CHAPTER 4

DISCUSSION AND CONCLUSION

Discussion

This project was to develop and implement a health promotion program for the elderly. It focused on training the Family Health Leaders(FHLs.) to assist the elderly to take care of themselves. The training program employed Participatory Learning Strategy training. That composed of two phases , phase 1 involved 2-days intensive training program which was followed by a follow-up by a training in phase 2. The target populations were the 50 Family Health Leaders that live in Ban Dondauykai, , Kham Khuan Kaeo District, Yasothon Province, Thailand. The criteria for the selection of the FHLs was ;

(1) That they could read and write Thai.

(2) That they were interested in Public Health.

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

(4) The Village Health Volunteers, or the Community Committee or the health personnel in Health Center selected them.

The discussion may be divided into the following section:

1. The Training Program uses the Participatory Learning strategy.

This project found that Participatory Learning was appropriate for the Family Health Leaders (FHLs.) training program. Even though most of the FHLs only received the primary education, this posed no problems to this training program.

They had fun in the process of Participatory Learning because they had the opportunity to participate in the group process with the trainers. Some had the opportunity to talk to the group , some had the opportunity to write and they presented to the class at various times during the training program. The FHL learned from the their experiences of the other members in the group.

Moreover, Participatory Learning also involves sharing of experiences between the trainers and the target subjects. In this study the target subject is the elderly. As part of the curriculum, an elderly which good health was invited to share his knowledge and experiences whit the FHLs. The atmosphere in this section was informal resulted in more participation from the FHLs in the discussion.

2. The project's specific objective result.

This project implemented 2 phases of training. The first phase training took place at the beginning of the program that was carried out as 2-days intensive training. Accord phase training or follow-up training was conducted 5 months after the first phase training. In this phase, the training took place in the community and was used to fill the gaps in knowledge, attitude and practice of the FHLs. By the end of the project it was found that there were changes in FHLs' Knowledge, Attitude and Practice from this training as follows;

2.1 Changing the score of the FHLs' knowledge.

The mean score of the FHLs' knowledge after the follow-up training was statistically higher than before FHLs receiving any training. When the knowledge score are categorizing into low level moderate level and high level, the FHLs performed better after the follow-up training. None of FHLs score in the low level there was an increased in high level score. The knowledge level score post follow-up training there were 49 at the higher level of knowledge (98 %) and 1 at the

moderate level of knowledge (2 %). It's increased from the moderate and low level of knowledge by pre 2-days intensive training.

2.2 Changing the score of the FHLs' Attitude

The mean score of the FHLs' knowledge after the follow-up training was statistically higher than before FHLs receiving any training. When the attitude score are categorizing into low level, moderate level and high level, the FHLs performed better after the follow-up training. None of FHLs score in the low level there was an increased in high level score. The attitude level score post follow-up training there were 49 at the higher level of attitude (98 %) and 1 at the moderate level of knowledge (2 %). Its increased from the moderate and low level of attitude by pre 2-days intensive training.

2.3 Changing the score of the FHLs' Practice

The mean score of the FHLs' knowledge after the follow-up training was statistically higher than before FHLs receiving any training. When the attitude score are categorizing into low level, moderate level and high level, the FHLs performed better after the follow-up training. None of FHLs score in the low level there was an increased in high level score. Even though the score increase without a significant difference but the practice level score post follow-up training there were 31 at the higher level of practice (62 %) and 19 at the moderate level of practice (38 %). Its increased from the moderate and low level of practice by pre 2-days intensive training. (See table 3.17 page 46)

3. Changing in the FHLs Practice.

By the end of this project I found that some of the practice of the Family Health Leaders could not be changed but some could be change a little (detailed in the appendix 3 page 80) these are as follows;

3.1 from the question of the practice D. 8 "The members of your family eat brown rice."

Before any training took place, there were 38 FHLs that never eat brow rice, 10 of the FHLs eat brow rice occasionally and 2 of the FHLs eat brown rice regularly. After both phase of training program, there were 35 FHLs that never eat brow rice, 13 of the FHLs eat brow rice occasionally and 2 of the FHLs eat brown rice regularly. The Family Health Leaders know about the benefit of the brown rice but they did not like to eat it because;

1) They say, "It is not delicious".
2) There was no brown rice available in the village.
3) The others member in the family did not like to eat brown rice. If the Family Health Leaders want brown rice is a burden in term of cooking.

3.2 from the question of the practice D. 10 "You prepare cigarettes, the betel palm and the piper betel for the elderly."

Before any training took place , there were 16 FHLs that never, 10 FHLs that occasionally and 24 FHLs that regularly prepare the cigarettes and the betel palm and the piper betel for the elderly. After phase of training program, there was 24 FHLs that never, 12 FHLs that occasionally and 14 FHLs that regularly prepare the cigarettes and the betel palm and the piper betel for the elderly. The Family Health Leaders know about the problems caused by cigarettes and the betel palm and the piper betel but they still prepare them for the elderly because;

1) The Participatory Learning training strategy did not make the people stop smoking or change smoking behavior in the short time available.

2) The FHLs were afraid to tell the elderly was wrong because of the elderly status and it common practice for younger people to prepare it for them.

3) The culture of the village is that the people usually bring cigarettes, betel palm and piper betel to cultural ceremonies such as the opening of a new house, a marriage ceremony, ect.

4) The son and daughter usually bring cigarettes, betel palm and piper betel to the elderly as a simply gift of respect of seniority.

3.3 from the question of the practice D. 13 " You advise the elderly to always wear a safety belt in a car or to wear a helmet when riding a motorcycle."

Before any training took place there were 20 FHLs that never, 10 FHLs that occasionally and 20 FHLs that regularly always wear a safety belt in a car or to wear a helmet when riding a motorcycle. After phase training program, there were 20 FHLs that never, 10 FHLs that occasionally and 20 FHLs that regularly always wear a safety belt in a car or to wear a helmet when riding motorcycle. The Family Health Leaders know the benefits of the safety belt and the helmet but they did not change their behavior because;

1) Most of the people in the village have no car.
2) Some of the Family Health Leaders have no motorcycle.
3) Some of the Family Health Leaders have no the helmet.

3.4 from the question of the practice D. 16 " You take the elderly away from their village to another place for recreation at least once per year."

Before any training took place , there were 17 FHLs that never, 21 FHLs that occasionally and 12 FHLs that regularly took the elderly away from their village to another place for recreation at least once per year. After phase training program there were 17 FHLs that never, 21 FHLs that occasionally and 12 FHLs that regularly take the elderly away from their village to another place for recreation at least once per year. In this item there was no change because;

1) The 6 months training program implement was in the wet season and the people don't like to tour at that time.

2) Most of the Family Health Leaders can't effort it. (Total little income 1,000-1,500 bath per month).

3) Most Family Health Leaders make recreation in their own village and don't see the need to go another place.

4) The elderly don't want to ride for a long time because they get carsick (vomits and dizziness).

3.5 from the question of the practice D. 20 "You plan some activities for the elderly on important day at least twice a year such as birthdays, New Year Days or Song Kran days."

Before any training took place , there were 9 FHLs that never, 22 FHLs that occasionally and 19 FHLs that regularly plan some activities for the elderly on important day at least twice per year such as birthdays, New Year Days or Song Kran days. After phase training program, there were 7 FHLs that never, 24 FHLs that occasionally and 19 FHLs that regularly plan some activities. There were a little change in practice because;

1) New Years and Song Kran fell within the period of the project.

2) On New Year and Song Kran days the elderly received a simple gift. (Such as fruits, sweetmeats and some money) from their son and daughters that live away but visit at this time.

3) On Song Kran days the people have some activities for the elderly at the temple every year.

4) It is not common practice in this village to give gifts on birthdays especially to elderly people.

4. The changes in the elderly's Quality of life.

By the end of the project, for the submitted in the partial fulfillment of the requirements for the Degree of Master of Public Health. I must evaluate the elderly's quality of life. There were the 47 elderly surveyed because 6 had gone away from the village to the other place. The results were as follows;

4.1 There were no change or a little changing.

1) The Body Mass Index (BMI) because the BMI can not change in the time 6 month of the training program and the elderly has the stable weight and a little changing in the 6 month.

2) A problem with their eyesight, because the training program can not change the problem with their eyesight.

3) Problems with their teeth because the elderly have no more money for buy the false teeth.

4) Adequate income per month, because the training program can not change the total income per month.

5) Smoking tobacco because the training program can not change the smoking behavior in only 6 months.

6) Health welfare Card because the elderly had known and correct practice when they go to the health service.

4.2 There were changes in the elderly's quality of life.

1) The elderly usually exercise in their routine work.

2) There was an increase in regular visits to the health center with regard to their hypertension and diabetes mellitus problems. Therefore management of hypertension and diabetes mellitus away the elderly have improved.

3) The Urinary and evacuation problems because the elderly have more exercise than the before training program and their diet have improved food.

4) The problem sleeping because the elderly have more exercise than the before training and they have more the activities with other people in the community that may lend to having better mental health.

Conclusion

In summary, the following major conclusions emerged from this study:

1) The Family Health Leaders (50 participants) can involve themselves in establishing a Participatory Learning strategy in both phases of the training.

2) Post intervention, the Family Health Leaders have a better knowledge, than pre intervention without a significant difference (table 25,P-value = 0.784)

3) Post intervention, the Family Health Leaders has better attitude than pre intervention without a significant difference (table 28,P-value = 0.595)

4) Post intervention, the Family Health Leaders has better practice than pre intervention with a significant difference (table 31,P-value = 0.090)

5) A certain aspect of the elderly's quality of life was change as a result of the training program. However major change may not be seen in a relatively short time of 6 months. Therefore, future evaluation may be able to assess the elderly quality of life further.