requested to work from home.

Figure 5.1

Percentage of older persons who had worked in the past 12 months who reported work-related difficulties because of the COVID-19 pandemic by age, gender and area of residence

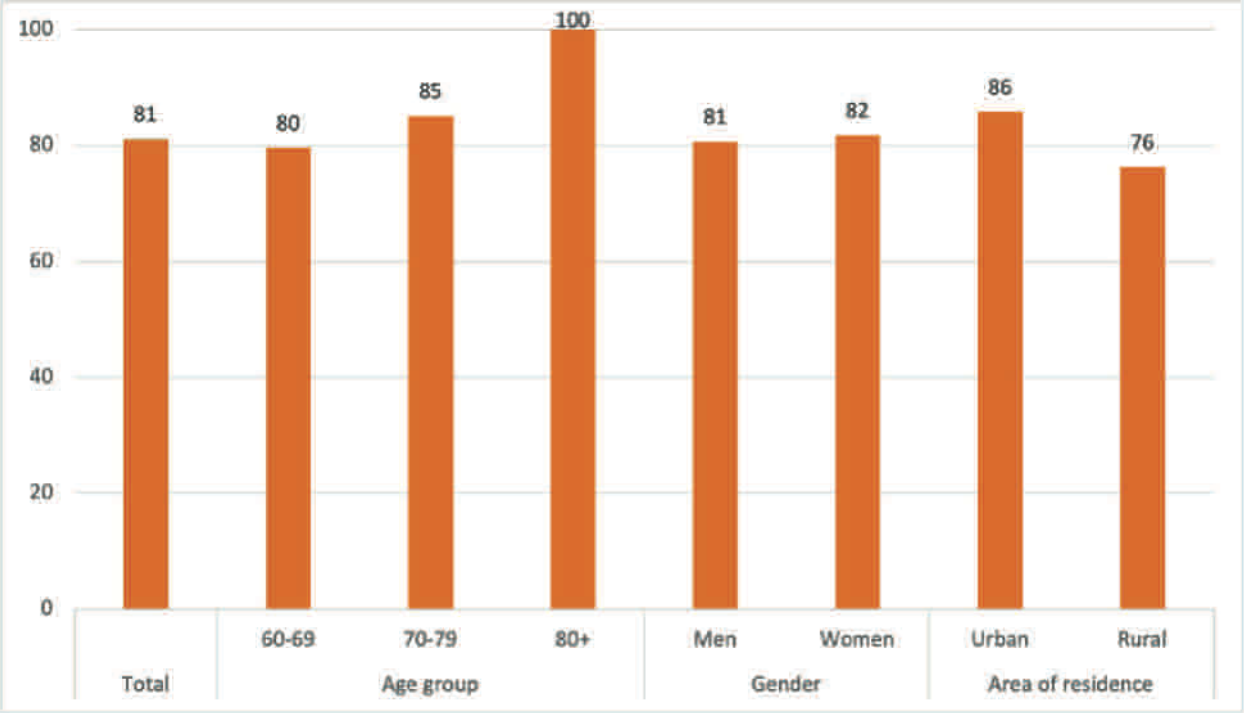
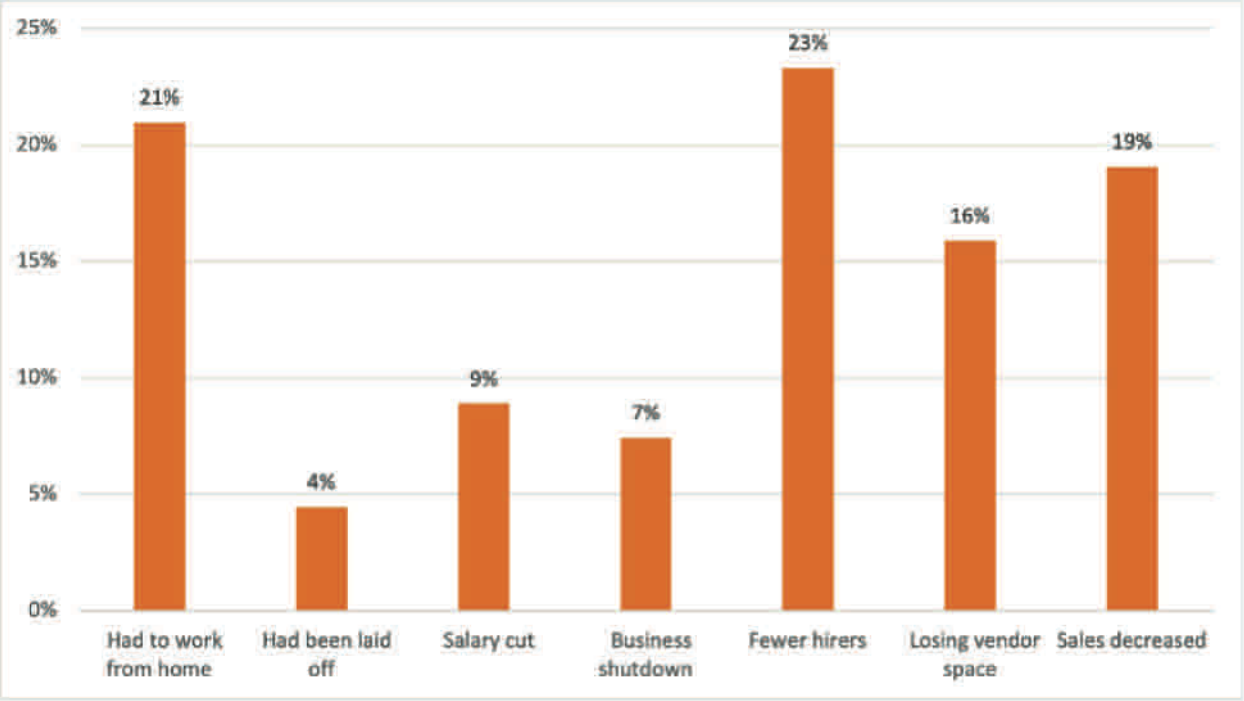


Figure 5.2

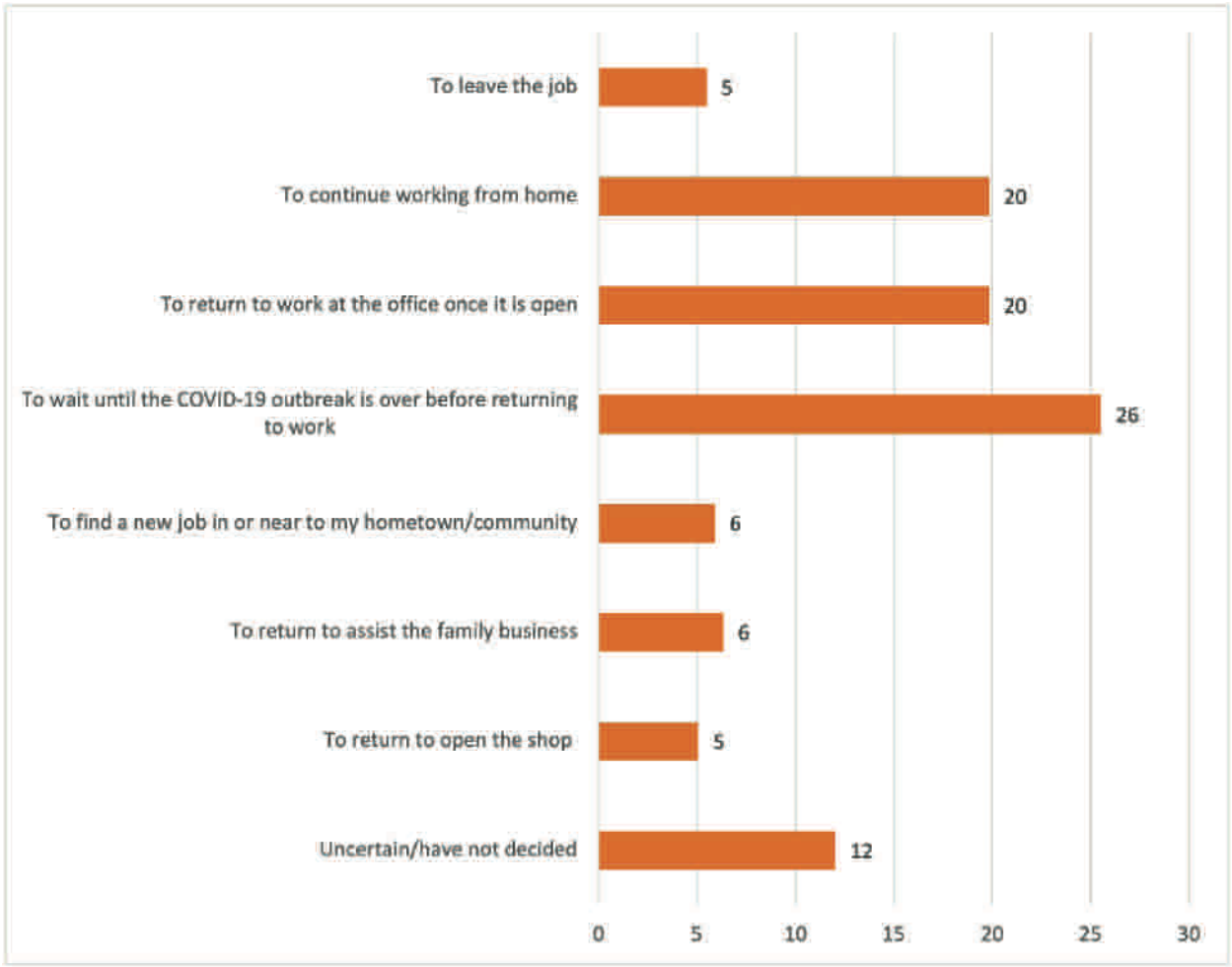
Selected impacts of COVID-19 on work and employment for older persons who had worked in the past 12 months



Of those whose job and work were disrupted by the COVID-19 crisis, the vast majority (88 per cent) indicated that they had a plan in place for after the pandemic. Figure 5.3 shows that one fifth (20 per cent) plan to continue working from home, even when the COVID-19 crisis is over. The same percentage reported that they plan to resume working at their office once it is allowed to reopen. Although around 30 per cent of respondents plan to wait until the COVID-19 pandemic is over before returning to work or reopening their shops, 6 per cent said that they would return to assist their family businesses and 5 per cent indicated that they would leave their job.

Figure 5.3

Job plans for after the COVID-19 pandemic is over among older persons whose job and work have been affected (percentage distribution)



It should be noted here that the definition of the time "after the COVID-19 pandemic is over" was left up to the respondents to determine. There is a possibility that respondents interpreted the end point of the pandemic as the relaxation of the government's lockdown measures. Similarly, there is a chance that the respondents considered the arrival of a COVID-19 vaccine to be the end point. Therefore, what respondents considered to be the end point might not have corresponded to the COVID-19 situation, at least at the time of writing.

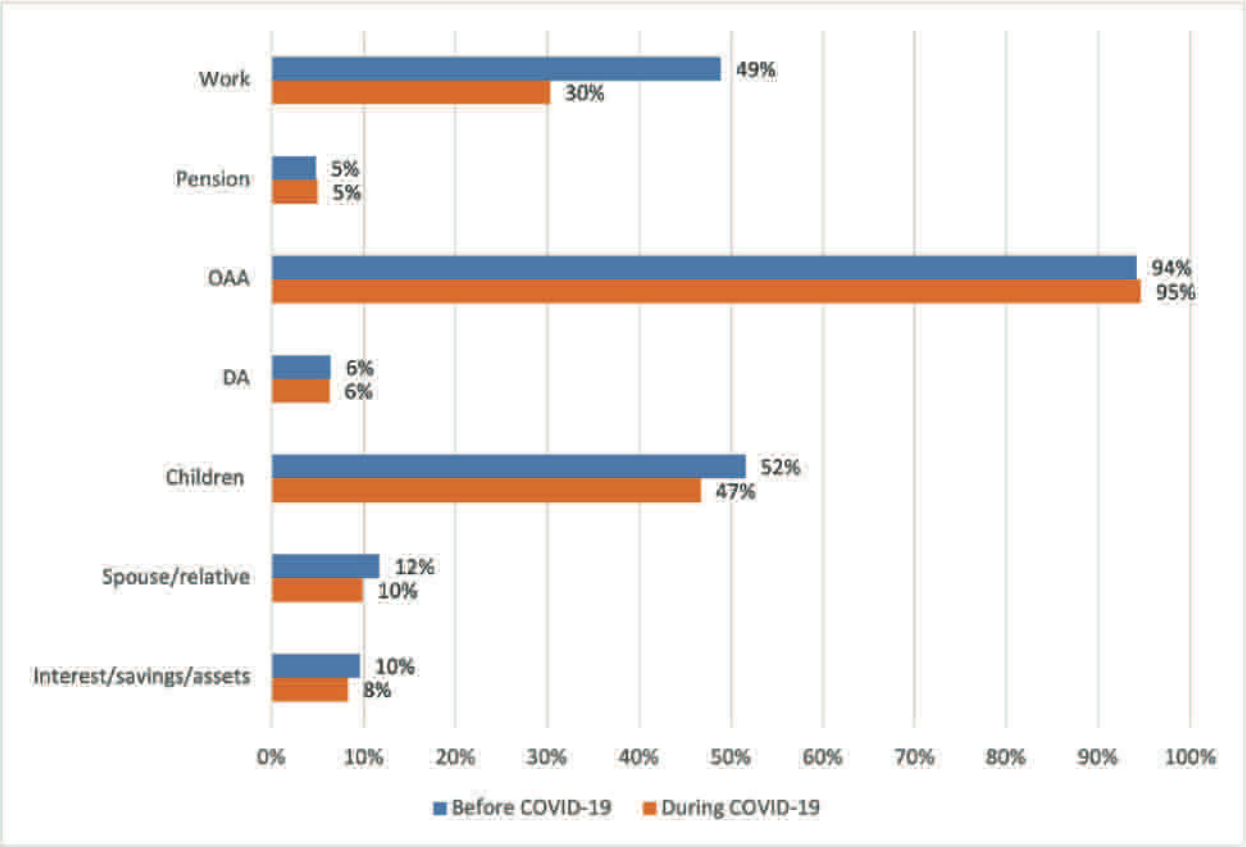
Source of monetary support

Figure 5.4 shows the percentage of respondents who received any income in the past 12 months, before and during the COVID-19 pandemic. The results show that the OAA was virtually universal among all respondents. Despite the government's OAA scheme, about half of the respondents indicated that children were an income source in both periods. During the COVID-19 crisis, the percentage that reported income from children dropped modestly, from 52 per cent to 47 per cent. Notably, the results refer only to monetary support from children and not material support in the broader sense, which would include in-kind material support (Knodel et al., 2016).

Work is another important income source for older persons. About half of the respondents reported work as a source of income before the COVID-19 crisis. However, this proportion substantially declined to 30 per cent during the crisis. Income from other family members including spouses and relatives was relatively uncommon among the respondents. Only 12 per cent reported receiving income from spouses and relatives before the COVID-19 pandemic. Income from interest, savings and assets was also uncommon. The percentage of respondents who cited income from both family and savings decreased modestly during the COVID-19 pandemic. The decline in the prevalence of income from several potential sources probably points to older persons' lower levels of economic well-being.

Figure 5.4

Sources of income during the past 12 months, before and during the COVID-19 pandemic



Abbreviation: DA, Disability Allowance.

Table 5.1 shows that the percentage of older persons who cited work as an income source during the COVID-19 crisis declined rapidly as age increased. Men were more likely to report work than women, and urban respondents were more likely to cite work than their rural counterparts. In contrast, the percentage of older persons who reported income from children during the COVID-19 crisis increased with age. Women were more likely to report income from children than men, and rural respondents were more likely to report income from children than their urban counterparts.

Older persons aged 80 years and over were more likely to report the government's OAA as an income source during the COVID-19 crisis than those in their 60s and 70s. Women were more likely to report the OAA as a source of income than men. Rural respondents were more likely to report the OAA as an income source than respondents in urban areas. Nonetheless, these differences were insignificant because nearly all respondents reported receiving the OAA.

Table 5.1

Older persons' sources of income during the COVID-19 pandemic by age, gender and area of residence

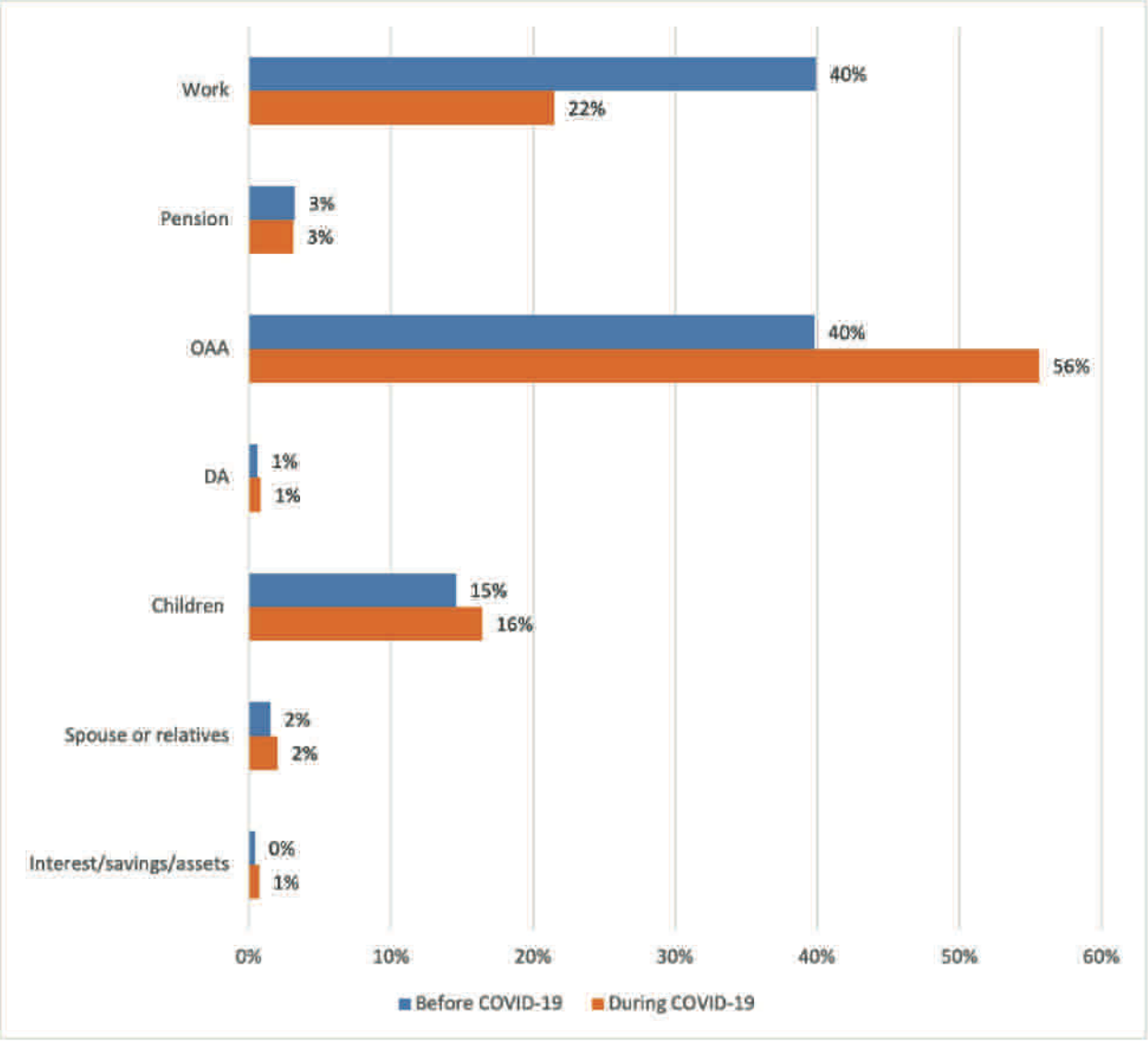
Percentage of respondents receiving any income from each sourcew	Age group			Gender		Area of residence	
	60–69	70–79	80+	Men	Women	Urban	Rural
Work	39.9	21.0	8.2	35.0	26.5	35.9	26.7
Pension	5.0	6.1	2.0	6.9	3.4	6.2	4.1
OAA	93.5	95.2	98.0	92.3	96.3	92.7	95.9
Disability Allowance	4.2	8.8	9.5	7.7	5.1	4.8	7.3
Children	39.7	54.3	60.5	40.9	51.3	36.9	53.8
Spouse or relative	11.3	8.2	7.5	7.7	11.7	10.2	9.7
Interest/savings/assets	7.4	10.1	8.2	9.1	7.6	10.4	6.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Respondents were also asked to indicate their main income source before and during the pandemic (Figure 5.5). In total, 40 per cent of the respondents reported that the OAA was their main source of income before the COVID-19 pandemic. The same proportion of respondents cited work as their main income source, whereas 15 per cent indicated that they relied mainly on income from their children.

During the pandemic, the OAA has become the most important source of main income for the respondents. The percentage of respondents reporting the OAA as their primary income source increased substantially, from 40 per cent to 56 per cent, during the COVID-19 crisis. At the same time, the percentage of respondents who reported work as their main source of income decreased significantly by almost half, from 40 per cent to 22 per cent, during the pandemic.

Figure 5.5

Main sources of income in the past 12 months, before and during the COVID-19 pandemic



Abbreviation: DA, Disability Allowance.

Table 5.2 shows the noticeable age, gender and urban–rural differences in respondents' main income source during the COVID-19 crisis. Around 22 per cent of respondents in their 60s, compared with 14 per cent of those in their 80s, cited work as an income source. In contrast, 16 per cent of those in their 60s, compared with 19 per cent of those aged 80 years and over, cited children as their primary income source. Men were more likely than women to report the OAA or children as their main source of income, whereas women were substantially more likely to report work or a pension as their primary income source. For urban respondents, the OAA was the most typical main source of income, followed by children. For rural respondents, the OAA was the most important main source of income, followed by work.

Table 5.2

Older persons' primary income source during the COVID-19 pandemic by age, gender and area of residence

Primary income source (percentage distribution)	Age group			Gender		Area of residence	
	60–69	70–79	80+	Men	Women	Urban	Rural
Work	21.5	29.3	14.1	2.7	26.1	17.7	25.3
Pension	3.1	3.1	3.7	1.4	4.2	2.2	3.7
OAA	55.6	49.9	59.8	72.1	54.9	56.2	48.3
Disability Allowance	0.8	0.7	1.1	0.7	1.1	0.6	1.0
Children	16.4	14.3	18.6	21.1	12.2	19.8	18.1
Spouse or relative	2.0	2.5	1.3	0.7	0.9	2.8	2.5
Interest/savings/assets	0.7	0.1	1.3	1.4	0.5	0.7	1.2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Abbreviation: DA, Disability Allowance.

Table 5.3 examines the main source of income reported by respondents during COVID-19 compared with main income source before the pandemic. Around two fifths of respondents who reported work as their main income source before the COVID-19 pandemic reported the OAA as their main source of income during the crisis. At the same time, a slight decline occurred in children as the main source of income support. Around 10 per cent of respondents who reported relying on income from children cited other current sources, particularly the OAA. A similar pattern was observed among those who reported income from a spouse or relative as their primary source. The results highlight the significant economic impact of the COVID-19 crisis on older persons in relation to their work and employment or family members on whom they had relied.

Table 5.3

Main income source during the COVID-19 pandemic compared with main income source before the pandemic

Primary income source during COVID-19 (percentage distribution)	Primary income source before COVID-19						
	Work	Pension	OAA	DA	Children	Spouse/ relative	Interest/ savings/ assets
Work	52.3	2.6	1.0	0.0	0.6	0.0	0.0
Pension	0.2	94.9	0.0	0.0	0.0	0.0	0.0
OAA	39.3	2.6	95.7	57.1	7.8	15.8	0.0
Disability Allowance	0.2	0.0	1.0	42.9	0.6	0.0	0.0
Children	6.5	0.0	1.8	0.0	89.9	0.0	0.0
Spouse or relative	1.2	0.0	0.4	0.0	0.0	84.2	0.0
Interest/savings/assets	0.2	0.0	0.0	0.0	1.1	0.0	100.0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Abbreviation: DA, Disability Allowance.

Income and expenses

The survey also asked respondents if their income was affected by the COVID-19 pandemic. As Table 5.4 shows, the majority (58 per cent) indicated that their income was lower during the pandemic, whereas around 41 per cent reported that it had remained unchanged. Under 1 per cent had a higher income. Table 5.4 also shows that the percentage of respondents with a lower income declined with age. Men were slightly more likely to experience a lower income than women, and urban respondents were more likely to have a lower income during the COVID-19 pandemic than their rural counterparts.

Figure 5.6 shows, in more detail, the main income source during the pandemic of those who experienced a lower income. Among those who experienced a lower income, the majority (60 per cent) relied mainly on income from work, and around one third (32 per cent) reported the OAA as their main income source.

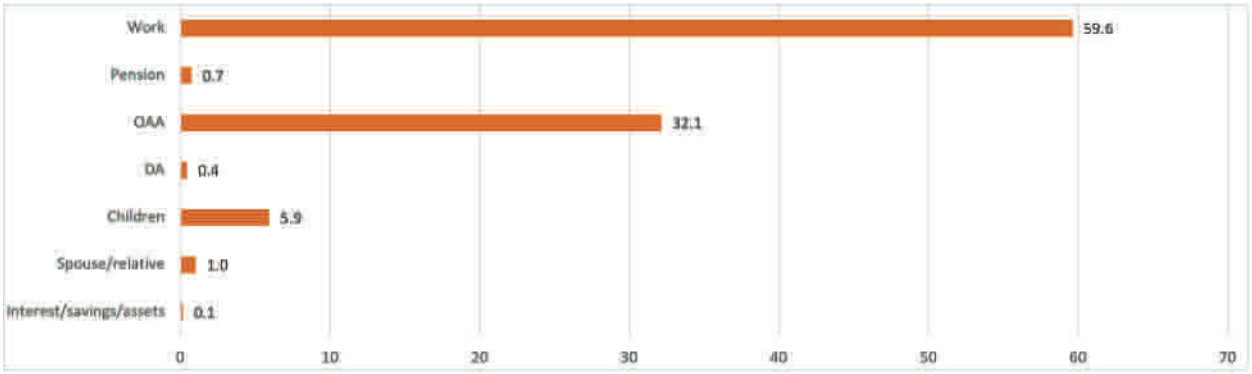
Table 5.4

Impact of COVID-19 on income by age, gender and area of residence

Percentage distribution of income change during COVID-19	Total	Age group			Gender		Area of residence	
		60–69	70–79	80+	Men	Women	Urban	Rural
Higher	0.2	0.3	0.0	0.0	0.2	0.2	0.2	0.1
Steady	41.4	31.1	50.1	72.0	39.6	42.8	33.7	47.1
Lower	58.4	68.6	49.9	28.0	60.2	57.0	66.1	52.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Figure 5.6

Main income source of older persons whose income was lower during the COVID-19 pandemic (percentage distribution)

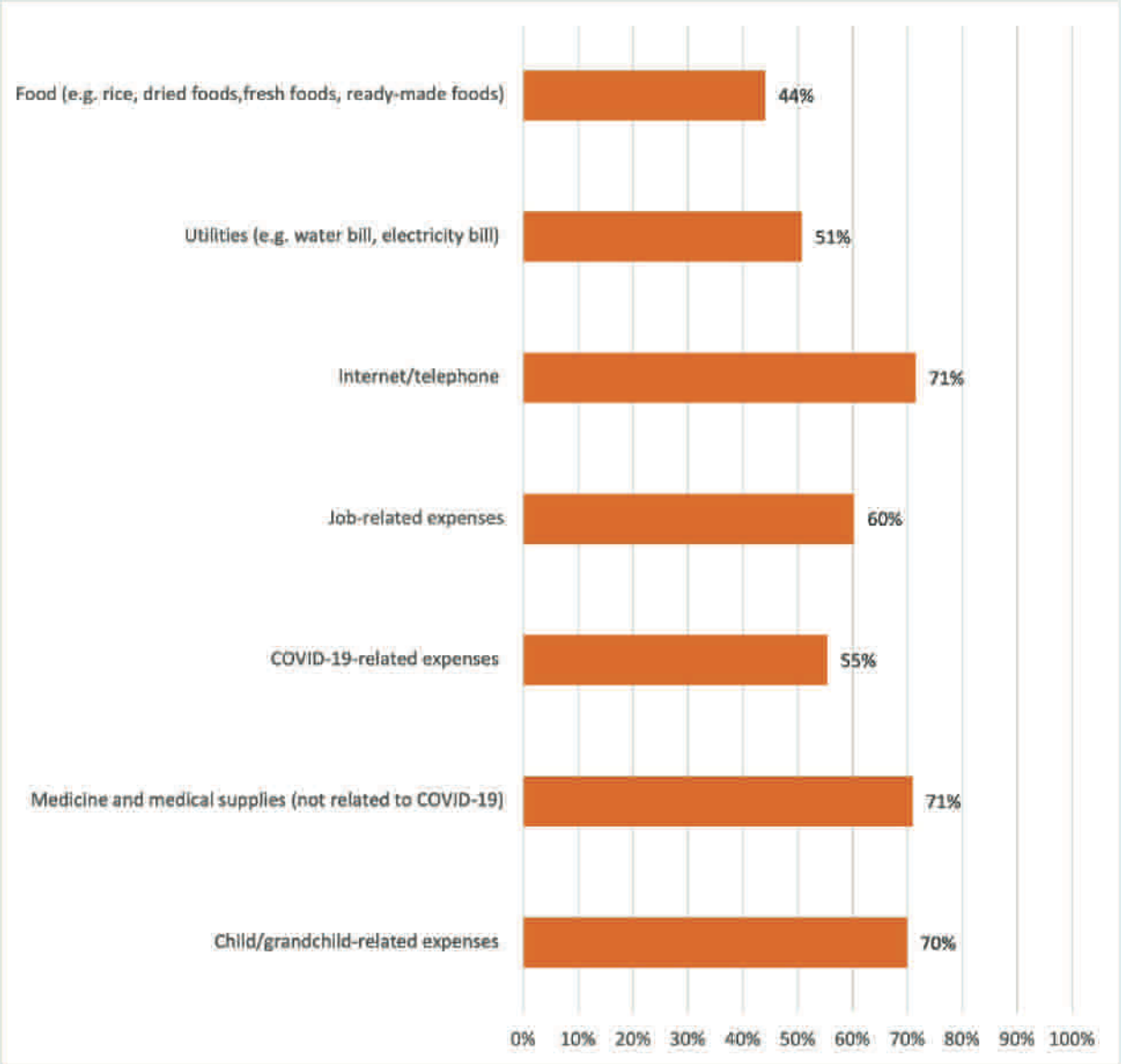


Abbreviation: DA, Disability Allowance.

The survey included questions about expenses potentially affected by the COVID-19 pandemic. The items included COVID-19-related expenses, such as expenses related to facemasks and hand sanitiser and COVID-19 testing fees, as well as expenses incurred in normal circumstances, such as expenses related to food and groceries and utilities.

As Figure 5.7 shows, medical expenses not related to COVID-19, bills related to the Internet and telephone, and expenses related to childcare or grandchildcare were the three most common expenses reported to have been affected by the pandemic. Furthermore, 60 per cent of respondents reported that COVID-19 had affected their job expenses, whereas around half (51 per cent) indicated that utility bills had been affected.

Figure 5.7
Selected expenses affected by COVID-19



Income adequacy and debt

The survey asked respondents to assess whether their overall income before and during the COVID-19 pandemic was adequate. The results are presented in Figure 5.8. The percentage indicating that their income was adequate or better decreased from 54 per cent to 37 per cent. Consistently, respondents saying that their income was sometimes or always inadequate increased significantly, from 46 per cent to 64 per cent. Figure 5.9 shows that one third of the respondents whose income before the pandemic was adequate indicated that their income was no longer adequate during the pandemic. Among those whose income was sometimes inadequate, one quarter indicated that their financial status had worsened during the COVID-19 crisis.

Figure 5.8

Income adequacy before and during the COVID-19 pandemic

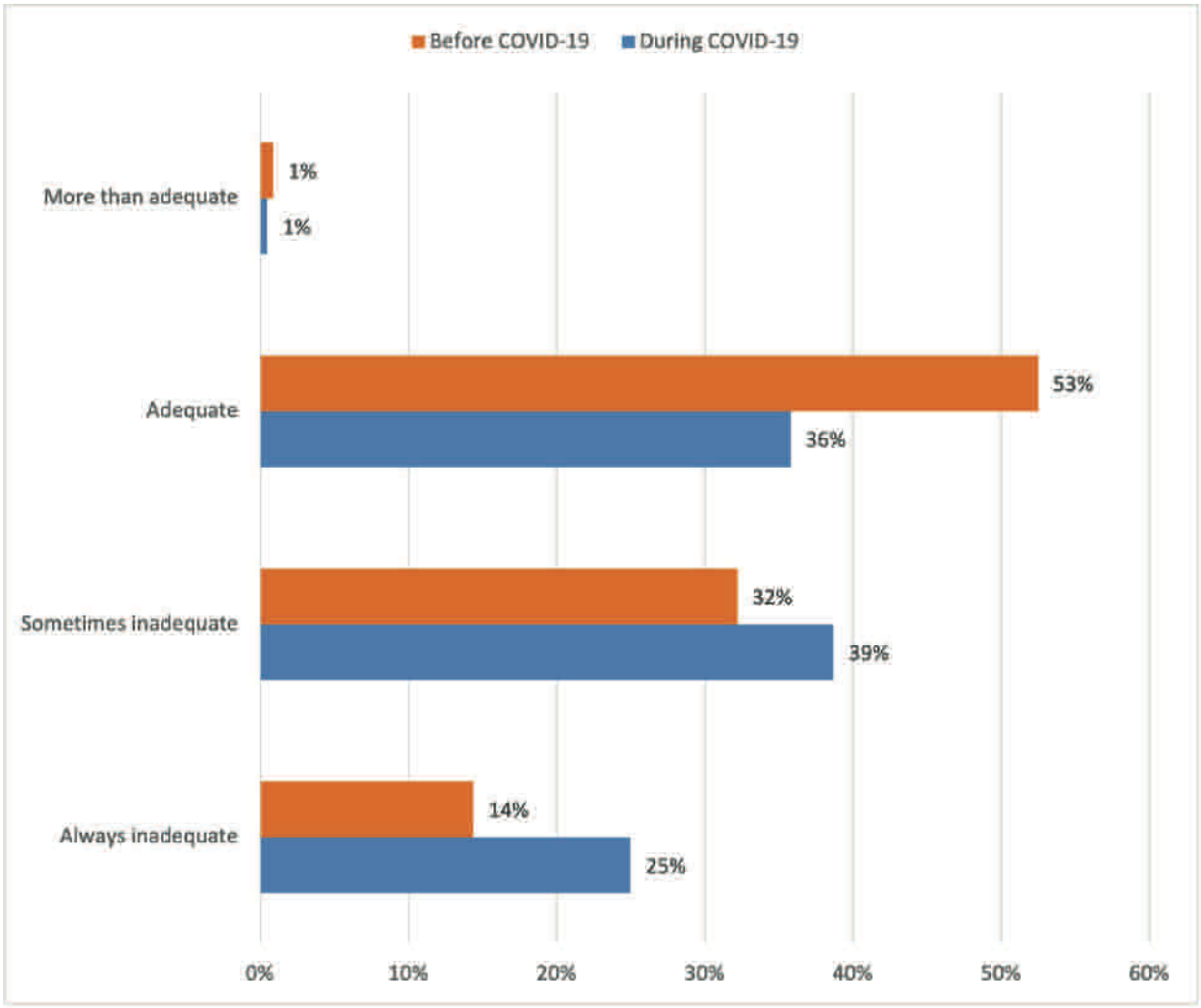
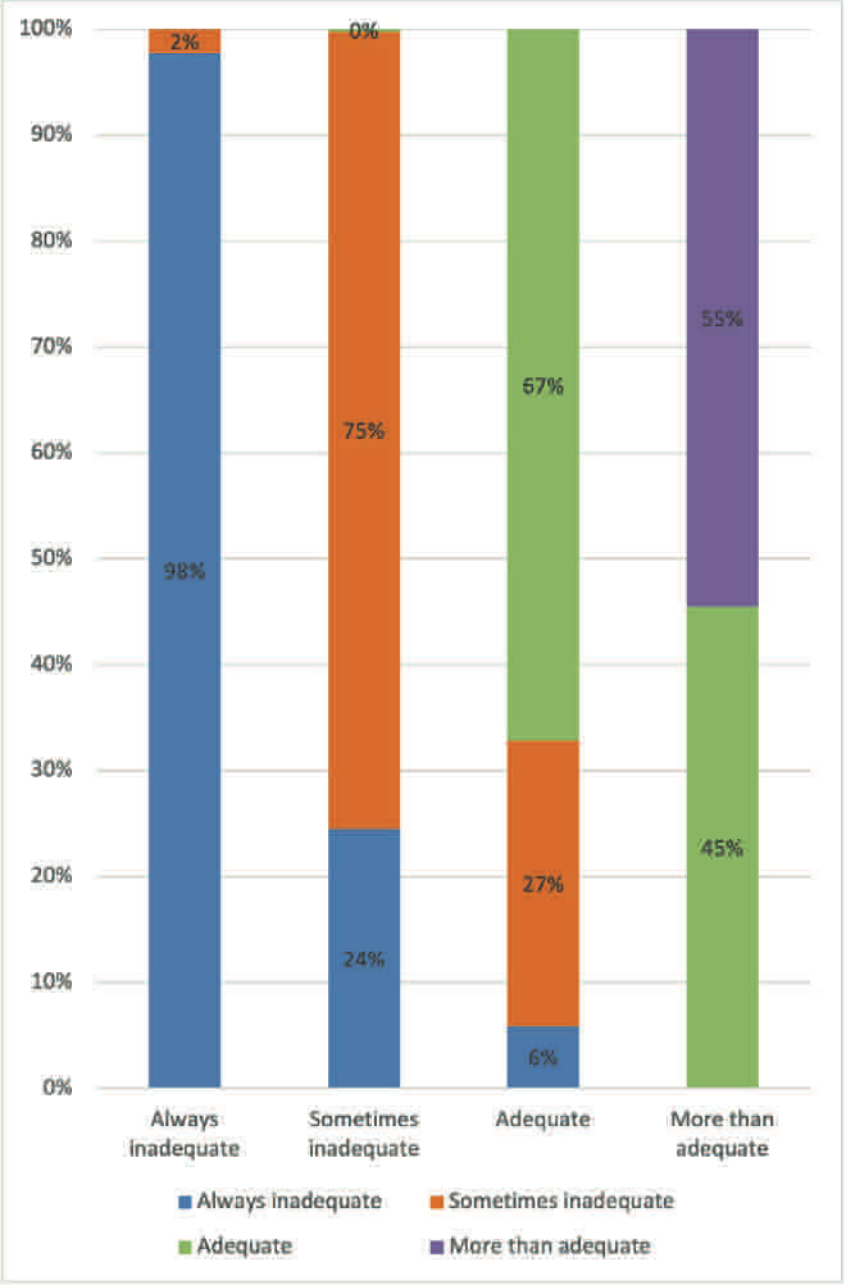


Figure 5.9

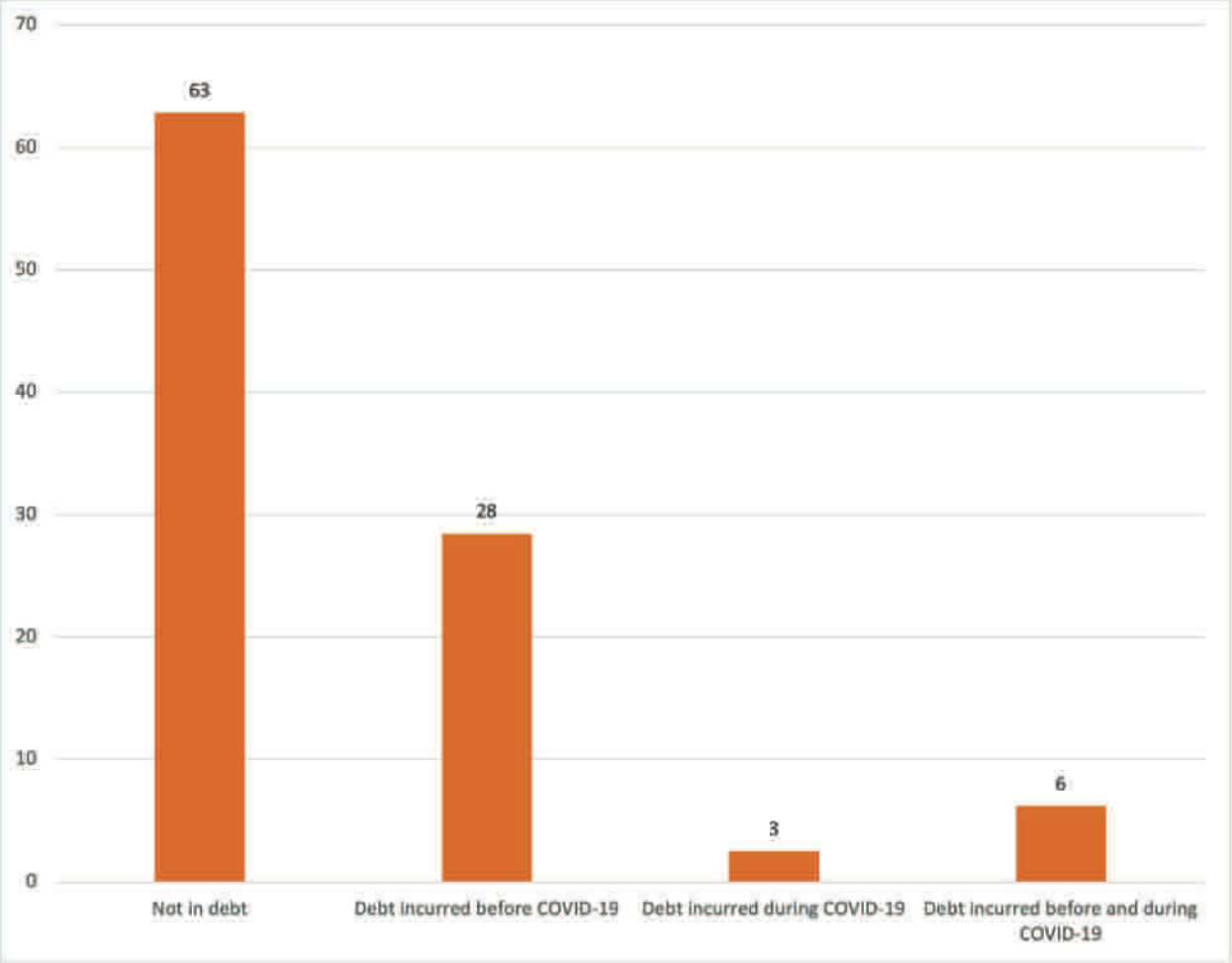
Income adequacy before the COVID-19 pandemic compared with income adequacy during the pandemic



Besides self-assessed income adequacy, the financial vulnerability of older persons was also objectively assessed by their debt status. Respondents were asked in the survey whether they were currently in debt and whether the debt had been incurred before or during the pandemic. Figure 5.10 shows that the majority of respondents did not have any debt, and 28 per cent carried debt that had been incurred before the pandemic. Around 1 in 10 respondents reported acquiring new debt during the pandemic. This included 3 per cent with completely new debt incurred during the pandemic and 6 per cent with new debt incurred during the COVID-19 crisis in addition to debt that they carried from before the pandemic.

Figure 5.10

Percentage distribution of respondents by debt status



As Figure 5.11 shows, the percentage of respondents with debt incurred during COVID-19 differed substantially by age and modestly by gender and area of residence. The percentage of respondents with new debt during the COVID-19 pandemic decreased with age. Younger respondents were more likely to have new debt during the pandemic than their older counterparts. Older women and urban residents were more likely to acquire new debt during the pandemic than their counterparts.

Figure 5.11

Percentage of respondents carrying debt incurred during COVID-19 by age, gender and area of residence

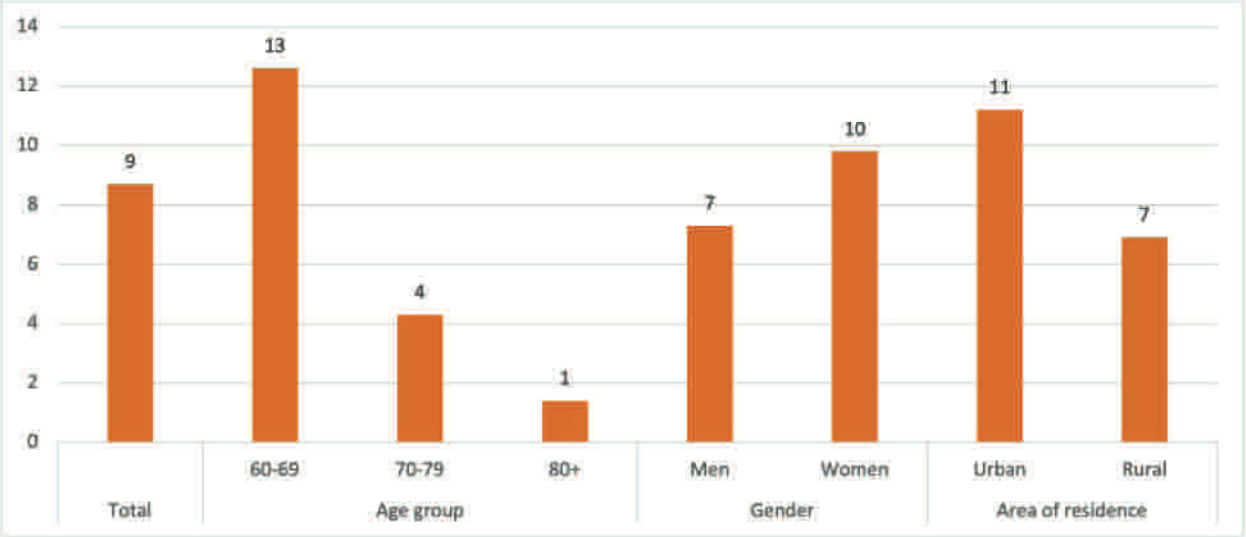


Table 5.5 summarizes all objective and subjective indicators of the economic impact of the COVID-19 pandemic on older persons.

Table 5.5

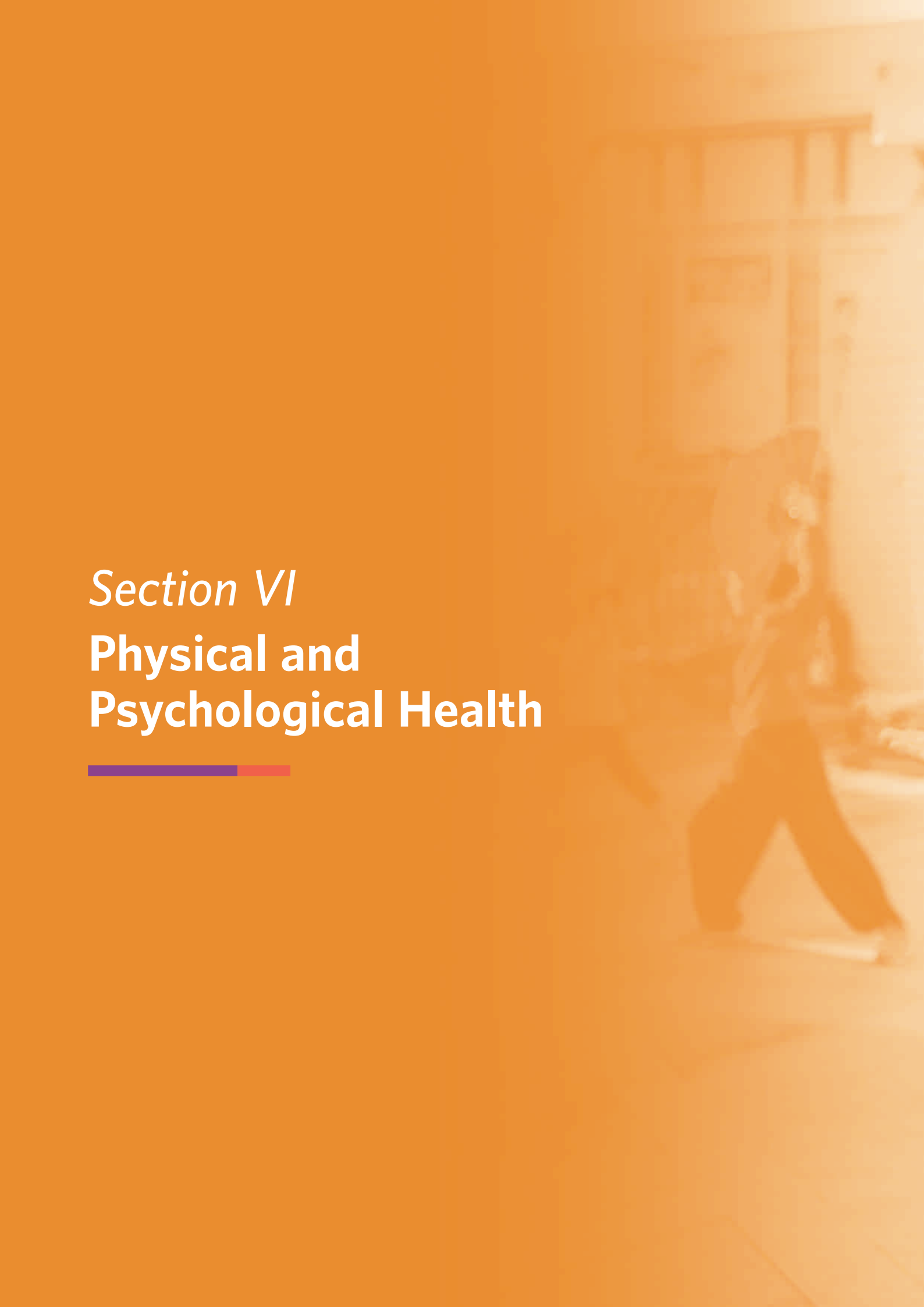
Objective and subjective indicators of the economic impact of the COVID-19 pandemic on older persons

During COVID-19 crisis	Percentage
Objective indicator	
Lower income	58.4
Debt incurred during COVID-19a	8.7
Subjective indicator	
Income becoming "sometimes" or "always" insufficient	63.7

[a] Includes those with debt incurred before and during COVID-19.

Section VI

Physical and Psychological Health



As noted in the introduction, the available data show that older adults and those with underlying medical conditions are at a higher risk of more serious illness and death from COVID-19. Since chronic illnesses are more prevalent in older persons than in any other age group, the effect of COVID-19 is more likely to be worse for older persons. The impact of health problems goes beyond the individual older person. It translates, at a higher level, into a higher demand for medical services and social assistance. This section examines the physical and psychological health of respondents using subjective measures, with a focus on how their health was affected by the COVID-19 pandemic.

Self-assessed health

In the survey, respondents were asked to rate their health before the COVID-19 pandemic. The response scale ranged from "very poor" to "very good" health. Although self-rated health is a frequently used survey question, it should be noted that the question posed in this survey has a much longer timespan (i.e. four months) than other surveys. Caution is therefore needed when interpreting and comparing the results with other surveys.

As Figure 6.1 shows, only a small number of respondents fell into the two lowest categories. Almost half said that their health before the pandemic was fair. Around the same proportion of respondents rated their health as good or very good. When asked to compare their health during the pandemic with their health before the crisis, the vast majority indicated that their health was about the same. Figure 6.2 shows that around one fifth felt that their health was worse than before. Those who rated their health during the pandemic as better than before accounted for only 3 per cent.

Figure 6.1
Percentage distribution of self-rated health before the COVID-19 crisis

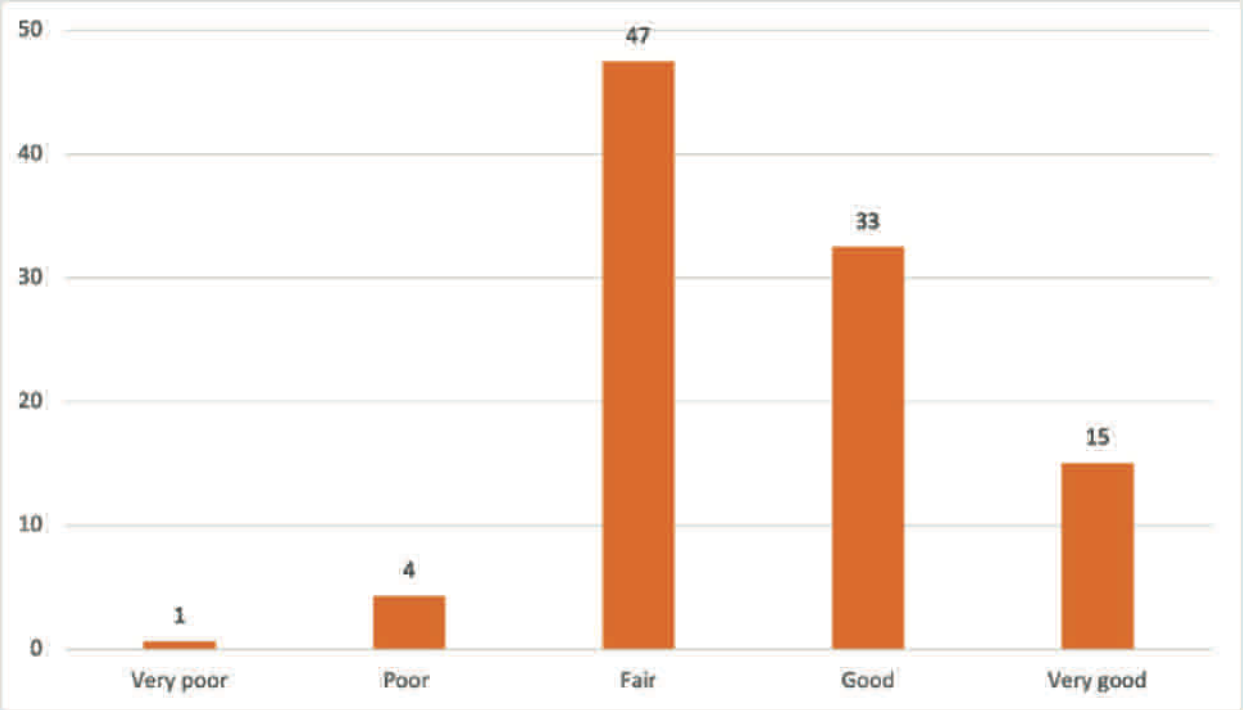
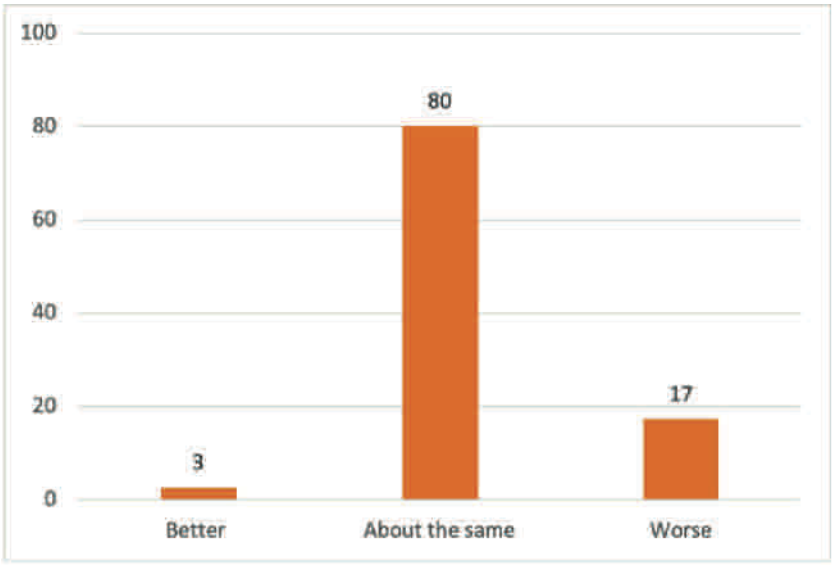


Figure 6.2

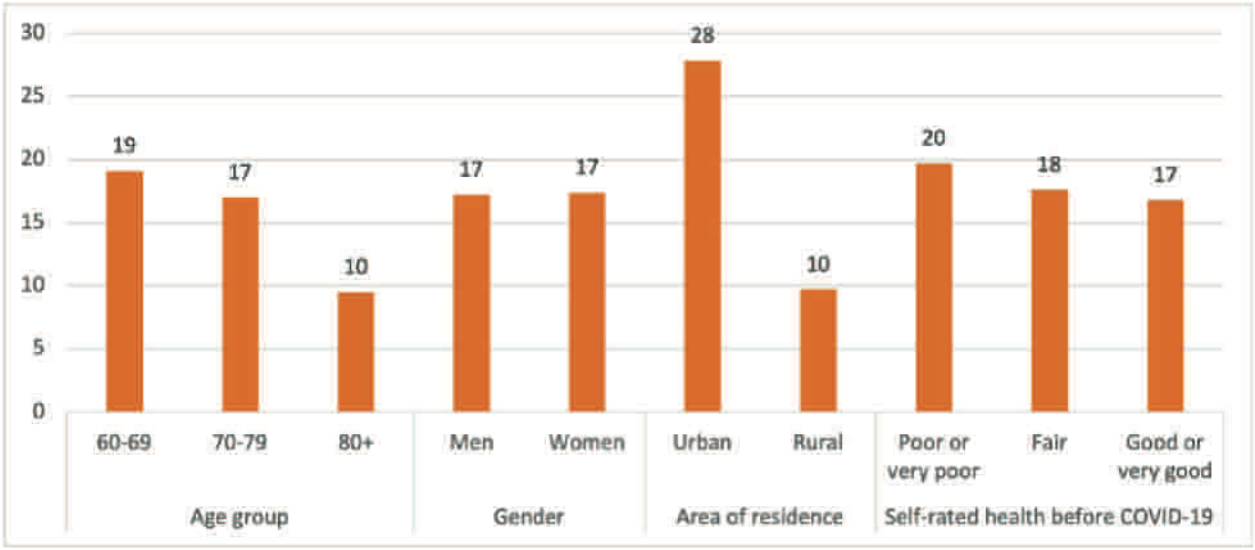
Percentage distribution of self-rated health during the COVID-19 pandemic compared with before the pandemic



Although the results suggest that the health of the great majority of older persons was not significantly affected by the COVID-19 pandemic, it is important to look closer at those who rated their health as worse during the COVID-19 crisis. Figure 6.3 shows that the percentage of respondents reporting worse health during the pandemic varied modestly with age but somewhat more so by area of residence. Respondents aged 60–69 years were more likely to report worse health than those in the other two age groups. Those residing in urban areas were almost three times as likely as those in rural areas to rate poorer health. Interestingly, one fifth of the respondents who indicated that their health became worse during the pandemic were already in poor or very poor health. Around 17 per cent who reported worse health during the pandemic had good or very good health beforehand.

Figure 6.3

Percentage of respondents reporting worse health during COVID-19 by age, gender, area of residence and self-rated health before the pandemic

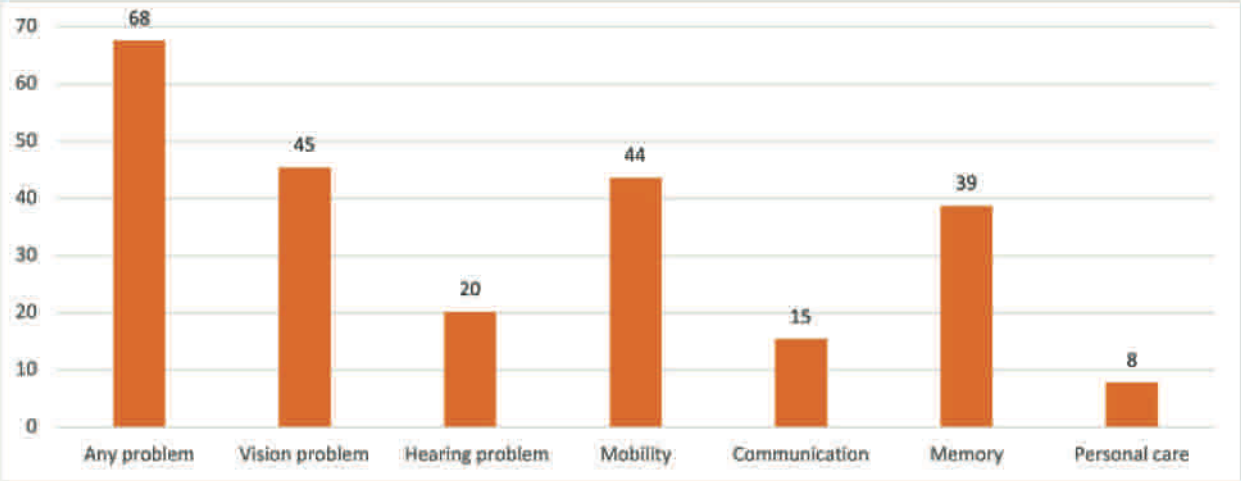


Health problems

Respondents were also asked to report whether they experienced any selected health problems, including functional difficulties, before the COVID-19 pandemic. Figure 6.4 shows that, overall, two thirds of respondents reported having at least one of the health problems. The most common were vision and mobility problems, and 39 per cent indicated that they experienced problems with their memory. Considerably fewer respondents indicated that they had difficulties with communication (15 per cent) or personal care (8 per cent).

Figure 6.4

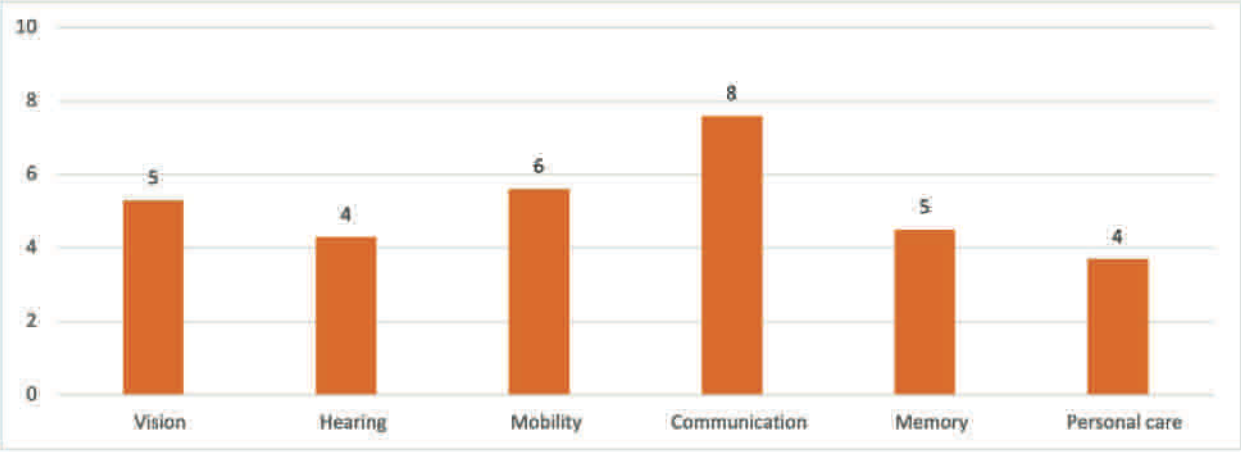
Percentage of respondents experiencing selected health problems before the COVID-19 pandemic



Respondents were asked to compare their problems during the pandemic with those before the pandemic. As Figure 6.5 shows, only small percentages reported that their health problems had become worse during the COVID-19 crisis, varying between 4 per cent and 8 per cent.

Figure 6.5

Percentage of respondents reporting worse health problems during the COVID-19 pandemic



Psychological health

To measure the impact of COVID-19 on psychological health, respondents were asked about specific symptoms: loss of appetite, no hope in life, and feeling unhappy, sad, worried and lonely. The response categories were "never", "sometimes" and "always". Table 6.1 summarizes the results. Overall, one quarter of respondents reported experiencing at least one of the selected symptoms either sometimes or always during the pandemic. The most common psychological symptom was feeling worried (57.2 per cent), followed by loss of appetite, which 47 per cent reported experiencing sometimes or always during the pandemic. Around one quarter of respondents reported feeling unhappy or lonely during the COVID-19 crisis, whereas 18 per cent felt sad and 16 per cent felt a loss of hope in their life.

Table 6.1 also shows in detail the variation in age, gender and area of residence of those who experienced psychological symptoms. The percentage of respondents experiencing each psychological symptom increased with age. A modest gender difference was observed among those experiencing loss of appetite and loneliness. The difference was more pronounced among those who felt worried sometimes or always during COVID-19. Notably, as indicated in previous studies (Teerawichitchainan et al., 2019), women are more sensitive to their health and less hesitant to admit that they have a problem than men. Urban residents were more likely than their rural counterparts to experience the selected psychological symptoms.

Table 6.1

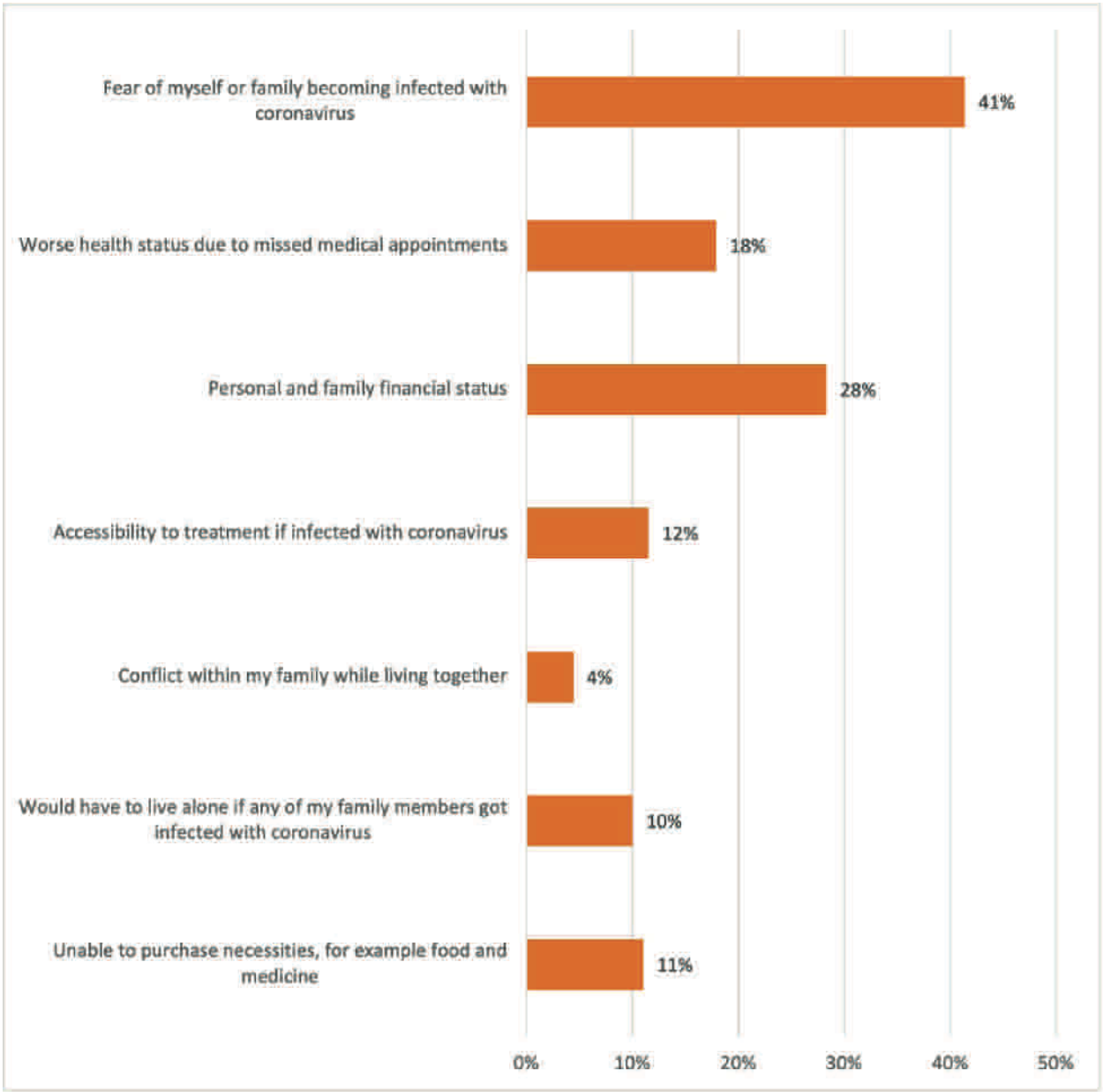
Percentage of respondents reporting selected psychological symptoms either sometimes or always during the COVID-19 pandemic by age, gender and area of residence

	Total	Age group			Gender		Area of residence	
		60–69	70–79	80+	Men	Women	Urban	Rural
Loss of appetite	47.3	46.3	47.1	53.1	45.8	48.5	59.1	38.8
No hope in life	16.4	17.3	15.7	14.3	16.6	16.3	21.4	12.8
Unhappy	23.3	25.0	22.3	17.0	21.2	24.9	29.9	18.4
Sad	17.9	18.8	17.6	14.3	17.7	18.0	23.7	13.6
Worried	57.2	62.8	54.0	38.8	51.6	61.7	65.4	51.3
Lonely	25.0	24.3	26.9	23.8	23.9	26.0	34.4	18.3
Any symptom	24.3	24.5	25.3	21.1	24.1	24.5	29.2	17.6

Respondents who reported feeling worried were asked another question about what worried them. Figure 5.5 shows selected issues that worried respondents during the pandemic: 41 per cent indicated that they were worried about themselves and their family members contracting the virus, and 28 per cent reported that they were concerned about their own or their family's financial status. Almost one in five (18 per cent) were worried about their health, as the confinement measures caused them to miss medical appointments. Around 10–12 per cent were worried about access to health care and changes in their living arrangements if they or any of their family members had COVID-19, along with the difficulty of buying necessities. Only 4 per cent felt worried about conflicts that may happen within their family when the family members had to live together.

Figure 6.6

Selected issues that worried older persons during the COVID-19 pandemic



Before the COVID-19 pandemic, many older adults living alone had been reported to have experienced greater psychological symptoms, especially loneliness. This has led to greater concern that forced quarantine and social distancing due to the COVID-19 crisis may exacerbate the manifestation of these symptoms (Bierman and Schieman, 2020) and put people at greater risk of depression and anxiety (Armitage and Nellums, 2020; Santini et al., 2020). Table 6.2 examines whether respondents living independently during the COVID-19 pandemic, either alone or with a spouse only, were worse off in terms of psychological health. Overall, the results indicate a small difference in all self-reported psychological symptoms, except loneliness, between respondents who live alone or with a spouse only and those living with at least one child. Respondents living independently were modestly more likely to experience loneliness than those coresiding with at least one child. Nonetheless, differences between those living alone and those living with at least one family member are noteworthy. Around one third of solo dwellers indicated they felt lonely during the COVID-19 pandemic, compared with 29 per cent of those living with a spouse only and 23 per cent of those coresiding with a child. The results further indicate that respondents living alone were more likely to report feeling unhappy than those living with a spouse or a child. Interestingly, the percentages reporting sadness and loss of hope were higher for respondents living with a spouse only than those living alone and in other types of living arrangement. The results in Table 6.2 further show that feeling worried was greater among those coresiding with children than those living independently.

Table 6.2

Percentage of respondents reporting selected psychological symptoms either sometimes or always during the COVID-19 pandemic by selected types of living arrangement

Percentage of respondents reporting symptom sometimes or always	Living alone	Living with a spouse only	Living alone or with a spouse only	Co-residing with a child
Loss of appetite	47.1	42.9	44.2	48.1
Loss of hope	11.8	18.4	16.3	15.9
Unhappy	25.0	21.8	22.8	23.2
Sad	16.2	20.4	19.1	16.7
Worried	48.5	53.7	52.1	56.7
Lonely	33.8	29.3	30.7	23.1

Section VII

Routines and Life Satisfaction during the COVID-19 Pandemic

The COVID-19 pandemic has rapidly and fundamentally changed many parts of people's lives. Trying to maintain a normal routine can be very challenging, particularly for older persons. The challenges they face include the government's requirements for home confinement, which reduces physical activity (Bentlage et al., 2020) and causes a lack of physical contact with family members, friends and other people in the community (WHO, 2020).[7] Staying engaged in community activities in later life is an essential element in promoting active ageing (WHO, 2002), because it contributes to older adults' social support (e.g. emotional support, social contact) and thereby affects their physical and psychological well-being (Knodel et al., 2015). To foster active ageing during the COVID-19 pandemic, it is thus important to see if and the extent to which older persons' routines and social participation have been affected.

The survey included information on assistance and care provided by respondents to the household and particular family members, such as a grandchild and an elderly family member, before and during the period of the COVID-19 pandemic. Table 7.1 shows that a substantial proportion of the respondents indicated that they helped sometimes with all the activities listed before the pandemic. The provision of care and assistance to the household ranged from 21 per cent to 37 per cent.

Moreover, a substantial proportion of the respondents regularly did each of the household chores listed. More than half did the housework, and 40–42 per cent took care of a household member regularly. Looking at the results overall, almost 90 per cent helped their family with each of the household chores at least sometimes before the pandemic. In addition, virtually none of the activities differed substantially before and during the pandemic.

Table 7.1
Contribution to the household before and during the COVID-19 pandemic

Percentage of respondents who did household chores	Before COVID-19		During COVID-19	
	Sometimes	Regularly	Sometimes	Regularly
Cooking/preparing meals	31.1	53.4	31.2	53.7
Laundry/ironing	26.6	54.9	28.0	54.9
House cleaning	30.9	57.0	32.1	56.6
Gardening/plant watering	36.8	53.2	37.2	53.3
Taking care of a grandchild under 15 (both coresident and non-coresident)	29.1	39.9	28.0	38.4
Taking care of an older family member	21.4	42.2	20.6	41.6

[7] WHO (2020). Older people & COVID-19. Available at https://www.who.int/teams/social-determinants-of-health/covid-19.

Table 7.2

Percentage of respondents who experienced difficulties in undertaking activities

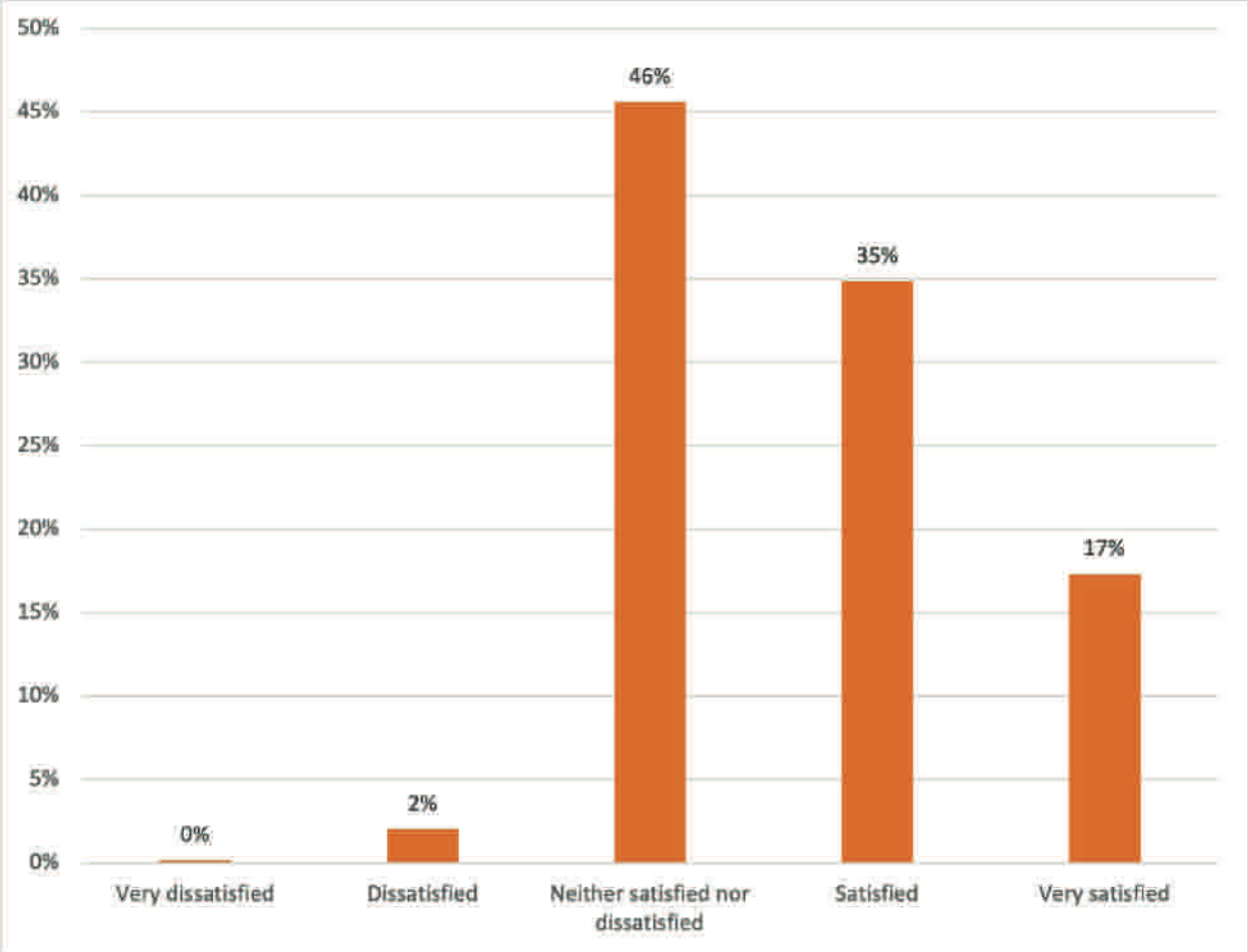
	Total	Age group			Gender		Area of residence	
		60–69	70–79	80+	Men	Women	Urban	Rural
Running errands	54.9	61.7	50.0	34.7	58.0	52.3	52.7	56.5
Getting food/groceries	58.4	64.2	55.6	37.4	57.7	58.9	55.8	60.3
Keeping medical appointments	55.7	55.3	57.4	53.1	57.1	54.5	53.9	57.0
Keeping medical appointments	51.1	50.6	53.5	47.6	51.3	51.0	41.7	58.0
Attending religious ceremonies	46.0	46.3	49.2	36.7	49.5	43.3	37.3	52.4
Meeting with family and relatives	45.7	47.0	47.1	36.1	50.7	41.6	37.3	51.8
Meeting with friends	46.4	46.7	48.1	40.8	47.4	45.6	34.7	54.9
Participating in social activities	46.4	46.7	48.1	40.8	47.4	45.6	34.7	54.9

The survey also collected information on any difficulties in undertaking a variety of routine activities, such as grocery shopping, visiting clinics and attending religious ceremonies. Table 7.2 shows that around half of the respondents experienced difficulties in maintaining each of the routine activities shown. Substantial differences existed in relation to the characteristics of the respondents in almost all of the routine activities listed. The percentages of the respondents reporting difficulties in running errands and getting groceries were substantially higher among respondents aged 60–69 years and lower among those aged 80 years and over. For activities related to social gatherings, the percentage of respondents reporting difficulties was highest among those in their 70s but lowest among those in their 80s. The decrease in the proportion among those in their 80s is probably associated with their lower levels of opportunity to undertake such activities because of poorer health and higher levels of frailty. Table 7.2 also shows that older men were more likely than older women to experience difficulties in maintaining their routine activities and that rural residents were more likely to report difficulties than their counterparts in all activities listed.

Life satisfaction

To assess how the COVID-19 pandemic has affected older people's satisfaction with life, the survey asked respondents to rate their satisfaction before the pandemic on a scale of 1 to 5: very dissatisfied, dissatisfied, neither dissatisfied nor satisfied, satisfied or very satisfied. The results presented in Figure 7.1 show the distribution of life satisfaction scores before the COVID-19 pandemic. The majority of respondents were satisfied with their life before COVID-19, with only 2 per cent reporting their life as dissatisfying or very dissatisfying.

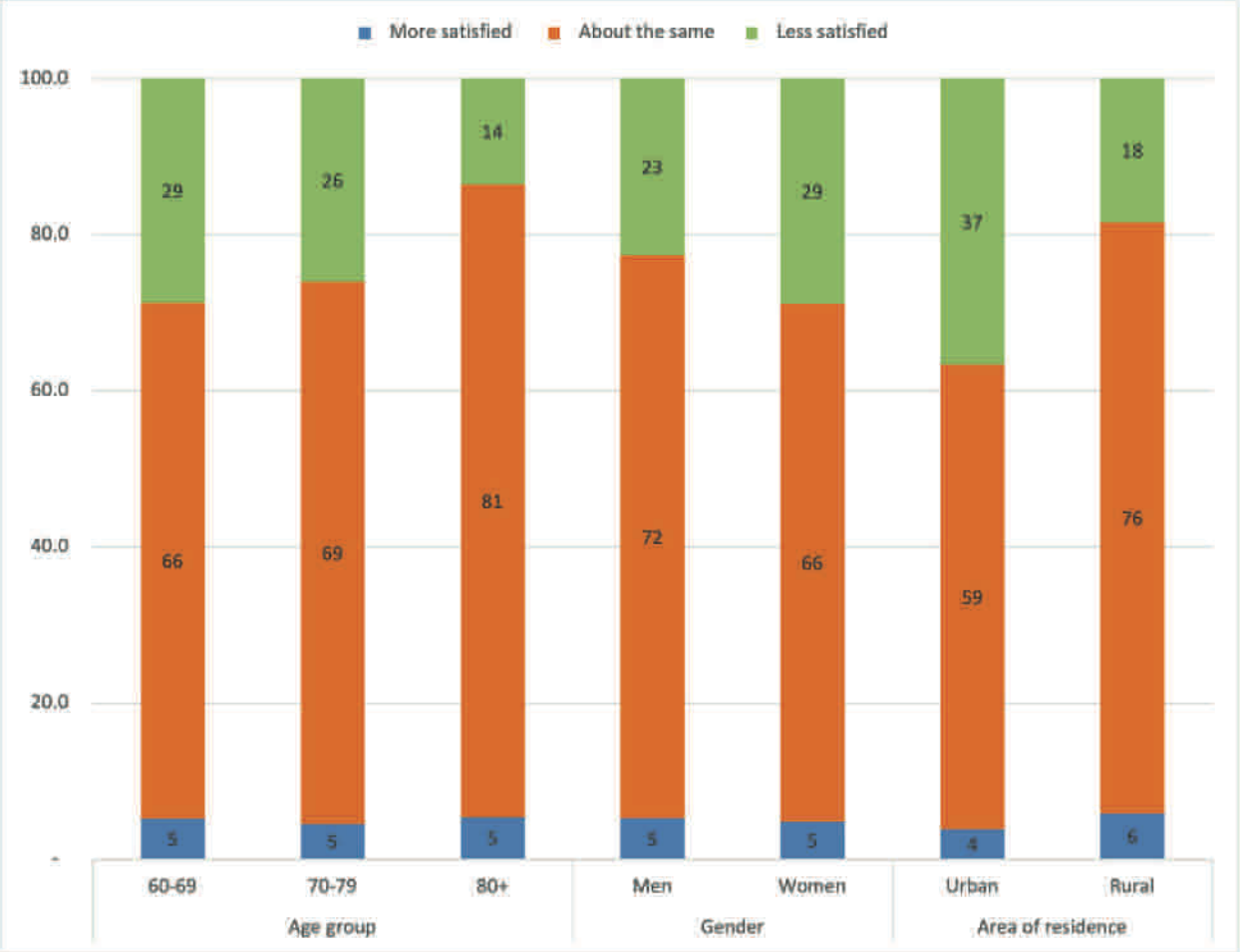
Figure 7.1
Life satisfaction before the COVID-19 pandemic



The respondents were asked to compare their life satisfaction before the pandemic with their life satisfaction during the COVID-19 crisis. As Figure 7.2 shows, the great majority reported the same level of life satisfaction before and during the pandemic. One quarter reported that their satisfaction with life was lower. The change in life satisfaction differed moderately by age and gender of the respondents. The percentage of respondents reporting lower life satisfaction declined with age and was higher among women than among men. Urban older persons were twice as likely as their rural counterparts to report lower life satisfaction during the COVID-19 pandemic.

Figure 7.2

Percentage distribution of changes in life satisfaction due to COVID-19 by age, gender and area of residence



Section VIII

Knowledge and understanding of COVID-19

The COVID-19 situation is changing rapidly. False information and rumours have spread as fast as the virus. Obtaining reliable information about the pandemic is therefore important to people's lives, particularly for older persons in many ways. Older persons are more likely to have limited access to information than younger generations. Sources of information are also limited because of a lack of technological equipment and knowledge of how to use it. This limited access is also associated with older persons' education level. The abilities to read, write and speak are associated with higher levels of education and thus being more able to access important information and health-care services and adopt new technologies.

Sources of COVID-19 information

Table 8.1

Sources of COVID-19 information by age, gender and area of residence

Percentage of respondents obtaining information from each source	Total	Age group			Gender		Area of residence	
		60–69	70–79	80+	Men	Women	Urban	Rural
Television/radio	93.0	93.4	93.1	91.2	93.8	92.4	94.4	92.0
Newspaper	29.4	34.7	25.5	14.3	31.8	27.6	26.3	31.7
CCSA	66.8	70.2	63.6	59.2	68.1	65.8	56.6	74.3
Government website	11.0	12.4	8.5	10.2	11.1	10.9	10.8	11.1
SMS	12.5	15.4	9.6	6.1	14.2	11.1	13.7	11.7
Social media	24.2	32.1	16.0	7.5	24.3	24.2	27.6	21.8
Family	82.0	81.5	83.0	81.6	82.7	81.4	73.7	87.9
Community leader	77.1	75.1	79.8	79.6	80.3	74.5	70.7	81.7
Village volunteer	75.0	74.3	75.5	77.6	74.8	75.2	67.2	80.8

Abbreviation: CCSA, Centre for COVID-19 Situation Administration.

This survey asked respondents about a range of potential sources from which they could obtain COVID-19 information during the outbreak. Virtually all respondents indicated that they received information from at least one of the sources listed. As Table 8.1 shows, television or radio and family were the two primary information sources for older persons. Overall, 93 per cent received information from television or radio, whereas 82 per cent obtained 'word of mouth' information from their family. The proportion of respondents reporting that they received COVID-19 information from a government website or SMS was fairly low. Established in March 2020 under the Declaration of an Emergency Situation, the Centre for COVID-19 Situation Administration (CCSA) has become another main source of information for Thai people. CCSA provides a live daily television and radio broadcast to update people on the COVID-19 situation and related information on the government's lockdown and relief measures. The centre also disseminates essential knowledge and information regarding COVID-19 through electronic media such as Facebook. According to this survey, although only two thirds of the respondents indicated that they received information from CCSA, it is likely that those who reported television or radio had received information from its television and radio programmes.

Table 8.1 shows that the sources of COVID-19 information varied by age, gender and area of residence of older persons. For Internet- and technology-related sources such as social media and SMS, the proportion of older persons relying on these sources decreased with age and was higher in urban areas than in rural areas. In contrast, no significant differences existed in word of mouth from family or community leaders and village volunteers with respect to the respondents' age and gender. However, an urban–rural difference was evident, with modestly higher proportions of rural respondents reporting that they received COVID-19 information by word of mouth.

Knowledge and practices regarding COVID-19

The successful fight against COVID-19 requires people's adherence to control measures, which largely depends on their knowledge, attitudes and practices (Zhong et al., 2020). To assess older persons' knowledge of COVID-19, the survey asked respondents to answer "true" or "false" to statements regarding their higher risk of becoming infected, the transmission route and incubation period of the coronavirus, and prevention practices. As Figure 8.1 shows, nearly all respondents gave correct answers to all the statements except the one about the incubation period, to which less than half gave the correct answer. Given this, overall, around 43 per cent gave correct answers to all the statements. As shown in Figure 8.2, the percentage of respondents who gave all the correct answers differs little by older persons' age and gender. However, it is interesting that the percentage of respondents who gave all the correct answers was higher in rural areas than in urban areas.

Figure 8.1

Percentage of respondents who gave a correct answer to each statement about COVID-19 and its prevention

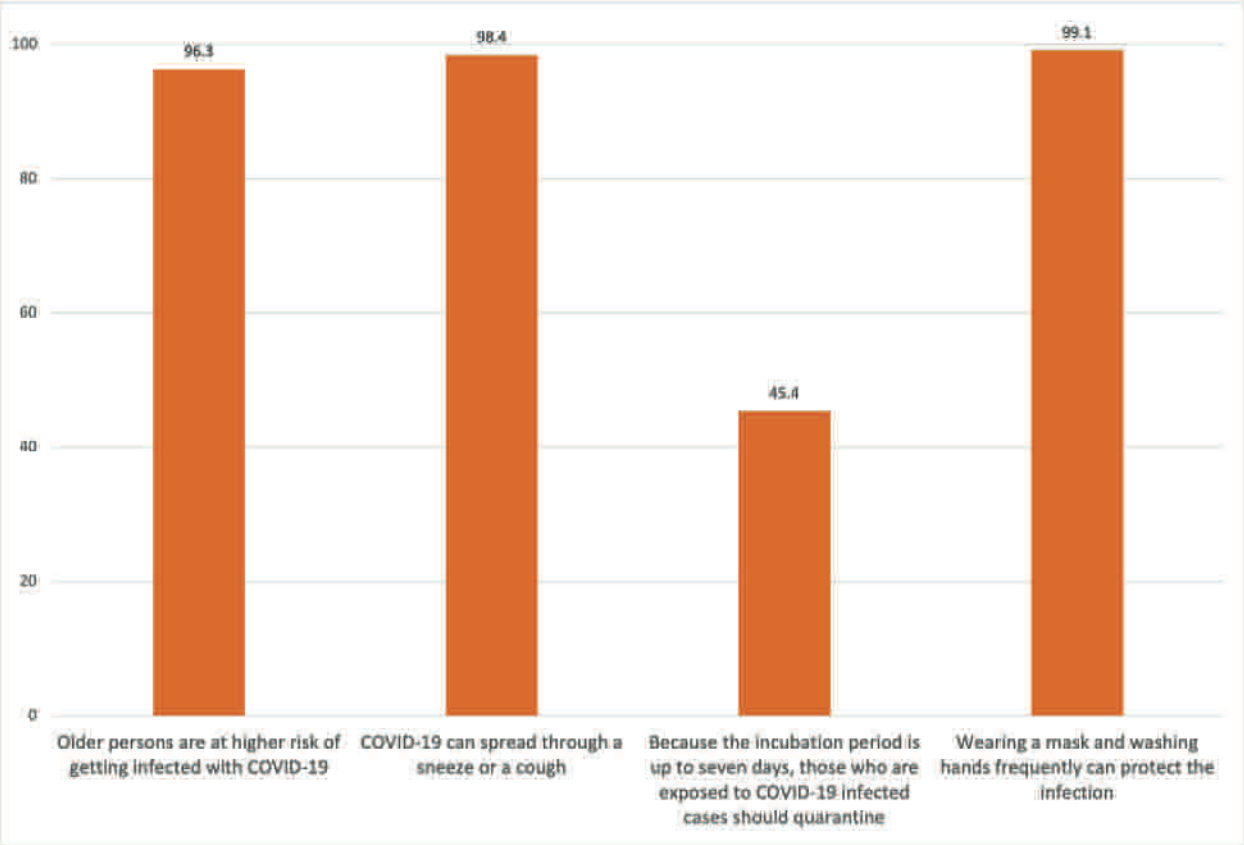
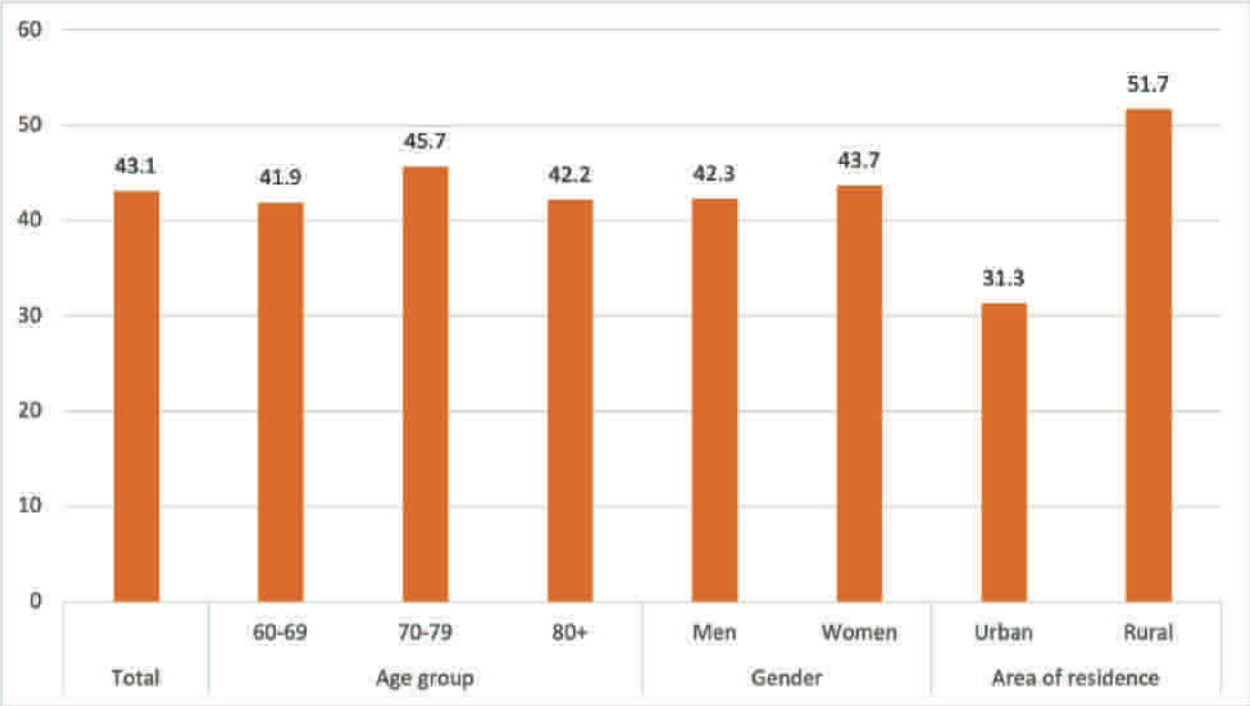


Figure 8.2

Percentage of respondents who gave correct answers to all the statements by age, gender and area of residence



The survey also collected information on how respondents complied with health recommendations, including avoiding leaving the house, social distancing from others, washing hands frequently, wearing a facemask in public and avoiding sharing meals with others. As Figure 8.3 shows, well over 80 per cent of the respondents indicated that they always wore a facemask in public and washed their hands frequently during the COVID-19 pandemic. The vast majority reported always keeping their distance from others and avoiding sharing their meals with others. The percentage of respondents who reported always avoiding leaving the house was lower than the percentages of the respondents who reported "always" for any of the other practices.

Figure 8.3

Preventive actions undertaken by older persons during the COVID-19 pandemic

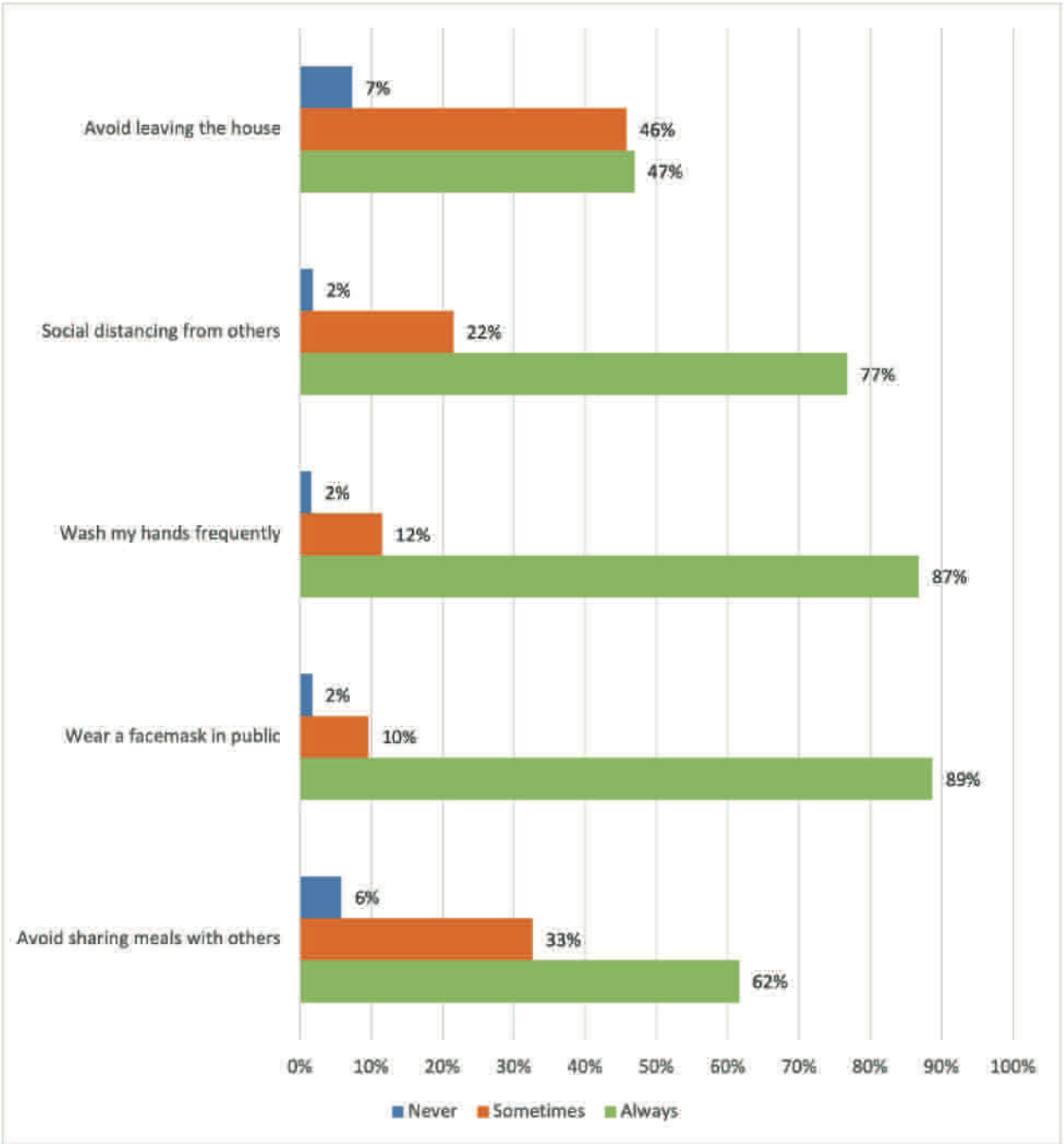


Table 8.2 shows the modest age differences in the percentages of respondents who reported that they always undertake each of the selected preventive actions. Respondents aged 80 years and over are less likely than those in their 70s and 60s to undertake all preventive practices, except the confinement practices. The percentage of respondents who reported avoiding leaving the house is significantly higher among respondents aged 80 years and over than among their younger counterparts. This is probably due to their health, as those in their 80s are more likely to experience disability and functional limitations, whereas those in their 60s or 70s tend to be more socially active and have broader contact (Sun et al., 2020).

No distinct difference existed between older men and older women in the percentages of respondents who reported that they always undertook the preventive actions listed. The proportions of rural residents who reported always avoiding leaving the house and sharing meals with others were modestly higher than those of urban residents.

Table 8.2

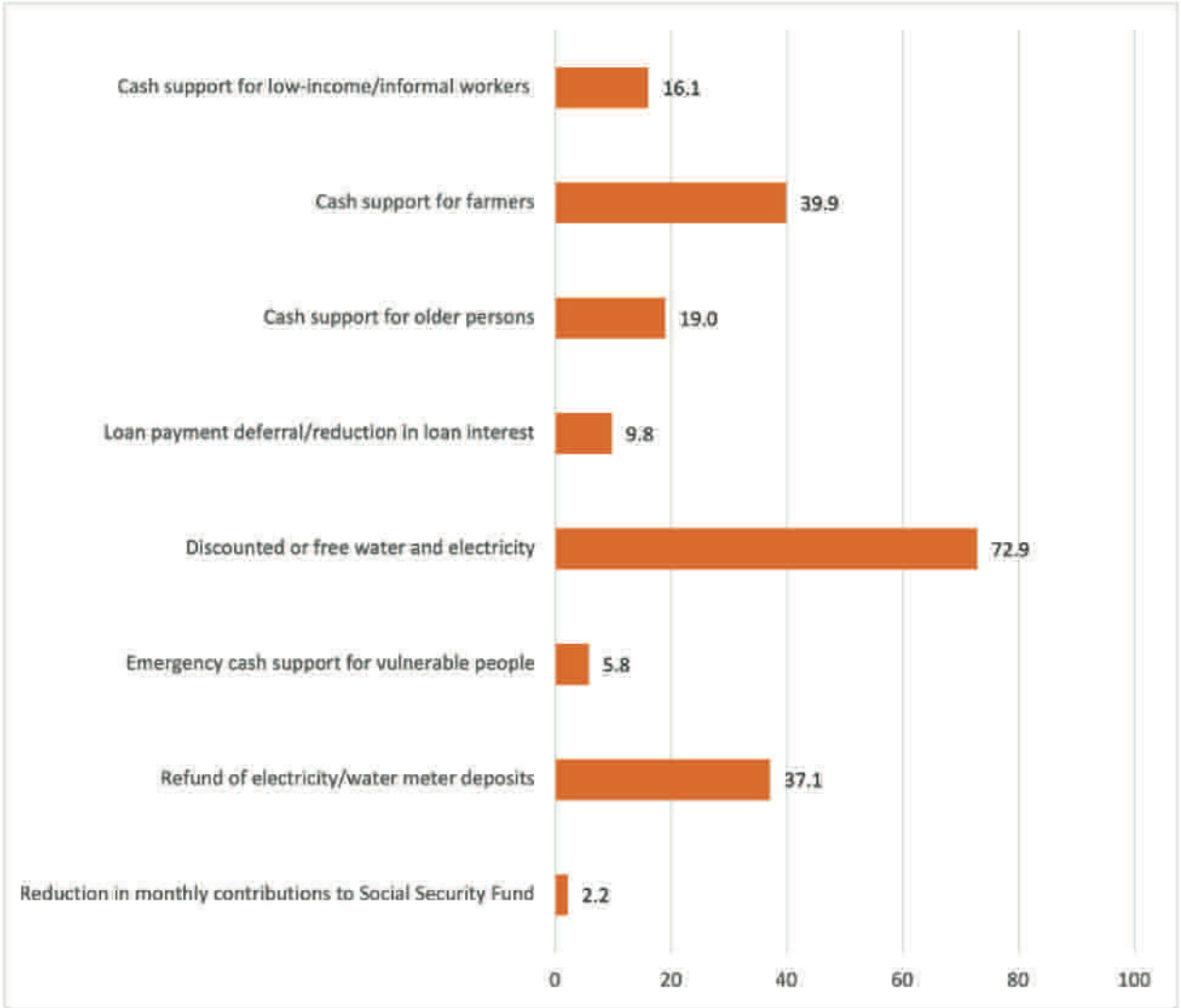
Percentage of respondents who reported always undertaking the selected preventive actions by age, gender and area of residence

Percentage of respondents who reported always undertaking each preventive action	Age group			Gender		Area of residence	
	60–69	70–79	80+	Men	Women	Urban	Rural
Avoid leaving the house	42.9	46.0	68.7	46.4	47.4	45.4	48.0
Social distancing from others	77.4	76.9	73.5	77.0	76.5	76.4	77.0
Wash my hands frequently	89.4	85.1	78.9	85.8	87.7	89.8	84.7
Wear a facemask in public	90.4	89.1	79.6	87.2	89.9	89.4	88.2
Avoid sharing meals with others	60.3	64.1	61.9	63.1	60.4	56.8	65.2

To contain the spread of COVID-19, strict restrictions were implemented on business operations and social interactions, causing many people to lose their jobs and encounter financial hardship and stress. A range of assistance and support programmes have been introduced by the Thai government to relieve the adverse impact of COVID-19, especially for low-income and vulnerable people. The survey asked respondents if they had received any assistance from the government during the COVID-19 pandemic. As Figure 8.4 shows, 16 per cent of respondents had received cash support of B5,000 for three months from the first rolled-out cash transfer scheme intended to financially aid temporary employees, contract employees and self-employed individuals not covered by the social security system. Another 40 per cent reported that they had been eligible and had received cash support of the same amount from the cash transfer scheme for farmers. Around one fifth of respondents indicated that they had received cash support of B1,000 for three months from the cash transfer scheme for vulnerable people. Since each beneficiary can register for only one programme, overall three quarters of respondents had received financial support from the government. Almost three quarters of the older persons indicated that they had benefited from the discounted or free use of water and electricity programmes intended to reduce people's cost of living.

Figure 8.4

Percentage of respondents receiving selected COVID-19-related assistance from the government



Section IV

Conclusion

Overall, the well-being of Thai older persons has been affected during the COVID-19 pandemic and lockdown period. However, it may be premature at this point to conclude on the extent of the negative impact of the crisis on older persons, particularly the economic consequences, which usually take time to fully unfold. The findings in this report show that many Thai older persons have been experiencing a higher level of economic insecurity in their later life.

Older persons who continued to work into old age to earn an income have been at risk of employment disruption. One third of working older adults became unemployed, lost vendor spaces or were forced to accept a lower salary. As has traditionally been the case when older persons become less able to work or their health worsens, they have relied on their family members, particularly their adult children, to provide financial support. Owing to the COVID-19 crisis, it may also be challenging for these family members to provide financial support to older parents. This is evidenced by fewer older parents reporting that they received money from their children and spouses. The COVID-19 crisis shows that the government's OAA programme serves as the foundation of economic security for older adults, but the benefit is still relatively small, and it is insufficient even in normal times.

During the COVID-19 pandemic and lockdown period, one out of four Thai older persons experienced at least one psychological symptom and reported that their life satisfaction was lower, indicating higher risks of new or worsening mental health problems in their later life. Although the lockdown and accompanying public health measures have proven successful in containing the spread of COVID-19, they were found to cause negative emotions among older persons, particularly those who were vulnerable. Older persons living alone, for example, were significantly more likely to experience loneliness than those living in other arrangements. A particularly striking result is that those in urban areas bore a disproportionate impact of the COVID-19 crisis in relation to many aspects of well-being compared with their rural counterparts. It is therefore not surprising that older persons in urban areas were twice as likely as their rural counterparts to report lower life satisfaction.

As Thailand continues through the COVID-19 crisis, safeguarding the economic and social security of older persons requires policy efforts at many levels. Policies and measures to support people and businesses affected by the outbreak must take into account the older population that wants to work and that relies on this income. Particular attention should be given to urban–rural differentials associated with the impact of COVID-19 to minimize any potential bias in planning and response to the crisis.

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Annex I

Methodology of the Survey

Target sample

The survey targeted respondents aged 60 years and over who resided in the sampled communities and villages in the selected provinces. At the survey design phase (June 2020), the COVID-19 situation in Thailand had improved such that the lockdown measures, including interprovincial travel, had been eased. Despite this, the government has still urged people to strictly adhere to hygiene, sanitizing and physical and social distancing measures. Given this, conducting face-to-face interviews for the survey seemed very challenging. Given that mobile phones are universally available in almost every household in Thailand, telephone and online surveys were considered alternative modes of data collection. After considering the advantages and disadvantages of both modalities, it was decided that a self-administered online questionnaire would be conducted. A more detailed discussion of this can be found in the survey design subsection.

To determine a proper sample size for the online survey, a range of important factors were taken into account. These included not only the factors often considered under normal circumstances, such as time, budget and sufficient numbers of respondents in different categories of substantive interest, but also the characteristics of the target sample in relation to the requirement of online surveys and the possibility of the COVID-19 situation worsening again. In previous studies, the response rates in web-based or Internet-based surveys have reportedly varied between 20 per cent and 50 per cent (Keererat, 2002). Rattanamanee et al. (2019) proposed that an acceptable response rate for Internet-based surveys should not be less than 50 per cent. Our initial plan was to collect information from 600 cases. Adjusting the figure for the 50 per cent response rate resulted in 1,200 cases (= 600/[10–0–50 per cent]).

The survey recruited all individuals aged 60 years and over who resided in the sampled communities and villages in the sampled provinces on the date of the survey and who were willing to take part. Potential respondents who showed any signs of illness or dementia or were deaf and mute were excluded from the survey.

Survey design

The sampling of cases involved several stages and relied on the probability sampling method. Before deciding to use the probability sampling method, we had considered a non-probability sampling method in which the questionnaires would be distributed through various online communication channels and would be openly accessible to any potential respondents so that they could visit and decide whether to participate (Fricker, 2017). However, based on the data from the "2017 Survey of Older Persons in Thailand" (NSO, 2017) and the "2014 Survey on Household Usage of Information and Communication Technology" conducted by the NSO, around half of older persons own or use at least one type of technological equipment (e.g. desktop computers, laptops, tablets, personal digital assistants, mobile phones). Around one third reside in households with Internet access, but only 3.3 per cent have reported using the Internet during the past year. As those with limited Internet use tend to be socioeconomically disadvantaged, the use of non-probability sampling probably results in greater risks of coverage errors, selection bias and non-response errors compared with the probability sampling method.

The first step of sampling involved dividing Thailand into five strata: Northern, Central, North-East and Southern regions and the Bangkok Metropolitan Area. Each stratum was further subdivided into two substrata: urban areas and rural areas. For the purpose of sampling, the official administrative definition of municipal and non-municipal areas was adopted to define urban and rural areas. Then, within each region, two provinces were selected. To ensure a minimum response rate of 50 per cent, we selected one province from the top three provinces in each region with the largest proportions of older persons based on the population registry as at 31 December 2019.

In addition, to increase the chance of covering poor and vulnerable older persons in the survey, another province was selected from those with

the highest percentages of older persons who are economically and socially vulnerable, as identified by two indicators: having no job or income and being deserted by their family, the community or the government. The information was obtained from the Thai People Map and Analytics Platform (TPMAP), the public platform designed to provide poverty data at provincial and national levels[8]

In each of the selected provinces, one municipal city located in an urban area and one subdistrict (tambon) located in a rural area were selected randomly from the list of municipal cities and subdistricts. For the Bangkok Metropolitan Area, all 50 districts were categorized into two groups: inner- and middle-layer districts, and outer-layer districts. In each group, one district was randomly selected.

The target number of respondents in each selected area was calculated based on the actual distributions of older persons by region and area of residence (urban or rural). However, because the 2019 population registry does not classify older persons by area of residence, the survey adopted the urban–rural distributions from the "2017 Survey of Older Persons in Thailand" (NSO, 2017). Nonetheless, the distributions of older persons by region taken from the two sources are very similar, as shown in Table 1. The distribution of the target sample by region, province and area of residence is presented in Table 2.

Table 1

Geographical distribution of older persons in Thailand from two national sources

Region	Population registry (December 2019)	The "2017 Survey of Older Persons in Thailand"		
		All	Urban	Rural
Bangkok	9.6%	9.6%	100%	-
Central	25.8%	25.8%	43.5%	56.5%
Northern	20.5%	21.2%	34.4%	65.6%
North-East	31.7%	31.6%	28.9%	71.1%
Southern	12.4%	11.8%	32.8%	67.2%
Total	**100%**	**100%**	**41.2%**	**58.8%**

Sources: The Older Persons Statistics, Population Registrar, Ministry of Interior; The "2017 Survey of Older Persons in Thailand" (NSO, 2017).
Note: Authors' calculation.

[8] TPMAP is a collaboration between the Office of the National Economic and Social Development Council and the National Electronics and Computer Technology Center, Ministry of Science and Technology. Further information is available at https://www.tpmap.in.th.

Table 2

Target sample numbers in sampled provinces and areas

Region	Sampled province	Municipal city/tambon	Target sample
Bangkok		Inner/middle district	57
		Outer district	58
Central	Samut Songkram	Urban	67
		Rural	87
	Ayuddhaya	Urban	67
		Rural	88
Northern	Lampang	Urban	42
		Rural	80
	Chiang Rai	Urban	43
		Rural	81
North-East	Nakon Ratchasima	Urban	55
		Rural	136
	Buriram	Urban	55
		Rural	135
Southern	Songkla	Urban	25
		Rural	50
	Phang Nga	Urban	24
		Rural	50
Total			**1,200**

Once the sampled municipal areas and subdistricts were identified, the data collection process began by local administrative offices (i.e. subdistrict municipal offices and subdistrict administration offices) and local government offices, including subdistrict health-promoting hospitals, municipal health service centres and community hospitals, being contacted. This was done to request their coordination in (1) disseminating information regarding the survey and the online questionnaires through their various communication channels and (2) connecting with a range of volunteer groups, such as public health volunteers and older person volunteers, to ask for their help in circulating the survey information and questionnaire via the Line application directly to older persons or family members residing in the same households.

To ensure that the questionnaires successfully reached all target respondents, including the vulnerable, we categorized potential respondents into three groups based on their potential literacy and availability of a smartphone and Internet access. Different modes of data collection were arranged to fit their situation. For older persons who could read and write and had mobile phones with the Line application, local intermediaries (typically village health volunteers, older person volunteers, and social development and human security volunteers) were requested to distribute the questionnaires directly to them via Line so that they could complete the survey by themselves.

For older persons who could read and write but who did not have mobile phones with Line, we further categorized them into two subgroups according to living arrangements.

- Living in a household with children or other family members present: the local intermediaries were asked to send the questionnaires via Line to the children or family members to help the older persons complete the survey.

- Living alone: the local intermediaries were asked to help this group of older persons complete the survey through Line on the volunteers' mobile phones.

For older persons who could neither read nor write and did not have mobile phones with Line, we categorized them into two subgroups according to their living arrangements.

- Living in a household with children or other family members present: the local intermediaries were asked to conduct face-to-face interviews and complete the survey through Line on their mobile phones.

- Living alone: the local intermediaries were asked to conduct face-to-face interviews directly with these older persons and complete the survey through Line on their mobile phones.

Survey instrument

The team developed a survey questionnaire that fit with the online survey. Google Docs, a free-of-charge application, was used to create the questionnaire. The application allowed our team to modify the questionnaire online and provided access to data files whenever an Internet connection was available.

Much of the questionnaire content was influenced by the literature and available evidence on related issues regarding older persons and COVID-19, as well as previous questionnaires used in surveys conducted in Thailand to assess the impact of COVID-19 on the general population and specific groups, such as youths and labourers. An extensive review of the literature was conducted to ensure complete coverage of all possible effects and establish a guideline for designing questions and answers based on these previously conducted online questionnaires.

The questionnaire

was composed of 24 close-ended questions on the following topics:

1. Personal data, including age, sex, level of education, marital status and number of children (no. 1–5)
2. Housing and living arrangements before and during the covid-19 outbreak (no. 6.1–6.6)
3. Employment, income, sources of income, expense, debt and household activities before and during the covid-19 outbreak (no. 7–13.1)
4. Self-assessed physical and mental health and life satisfaction before and during the covid-19 outbreak (no. 14–18.1)
5. Financial assistance and services received from the government, and private and public sectors (no. 19–20.4)
6. Sources of news and information on the covid-19 situation (no. 21–22)
7. Knowledge and understanding of covid-19 (no. 23–24).

Ethical consideration

This survey was reviewed and approved by the Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group of Chulalongkorn University (COA No. 150/2563).

Survey implementation

Data collection took place during July 2020 and was closely monitored by the research team. A total of 1,230 individuals who were aged 60 years and over and who resided in the sampled areas participated in the survey. Virtually all the individuals completed the survey with assistance from the local intermediaries. The median interview time was around 25 minutes; the times varied modestly between 20 minutes and 40 minutes. Very few older adults refused to participate in the survey, being more receptive to social interactions with the survey team following the lockdown situation. The survey's overall response rate varied greatly between 0 per cent for online surveys and 93 per cent for face-to-face interviews. A cloth facemask was presented to the respondents to express our gratitude for the time they gave to participate in the survey.

Annex II

Questionnaire

THE IMPACT OF COVID-19 ON OLDER PERSONS IN THAILAND

(Population aged 60 years and over)

*** denotes required information**

About the survey

This survey is carried out by the College of Population Studies, Chulalongkorn University, on behalf of the United Nations Population Fund (Thailand) to assess economic, social and health impacts of the COVID-19 pandemic on Thai older persons. The survey also aims to explore their knowledge and practice regarding COVID-19 prevention, as well as assistance and services received to alleviate unfavourable impacts. The data obtained will support the government and relevant stakeholders in prioritizing the older population and designing effective relief measures that better respond to their needs and conditions.

- Participation in this survey will take approximately 20–30 minutes.
- If any of the questions make you feel uncomfortable or uneasy, you may withdraw from the survey at any time. Withdrawal or refusal to participate in the survey will not result in any penalty or loss of benefits.
- All of your responses collected through this survey will be kept confidential and anonymous. Survey results will be reported in aggregated form only.

For a full description of the survey, please follow this link:
https://www.dropbox.com/s/nni0htuilcfqa68/Information%20sheet.pdf?dl=0

We look forward to your participation in the survey. Thank you for your kind consideration.

Informed consent form (only for the population aged 60 years and over)

1. Are you willing to take the survey? *

If the respondent is not willing to take the survey, the interviewer, please terminate the interview.

(Choose only one answer)

▢ Yes, I am willing to take the survey.

▢ No, I am not willing to take the survey.

2. Do you confirm that you have read and understood about the objectives of the survey as well as your rights as a survey participant? *

(Choose only one answer)

▢ Yes, and I will continue to complete the survey.

▢ Yes, but I will not take part in the survey.

Questions

3. How old are you? (completed age from your last birthday) *

(Choose only one answer)

▢ 60	▢ 71	▢ 82	▢ 93
▢ 61	▢ 72	▢ 83	▢ 94
▢ 62	▢ 73	▢ 84	▢ 95
▢ 63	▢ 74	▢ 85	▢ 96
▢ 64	▢ 75	▢ 86	▢ 97
▢ 65	▢ 76	▢ 87	▢ 98
▢ 66	▢ 77	▢ 88	▢ 99
▢ 67	▢ 78	▢ 89	▢ 100 years and over
▢ 68	▢ 79	▢ 90	
▢ 69	▢ 80	▢ 91	
▢ 70	▢ 81	▢ 92	

4. Gender of older person *

(Choose only one answer)

▢ 1. Male ▢ 2. Female ▢ 3. Other (specify): _____

5. What is the highest level of education you have completed? *

(Choose only one answer)

▢ 1. No education

▢ 2. Lower than primary education

▢ 3. Primary education or equivalent

▢ 4. Lower secondary education or equivalent

▢ 5. Higher secondary education or equivalent

▢ 6. Diploma or vocational education

▢ 7. College/bachelor's

▢ 8. Master's degree or higher

6. What is your current marital status? *

(Choose only one answer)

▢ 1. Single (never married)

▢ 2. Married (both spouse in the same household and not in the same household)

▢ 3. Widowed

▢ 4. Divorced/separated

7. How many living children do you have? (including step or adopted children) *

(If the respondent doesn't have any living biological, step or adopted children, please type "0")

_____

8. Where do you currently live? *

(Choose only one answer)

- ▢ 1. Wang Thong Lang district, Bangkok
- ▢ 2. Minburi district, Bangkok
- ▢ 3. Bang Chakreng sub-district, Samut Songkhram province
- ▢ 4. Bangkaew sub-district, Samut Songkhram province
- ▢ 5. Rong Chang sub-district, Phra Nakhon Si Ayutthaya province
- ▢ 6. Ko Koet sub-district, Phra Nakhon Si Ayutthaya province
- ▢ 7. Lampang city, Lampang province
- ▢ 8. Wo Kaeo sub-district, Lampang province
- ▢ 9. Chiang Rai city, Chiang Rai province
- ▢ 10. Pa Sang sub-district, Chiang Rai province
- ▢ 11. Muang Mai Khok Kruat sub-district, Nakhon Ratchasima province
- ▢ 12. Ban Ko sub-district, Nakhon Ratchasima province
- ▢ 13. Satuek sub-district, Buri Ram province
- ▢ 14. Samet sub-district, Buri Ram province
- ▢ 15. Kho Hong sub-district, Songkhla province
- ▢ 16. Tha Kam subdistrict, Songkhla province
- ▢ 17. Phang Nga city, Phang Nga province
- ▢ 18. Bo Saen sub-district, Phang Nga province

9. Is it (the above place of residence) the same where you normally/usually live? *

(Choose only one answer)

- ▢ 1. Yes (skip to question no. 12)
- ▢ 2. No (continue to question no. 10)

10. In what province is your usual place of residence located? *

(Choose only one answer)

- ▢ Krabi
- ▢ Bangkok
- ▢ Kanchanaburi
- ▢ Kalasin
- ▢ Kamphaeng Phet
- ▢ Khon Kaen
- ▢ Chanthaburi
- ▢ Chachoengsao
- ▢ Chon Buri
- ▢ Chai Nat
- ▢ Chaiyaphum
- ▢ Chumphon
- ▢ Trang
- ▢ Tak
- ▢ Nakhon Nayok
- ▢ Nakhon Pathom
- ▢ Nakhon Phanom
- ▢ Nakhon Ratchasima
- ▢ Nakhon Si Thammarat
- ▢ Nakhon Sawan
- ▢ Nonthaburi
- ▢ Narathiwat
- ▢ Nan
- ▢ Bueng Kan
- ▢ Buri Ram
- ▢ Pathum Thani
- ▢ Prachuap Khiri Khan
- ▢ Prachin Buri
- ▢ Pattani
- ▢ Phra Nakhon Si Ayutthaya
- ▢ Phayao
- ▢ Phangnga
- ▢ Phatthalung
- ▢ Phichit
- ▢ Phitsanulok
- ▢ Phuket
- ▢ Maha Sarakham
- ▢ Mukdahan
- ▢ Yala
- ▢ Yasothon
- ▢ Ranong
- ▢ Rayong
- ▢ Ratchaburi
- ▢ Roi Et
- ▢ Lop Buri
- ▢ Lampang
- ▢ Lamphun
- ▢ Si Sa Ket
- ▢ Sakon Nakhon
- ▢ Songkhla
- ▢ Satun
- ▢ Samut Prakan
- ▢ Samut Songkhram
- ▢ Samut Sakhon
- ▢ Saraburi
- ▢ Sa Kaeo
- ▢ Sing Buri
- ▢ Suphan Buri
- ▢ Surat Thani
- ▢ Surin
- ▢ Sukhothai
- ▢ Nong Khai
- ▢ Nong Bua Lam Phu
- ▢ Amnat Charoen
- ▢ Ang Thong
- ▢ Loei

11. In what area is your usual place of residence located?

(If your residence is located in Bangkok, please choose "Municipal area")

- ▢ 1. Municipal area
- ▢ 2. Non-municipal area

12. In your usual place of residence, with whom do you live?*

(Please answer all questions and tick only one answer per row)

	Yes	No
Spouse	☐	☐
Child(ren) (including step and adopted)	☐	☐
Grandchild age 15 years and younger	☐	☐
Grandchild age over 15 years	☐	☐
Sibling/relative	☐	☐
Friend	☐	☐
Caretaker	☐	☐
Housemaid/servant	☐	☐
Other non-relative (e.g. employer)	☐	☐

13. Does your usual place of residence have any of the following items? *

(Please answer all questions and tick only one answer per row)

	Yes	No
1. Radio	☐	☐
2. Television	☐	☐
3. Mobile phone (including smartphone)	☐	☐
4. Desktop/laptop/tablet	☐	☐
5. Internet	☐	☐

14. During the COVID-19 outbreak (from March to May 2020), have you moved to live elsewhere, or had someone move in to live with you? *

(Moving is defined here as inter-community and inter-jurisdictional moving. It means to stay and live in a new place located outside the usual community, districts or provinces. Visits are not included.)

Choose only one answer

- ▢ 1. Never left the usual residence and had no one moving in (skip to question no. 16)
- ▢ 2. Never left the usual residence and had someone moving in (skip to question no. 16)
- ▢ 3. Moved out of the usual residence (continue to question no. 15)

15. If you left your place of residence, where did you move to? *

(Choose only one answer)

- ▢ 1. Other village, same sub-district
- ▢ 2. Other sub-district, same district
- ▢ 3. Other district, same province
- ▢ 4. Other province

16. During the last 12 months before the COVID-19 outbreak (before March 2020), did you work? *

(Work is defined here as any paid economic activities)

(Choose only one answer)

- ▢ Yes (skip to question no. 18)
- ▢ No (continue to question no. 17)

17. Are you looking for a job? *

(Choose only one answer)

- ▢ Yes (skip to question no. 23)
- ▢ No (skip to question no. 23)

18. If you had worked before the COVID-19 outbreak (before March 2020), what was your employment status? *

(Choose only one answer)

- ▢ 1. Employer
- ▢ 2. Own account
- ▢ 3. Assisting family business
- ▢ 4. Civil servant/government employee/public enterprise employee
- ▢ 5. Private employee
- ▢ 6. Factory worker
- ▢ 7. Construction worker/craftsman
- ▢ 8. Casual worker
- ▢ 9. Agricultural worker
- ▢ 10. Taxi driver/motorcycle driver/other driver
- ▢ 11. Street vendor
- ▢ 12. Home-based worker
- ▢ 13. Others (specify): _____

19. Did your work involve agricultural sector (including forestry and fishery)? *

(Choose only one answer)

- ▢ 1. Yes
- ▢ 2. No

20. During the COVID-19 outbreak (from March to May 2020), was your work affected by COVID-19? *

(Choose only one answer)

- ▢ 1. Yes (continue to question no. 21)
- ▢ 2. No (skip to question no. 23)

21. How was your work affected by COVID-19? *

(Choose only one answer)

- ▢ 1. Had to work from home
- ▢ 2. Were laid off
- ▢ 3. Salary cut
- ▢ 4. Business closed down
- ▢ 5. Fewer hirers
- ▢ 6. Losing vendor space
- ▢ 7. Others (specify): _____

22. How do you plan about your work after the COVID-19 outbreak is over? *

(Choose only one answer)

- ▢ 1. To leave the job
- ▢ 2. To continue working from home
- ▢ 3. To return to work at the office once it is open
- ▢ 4. To wait until the COVID-19 outbreak is over and return to work
- ▢ 5. To find a new job within or nearby hometown community
- ▢ 6. To return to assist the family's business
- ▢ 7. Uncertain/have not decided
- ▢ 8. Others (specify): _____

23. In the past 12 months before the COVID-19 outbreak (before March 2020), what was your total income (including income from all sources, for example, work, pension, old-age allowance, disability allowance)? *

(Choose only one answer)

- ▢ 1. Less than 10,000 baht/per year
- ▢ 2. 10,000–19,999 baht/per year
- ▢ 3. 20,000–29,999 baht/per year
- ▢ 4. 30,000–39,999 baht/per year
- ▢ 5. 40,000–49,999 baht/per year
- ▢ 6. 50,000–59,999 baht/per year
- ▢ 7. 60,000–69,999 baht/per year
- ▢ 8. 70,000–79,999 baht/per year
- ▢ 9. 80,000–89,999 baht/per year
- ▢ 10. 90,000–99,999 baht/per year
- ▢ 11. 100,000–299,000 baht/per year
- ▢ 12. 300,000–399,999 baht/per year
- ▢ 13. 400,000–499,999 baht/per year
- ▢ 14. 500,000 or more baht/per year
- ▢ 15. Do not know/No answer

24. During the COVID-19 outbreak (from March to May 2020), was your income affected by COVID-19? *

(Choose only one answer)

- ▢ 1. Not affected
- ▢ 2. Yes, income was lower
- ▢ 3. Yes, income was higher
- ▢ 4. Don't know

25. Prior to the COVID-19 outbreak (before March 2020), did you receive income from any of the following sources? *

(Please answer all questions and tick only one answer per row)

	Yes	No
1. Work	▢	▢
2. Pension	▢	▢
3. Old Age Allowance	▢	▢
4. Disability Allowance	▢	▢
5. Children (including step and adopted)	▢	▢
6. Spouse/parent/sibling/relative	▢	▢
7. Interest/saving/asset	▢	▢

26. Prior to the COVID-19 outbreak (before March 2020), what was your main income source? *

(Choose only one answer)

▢ 1. Work

▢ 2. Pension

▢ 3. Old Age Allowance

▢ 4. Disability Allowance

▢ 5. Children (including step and adopted)

▢ 6. Spouse/parent/sibling/relative

▢ 7. Interest/saving/asset

27. During the COVID-19 outbreak (from March to May 2020), did you receive income from any of the following sources? *

(Please answer all questions and tick only one answer per row)

	Yes	No
1. Work	▢	▢
2. Pension	▢	▢
3. Old Age Allowance	▢	▢
4. Disability Allowance	▢	▢
5. Children (including step and adopted)	▢	▢
6. Spouse/parent/sibling/relative	▢	▢
7. Interest/saving/asset	▢	▢

28. During the COVID-19 outbreak (from March to May 2020), what was your main income source? *

(Choose only one answer)

▢ 1. Work

▢ 2. Pension

▢ 3. Old Age Allowance

▢ 4. Disability Allowance

▢ 5. Children (including step and adopted)

▢ 6. Spouse/parent/sibling/relative

▢ 7. Interest/saving/asset

29. In the past 12 months before the COVID-19 outbreak (before March 2020), was your income adequate for living? *

▢ 1. Always inadequate

▢ 2. Sometimes inadequate

▢ 3. Adequate

▢ 4. More than adequate

30. During the COVID-19 outbreak (from March to May 2020), was your income adequate for living? *

- ▢ 1. Always inadequate
- ▢ 2. Sometimes adequate
- ▢ 3. Adequate
- ▢ 4. More than adequate

31. To what extent did the COVID-19 affect your spending? *

(Please answer all questions and tick only one answer per row)

	No impact	Have an impact	Not applicable/ no activities
1. Food (e.g. rice, dried foods, seasonings, fresh foods, ready foods)	▢	▢	▢
2. Utility (e.g. water bill, electricity bill)	▢	▢	▢
3. Internet/telephone	▢	▢	▢
4. Job expenses (e.g. material cost, fuel cost, etc.)	▢	▢	▢
5. COVID-19 related expense (e.g. face mask, hand sanitizer, COVID-19 testing fee, etc.)	▢	▢	▢
6. Medicine and medical supplies (not related to COVID-19)	▢	▢	▢
7. Child/grandchild-related expense (e.g. online learning equipment fee, living expenses during school breaks, etc.)	▢	▢	▢

32. Do you currently have any debt? *

(Choose only one answer)

- ▢ 1. No
- ▢ 2. Yes, the debt was incurred before the COVID-19 (before March 2020)
- ▢ 3. Yes, the debt was incurred during the COVID-19 (from March to May 2020)
- ▢ 4. Yes, the debt was incurred before and during the COVID-19

33. Prior to the COVID-19 outbreak (before March 2020), did you do any of the following household activities? *

(Please answer all questions and tick only one answer per row)

	Often	Sometimes	Never	No activity
1. Cooking/preparing meals	☐	☐	☐	☐
2. Laundry/ironing	☐	☐	☐	☐
3. House cleaning	☐	☐	☐	☐
4. Gardening/plant watering	☐	☐	☐	☐
5. Taking care of any grandchild under 15 (both coresident and non-coresident)	☐	☐	☐	☐
6. Taking care of an older family member	☐	☐	☐	☐
7. Taking care of a disabled family member	☐	☐	☐	☐

34. During the COVID-19 outbreak (from March to May 2020), did you do any of the following household activities? *

(Please answer all questions and tick only one answer per row)

	Often	Sometimes	Never	No activity
1. Cooking/preparing meals	☐	☐	☐	☐
2. Laundry/ironing	☐	☐	☐	☐
3. House cleaning	☐	☐	☐	☐
4. Gardening/plant watering	☐	☐	☐	☐
5. Taking care of any grandchild under 15 (both coresident and non-coresident)	☐	☐	☐	☐
6. Taking care of an older family member	☐	☐	☐	☐
7. Taking care of a disabled family member	☐	☐	☐	☐

35. How would you rate your health before the COVID-19 outbreak (before March 2020)? *

(Choose only one answer)

	1	2	3	4	5	
Very poor	▢	▢	▢	▢	▢	Very ,good

36. Prior to the COVID-19 outbreak (before March 2020), did you experience any of the following difficulties? *

(Please answer all questions and tick only one answer per row)

	Not at all	With some difficulty	Yes
1. Vision (with or without eyeglasses)	▢	▢	▢
2. Hearing (with or without hearing aids)	▢	▢	▢
3. Mobility	▢	▢	▢
4. Communication	▢	▢	▢
5. Memory	▢	▢	▢
6. Personal care (e.g. bathing, putting on clothes)	▢	▢	▢

37. Compared to before the COVID-19 outbreak (before March 2020), how would you rate your health during the COVID-19 outbreak (from March to May 2020)? *

(Choose only one answer)

▢ 1. Better than before the COVID-19

▢ 2. About the same as before the COVID-19

▢ 3. Worse than before the COVID-19

38. During the COVID-19 outbreak (from March to May 2020), did you experience any of the following difficulties? *

(Please answer all questions and tick only one answer per row)

	Worse	About the same	Better
1. Vision (with or without eyeglasses)	▢	▢	▢
2. Hearing (with or without hearing aids)	▢	▢	▢
3. Mobility	▢	▢	▢
4. Communication	▢	▢	▢
5. Memory	▢	▢	▢
6. Personal care (e.g. bathing, putting on clothes)	▢	▢	▢

39. During the COVID-19 outbreak (from March to May 2020), how frequently did you experience the following symptoms or feelings? *

(Please answer all questions and tick only one answer per row)

	Never	Sometimes	Often/always
1. Loss of appetite	▢	▢	▢
2. No hope in life	▢	▢	▢
3. Unhappy	▢	▢	▢
4. Sad	▢	▢	▢
5. Lonely	▢	▢	▢

40. During the COVID-19 outbreak (from March to May 2020), how frequently did you feel worried or concerned on any issues? *

(Choose only one answer)

▢ 1. Never (skip to question no. 42)

▢ 2. Sometimes (continue to question no. 41)

▢ 3. Often/always (continue to question no. 41)

41. Please indicate the issue of your concern? *

(Choose only one answer)

- ▢ 1. No worry or concern
- ▢ 2. Fear of myself or family becoming infected with coronavirus
- ▢ 3. Worse health status due to missed medical appointments
- ▢ 4. Personal and family financial status
- ▢ 5. Accessibility to the treatment if infected with coronavirus
- ▢ 6. Conflict within my family while living together
- ▢ 7. Would have to live alone if any of the family members got infected with coronavirus
- ▢ 8. Unable to purchase necessities, for example food and medicine.
- ▢ 9. Others (specify):

42. When you have stress, how do you deal with it? *

(Choose only one answer)

- ▢ 1. No stress at all
- ▢ 2. Learning to live with stress
- ▢ 3. Asking superstitions for help (e.g. bribing the gods)
- ▢ 4. Chanting/praying
- ▢ 5. Thinking that everything that comes into existence can perish
- ▢ 6. Talking with friends
- ▢ 7. Talking with family members
- ▢ 8. Others (specify): _____

43. Was any of the following daily life routines affected by COVID-19? *

(Please answer all questions and tick only one answer per row)

	Yes	No
1. Leaving the house to run errands	☐	☐
2. Leaving the house to buy groceries	☐	☐
3. Keeping medical appointments	☐	☐
4. Attending religious ceremonies	☐	☐
5. Meeting with family members and relatives	☐	☐
6. Meeting with friends	☐	☐
7. Participating in social activities	☐	☐

44. How were you satisfied with your life before the COVID-19 outbreak (before March 2020)? *

(Choose only one answer)

	1	2	3	4	5	
Very dissatisfied	☐	☐	☐	☐	☐	Very dissatisfied

45. Compared to before the COVID-19 outbreak (before March 2020), how were you satisfied with your life during the COVID-19? *

(Choose only one answer)

☐ 1. More satisfied than before the COVID-19

☐ 2. About the same as before the COVID-19

☐ 3. Less satisfied than before the COVID-19

46. Did you or your spouse receive any of the following assistance and supports from either public or private sector? *

(Please answer all questions and tick only one answer per row)

	Yes	No	Not eligible	Did not know
1. Cash support of THB 5,000 for 3 months for low-income earners/informal workers	▢	▢	▢	▢
2. Cash support of THB 5,000 for 3 months for farmers	▢	▢	▢	▢
3. Cash support of THB 3,000 for 3 months for older persons	▢	▢	▢	▢
4. Loan payment deferral/reduction of loan interest	▢	▢	▢	▢
5. Discounted or free water and electricity	▢	▢	▢	▢
6. Emergency cash support for vulnerable people	▢	▢	▢	▢
7. Free meals	▢	▢	▢	▢
8. Free shelters/temporary housing	▢	▢	▢	▢
9. Free medicine, medical supplies, face mask and hand sanitizer	▢	▢	▢	▢
10. Refund of electricity/water metre deposits	▢	▢	▢	▢
11. Reduction in monthly contributions to Social Security Fund	▢	▢	▢	▢

During the COVID-19 outbreak (from March to May 2020), did you receive any of the following health/medical services from the government?

47. Home visit by health professionals *

(Choose only one answer)

☐ 1. Yes

☐ 2. No

48. Home visit by village health volunteers *

(Choose only one answer)

☐ 1. Yes

☐ 2. No

49. Home visit by older person volunteers *

(Choose only one answer)

☐ 1. Yes

☐ 2. No

☐ 3. Older person volunteers not available

50. Any assistance or service from the local administrative office *

(Choose only one answer)

☐ 1. Yes

☐ 2. No

51. During the COVID-19 outbreak (from March to May 2020), did you receive information regarding COVID-19 from any of the following sources? *

(Please answer all questions and tick only one answer per row)

	Yes	No
1. TV/radio	▢	▢
2. Newspaper	▢	▢
3. The Centre of COVID-19 Situation Administration (CCSA)	▢	▢
4. Government's website	▢	▢
5. SMS	▢	▢
6. Internet, social media (e.g. LINE application)	▢	▢
7. Family member	▢	▢
8. Community leader	▢	▢
9. Village volunteer	▢	▢

52. During the COVID-19 outbreak (from March to May 2020), how did you protect yourself from COVID-19? *

(Please answer all questions and tick only one answer per row)

	Never	Sometimes	Often/always
1. Avoid leaving the house	▢	▢	▢
2. Social distancing from others	▢	▢	▢
3. Wash my hands frequently	▢	▢	▢
4. Wear a facemask in public	▢	▢	▢
5. Avoid sharing meals with others	▢	▢	▢

53. Please indicate whether the following statements are true or false? *

(Please answer all questions and tick only one answer per row)

	True	False
1. Older persons with chronic conditions are at higher risk of getting infected with COVID-19.	▢	▢
2. COVID-19 can spread through a sneeze, a cough or even talking.	▢	▢
3. Because the incubation period is 3–7 days, those who are exposed to COVID-19 infected cases should be quarantined for 7 days.	▢	▢
4. Wearing a facemask and washing hands frequently can prevent the COVID-19 infection.	▢	▢

54. Did the participant complete the questionnaire by oneself? *

(Choose only one answer)

▢ 1. The participant completed all of the questionnaire.

▢ 2. The participant completed only some parts of the questionnaire.

▢ 3. The caretaker (e.g. children, relative, etc.) completed all of the questionnaire.

Thank you for your time to complete the survey!

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