The Effectiveness of the Elderly’s Participation in Health Promotion Program at a Primary Care Unit in Khon Kaen Province

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ABSTRACT

The purpose of this research was to study the effects of participation in health promotion program which contributed to health promotion behaviours of the elderly at a primary care unit level. A participatory action research was designed to explore the process of an elderly health promotion program development. The qualitative and quantitative data was collected by participatory observation and in-depth interview. The structured interview was based on used heath promotion behaviors proposed by Pender’s Model of health promotion. The subjects include 29 elderly living in Chaiso sub-district of Khon Kaen Province who volunteered to join the health promotion program at Chaiso health center.

The findings suggested that elderly health promotion program development process should include problem identification and problem solving, setting the elderly health promotion group, planning for the elderly health promotion program and group process. The results revealed that health promotion behaviors of the elderly before and after participating in elderly health club activities was significantly different (p<.05). The benefits gained from the participation included enhancing physical and psychological health, particularly their self esteem which enable them to being viewed as a worthwhile member in the community.

It was concluded that the health promotion program could empower participants to create and share their life experiences and enhance their health promotion behaviors and life satisfaction from being a member of the elderly health club.

Keywords: Health Promotion, Thai Elderly
INTRODUCTION

In the past two decades, many new industrialized countries including Thailand have had social and economic changes. There has been an increasing economic growth from an agricultural sector to industrial and service sectors [1]. With the aging of the world population, more than one-quarter of the world’s population will be over the age of 60 by the year 2100 [2]. As in most other countries, the proportion of elderly people is increasing every year in Thailand due to decreasing birth rates and increasing longevity. The proportion of those 60 years and older in Thailand was approximately 9.2% in 2005, and is expected to rise 17.1% in 2025 [3]. The average life expectancy is predicted to increase from 70.8 years in 2005 to 76.8 in 2025. As individuals live longer, health promotion behaviors become even more important, particularly with regard to maintaining functions and independence and improving quality of life (QoL) [4-6]. Issues in health promotion for older persons are related to their independence in every day life, high cognitive and physical function, and active engagement with life. US Department of Health and Human Services [7] on health promotion and aging highlighted regular exercise, smoking cessation, avoiding excessive alcohol, good nutrition, and having age-appropriate immunization. These behaviors are encouraged with the intention of reducing in premature mortality and ensuring better life quality [8]. There is considerable evidence that health-promoting behaviors of older adults offer the potential for improving health status and QoL as well as reducing the cost of health care [9-12].

The aging of the population will have significant economic and political implications that will affect the nature of our society and so of our nation’s future. The elderly will be more interested in funding and supporting different social programs than their middle-aged children, changing the pattern of the national budget. As they become less able to access information, their health behaviors may change. Finally there is the cost of supporting the care and maintenance of this elderly population – a cost that will be borne by a workforce that is becoming proportionally smaller in relation to the supported population [13].

The concept of empowerment is to empower people are ensuring they help determine the way their health is to be promoted and acknowledging the value of their
perspective. It is about helping people to acquire the skills and self-assurance to take greater control of their lives and their health [14]. Principles of empowerment have been used in preventive intervention with a variety of health problems. The interventions have ranged in focus from HIV prevention in minority populations to general health promotion in large cities [15]. Choksawadphinyo [16] used empowerment-based model for enhancing self care of persons living with HIV/AIDS in Thailand. The proposed model guided the clients to develop the ability to solve their problems by themselves, which would lead to conduct appropriate self-care and improve their health and well-being. In addition, Squire [17] explains that older people should have their fundamental needs for autonomy and empowerment met so that they can participate in their chosen lifestyle. This requires the provision of health promoting environments in the community. Health officers and voluntary should be responsible for providing care that older people can choose for themselves, having a positive view of the health of older people and accepting them as partners in promoting and maintaining their health care. Empowerment and autonomy can still work along with interdependence such as living together, and support one another, respecting older people’s values and beliefs and helping them to make their choice of care.

This study aimed to demonstrate that helping elderly people participate in a health promotion program and contribute to the community by sharing their life experiences would enable them to be included as worthwhile members of that community rather than being viewed as a burden.

**MATERIALS AND METHOD**

The authors applied a participatory action research study which was based on the elderly’s participation on health promotion program that lends itself of informing community change. Two types of questionnaires were used in the study: 1) Self-administering questionnaires which was used to evaluate the elderly’s feeling related to health promotion group activities. 2) The structured interview based on health promotion behaviors questionaries which was used before and after six months of the participation in health promotion program. Cronbach’s Coefficient Alpha was used to
analyze the internal consistency of each part of the questionnaire. The coefficients were 0.89 for health promotion behaviors questionnaire.

**POPULATION AND SAMPLE**

There were 29 participants including 18 females and 11 males. All were between 59 to 84 years old. Ten had previous experience in an elderly group recreation at the Temple of Chaiso sub-district. Most of the group were married with living spouses and the rest, widow or widowers. Two were married couples. Most of them still working as farmers and most of women were house keepers, two men were retired government officers. This background was helpful in understanding that some of the elderly group members were economically self sufficient and some were supported by theirs children. As noted in the study, some of the activities required financial consideration.

**DATA ANALYSIS**

Qualitative data was analysed by using content analysis. The elderly’s interaction process in health promoting programs was analysed. The effects of the elderly participation in health promotion program were presented in terms of mean, standard deviation, and t-tests.

**RESULTS**

The major finding of this study was the elderly’s health promotion program undergo problem identification and problem solving, setting for the elderly health promotion group, planning for the elderly’s health promotion program consisting of Thai traditional dances and health promotion group meeting three days a week for six months at Chaiso Health Center. The results revealed that health promotion behaviors of the elderly before and after participating in elderly’s health club activities was significantly different (p< .05). Nevertheless, there was no significant change in diet behavior.
Table 1  Program effects on health promotion behaviors

<table>
<thead>
<tr>
<th>Health promotion behaviors</th>
<th>X</th>
<th>S.D.</th>
<th>t-test</th>
<th>df</th>
<th>p-value</th>
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<tr>
<td>1. Social interaction</td>
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<tr>
<td>Before</td>
<td>42.30</td>
<td>4.45</td>
<td>3.83</td>
<td>28</td>
<td>.001*</td>
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<tr>
<td>After</td>
<td>46.12</td>
<td>2.73</td>
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<td>2. Spiritual health</td>
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<td>Before</td>
<td>38.03</td>
<td>4.37</td>
<td>2.43</td>
<td>28</td>
<td>.021*</td>
</tr>
<tr>
<td>After</td>
<td>40.09</td>
<td>3.01</td>
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<td>3. Physical activity</td>
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<tr>
<td>Before</td>
<td>23.12</td>
<td>3.47</td>
<td>2.84</td>
<td>28</td>
<td>.008*</td>
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<tr>
<td>After</td>
<td>25.21</td>
<td>1.76</td>
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<td>4. Safety habit</td>
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<tr>
<td>Before</td>
<td>16.57</td>
<td>2.54</td>
<td>2.23</td>
<td>28</td>
<td>.033*</td>
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<tr>
<td>After</td>
<td>17.84</td>
<td>1.83</td>
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<td>5. Stress management</td>
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<td>Before</td>
<td>15.63</td>
<td>2.34</td>
<td>2.70</td>
<td>28</td>
<td>.011*</td>
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<tr>
<td>After</td>
<td>17.33</td>
<td>2.01</td>
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<td>6. Diet behavior</td>
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<td>Before</td>
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<td>1.75</td>
<td>28</td>
<td>.090</td>
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<td>After</td>
<td>18.60</td>
<td>2.72</td>
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</table>

* p-value < .05

Paired t-test result between the pretest and 6-month measures.
To strengthen the elderly’s health promotion program development, members need to actively participate in all phases; planning, decisions making, implementing and evaluation. The facilitating factors were the group leader’s capability, previous experiences in health volunteer work, regular attendance in group meetings, active participation in sharing ideas and experiences, mutual help, self satisfaction, and social support provided by the family. On the other hand, the hindering factors identified in the study included the deteriorating health of the members, lack of support on transportation, and household responsibilities, among others. However, participation in the elderly health promotion program resulted in the elderly’s improved physical and psychological health, especially their self esteem.

**DISCUSSION**

The participants in health promotion program were volunteers, elderly age between 59 and 84, and could attend all sessions of the study periods. Eight members had previous experience in being a member of an elderly’s club. Most (of the members) were economically self reliant, and had receiving retirement pensions. Some had experience in formal and informal leadership positions and roles in their present or past careers. Most of the members also belonged to a similar socio-economic status. It was found that health promotion behaviors of the elderly before and after participating in elderly’s health club activities were significantly different. However, there were no significant changes in diet behavior. The results were not different from others elderly’s health programs with similar activities.

This could explain that as they were participated in all sessions of the health promotion group the elderly could to exchange their life experiences and applied to all activities particularly health promotion behaviors and health problems. It has been emphasized that Thai traditional dance or any other safe exercise program for enhancing the physiological functioning in older adults should be enjoyable and nonthreatening [18]. Like in any other group process, the elderly health promotion group began with personal introductions. At first stage they did not feel comfortable to express their feeling. The facilitator conducted a group exercise for the members to get acquainted with one another, eliciting one’s name, age, and birthday. When a recall activity was asked for, many participants remembered data that were similar to their own. They were also asked to put the names in order of seniority, which made
them enjoyable [19]. In addition, the attendance rate (at approximately 90% of the presented) was relatively high compared to the previous studies with elderly populations [20,21]. The elderly health promotion group continuity in the study period rested on the concept of self regulation. This meant that the members had to rely on themselves to develop goals and objectives, plans and programs of action, and the important decision making process itself. The role of facilitator, while spread out across the study period, was that of a consultant, for instance, a mechanism for checking and clarifying the members’ aspirations, rather than being involved in the implementation functions. For example, when topics for discussion were planned for early in the group the facilitator clarified how they were prioritized and not intervened as to whether they were suitable or appropriate for the group.

Since the elderly’s health promotion program was provided at the elderly health club where the elderly lived, easy access to the program and the group dynamic among residents could be the reasons for the high attendance rate, and consequently time or environmental effects were not considered. Further study on elderly populations with different residential statuses or various health statuses, along with additional strategies to consider the characteristics of the target population is necessary.
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