CHAPTER 2

PROJECT DESCRIPTION

2.1 Introduction

This project was to develop a health promotion program aimed at the elderly. The main thrust of program to cured on training Family Health Leaders in a training program for promotion self health care using Participatory Learning techniques. This project was implemented at Bandondoeykai, Tambon Kaennoi , Kham Khuan Kaeo District, Yasothon Province. The target populations were 50 Family Health Leaders as trainees and 4 health personnel as trainers. The project was separated into 2 phases at 6 month time period of implementation.

The Family Health Leader is a member of the household who volunteers to participate in this project. The eligible household must have at least one elderly in the household. In this project, the elderly is defined as people aged 60 or more.

In Kham Khuan Kaeo District 98.1 % of the total of 5,405 elderly people have health problems. 92.45 % of the elderly have one or more chronic diseases. The major physical health problems are 94.34 % Osteoarthritis ,59 % sleepness, 47.17 % constipation, 30.19 % Peptic Ulcer and 13.21 % hypertension . 83 % have total income of less than 1,000 Baht per month, 10.1 % don't have any income themselves. (NCD. Section, KKK Public Health District Office:1999). Therefore, caring for the elderly is a probity in Kham Khuan Kaeo District.

2.2 Goal and Objective

1. General Objective

To develop and implement a health promotion program for the elderly focussing on the Family Health Leader.

2. Specific Objectives

2.1 To train the Family Health Leader so they know about the promotion of self health care for the elderly using a Participatory Learning strategy.

2.2 To encourage the Family Health Leader to have a more positive attitude toward the elderly.

2.3 For the Family Health Leader to advise the elderly about promotion of self-health care for the elderly.

2.4 To compare the Family Health Leader's basic conditioning factors with Knowledge, Attitude, Practice (KAP) pre-interventions and post-interventions

3. Expected Outcomes

3.1 Family Health Leader distributes to the elderly knowledge of self health care for the elderly.

3.2 The elderly have improved self-care behavior for health promotion.

3.3 The elderly have a improved quality of life using four indicators as below.

(1) Healthy both Physical and Mental Health

(2) They should have 20 or better teeth or more.

(3) The BMI is in the Normal curve (20-24.9 Kg/m^2)

(4) The elderly can self-care and help one another.

3.4 Adaptation of the program for training others in the knowledge for self-health cares.

2.3 Approaches, Methods, and/or techniques.

2.3.1 Technique

The project was to train the Family Health Leaders using training program for promoting self-care of the elderly. The training program consisted of (1) 2-days intensive training course by Participatory Learning Technique. (2) Retraining during monitoring & supervision. The supervision was took place during monthly home done though monthly home visit. Re training were done on the spot took where necessary and on issue that the FHLs may need additional training.

1) Participatory Learning (PL .)

The Participatory Learning is an essential tool in that process because the trainees do not miss opportunities for appropriate prevention, diagnosis and treatment. Training is about learning that an in-formed person will be had rationally to promote his and her health. It is about the ability to combine knowledge, attitude, and skill and that strength to shape one's life and contribute to lives of other.

2) Participatory Learning Component and Functioning

Participatory learning or education originated known as "popular education" in the 1950 with the efforts of Brazilian education, Paulo Freire, and his colleges to teach the oppressed peasant population basic literacy skills. Participatory education breaks down: "teacher-student" polarity, avoids manipulation by experts and emphasizes the collective nature of learning. (Pan American Health Organization, World Health Organization, 1996: 142-143 cite in Dares, 2000)

The purpose of Participatory Learning is to promote the presence of precursors to health behavior and to assist participant in making appropriate health

related decisions. This purpose can be performed through awareness raising –to increase members' interest in. Increase member's awareness of, health issues through group discussion, mutual support to help each other to cope with shared problems and their own experiences, or to change a health-damaging behavior education to impart skill, offer information and prepare members for life style behavior changing. (Ewles, L., & Smimneet, I., 1996: 162)

Participatory Learning uses a flexible approach and a variety of methods that fit. The purpose of education is to facilitate empowerment of individuals, groups through education and skill building process in order to make decisions or actions. This approach help people to identify their own concerns and gain the skills and confident to act upon them, It is a process of experience and perception of an individual's health. The strength of this style is that participants learn to trust their own judgment and at the same appreciate other people's rights and opinions. (Ewles, L., & Smimneet, I., 1996: 163) Then they will accept the problem and seek a way to solve the problem.

3) The Principles of Participatory Learning (PL) are:

1) Delegating decision-making powers to the participant.

2) Health educators should shift their role from instructors to facilitators who act as a catalyst to help participants, to identify their health concerns and areas for change, getting things going, and need to show warmth and empathy, encourage group members to express their felling, and provide counsel withdraw from the situation. (Pensirinapa, N. cited in Anulax, Y. et al. 2000:76-77).

To help participants to think critically or clarify about their values and attitudes which is the process of self-empowering people by modifying the way people feel about themselves through improving their self-awareness and self-esteem. (Ewles, L., & Smimneet, I., 1996: 183)

3) PL bases on adult learning and learner-centered approach.

4) PL no lecture. Encourages everyone to lean and everyone to teach.

5) PL uses principle of two-way communication.

6) PL has no interruption, and no domination or leading, but listening and learning.

7) PL uses vary activities. Using a variety of methods to energize participants and encourage them to get involved.

8) PL works in small group is advantage. (Downie, R., S., Tannahill, C., Tannahill, A.,1996:44 cite in Dares, 2000)

4. Components of Participatory learning are as follows;

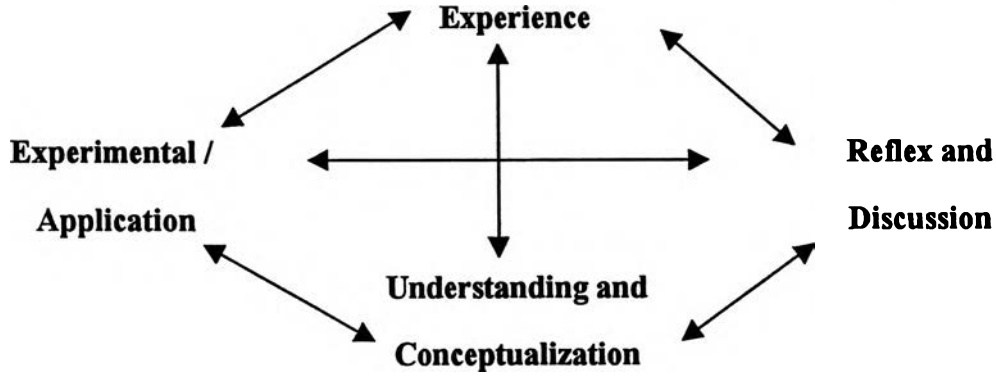
4.1 Experience

4.2 Reflex and Discussion

4.3 Understanding and Conceptualization

4.4 Experiment / Application

Figure 2.1 Components of Participatory learning



Source: WHO(1994) Life Skill Education in Schools; Geneva.

In this project, the component of PL were applied as follow,

In this project, the component of PL were applied as follow,

1. Experience	The trainers advise the trainees to use their own experience to develop their knowledge.
2. Reflect and Discussion	The trainers advise the trainees to have various activities to challenge their opinion, learn from their group and appreciate their opinions of their group.
3. Understanding and Conceptualization	The trainees understand the concept. Either the trainees started the conceptualization or the trainers continue till complete, or alternatively the trainers lead that the trainees then the trainees continue until this conceptualization is complete.
4. Experimental / Application	The trainees apply their knowledge to use in a similar situation of a different situation from their practice.

Source : Ministry of Public Health: 1999

2.3.2 Area for implementation

This project was implemented at Ban Dondauykai, Moo 4, Tambon Kaennoi, Kham Khuan Kaeo District, Yasothon Province, Northeast, Thailand.

2.3.3 Target Population

The project was introduced to 50 Family Health Leaders that live in Ban Dondauykai, Moo 4, Tambon Kaennoi, Kham Khuan Kaeo District, Yasothon Province, Northeast, Thailand.

3.1 Criteria for selection of the Family Health Leader

(1) That they could read and write Thai.

(2) That they were interested in Public Health.

(3) That they were willing to train in Family Health Leader program.

(4) They were selected from Village Health Volunteers, or Community Committee or and health personnel in Health Center.

3.2 The reasons for the selection of this village were because:

(1) I wanted to study the reality in this community and this village is only one that trained The FHLs in every family in Kham Khuan Kaeo District.

(2) The Family Health Leaders could be any member of the family because most people live with relatives who also act as caregivers.

(3) The purpose was to work in harmony with the National Primary Health Care Concept, so that the Family Health Leader was familiar with self-health care for the elderly.

(4) The concept of using the Family Health Leaders in promoting self health care is new and had never been implemented.

2.3.4 Methods for implementation.

1 Baseline data Collection

Data was collected before training to established information on the elderly's characteristic and the quality of life. The survey was done between 1—25 october 2000 on 53 the elderly people at the target village by 2 health personnel from Kaennoi Health Center.

1.1 Baseline Data Design

Using survey-collecting data in the 53 elderly people at the target village by 2 Health Personnel from Kaennoi Health Center.

1.2 Baseline Data Collecting Method

The 2 health personnel from Keannoi Health Center collected data using the following 2 instruments with all 53 Elderly people in the village.

1. General Data Questionnaire: consisting of 5 items covering Gender; Age; Education level; Income per month; Number of family members.

2. The Elderly's Quality of Life questionnaire survey from the medical Department, Ministry of Public Health. Both instruments are detailed in the appendix 3 page 81

1.3 Baseline Data Analysis

1 The Elderly General Data: The analysis of the data was based on the package program SPSS Version 8.0. The statistical methods used in the data analysis were based on the descriptive statistics, such as the percentage .the average and standard deviation.

2 The Elderly's Quality of Life: The analysis of the data was based on the package program SPSS Version 8.0. The statistical methods used in the data analysis were based on the percentage descriptive statistics.

1.4 Result of Baseline data

Table 2.1 Demographic Characteristic of the Elderly. (n = 53)

Characteristic	Frequency	Percentage
Gender		
Male	15	28.3
Female	38	71.7

Table 2.1 Demographic Characteristic of the Elderly. (Continue) (n = 53)

Characteristic	Frequency	Percentage
Age Groups (Years)		
60-69	31	58.5
70-74	10	18.9
75-79	9	17.0
> 80	3	5.7
Max = 90, Min = 60, Mean = 69.08 ,S.D.=7.15		
Marital Status		
Single	4	7.5
Couple	22	41.5
Single	1	1.9
Widows	26	49.1
Education		
No have the certificate of Education	3	5.7
Secondary Level	50	94.3
Occupational		
Not Occupational	20	37.7
Agricultural	32	60.4
Merchant	1	1.9
Total Income per month		
฿ < 1,000	44	83
฿ 1,000-1,999	9	17
Max = 1,800, Min = 100, Mean = 473.58 ,S.D.= 403		

Table 2.1 Demographic Characteristic of the Elderly. (Continue) (n = 53)

Characteristic	Frequency	Percentage
Source of Income		
From their occupational	32	60.4
From their son and daughter	21	39.6
Members in the Family		
1 - 4	22	41.5
5 - 6	14	26.4
> 6	17	32.1
Max = 9, Min = 1, Mean = 5.23 ,S.D.= 2.22		
FHLs' Status in the family		
Leader	39	73.6
Member	14	26.4

Table 2.1 displays frequency, percentage, mean and standard deviation of demographic characteristic of 53 the Elderly. It shows that the Elderly consisted of 15 male (28.3 %) and 38 female (71.7 %) The mean age of the Elderly was 69.08 years, ranging from 60 to 90 years with standard deviation of 7.15.

The educational background of the subjects ranged from those who had not the certificate of education (5.7 %) to those who had primary education (94.3 %).

The majority of the subjects were agricultural occupational (60.4 %). More than half of them were have received less than 1,000 baht per month (84 %).

The number of the Elderly' member with 1-4 members in each family was 41.5 %, 5-6 members 26.4 %, and 7-9 members 32.1 %. 39 Elderly were the Family Leaders and 14 Elderly were the family members in their family.

2 The Elderly's Quality of Life

Table 2.2 The number and percentage of the Elderly that pass quality of life indicators pre-intervention.(n=53)

	Quality of Life Indicators for the Elderly	Number of The elderly who pass the indicator *	%
1.	Body Mass Index (BMI.)	31	58.5
2.	Individuals routine activities.	53	100
3.	Received treatment when they got sick.	53	100
4.	They can access the health sector when they got sick.	53	100
5.	They have health examination every year.	30	56.6
6.	They usually an exercise.	30	56.6
7.	There is a rehabilitation center in the community.	0	0.00
8.	The Elderly Health Problems		
	8.1 hypertension	25	47.2
	8.2 Diabetes mellitus	22	41.5
	8.3 Rheumatoid and arthritic pain.	52	98.1
	8.4 Asthma	53	100
	8.5 Semi-Paralysis.	53	100
9.	Urinary : evacuation problems		
	9.1 Don't have problem with Urinary.	28	52.8
	9.2 Don't have problem with Evacuating.	37	69.8
10.	Don't have a problem sleeping.	18	34.0
11.	Don't have a problem with their eyesight.	33	62.3
12.	Don't have a problem walking.	46	86.8

*The criteria for pass the indicator of the elderly's quality of life see page 84

Table 2.2 The number and percentage of the Elderly that pass quality of life indicators pre-intervention.(Continue)

Quality of Life Indicators for the Elderly		Number	%
13.	Have more than 20 good teeth.	41	77.36
14.	Don't have a problem with their hearing.	50	94.34
15.	They get suitable food.	8	15.1
16.	They received adequate drinking water and an adequate domestic water supply.	53	100
17.	Good mental health.	44	83.0
18.	There is a suitable room for the elderly in the house they live in.	39	73.6
19.	There is the suitable toilet and suitable bathroom.	53	100
20.	There are no nuisances.	53	100
21.	Received the accepted by others.	51	96.2
22.	There are activities with other people in the community or at least they must be a member of a social group.	31	58.5
23.	There is a person to consult when they have any problems.	53	100
24.	They live in a genial or friendly family.	53	100
25.	They have an adequate income every month.	23	43.4
26.	They are not addicted to alcohol.	51	96.2
27.	They are not addicted to tobacco.	48	90.6
28.	They usually enjoy religious activity in the community.	41	77.4
29.	They receive (and benefit from) information about improving their lives.	53	100
30.	They have the health welfare card so they don't pay when they are sick or they receive free attention because a relative works for the government sector.	52	98.11
31.	They live safety in the community and their assets are safe.	53	100
32.	There is social welfare for the elderly.	53	100

2 Training Program

(1)Trainers

There were 5 trainers consisted of 2 health personnel from teamwork project, 2 health personnel from Kaennoi Health Center and a Dentist from Kham Khuan Kaeo Hospital who was a lecturer trainer.

(2) Content

Use the Handbook Health Promoting in the Elderly, by Ministry of Public Health, Thailand. The second edition in 1998.

2.1 Module for training: There were 5 modules,

1. Nutrition for the elderly.
2. Exercises for the elderly
3. Oral health for the elderly
4. Accident protection for the elderly
5. Mental health &Social interaction for the elderly.

(Detail of 5 module are shown in the appendix 4 page 91)

(3) Training Instruments

3.1 The Elderly Health Promotion Handbook, published by the Health Department Ministry of Public Health; Thailand. 1998. This was given to all the trainees in the program. This covers 1 food, 2 exercise, 3 oral health, 4-accident protection, and 5 social interaction and mental health.

3.2 Nine Items for healthy in the elderly, published by the Medical Department Ministry of Public Health; Thailand. 1999.

3.3 Posters about better tooth brushing, Dental Health Division, Health Department, Ministry of Public Health; Thailand. 1999.

3.4 Tooth brushing Model, there is a tooth model and a tooth brush model.

3.5 An Overhead Projector.

3.6 Transparencies.

3.7 Chemical pen.

3.8 Chart paper.

In this phase self-administered questionnaire was given before and after the training program. The questionnaire consisted of;

(1) General Data Questionnaire: consisting of 5 items and these are gender; age; education level; income per month; number of family members.

(2) Knowledge Questionnaire.

(3) Attitude Questionnaire.

(4) Practice Questionnaire.

(This questionnaire details are shown in the appendix 2 Page 72)

Project team members explained the questionnaires to the target population. Then the Family Health Leaders who participant in our program answered the questionnaire themselves.

(4) Data Analysis

The Family Health Leaders General Data:

The analysis of the data was based on the package program SPSS Version 7.5. The statistical methods used in the data analysis were based on the descriptive statistics, such as the percentage, the average and standard deviation and Chi-Square.

(5) Guide line for data analysis.

These questionnaires set the criteria for the score of Knowledge (K), Attitude (A) and Practice (P) dividing them into 3 level scale.

Table 2.3 The level of the subjects' knowledge, the level of the subjects' attitude and the level of the subjects' practice at pre and post training.

Level	Percentage	Score
High	> 80	48-60
Moderate	60 – 80	36-47
Low	< 60	20-35

Source : Somkid (2000) ,The project evaluation technique.

(6) The criteria used to set the score in the data analysis.

1. Part B of the questionnaire is about the subjects' knowledge.

1.1 The positive questions numbers 1,2,3,5,8,9,11,13,16, and 19 were score as follows; (See in the appendix 2 page 72)

Agree score 3

Uncertainly score 2

Don't agree score 1

1.2 The negative questions numbers 4,6,7,10,12,14,17,18 and 20 were score as follows; (See in the appendix 2 page 72)

Don't agree score 3

Uncertainly score 2

Agree score 1

2. Part C in the questionnaire is about the subjects' attitude.

2.1 The positive questions numbers 2,4,5,7,9,14,17,18,19 and 20 were score as follows; (See in the appendix 2 page 75)

Agree score 3

Uncertainly score 2

Don't agree score 1

2.2 The negative questions numbers 1,3,6,8,10,11,12,13,15, 16 and 20 were score as follows; (See in the appendix 2 page 75)

Don't agree	score 3
Uncertainly	score 2
Agree	score 1

3. Part D in the questionnaire was about the subjects' practice.

3.1 The positive questions numbers 1,3,5,6,7,8,9,12,13,15,16,17,18 and 20 were score as follows; (See in the appendix 2 page 78)

Regularly	score 3
Some time	score 2
Never	score 1

3.2 The negative questions numbers 2,4,10,11,14 and 19 were score as follows; (See in the appendix 2 page 78)

Never	score 3
Some time	score 2
Regularly	score 1

2.4. Sustainability

1 The training of health promotion in the elderly was included into the Village's Primary Health Care Plan.

2 The Elderly Leaders in the village shared idea in the development of The Village's Primary Health Care Plan.

3 The Family Health Leader and Community Leader organized a "Respected in the Elderly Week" in April every year.

2.5 Activity Plan with timetable

This project was implemented for 6 months and shown as below.

Table 2.4 Program scheduled achieved in the control of the project.

Activities	Dates
1. Pilot testing for validity and reliability a different village.	3-7 October 2000
2. Baseline data Collection in the elderly	1-25 October 2000
3. 2-days intensive training course using PL.	1-2 November 2000
4. Collecting data in the FHLs pre 2-days intensive training.	1 November 2000
5. Collecting data in the FHLs post 2-days intensive training.	2 November 2000
6. Monitoring&supervision monthly by 2 health personnel from Kaennoi Health Center.	20- 21 December 2000 25-26 January 2001 22-23 February 2001 22-23 March 2001
7. Data analysis of validity and reliability test	October 2000
8. Data analysis of Base line data in the elderly	November 2000
9. Data analysis of pre and post 2-days intensive training.	November - December 2000
10. Follow up training	26-27 April 2001
11. Collecting data in the FHLs post follow up training.	27 April 2001
12. Data analyses of the post follow up training.	May 2001
12. Collecting data in the elderly's quality of life.	May 2001
13. Data analysis of elderly's quality of life.	May 2001

Table 2.4 Program scheduled achieved in the control of the project.(Continue)

Activities	Dates
14. Data Collecting in the elderlys's QOL	1-15 May 2001
15. Data analysis of the elderlys's QOL	20-30 May 2001
16. Writing in Thai Edition	January–June 2001
17. Writing in English Edition	May-August 2001
18. Prepare to presentation	September 2001

2.6 Problems, conflicts, and means for resolution.

1. Problem

During this project some the elderly that lived in the target village moved to the another place during the pre-interventions to post-interventions program, making it impossible to the cover all the elderly in the village.

2. Means for resolution.

2.1 In the evaluation phase this project selects some elderly to evaluate during the observation phase, selected by simple random sampling selection.

2.2 The elderly who do not live in the target village in the last month of implementation were defined as the missing cases.