CHAPTER V

SUMMARY AND DISCUSSION

5.1 Summary

A cross-sectional analytic study on health-promoting behaviors and the quality of life of the elderly population in Srisamrong district, Sukhothai province was performed. A sample size of 398 elderly was selected, using stratified random sampling. Data was collected by one interviewer using a questionnaire adapted from WHOQOL-BREF. The study employed double entry technique, and statistical analysis used frequency, mean, standard deviation, and multiple regressions. Various socio-demographic characteristics of the participants in this study included: 63.6% female, 28.6% between 65-69 years of age, 59.0% married, 83.2% with primary school education, 67.3% able to read and write well, 55.3% unemployed, 44.2% with monthly income less than 1,000 baht, 78.6% living with spouse or children, and 56.3% living with an illness.

5.1.1 Quality of life and health-promoting behavior

The majority of the elderly volunteers in this study (75.6%) rated their quality of life as moderate, as measured within the following domains: social relationships (66.8%), psychological health (68.8%), environmental health (76.6%), and physical health (82.4%). Results regarding health-promoting behavior revealed that 46.0% of the elderly had good health-promoting behaviors. The volunteers in this study reported engaging in primary and secondary health-promoting behaviors such as abstaining from alcohol (90.7%), abstaining from smoking (87.2%), and following domestic safety practices (86.9%). Analysis of the relationships between each health-promoting behavior and corresponding quality of life found that social interaction, housing sanitation, regular exercise, stress management, and nutritional practices were the statistically significant factors affecting quality of life.

5.1.2 Health-promoting behaviors and their influencing factors

Factors found to be statistically significant in influencing and maintaining health-promoting behaviors among the elderly volunteers in this study were: social support from health-promoting personnel, availability of elderly community clubs, accessibility to health services, awareness of one's own health status, being literate, being female, and having a bachelor's degree level of education or higher. Accessibility to health services was an issue due to three major factors: high cost of transportation (2.8%), difficulty accessing health service centers (10.6%), and failure to visit health service centers altogether (8.1%) because of the long distance between volunteers' residences and the centers. The longest distance from a residence to a health services center was reported to be 12 kilometers. The first choice for health services utilization, therefore, was a health center (65.6%), although 19.8% of elderly surveyed had impaired access to health centers, and 5.8% reported low satisfaction with the health services provided there. In addition, the elderly reported low levels of participation in elderly community clubs (25.1%). As for social support, the elderly reported receiving poor social support from family members (44.5%), their neighborhoods (65.3%), and health-promoting personnel (42.0%).

Accessibility to health services was related to health-promoting behaviors. This study found that most of elderly had used a health services center at least once (91.9%), had easy access to a health services center (89.4%), lived less than 2 kilometers away from a health services center (80.6%), and could reach a health services center within a short period of time (91.5%). Regarding participation in elderly community clubs, over 69.1% of the elderly in the study reported having high participation in activities at their club, while a quarter of the volunteers (25.1%) reported low levels of participation. If a higher percentage of elderly had greater participation at these clubs, their overall quality of life would certainly be improved. This study, therefore, found that health-promoting behaviors of the elderly could be improved up to 33.8 percent if accessibility and availability of the elderly clubs were increased, as discussed above and in the previous chapter.

5.1.3 Quality of life and its influencing factors

Two key factors influenced the quality of life of the elderly volunteers in this study. First, awareness of one's own health status was found to be statistically correlated with actual level of health status; 45.7 percent of those with a high level of health status reported being aware of their good health. Second, availability and accessibility to community elderly clubs was found to be an important factor in determining the quality of life of the elderly in the study.

5.2 Discussion

The two goals of healthy people 2010 focus on increasing the quality and years of healthy life for each individual and eliminating health disparities (Resnick, 2003). The goals of health-promoting behaviors are to maintain function and independence and to improve quality of life (Leveille et al., 1999). Resnick (2000) categorized health promotion behaviors into two groups: primary health-promoting behaviors, for the prevention of disease before it occurs; and secondary health-promoting behaviors, for the detection of disease at an early stage. Fulfilling such expectations when caring for older people in the community can be a challenging task for health care workers and nurses. This study provided some answers as to how to improve the quality of life of the elderly in Srisamrong district, Sukhothai province, through fostering health-promoting behavior among this population and capitalizing upon the relationship between health-promoting behaviors and one's overall physical, environmental, and psychological well-being.

Quality of life is a complex phenomenon, and many factors are thought to influence it. A number of additional, notable findings in this study can assist health authorities in improving this parameter. Multiple regression analysis yielded from data in this study found a five-variable model comprised of social interactions, regular exercise, housing sanitation, stress management, and nutritional practices, which accounted for 23.3 percent of the variance in quality of life.

Results showed that the elderly have little opportunity to contact others outside their residence. This could be explained by the fact that the elderly live with their spouse or children and are usually unemployed (55.3%). The elderly are often

homebound because they are responsible for taking care of the residence when their spouse or children go to work. Leaving their residence to join the elderly community club or to attend social functions, therefore, would be difficult. A health-promoting program for the elderly must consider ways to incorporate this fact, or try to change this practice.

Awareness of one's own health status is another important factor influencing the elderly's quality of life. According to Pender's concept (Pender, R., 2006), health status perception is related to the observance and degree of adherence to health-promoting behavior. The people who realized that they had good health were more likely to engage in health-promoting activities than those who did not. According to Speake, Cowart, and Peilel, (1989) the elderly who had a high level of health status perception would be more likely to practice health-promoting behaviors than those who had a low level. A health-promoting program aimed at teaching or coaching the elderly to become aware of their own health status, as well as a service to provide regular health checkups, would be instrumental in improving the elderly's health and quality of life.

According to Hunkittikul (1996), accessibility to health services had a positive correlation with health-promoting behaviors. A study by Chareonyooth (1980) found that the distance between a patient's house and available health care services influenced whether they would use that health services center. In addition, the elderly will use health services only if they feel comfortable there, and access is convenient. These two factors must therefore be improved so that the elderly in this study will utilize the health care services, which in turn will improve their quality of life. Health-promoting personnel should make annual home visits in order to regularly monitor the physical health of the elderly. In addition, authorities at health service centers should provide special programs or services for the elderly in order to make visits to the centers more comfortable and convenient for them. Health services centers should also enhance the quality of services in order to pass the health services center quality standard.

Availability of community elderly clubs relates to health-promoting behaviors as well (Vilailerd, 1993 and Khumpeng, 1997). Those study volunteers who belonged to elderly community clubs were more likely to engage in health-promoting behaviors, especially with regard to nutritional practices. They received teaching about nutrition and learned to pay attention to their own health. This study found, however, that some villages had no community elderly club at all, while others had struggled unsuccessfully to establish one. Most of the community elderly clubs are located in the same area as a health center, which makes access to both facilities difficult for those elderly who live far away from the health center. Those elderly lacking access to the health center, therefore, have no access to the community elderly club either, which eliminates two important potential sources of beneficial health-promoting services. Improving access to community elderly clubs by having one in each village will solve this problem.

Social support from health-promoting personnel in this study had strongest link to health-promoting behaviors, a finding also supported by Metawee (1993).

5.3 Recommendations

The findings of this study can be used as the basis for guiding directions and planning for health-promoting activities as follows:

5.3.1 This study contributes to the expansion of knowledge about quality of life, which is essential for health personnel and related authorities who work with older populations. Health personnel and related authorities should further facilitate health-promoting behaviors by formally supporting interventions that enhance the quality of life of elderly individuals and improve the overall health of the community.

5.3.2 Health personnel and authorities affiliated with health service centers should be responsible for fine-tuning current programs in order to maximize convenience, minimize waiting time, and provide health information for elderly.

5.3.3 Authorities responsible for the elderly and their welfare should formally support and promote the establishment of an elderly club in each village. Maximizing membership at these clubs would in turn maximize the elderly's access to health-promotion information and other activities designed to enhance their well-being.

These activities should be informal, flexible, and not difficult for members, who should also be encouraged to share their experiences with the group and help one another. In addition, health care organizations and personnel working in the community should contribute some academic and financial support for these clubs.

5.3.4 The authorities responsible for the elderly should focus on creating health perception campaigns so that the elderly may improve awareness of their own health status. Health-promoting personnel should give information to elderly at every encounter and disseminate health information through local television, local radio, speaking towers, and local newspapers. They should also emphasize community outreach programs that help elderly with poor access to health services centers also gain information. In addition, they should also give information to relatives and caregivers who can encourage the elderly to take care of themselves continuously and reliably. Finally, they should facilitate health-promoting behaviors with special emphasis on social interaction, exercise, housing sanitation, stress management, and good nutritional practices.

5.4 Recommendations for Future Research

5.4.1 A cross-sectional design was used to identify the relationship between health-promoting behaviors and quality of life, thereby precluding causality. Future research should use a longitudinal design to better understand the impact of health-promoting behaviors on quality of life.

5.4.2 The study may be influenced by interviewer bias if the interviewer has worked in the community. Therefore, the interviewer should be from a different district than the one studied.

5.4.3 Whenever research relies on questionnaires, it is important to be careful of introducing sensitive question bias when collecting data. This issue did arise during the course of the study and had to be resolved by carefully explaining to the elderly about sensitive issues such as sexual relations among elderly volunteers.

5.4.4 For future research, gender ratios should be carefully considered when selecting the population sample and should be representative of the study population, since gender was shown to have an influence on health-promoting behaviors.