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# A MULTI-LEVEL MODEL OF FAITH-BASED SOCIAL CAPITAL IN INSTITUTIONAL ELDERLY CARE: INSIGHTS FROM INDONESIA'S COMMUNITY-DRIVEN CARE SYSTEM

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## ABSTRACT

This study develops and tests a multi-level quantitative model explaining how faith-based social capital shapes service quality in institutional elderly care within a community-driven care system. Drawing on social capital theory, the model distinguishes bonding (micro-level internal cohesion and trust), bridging (meso-level cross-community ties), and linking (macro-level vertical connections to authorities and resource holders) and posits faith-based moral norms as a mediating mechanism through which these relational resources translate into care quality. Survey data were collected from 252 caregivers working in faith-based elderly care institutions. The measurement model demonstrated satisfactory psychometric properties, with standardized factor loadings exceeding recommended thresholds and evidence of convergent and discriminant validity using covariance-based Structural Equation Modeling. Structural results indicate that bonding ($\beta = 0.32$, $p < 0.001$), bridging ($\beta = 0.24$, $p = 0.002$), and linking ($\beta = 0.18$, $p = 0.017$) social capital positively predict faith-based moral norms, which in turn strongly predicts elderly care quality ($\beta = 0.59$, $p < 0.001$). Bootstrapping confirms significant indirect effects for bonding ($\beta = 0.19$, 95% CI [0.12, 0.27]), bridging ($\beta = 0.14$, 95% CI [0.06, 0.22]), and linking ($\beta = 0.11$, 95% CI [0.02, 0.19]), supporting the proposed mediation pathways. The model explains 46% of the variance in moral norms and 35% of the variance in care quality. The findings advance social capital research by integrating three dimensions within a single multi-level framework and by empirically demonstrating faith-based moral norms as a mechanism linking relational structures to institutional care quality. Results highlight the importance of strengthening internal cohesion, cross-community collaboration, and vertical partnerships alongside values-based training to improve long-term care quality in non-welfare-state settings.

**KEYWORDS:** Social Capital; Faith-Based Organizations; Moral Norms; Elderly Care Quality; Structural Equation Modeling.

## 1. INTRODUCTION

Population ageing has become one of the most consequential demographic shifts of this century, as nearly all countries are experiencing a rapid rise in the proportion of older adults, longer life expectancy and declining fertility are jointly reshaping population structures toward increasingly older compositions (Gusman et al., 2025; Myers, 2016). This transition not only expands the number of people in later life but also amplifies the need for sustained support, including long-term care, assistance with activities of daily living, and consistent psychosocial services. As functional limitations and chronic health needs grow with age, social and health care systems face mounting pressure to provide care models that are more adaptive, affordable, and humane.

Alongside this transformation, the burden of care is becoming more visible across multiple levels, from households and communities to service-providing institutions. In many settings, families remain the primary caregivers; however, their capacity to sustain intensive support is often constrained by changing household structures, rising labor-force participation, population mobility, and economic demands. Care institutions confront similar pressures, particularly when service needs increase faster than the availability of care workers and operational resources (Nagel, 2025). This mismatch creates gaps between demand and service capacity, raising urgent questions about how elderly care can be organized sustainably without compromising quality and the dignity of care recipients.

The world needs care models that are not only efficient in terms of financing and implementation but also inclusive in reaching vulnerable groups, sustainable in resource management, and grounded in social values that cultivate concern and moral responsibility at this juncture. The search for approaches that can bridge demographic pressures, constrained state capacity, and the demand for humane care quality provides a critical context for this study (Gontijo et al., 2016; Tang et al., 2022; Xu & Zhao, 2022). The next section links these challenges to the role of social capital as a relational resource that can strengthen caregiving practices, particularly within community-driven and institutional elderly care settings.

To understand why some elderly care services are able to endure, expand, and maintain quality while others stagnate or deteriorate, recent scholarship increasingly positions social capital as a key determinant. Social capital is commonly conceptualized as a resource embedded in social relationships, encompassing norms of reciprocity, trust, and networks that enable individuals and organizations to coordinate effectively (Börzel & Risse, 2016; Cao et al., 2015; Ślęzak-Belowska & Paragi, 2025). The most widely used framework in social service research distinguishes three main forms: bonding social capital, rooted in close and relatively homogeneous ties within groups; bridging social capital, which connects different groups and broadens relational reach; and linking social capital, referring to vertical connections with institutions that hold authority and control access to resources. This distinction matters because the needs of older adults are rarely met through a single type of relationship; instead, they typically require a combination of strong internal networks, adaptive cross-community ties, and access to more formal forms of institutional support.

At the level of practice, evidence from social service research suggests that bonding social capital tends to contribute to the stability of everyday support because it is built through emotional closeness, mutual trust, and reciprocal commitment among caregivers, families, volunteers, and organizational managers. Such internal cohesion often correlates with more consistent caregiving, stronger solidarity, and a greater capacity to cope with work-related strain through tangible social support (Muhumuza et al., 2023; Sileo et al., 2022). Bridging social capital, in turn, expands opportunities for collaboration with external groups, including broader local communities, civil society organizations, and volunteer networks across diverse backgrounds, allowing services to access ideas, labor, and best practices that may otherwise be unavailable. Cross-group connections can also enhance public trust, facilitate access to non-material resources such as psychosocial support, and enable more flexible coordination as older adults' needs evolve. Linking social capital facilitates relationships with institutions that possess greater authority and resource capacity such as government agencies, donors, and health organizations which can strengthen the legitimacy of care providers, expand funding support, and improve access to training, regulation, and service standards. Taken together, these dimensions are associated not only with service quality but also with a care system's capacity to build trust, reduce fragmentation, and sustain operations under conditions of constraint (Deno, 2017; Mutesi et al., 2025).

The existing literature, however, remains contextually imbalanced. Much empirical evidence on social capital and outcomes in elderly care comes from Western countries supported by relatively established welfare-state arrangements in terms of regulation and service infrastructure. In such settings, social capital is often treated as a

complement to already available formal systems for example, to increase community participation, strengthen service coordination, or enhance trust in institutions. Consequently, the mechanisms of social capital in contexts where welfare-state capacity is more limited, and where care provision relies heavily on community-based organizations, philanthropy, or values-driven institutions, are still not sufficiently understood (Hardison-Moody & Yao, 2019; Li & Zhang, 2021; Tu, 2025). This contextual gap is important because the relationships among social networks, resource access, and care quality are likely to operate differently when formal systems are not dominant and care depends on more diverse social dynamics.

Although social capital is widely recognized as an important determinant in social services, the global research map still reveals substantial conceptual and methodological gaps. First, many studies examine bonding, bridging, or linking in isolation, leaving an incomplete understanding of how these dimensions jointly function within an ecosystem of elderly care. Yet care quality depends not only on internal cohesion but also on an organization's ability to collaborate across groups and secure more formal institutional support. The absence of integrative models tends to produce partial explanations that struggle to capture complex relational dynamics and offer limited leverage for explaining performance variation across real-world settings (Hooley et al., 2023; Kail et al., 2021).

Moreover, the literature has paid insufficient attention to **faith-based contexts**, despite the fact that many elderly care systems particularly outside the West operate through organizations grounded in religious values and identities. When care is provided by faith-based institutions, social relationships are shaped not only by resource exchange and interpersonal trust but also by a more explicitly normative moral framework, including spiritual obligations, service orientations, and internalized ethics of compassion. Yet these dimensions are often treated as cultural background rather than as analytic components that influence how social capital is formed, sustained, and translated into caregiving practice. As a result, mechanisms distinctive to faith-based organizations such as the ways moral values regulate caregiver behavior and service standards remain insufficiently specified.

Elderly care research also continues to be dominated by qualitative or descriptive studies that are rich in context but less equipped to test relationships among constructs in a measurable and generalizable way. Quantitative studies that explicitly link social capital to elderly care quality remain limited, especially those employing analytical designs capable of testing pathways and estimating effect sizes. This constraint hinders the development of comparable evidence across settings and limits the field's ability to propose data-informed models that can guide decision-making in service improvement (Bass et al., 2024; Myers, 2016; Oman & Syme, 2018). There is still no established multi-level quantitative model that maps a mediating mechanism via moral norms as a bridge between social capital and care quality. While some studies acknowledge the role of values, norms, or organizational culture, they rarely position these elements as causal mechanisms that are tested explicitly. In values-driven services, moral norms can function as regulatory devices that shape how trust is built, how solidarity is enacted, and how resources are deployed in caregiving practice. The absence of models that integrate the three dimensions of social capital while treating moral norms as an explanatory mechanism represents a critical gap that must be addressed if the literature is to move beyond the general claim that social capital "matters" toward a more precise understanding of how its effects operate (Gusman et al., 2025; Nagel, 2025).

Indonesia can be understood as a distinctive "social laboratory" for examining community-based and faith-based elderly care dynamics because service provision does not rest on a comprehensive welfare state. As a result, institutional and semi-institutional care spaces are often filled by community initiatives, philanthropy, and religious organizations that serve as primary actors in delivering daily support, meeting basic needs, and providing long-term care (Kail et al., 2021; Saint Ville et al., 2016). This configuration offers valuable empirical leverage for global scholarship, as the sustainability of services, trust formation, resource mobilization, and the reinforcement of care standards are likely to depend more heavily on social networks, moral legitimacy, and vertical ties to institutional actors than on mature state-backed social protection schemes. Indonesia's care system also differs structurally from dominant models in Europe or Japan, where elderly care provision is typically more institutionalized and supported by relatively strong policy frameworks, financing arrangements, and public infrastructure (Saint Ville et al., 2016; Wambura, 2024). These structural differences make Indonesia a strategically important setting for testing how social capital and faith-based moral norms operate to produce care quality when the state is not the primary backbone of the system.

Building on this context, the present study advances a theoretical proposition that the influence of social capital on elderly care quality does not operate purely through direct pathways but works through a normative mechanism that is particularly

salient in faith-based institutions: faith-based moral norms. The core novelty of this proposition lies in positioning faith-based moral norms as a causal bridge explaining how bonding, bridging, and linking social capital can be translated into caregiving practices that are more humane, consistent, and responsive. Strong internal ties, cross-group collaborative bridges, and vertical relations with institutional actors provide relational preconditions for service delivery; however, within faith-based settings, these relationships gain additional motivational force through moral norms that emphasize spiritual obligation, compassion as ethical practice, and collective responsibility toward vulnerable groups. The proposed conceptual pathway is that bonding, bridging, and linking social capital shape and strengthen moral norms, and these moral norms then guide caregiver standards of conduct, service orientation, and organizational commitment, ultimately improving care quality. To date, global literature has tended to treat religiosity and values as cultural context or organizational attributes rather than as mediating mechanisms tested explicitly within quantitative models, leaving limited understanding of how faith-based moral norms convert relational resources into service outcomes. Because these mechanisms operate across multiple relational levels from internal closeness to cross-community networks and institutional access a multi-level model that integrates the three dimensions of social capital is an analytical prerequisite for capturing this mediation process adequately.

The primary aim of this study is to develop and test a quantitative model that integrates bonding, bridging, and linking social capital within a single multi-level framework to explain variation in elderly care quality in community-driven and faith-based institutions in Indonesia, while assessing the mediating role of faith-based moral norms. By positioning Indonesia as an empirical case, the study seeks to enrich theory through evidence from a community-driven care system operating under non-welfare-state conditions, thereby broadening understanding of how social capital functions when state support is not the primary pillar. The anticipated theoretical contribution is a new framework that combines multi-level social capital with faith-based normative mechanisms to explain service outcomes and expands social capital scholarship to contexts that remain underrepresented in mainstream literature. The study offers practical value by providing an empirical basis for designing institutional interventions, network-strengthening strategies, and elderly care quality policies that better fit Southeast Asian realities, particularly within service ecosystems that rely on community organizations and values-based institutions.

## 2. LITERATURE REVIEW

### *2.1. Social Capital: Theoretical Foundations and Dimensions*

The concept of social capital has developed through three complementary intellectual traditions, each emphasizing different aspects. (Gontijo et al., 2016) conceptualizes social capital as a collective resource arising from civic participation, norms of reciprocity, and social trust that enable coordination and cooperation for the common good. From a structural-critical perspective, (Tang et al., 2022) frames social capital as the aggregate of actual or potential resources tied to the possession of relatively durable networks of relationships, thereby intersecting with power dynamics and the reproduction of inequality.

In contrast to both, (Isbel & Berry, 2016) highlights the functional character of social capital as an element of social structure that facilitates individual and collective action through mechanisms such as obligations, expectations, information channels, and norms supported by sanctions. This three-way comparison is particularly relevant to elderly care research because analysis often requires a simultaneous understanding of relational qualities, network structures, and institutional access as they operate together within service organizations. In a more operational development, (Xu & Zhao, 2022) introduced three dimensions of social capital for public service contexts: bonding, bridging, and linking.

Bonding refers to internal ties within relatively homogeneous groups that strengthen solidarity, emotional security, and proximity-based trust; bridging denotes cross-group connections that open opportunities for information exchange, collaboration, and broader access to resources; and linking captures vertical relations with actors holding authority such as government agencies, donors, or formal institutions that shape legitimacy, policy support, and access to larger-scale resources (Cao et al., 2015; Ong'ayo & Hassan, 2022). This framework underscores that social capital is not a single construct but a configuration of relationships with varied functions and, under certain conditions, may also produce unintended consequences when networks become exclusive or closed to outsiders (Su et al., 2024).

### *2.2. Bonding, Bridging, and Linking Social Capital in Social Services*

Social service research shows that social capital functions as a foundational social condition shaping

service effectiveness, the quality of provider–recipient relationships, and a community's capacity to manage risk. In public health, early studies linked social capital indicators especially social trust and community cohesion to a range of outcomes, including mortality and self-rated health (Baker, 2016; Kilaberia, 2021; Wakeel et al., 2025). Subsequent methodological advances encouraged multilevel analysis to distinguish effects operating at individual and community levels and to assess intervening mechanisms such as health-related behaviors (Börzel & Risse, 2016; Ślęzak-Belowska & Paragi, 2025).

Bonding social capital is commonly associated with social support, informal social control, and a sense of safety; bridging social capital is seen as a channel for mobilizing information and resources across groups; and linking social capital relates to access to formal services, advocacy, and the ability to secure and manage institutional resources. Broader evidence from review studies generally supports a positive association between social capital and health, although effect sizes and the strength of evidence vary across settings (Coutts & Velásquez, 2025; Gibbons et al., 2022; Muhumuza et al., 2023). Beyond health, education research emphasizes its contribution to academic achievement through support networks, parental involvement, and school norms that facilitate learning (Hardison-Moody & Yao, 2019; Mutesi et al., 2025; Sileo et al., 2022). In community development and welfare scholarship, Putnam (1993; 2000) highlights relationships between civic network density, reciprocity norms, and public institutional performance, while (Kim, 2025) and (Davey et al., 2021) argue that its benefits depend strongly on institutional design and power relations. (Deno, 2017) further shows that shared norms and trust can stabilize collective action without relying solely on state coercion an insight highly relevant for community-based care systems. Global patterns suggest that bonding strengthens internal cohesion and stability, bridging widens collaboration and innovation, and linking opens pathways to legitimacy, protection, and external resources that support service sustainability.

In caregiving and elderly services, evidence increasingly points to the importance of cross-actor relationships, although the base of studies remains less extensive than in health research. Studies in long-term care facilities indicate that residents' social integration, relationship quality with staff, and connectedness to the wider community are associated with better psychosocial outcomes. At the community level, recent work also maps social capital from micro to macro levels in relation to older adults' well-being; however, it more often emphasizes subjective well-being than institutional service quality as such. This pattern signals a clear opportunity to develop models that explicitly connect configurations of social capital to elderly care quality as a service outcome.

### *2.3. Faith-Based Organizations and Moral Norms in Elderly Care*

The role of faith-based organizations (FBOs) in social provision has been widely discussed, largely because of their capacity to reach vulnerable groups, mobilize volunteers, and deliver services in areas where the state's reach is limited. At the same time, scholarship underscores that FBOs are not uniform; they span a spectrum of religious expression, from historically affiliated entities to organizations that embed religious values into service design. Bielefeld and Cleveland (2013) summarize key definitional debates and methodological challenges in FBO research, including the difficulty of measuring organizational religious intensity in a comparable way, making conceptual clarity essential when FBOs are positioned as providers of elderly care (Tu, 2025; Wang & Chen, 2024).

The distinctive theoretical contribution of the present study lies in shifting attention from faith-based organizations as a category toward the mechanism of **moral norms** rooted in religious values and enacted through social relationships. Moral norms can be understood as internalized standards of appropriateness and behavioral expectations that guide caregiving even when material incentives are limited. Moral psychology suggests that moral judgment often draws on intuition, emotion, and relational structures rather than purely rational calculation (Junaidi et al., 2023), while the ethics of care tradition emphasizes morality grounded in relationships, responsibility, and attentiveness to vulnerability (Bass et al., 2024; Li & Zhang, 2021; Rocco & Aas, 2016). Moral expectations are reinforced through spiritual obligations, collective practices, and ethical narratives that emphasize service and altruism processes that can encourage prosocial orientations (Allen, 2025) and shape distinctive forms of social capital in religious communities (Kail et al., 2021).

Faith-based moral norms can therefore be positioned as a bridge between relational resources and caregiving practices that are consistent, empathetic, and accountable. Empirically, studies on spiritual care suggest that spiritual interventions or training may be associated with improvements in specific aspects of care experience, including caregiver burden and certain well-being dimensions, although variation in settings, designs, and indicators produces mixed patterns. Quantitative research on religiously affiliated nursing homes in high-income

countries also reports heterogeneous results, including findings indicating that religious affiliation does not automatically translate into stronger compliance or better quality (Hooley et al., 2023; Saadi et al., 2023). This inconsistency strengthens the case for treating moral norms as a mediator, as it enables an analytic distinction between institutional labels and the value-based mechanisms that shape day-to-day caregiving.

### *2.4. Elderly Care Quality: Frameworks and Determinants*

Classic approaches to care quality frequently draw on Donabedian's model, which conceptualizes quality as an interrelated set of structure, process, and outcomes (Donabedian, 1966 in (Oman & Syme, 2018)). Structure refers to organizational resources and conditions, including staffing, facilities, and governance; process captures how care is delivered, such as communication, responsiveness, and adherence to standards; and outcomes reflect impacts on safety, well-being, and recipient satisfaction. In elderly services, this framework remains central but benefits from additional attention to dignity, person-centeredness, and quality of life, given the relational and long-term character of care in later life. Globally, WHO emphasizes quality management in long-term care to protect older adults' well-being and dignity across home, community, and institutional settings. The ICOPE framework advocates integrated and person-centered approaches, while OECD highlights the need for indicators enabling cross-national monitoring of long-term care quality (Norman, 2019; Saint Ville et al., 2016; Yap et al., 2019).

Within nursing home quality research, determinants such as staffing adequacy, competence, regulation, and quality measurement systems are repeatedly emphasized, including how indicators are shaped by accountability regimes. Accordingly, elderly care quality is not solely a function of clinical capacity but also of the institutional ecology that structures incentives, work culture, and relationships with families and communities. Consistent with this view, evidence across social services suggests that networks, trust, and norms can improve outcomes such as trust in providers, responsiveness, social support, and satisfaction. In elderly care, however, these links are often examined in fragmented ways for instance, focusing on family support or community cohesion without explicitly connecting them to care quality as an integrated service construct. Integrating Donabedian's framework in (Wambura, 2024) with multi-dimensional social capital and a moral-norm mechanism thus offers a pathway to strengthen understanding of quality determinants from a social-institutional perspective rather than relying primarily on clinical and administrative explanations.

### *2.5. The Research Gap: Absence of Multi-Level, Faith-Based Quantitative Models*

Accumulated evidence indicates that social capital is associated with diverse social and health outcomes, and some studies have used multilevel approaches to separate influences at individual and contextual levels. Yet when attention shifts to community- and faith-based institutional elderly care, several gaps remain pronounced. Many studies still treat social capital as a single construct or emphasize only one dimension, meaning the dynamics of bonding, bridging, and linking are rarely integrated within a unified framework, even though they may operate through distinct pathways. Moreover, although multilevel analysis has become common in social epidemiology, its application to modeling institutional elderly care quality remains limited and is more frequently oriented toward well-being rather than service quality.

Research on FBOs is rich in descriptive insight, but definitional and measurement challenges continue to weaken comparative quantitative evidence, particularly when value-based mechanisms such as faith-based moral norms are not treated as testable mediators. Geographic bias also persists, as much of the evidence derives from high-income settings with relatively established welfare-state infrastructures, leaving actor configurations and institutional logics in non-welfare contexts underexplored through quantitative models. These limitations point to a clear scientific need for a multi-level quantitative model that integrates the three dimensions of social capital and tests faith-based moral norms as an explanatory mechanism shaping elderly care quality.

### *2.6. Conceptual Model and Hypothesis Development*

Theoretically, the relationship between bonding social capital and faith-based moral norms can be explained by the intensity of interaction and the homogeneity of values within a group. Dense internal networks tend to strengthen value socialization, reinforce informal social monitoring, and stabilize expectations regarding what is considered "appropriate" behavior in caregiving, particularly when religious norms serve as a shared moral language (Herzog et al., 2020; Lau et al., 2020). Bridging social capital, although it operates across group boundaries, can foster the articulation of moral norms through cooperation, exchange, and cross-identity learning that require commonly acceptable ethical standards of service; in this process, religious values are often translated into more universal ethics

such as compassion, trustworthiness, and service orientation. Linking social capital enables care organizations to access institutional legitimacy, material support, and accountability frameworks, which can further strengthen the internalization of moral norms through standard operating procedures, training, and the reinforcement of organizational culture.

Downstream, faith-based moral norms are expected to enhance care quality because they provide relatively stable prosocial motivation, cultivate a sense of responsibility, and reduce opportunistic behavior in the inherently asymmetric relationship between caregivers and vulnerable older adults consistent with arguments that norms, trust, and care ethics shape the quality of service relationships (Ndlovu, 2025; Widyaningrum et al., 2026). Based on this logic, the hypotheses to be tested in the SEM model are as follows:

H1: Bonding social capital positively influences faith-based moral norms.

H2: Bridging social capital positively influences faith-based moral norms.

H3: Linking social capital positively influences faith-based moral norms.

H4: Faith-based moral norms positively influence care quality.

H5a: Faith-based moral norms mediate the effect of bonding social capital on care quality.

H5b: Faith-based moral norms mediate the effect of bridging social capital on care quality.

H5c: Faith-based moral norms mediate the effect of linking social capital on care quality.

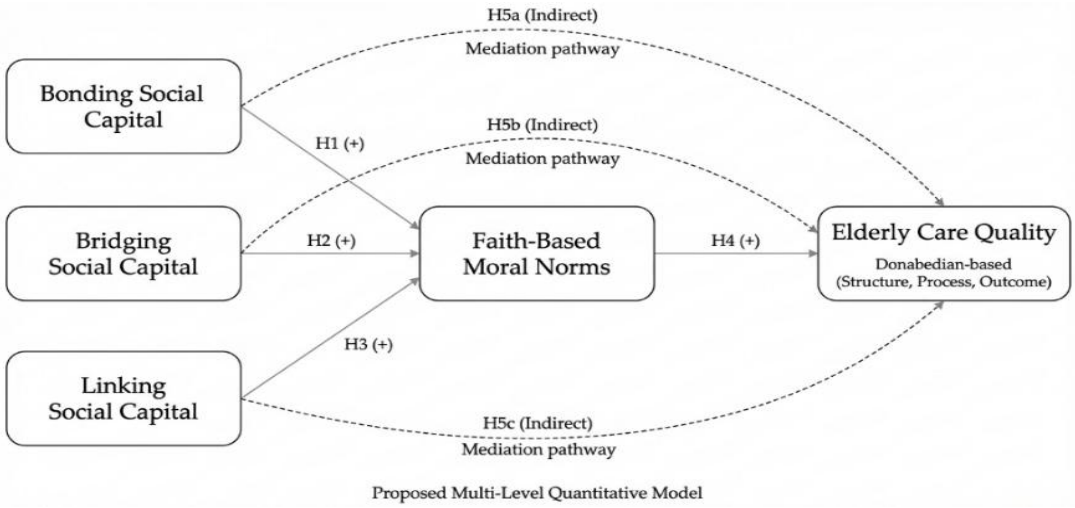


*Figure 1: Framework Research*

## 3. METHOD

### *3.1. Research Design*

This study employs an explanatory quantitative design to test the causal relationships among three dimensions of social capital (bonding, bridging, and linking), faith-based moral norms as a mediating variable, and elderly care quality as the outcome. An explanatory approach is appropriate because it enables the structured development and empirical testing of a multi-level theoretical model, relies on quantitative data collected directly from caregivers as key actors in daily care practices, and aligns with the social capital and social service research tradition that treats relationships, norms, and resource access as measurable constructs. To address these aims, the analysis uses Structural Equation Modeling (SEM), which allows simultaneous testing of relationships among latent constructs while assessing the measurement quality of indicators for each construct.

### *3.2. Conceptual Framework*

The proposed framework integrates social capital across multiple levels of social relations. Bonding social capital is positioned at the micro level and represents the quality of internal ties, including trust, emotional closeness, and reciprocal support among caregivers and within everyday caregiving relationships. Bridging social capital is situated at the meso level and reflects cross-community relationships and collaborative capacity that extend support networks beyond the core group. Linking social capital is placed at the macro level and emphasizes vertical connections with authoritative actors and external institutions, including religious organizations, public agencies, and donors, which can provide legitimacy and resources. These three dimensions are expected to shape faith-based moral norms, defined as a set of religiously grounded moral expectations expressed through moral obligation, spiritual orientation in caregiving, and value-driven

service behavior. Faith-based moral norms are then theorized as the mechanism that enhances elderly care quality, reflected in empathy, responsiveness, and perceived well-being of older residents. Structurally, the model specifies the following pathway: X1 (Bonding), X2 (Bridging), and X3 (Linking) influence M (Moral Norms), which in turn influences Y (Care Quality). Accordingly, the model tests direct effects along the paths from X to M and from M to Y, as well as indirect effects through the mediation pathway from X to M to Y.

### *3.3. Variables and Operational Definitions*

All constructs are measured using a five-point Likert scale, ranging from the lowest to the highest level of agreement, to capture respondents' perceptions and experiences in a standardized manner.

Bonding Social Capital (X1) is operationalized as the strength of internal ties that support daily caregiving practice. It is measured through four indicators: mutual trust among caregivers, emotional closeness with elderly residents, internal solidarity, and reciprocity in caregiving tasks. These indicators capture internal cohesion and relational trust that facilitate stable coordination of caregiving responsibilities.

Bridging Social Capital (X2) is operationalized as the capacity to build cross-group relationships that broaden access to support beyond the core community. Indicators include collaboration with community groups, access to volunteers, social activities with external communities, and resource sharing across institutions. This measurement aims to capture the extent to which organizations and caregivers connect with external actors and mobilize resources through more diverse networks.

Linking Social Capital (X3) represents vertical relationships that connect care institutions with holders of authority or formal resources. It is measured through support from faith-based organizations, connections with local government, assistance from donors, and institutional legitimacy from external authorities. This dimension emphasizes access to legitimacy, material support, and policy-related backing that can strengthen service sustainability.

Faith-Based Moral Norms (M) are operationalized as religiously grounded moral standards that shape caregiving motivation and behavior. Indicators include caregiving as religious duty, moral responsibility toward the elderly, compassion as spiritual practice, and normative expectations from religious teachings. This mediator captures the internalization of religious values as behavioral guidance and standards of appropriateness in service delivery.

Elderly Care Quality (Y) is operationalized as the quality of elderly care as perceived and enacted by caregivers. It is measured through responsiveness of care, emotional support, hygienic and safety practices, and perceived well-being of elderly residents. These indicators reflect key process and outcome dimensions of care quality in institutional settings.

### *3.4. Population and Sampling*

The study population consists of caregivers working in faith-based elderly care institutions in Indonesia, including organizations affiliated with Christian, Catholic, Islamic, and other religious social traditions. Sampling uses a purposive approach, based on the rationale that respondents must have sufficient experience and direct involvement in caregiving activities to provide accurate assessments of social relationships, faith-based moral norms, and care quality. Inclusion criteria are a minimum of six months of employment, direct involvement in elderly care activities, and willingness to complete the survey. A minimum sample size of 200 respondents is specified to ensure adequate power for SEM, particularly for a model with five latent constructs and robust mediation testing, consistent with common recommendations in SEM literature (Hair et al., 2019).

### *3.5. Instrument Development and Data Collection*

Data are collected using a structured questionnaire with five-point Likert responses. Item development is guided by theoretical frameworks of social capital, moral norms, and elderly care quality to ensure that each construct is represented by conceptually coherent indicators. Instrument development follows a sequential process. First, items are generated from international literature to ensure construct alignment and coverage. Second, expert judgment is conducted by researchers or practitioners with relevant expertise in social capital and social services to assess clarity, relevance, and conceptual accuracy. Third, a pilot test with approximately 30 respondents is carried out to evaluate initial validity, identify ambiguity, and assess readability and response consistency. Fourth, items are revised and finalized based on pilot results and expert feedback, including wording refinement to improve comprehension without altering substantive meaning. Fifth, the main data collection is implemented through structured interviews or an online survey platform, depending on institutional access and readiness, with procedures emphasizing informed consent and confidentiality to ensure respondents understand the study purpose and data protection measures.

### *3.6. Data Analysis Technique (SEM)*

The analysis follows two standard SEM stages: assessment of the measurement model and testing of

the structural model.

1. **Measurement Model (Outer Model)**
   Confirmatory Factor Analysis (CFA) is used to verify that the indicators adequately reflect their intended latent constructs. Evaluation applies several criteria: factor loadings greater than 0.60 to indicate sufficient indicator contribution, Average Variance Extracted (AVE) greater than 0.50 to demonstrate convergent validity, Composite Reliability (CR) greater than 0.70 to indicate internal reliability, and discriminant validity assessed using the Fornell–Larcker criterion to confirm that each construct is empirically distinct. If any indicators fail to meet these thresholds, they are reviewed conceptually and statistically before decisions are made to revise or remove items, ensuring measurement quality is maintained without undermining construct representation.
2. **Structural Model (Inner Model)**
   The second stage tests the hypothesized causal relationships among constructs, including direct effects along the paths from X to M and from M to Y, as well as indirect effects along the mediation pathway from X to M to Y. Model adequacy is evaluated using commonly reported SEM fit indices, including RMSEA below 0.08, CFI above 0.90, and TLI above 0.90, to confirm that the theoretical model fits the empirical data. Mediation significance is assessed using bootstrapping, enabling more reliable evaluation of indirect effects through confidence intervals and statistical significance. Through these procedures, the analysis not only determines whether relationships among constructs are statistically significant but also clarifies how the three dimensions of social capital operate through faith-based moral norms to shape elderly care quality.

## 4. RESULT AND DISCUSSION

### *4.1. Sample Profile and Data Screening*

A total of 285 questionnaires were collected from caregivers working in faith-based nursing homes. After a data quality check, 16 responses were excluded due to missing data exceeding 20% or inconsistent response patterns, and 17 responses were eliminated due to indications of extreme repetitive responses (straight-lining) that could potentially reduce measurement validity. Therefore, the analysis was conducted on 252 respondents who met the inclusion criteria and had data suitable for SEM estimation. The proportion of missing data in the final dataset was low (approximately 2%) and did not show any systematic patterns that would interfere with model estimation, allowing the analysis to proceed to the measurement and structural model testing stages.

***Table 1: Sample Characteristics***

| Variable | Category/Statistic | n | % | Mean | SD |
|---|---|---|---|---|---|
| Gender | Female | 156 | 61.9 | | |
| | Male | 96 | 38.1 | | |
| Age (years) | | | | 34.6 | 8.9 |
| Education | High school | 104 | 41.3 | | |
| | Diploma | 73 | 29.0 | | |
| | Bachelor+ | 75 | 29.8 | | |
| Tenure (years) | | | | 5.2 | 3.7 |
| Faith-based institution | Islamic | 121 | 48.0 | | |
| | Christian | 60 | 23.8 | | |
| | Catholic | 45 | 17.9 | | |
| | Other | 26 | 10.3 | | |
| Region | Java | 176 | 69.8 | | |
| | Sumatra | 38 | 15.1 | | |
| | Others | 38 | 15.1 | | |
| Final analytical sample | | 252 | 100 | | |

Source: data proceed

Based on the sample characteristics in Table 1, the analysis was conducted on 252 caregivers as the final sample. The composition of respondents showed a greater proportion of women than men, which is in line with the general trend that caregiving work is often dominated by women in social service practices. Demographically, the average age of respondents fell within the productive adult range with quite wide variation, indicating a mix of relatively young and experienced workers. Length of service also showed a moderate distribution, reflecting the presence of caregivers with sufficient adaptation time to the work rhythm and institutional culture. Respondents came from several religious affiliations and diverse regions; thus the data reflect a variety of contexts within faith-based eldercare organizations relevant to testing the proposed multi-level model.

### *4.2. Descriptive Statistics and Inter-Construct Correlations*

Respondents showed relatively high levels of faith-based moral norms (M = 4.21, SD = 0.52) and elderly care quality (M = 4.05, SD = 0.49), while the dimensions of social capital were at medium to high levels, namely bonding (M = 4.02, SD = 0.51), bridging (M = 3.68, SD = 0.55), and linking (M = 3.45, SD = 0.60). Correlations between constructs showed a consistent pattern of positive relationships, especially between faith-based moral norms and elderly care quality ($r = 0.59$, $p < 0.01$), which provides an initial indication that faith-based moral norms are associated with better service quality.

*Table 2: Descriptive Statistics and Correlations*

| Construct | Mean | SD | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|---|
| 1. Bonding | 4.02 | 0.51 | 1.00 | | | | |
| 2. Bridging | 3.68 | 0.55 | 0.51** | 1.00 | | | |
| 3. Linking | 3.45 | 0.60 | 0.44** | 0.46** | 1.00 | | |
| 4. Moral Norms | 4.21 | 0.52 | 0.55** | 0.49** | 0.41** | 1.00 | |
| 5. Care Quality | 4.05 | 0.49 | 0.48** | 0.42** | 0.39** | 0.59** | 1.00 |

Source: data proceed

Table 2 shows that the average scores across all constructs are at a medium to high level, with faith-based moral norms and elderly care quality showing the highest averages compared to the other constructs. This pattern indicates that faith-based value orientations and norms tend to be strong among caregivers, and are associated with relatively good perceptions of service quality. The social capital dimension shows clearer variations; bonding is higher than bridging and linking, which can be interpreted as indicating that internal relations and group cohesion are more prominent than cross-community connections or vertical relations with authoritative actors. Furthermore, the correlation matrix displays a consistent positive relationship between the constructs, with the strongest association emerging between moral norms and care quality. This correlation pattern provides an initial indication of a theoretical link between the variables, but testing for causality and mediating mechanisms still requires evaluation using SEM at a later stage.

### *4.3. Measurement Model Assessment*

#### *4.3.1. Confirmatory Factor Analysis: Factor Loadings, Reliability, and Convergent Validity*

The CFA results show that all indicators load on the expected constructs with standardized loadings ranging from 0.67–0.86, thus meeting the minimum criteria (>0.60). Construct reliability is also adequate with Composite Reliability (CR) values in the range of 0.82–0.89, while Average Variance Extracted (AVE) is in the range of 0.54–0.66, indicating good convergent validity. These findings confirm that the indicators used have adequate internal consistency and construct representation capabilities to continue testing the structural model.

*Table 3: Measurement Model Results (CFA)*

| Construct | Item | Std. Loading | CR | AVE |
|---|---|---|---|---|
| Bonding | BON1 | 0.78 | 0.85 | 0.59 |
| | BON2 | 0.82 | | |
| | BON3 | 0.76 | | |
| | BON4 | 0.71 | | |
| Bridging | BRI1 | 0.74 | 0.82 | 0.54 |
| | BRI2 | 0.79 | | |
| | BRI3 | 0.67 | | |
| | BRI4 | 0.72 | | |
| Linking | LIN1 | 0.70 | 0.84 | 0.56 |
| | LIN2 | 0.73 | | |
| | LIN3 | 0.81 | | |
| | LIN4 | 0.75 | | |
| Moral Norms | MOR1 | 0.83 | 0.89 | 0.66 |
| | MOR2 | 0.86 | | |
| | MOR3 | 0.79 | | |
| | MOR4 | 0.77 | | |
| Care Quality | QUAL1 | 0.80 | 0.85 | 0.59 |
| | QUAL2 | 0.84 | | |
| | QUAL3 | 0.69 | | |
| | QUAL4 | 0.74 | | |

Source: data proceed

The CFA results in Table 3 indicate that the indicators used have an adequate contribution in reflecting the latent constructs, as indicated by standardized loadings that are generally above the recommended threshold. Conceptually, this confirms that the items compiled are able to capture key aspects of bonding, bridging, and linking social capital, as well as consistently measure faith-based moral norms and elderly care quality. High Composite Reliability values for all constructs indicate good internal consistency, while AVE that meets the criteria indicates that the indicator variation is explained more by the constructs themselves than by measurement error. The quality of the measurements at this stage provides a strong empirical basis for continuing the analysis of structural relationships, as the constructs used have met the prerequisites for reliability and convergent validity.

### *4.3.2. Discriminant Validity (Fornell–Larcker Criterion)*

Discriminant validity was evaluated using the Fornell–Larcker criterion. The square root of the AVE for each construct ranged from 0.73 to 0.81 and was consistently greater than the correlations between constructs, indicating that each construct had adequate empirical distinction and did not exhibit measurement overlap that would interfere with the interpretation of structural relationships.

***Table 4: Fornell–Larcker***

| Construct | Bonding | Bridging | Linking | Moral Norms | Care Quality |
|---|---|---|---|---|---|
| **Bonding** | 0.77 | 0.51 | 0.44 | 0.55 | 0.48 |
| **Bridging** | 0.51 | 0.73 | 0.46 | 0.49 | 0.42 |
| **Linking** | 0.44 | 0.46 | 0.75 | 0.41 | 0.39 |
| **Moral Norms** | 0.55 | 0.49 | 0.41 | 0.81 | 0.59 |
| **Care Quality** | 0.48 | 0.42 | 0.39 | 0.59 | 0.77 |

Source: data proceed

The discriminant validity evaluation in Table 4 shows that the square root of the AVE for each construct is greater than its correlation with other constructs. This finding indicates that each construct has sufficient empirical distinction, so that bonding, bridging, and linking social capital do not overlap excessively, and that faith-based moral norms and elderly care quality can be separated as distinct constructs. This clarity of boundaries between constructs is important because it ensures that the causal relationships tested in the structural model are not driven by measurement redundancy. By meeting the Fornell–Larcker criteria, the measurement model can be considered to have both conceptual accuracy and empirical robustness to support inferences at the hypothesis testing stage.

### *4.3.3. Model Fit Indices*

The model fit test showed good results. The measurement model had adequate fit indices (RMSEA = 0.038, CFI = 0.965, TLI = 0.957), while the structural model also met the fit criteria (RMSEA = 0.043, CFI = 0.958, TLI = 0.949). These values indicate that the model specification is consistent with the data covariance structure and is suitable for interpreting causal relationships between constructs.

***Table 5: Model Fit Indices***

| Model | $\chi^2$ | df | $\chi^2$/df | RMSEA | CFI | TLI | SRMR |
|---|---|---|---|---|---|---|---|
| **Measurement model (CFA)** | 214.3 | 160 | 1.34 | 0.038 | 0.965 | 0.957 | 0.041 |
| **Structural model (SEM)** | 238.7 | 163 | 1.46 | 0.043 | 0.958 | 0.949 | 0.046 |

Source: data proceed

The model fit indices in Table 5 indicate that both the measurement and structural models meet the recommended goodness-of-fit criteria. A low RMSEA value indicates limited approximation error, while high CFI and TLI values confirm that the proposed model provides substantial improvement over the null model. Methodologically, these results imply that the covariance structure of the data can be adequately explained by the proposed construct specifications and causal relationships, allowing interpretation of the path coefficients in the structural model to be based on strong model fit. Thus, the developed model not only meets measurement standards but is also statistically compatible with the empirical data obtained from caregivers.

## *4.4. Structural Model*

### *4.4.1. Direct Effects and Hypothesis Testing*

The results of the structural path estimation show that bonding social capital has a positive effect on faith-based moral norms ($\beta = 0.32$, $p < 0.001$), thus supporting H1. A positive effect was also found for bridging social capital on faith-based moral norms ($\beta = 0.24$, $p = 0.002$), which supports H2, as well as for linking social capital on faith-based moral norms ($\beta = 0.18$, $p = 0.017$), thus supporting H3. Furthermore, faith-based moral norms showed a strong positive effect on elderly care quality ($\beta = 0.59$, $p < 0.001$), which supports H4.

*Table 6: Direct Effects*

| Hypothesis | Path | Std. β | SE | t/CR | p-value | Decision |
|---|---|---|---|---|---|---|
| **H1** | Bonding → Moral Norms | 0.32 | 0.07 | 4.78 | <0.001 | Supported |
| **H2** | Bridging → Moral Norms | 0.24 | 0.08 | 3.12 | 0.002 | Supported |
| **H3** | Linking → Moral Norms | 0.18 | 0.07 | 2.39 | 0.017 | Supported |
| **H4** | Moral Norms → Care Quality | 0.59 | 0.06 | 9.65 | <0.001 | Supported |

Source: data proceed

Table 6 summarizes the results of the direct effects tests, which are the core of the structural model. All three dimensions of social capital demonstrate a positive influence on faith-based moral norms, with bonding having the strongest contribution among the three, followed by bridging and linking. This pattern indicates that internal cohesion, cross-community cooperation, and vertical connections play a role in strengthening faith-based moral norms, although their respective effects are not identical. Furthermore, the path from faith-based moral norms to elderly care quality demonstrates a large and significant positive effect, confirming that internalized moral norms are closely related to the quality of care perceived and delivered by caregivers. These findings provide empirical support for the direct hypotheses (H1–H4) and also prepare the foundation for assessing whether moral norms function as a mediating mechanism in the next step.

### *4.4.2. Explained Variance ($R^2$) for Endogenous Constructs*

The model demonstrated significant explanatory power. Variation in faith-based moral norms was explained by bonding, bridging, and linking social capital with an $R^2 = 0.46$, while variation in elderly care quality was explained by faith-based moral norms with an $R^2 = 0.35$. These findings suggest that cross-level social capital configurations contribute substantially to shaping faith-based moral norms, which subsequently play a significant role in the quality of elderly care.

*Table 7: Explained Variance*

| Endogenous construct | Predictors | $R^2$ |
|---|---|---|
| Faith-Based Moral Norms | Bonding, Bridging, Linking | 0.46 |
| Elderly Care Quality | Faith-Based Moral Norms | 0.35 |

Source: data proceed

Table 7 shows that the combination of bonding, bridging, and linking social capital explains a significant proportion of the variation in faith-based moral norms, indicating that faith-based moral norms are not isolated phenomena but rather are rooted in the configuration of social relations at various levels. Furthermore, faith-based moral norms also explain significant variation in elderly care quality, indicating that care quality is not only influenced by technical factors but also by normative mechanisms that shape how caregivers deliver services. The $R^2$ values for these two endogenous constructs confirm that the model has substantial explanatory power in the context of service organization behavior, while also strengthening the relevance of a multilevel approach to understanding the quality of elderly care in faith-based institutions.

## *4.5. Mediation Analysis*

### *4.5.1. Bootstrapped Indirect Effects (H5a–H5c)*

Mediation tests were conducted using bootstrapping with a 95% confidence interval. The results show that faith-based moral norms mediate the effect of bonding social capital on elderly care quality ($\beta$_indirect = 0.19, 95% CI [0.12, 0.27]), thus supporting H5a. Mediation was also significant in the bridging social capital pathway ($\beta$_indirect = 0.14, 95% CI [0.06, 0.22]), which supports H5b, and the linking social capital pathway ($\beta$_indirect = 0.11, 95% CI [0.02, 0.19]), which supports H5c. This pattern confirms that faith-based moral norms act as a mechanism that bridges cross-level social capital to improve the quality of elderly care.

*Table 8: Bootstrapped Indirect Effects*

| Hypothesis | Indirect Path | Indirect β | Boot SE | 95% CI (L) | 95% CI (U) | Decision |
|---|---|---|---|---|---|---|
| **H5a** | Bonding → Moral Norms → Care Quality | 0.19 | 0.4 | 0.12 | 0.27 | Supported |
| **H5b** | Bridging → Moral Norms → Care Quality | 0.14 | 0.4 | 0.06 | 0.22 | Supported |
| **H5c** | Linking → Moral Norms → Care Quality | 0.11 | 0.4 | 0.02 | 0.19 | Supported |

Source: data proceed

The results of the mediation test in Table 8 show that all three indirect effect pathways from bonding, bridging, and linking social capital to elderly care quality through faith-based moral norms are

significant, as indicated by confidence intervals that do not cross zero. This finding confirms that moral norms function as a mechanism that bridges social capital to service quality, so that the relationship between social capital and care quality is not solely direct, but rather operationalized through the internalization of moral obligations, spiritual orientation, and normative expectations that guide caregiving actions. The different magnitudes of indirect effects across dimensions also signal that the internal pathway (bonding) tends to be stronger in shaping moral norms relevant to service quality, while bridging and linking continue to make significant contributions through strengthening external networks and institutional support. Bootstrapping testing provides more robust evidence for this study's mechanistic argument.

### *4.6. Summary of Hypothesis Testing*

The results of this study support all of the proposed hypotheses. All three dimensions of social capital bonding, bridging, and linking are positively associated with strengthening faith-based moral norms, and faith-based moral norms positively influence elderly care quality. Bootstrapping testing confirms that faith-based moral norms act as mediators linking cross-level social capital to the quality of elderly care, thus clarifying the internal mechanisms that bridge relational resources into better care practices.

***Table 9: Hypothesis Summary***

| Hypothesis | Statement (short) | Expected | Result |
|---|---|---|---|
| **H1** | Bonding → Moral Norms | + | Supported |
| **H2** | Bridging → Moral Norms | + | Supported |
| **H3** | Linking → Moral Norms | + | Supported |
| **H4** | Moral Norms → Care Quality | + | Supported |
| **H5a** | Bonding → Moral Norms → Care Quality | + | Supported |
| **H5b** | Bridging → Moral Norms → Care Quality | + | Supported |
| **H5c** | Linking → Moral Norms → Care Quality | + | Supported |

Source: data proceed

The summary in Table 9 shows that all proposed hypotheses received empirical support. The direct effects of bonding, bridging, and linking social capital on faith-based moral norms were positive and significant, as was the influence of faith-based moral norms on elderly care quality. Tests of indirect effects confirmed the mediating role of moral norms in all three pathways, strengthening the study's theoretical contribution to the mechanism of social capital conversion into service quality. This table allows readers to see the consistency of the results with the conceptual framework and also confirms that the study's main novelty, namely faith-based moral norms as a mediator in the multi-level model, is supported by a stable and significant pattern of estimates.

To facilitate the reader's understanding of the structure of the relationships between the tested constructs, Figure 2 presents the proposed SEM model along with the hypothesized direction of influence. This diagram summarizes the three dimensions of social capital as an exogenous variable, faith-based moral norms as a mediator, and elderly care quality as an outcome, while also emphasizing that empirical testing was conducted on both the direct and indirect paths through a mediating mechanism. This visualization serves as an interpretive framework for the results of the structural path estimation and mediation testing reported in the following sections.

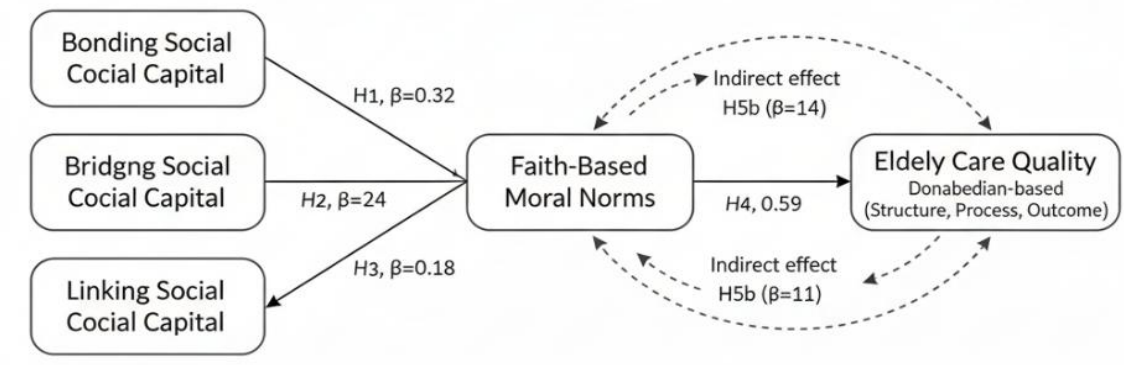


***Figure 2: Proposed Structural Equation Model (SEM) and Hypothesized Paths***

As shown in Figure 2, the model predicts that bonding, bridging, and linking social capital will strengthen faith-based moral norms (H1–H3), which in turn will improve elderly care quality (H4). The model also tests three mediation paths that position faith-based moral norms as the explanatory mechanism linking each dimension of social capital to care quality (H5a–H5c). Building on this framework, the following section presents the path coefficient estimates, the significance of the direct effects, and the magnitude and significance of the indirect effects based on the bootstrapping procedure.

## 5. DISCUSSION

This study aims to explain how three dimensions of social capital across different levels of social relations contribute to elderly care quality through the mechanism of faith-based moral norms. Empirically, the model demonstrates good adequacy in both measurement and structural components, allowing the causal pathways to be interpreted with a reasonable level of confidence. At the structural level, bonding, bridging, and linking social capital are positively associated with stronger faith-based moral norms (H1–H3), and faith-based moral norms positively influence elderly care quality (H4). More importantly, bootstrapping results confirm that faith-based moral norms serve as a significant mediating mechanism across all three pathways (H5a–H5c), indicating that the value of social capital in faith-based institutions is not limited to the mere existence of networks, but is realized through the internalization of moral norms that subsequently guide caregiving practice. The model's explanatory power is also substantial: the three dimensions of social capital account for 46% of the variance in moral norms, while moral norms explain 35% of the variance in care quality. Overall, these findings strengthen the argument that community-driven and faith-based care systems require an integrated explanation combining relational structures and normative mechanisms to understand service quality more precisely.

Support for H1 indicates that bonding social capital has a positive effect on faith-based moral norms ($\beta$ = 0.32). Substantively, this can be read as evidence that internal cohesion, trust among caregivers, and reciprocity in care tasks create a social environment conducive to value socialization and consistent moral expectations. In elderly care institutions, bonding is not merely a comfortable interpersonal relationship; it functions as a space of internalization in which moral language, service practices, and standards of appropriateness are learned and sustained collectively. When caregivers feel trusted and supported, norms related to moral obligation and service orientation are more likely to be enacted as habitual work practices rather than treated as formal requirements.

H2 is also supported, meaning that bridging social capital positively influences moral norms ($\beta$ = 0.24). This result suggests that cross-community ties, access to volunteers, and social activities with external actors contribute to strengthening faith-based moral norms. Theoretically, bridging is often positioned as a cross-group resource channel; however, in values-driven caregiving settings, it may also function as a mechanism of social comparison and moral learning. When institutions connect with other communities, ethical standards and care practices can be reinforced through exposure to good practice, informal evaluation, and social recognition that underscores the importance of dignified service. In this sense, bridging not only expands access but also cultivates a normative climate that supports prosocial action in care delivery.

Support for H3 further indicates that linking social capital also strengthens moral norms ($\beta$ = 0.18), although the magnitude is smaller than that of bonding and bridging. This pattern aligns with the idea that vertical connections, such as ties to larger faith-based organizations, local government, or donors, often operate through legitimacy, material support, and accountability frameworks. In practice, such relationships may bring operational standards, reporting requirements, or capacity-building programs that clarify behavioral expectations, making previously implicit moral norms more explicitly articulated through training, procedures, or organizational culture. The relatively smaller effect can be interpreted to mean that the internalization of moral norms is shaped most strongly by everyday interaction and the internal social climate, while still being reinforced by institutional structures and external legitimacy that provide direction and stability.

Support for H4 indicates that faith-based moral norms have a strong positive effect on elderly care quality ($\beta$ = 0.59). This finding clarifies the role of religiously grounded moral norms as a key factor shaping service responsiveness, emotional support, hygiene and safety practices, and perceived well-being among older residents. In relational and long-term care contexts, quality is not produced solely by facilities or technical competence, but also by the moral orientation that shapes how caregivers interpret older adults' needs, respond to vulnerability, and sustain consistent service behavior under constraints. Internalized moral norms can strengthen intrinsic motivation, reduce opportunistic tendencies, and improve interaction quality, which often constitutes the core of residents' experience in

institutional care. In other words, faith-based moral norms operate as a regulatory device linking values to action, making care quality more likely to be maintained even when resources are limited.

The most important contribution of this study is the empirical support for H5a–H5c, showing that faith-based moral norms mediate the effects of bonding (β_indirect = 0.19), bridging (β_indirect = 0.14), and linking (β_indirect = 0.11) social capital on elderly care quality. These mediation results advance social capital debates by shifting attention from whether social capital is beneficial to the mechanisms through which its benefits are realized. In faith-based institutions, social networks and access to resources do not automatically yield higher service quality unless they help generate moral norms that guide caregiving practice. Strong internal ties, cross-community networks, and vertical connections can be understood as relational infrastructure, while faith-based moral norms function as the operational mechanism that activates this infrastructure into behavioral standards, service commitment, and consistent practice.

Differences in the size of indirect effects are also substantively informative. The bonding pathway shows the largest mediated effect, suggesting that moral norms are most effectively produced and sustained through close relationships and intensive internal interaction in everyday caregiving. Bridging and linking remain significant but contribute more moderately, implying that external networks and vertical ties primarily reinforce norms through access, legitimacy, and institutional support that help maintain normative stability. Thus, the multi-level structure reflects distinct functions in shaping moral norms and service quality rather than serving as a purely terminological distinction.

This study offers three main contributions. First, it integrates bonding, bridging, and linking social capital into a single coherent model, clarifying the differential role of each dimension in shaping a normative mediator. Second, it positions faith-based moral norms as a measurable mediating mechanism tested quantitatively, addressing a gap in literature that often treats religiosity as an organizational attribute rather than an explanatory pathway. Third, the model expands the empirical domain of social capital and service quality research by focusing on community-driven and values-based care systems, thereby enriching theory that has largely been developed within more established welfare-state settings. By demonstrating that moral norms bridge social capital and service quality, the study provides a conceptual framework better suited to understanding elderly care quality where formal state resources are not the primary support pillar.

Practical implications underscore that improving service quality cannot rely solely on technical interventions; it must also address the relational ecology and moral norm formation that sustain caregiving practice. To strengthen bonding, institutional management can develop teamwork mechanisms, peer support structures, and routines for ethical reflection that maintain trust and task reciprocity, preventing moral norms from eroding under work pressure. Strengthening bridging can be pursued through structured partnerships with local communities, organized volunteer programs, and inter-institution forums for sharing best practices, which not only expand resources but also reinforce a normative climate through recognition and cross-community learning. Strengthening linking requires more stable institutional relations with authoritative actors, including religious bodies, local government, and donors, so that legitimacy and resource support are tied to capacity-building agendas, training, and standardized work practices aligned with institutional values.

At the policy level, these results provide an empirical basis for designing realistic elderly care system strengthening in non-welfare-state environments. Rather than mechanically adopting high-income country models, policy can focus on network strengthening and collaborative governance by recognizing faith-based institutions as key service providers while building accountability mechanisms and capacity support. Support frameworks may include standardized caregiving training facilitation, cross-institution partnership schemes, and quality-linked funding that promotes improvement without undermining the value-based character that motivates prosocial commitment. For Southeast Asia, the findings are particularly relevant because they indicate that care quality can be improved through strategies that combine multi-level network development with moral norm internalization rather than relying primarily on facility expansion.

Despite strong empirical support, several limitations should be noted:

1) Caregiver perception-based data may involve social desirability bias; future studies could add objective indicators such as hygiene audits, safety incident records, or third-party assessments.
2) The cross-sectional design limits stronger causal inference; longitudinal studies would help assess whether changes in social capital lead to changes in moral norms and care quality over time.
3) Heterogeneity across faith-based institutions may produce differing mechanisms; multi-group analysis, for example by religious affiliation or region, could enrich understanding of when moral-norm mediation strengthens or weakens.

Future research can deepen theoretical contribution while enhancing policy relevance by incorporating these extensions into efforts to build dignified and sustainable care systems.

## 6. CONCLUSION

This study concludes that social capital operates as a multi-level relational resource that shapes institutional elderly care quality primarily through faith-based moral norms. The findings indicate that bonding, bridging, and linking social capital each contribute to strengthening caregivers' internalized moral obligations and spiritually grounded service orientations, and these norms, in turn, translate into higher perceived care quality in terms of responsiveness, emotional support, safe and hygienic practices, and residents' well-being. The study advances social capital theory beyond single-dimension explanations and clarifies how relational structures become actionable in values-based care settings where state welfare support is limited by empirically validating a mediating mechanism that has rarely been modeled in quantitative research. The results suggest that improving care quality requires not only operational resources but also deliberate investment in internal cohesion, cross-community collaboration, and vertical partnerships, alongside organizational strategies that institutionalize moral norms through training, supervision, and service standards. The proposed framework offers a robust basis for strengthening community-driven, faith-based long-term care systems and provides evidence relevant for policy and institutional design in similar non-welfare contexts.

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