

**STRENGTHENING CAPABILITY
OF FAMILY HEALTH LEADERS ON SUSTAINABLE
COMMUNITY-BASED HEALTH PROMOTION**



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HEALTH PROMOTION**



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STRENGTHENING CAPABILITY OF FAMILY HEALTH LEADERS ON SUSTAINABLE COMMUNITY-BASED HEALTH PROMOTION

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ABSTRACT

The Family Health Leader Project (FHL) was initiated in 1999. Since then, there has been no retraining or any further health promotion. The purpose of this study was to assess family leaders' knowledge, ability, leadership and motivation regarding self-care and health promotion. A quasi-experimental, One-Group, Pre-Test-Post-Test design was done in Ban Nern Phi, Panthong District, Chonburi Province. Health personnel and village health volunteers were recruited for training as facilitators to strengthen capabilities of 36 family health leaders. The intervention to strengthen capabilities lasted for 7 months and included participatory training, Technical Cooperation among Developing Village (TCDV) and networking. A Within Subject Repeated Measure ANOVA was used to measure changes of outcome variables immediately after the intervention, and then three and six months later.

It was found that knowledge of self-care and health promotion, ability, leadership and motivation were significantly increased among the family health leaders after the intervention ($p < 0.01$). Family health leaders cooperated with the community committee to set up an exercise club and received support from the local authority. This activity was extended to involve nutrition. During the intervention, family health leaders developed a vision for a healthy community and then proposed a one year action plan to the local authority to implement their vision. Family health leaders also sought to extend their network by involving both the community committee and local authority. Neighboring communities were asked to join their activities, share their experiences, and network. The family health leaders were the key persons bringing good health to family members. The strategy to strengthen the capabilities of family health leaders improved health promotion within the community and also developed networks vertically and horizontally. Periodically participatory learning, TCDV, and group empowerment are recommended to encourage the family health leaders to maximize their potential for family self-care and health promotion in the future.

KEY WORDS: STRENGTHENING CAPABILITY/ FAMILY HEALTH LEADERS /
COMMUNITY-BASED HEALTH PROMOTION

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การสร้างเสริมศักยภาพของแกนนำสุขภาพประจำครอบครัวในการส่งเสริมสุขภาพบนพื้นฐานของชุมชนอย่างยั่งยืน (STRENGTHENING CAPABILITY OF FAMILY HEALTH LEADERS ON SUSTAINABLE COMMUNITY-BASED HEALTH PROMOTION)

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บทคัดย่อ

แกนนำสุขภาพประจำครอบครัวเป็นบุคคลสำคัญในการดูแลสุขภาพของตนเองสมาชิกครอบครัว และการส่งเสริมสุขภาพ การวิจัยเรื่องนี้มีวัตถุประสงค์เพื่อเปรียบเทียบความรู้ ความสามารถ ภาวะผู้นำและแรงจูงใจของแกนนำสุขภาพประจำครอบครัวในการส่งเสริมสุขภาพชุมชนก่อนและหลังการพัฒนาศักยภาพ และประเมินกระบวนการจัดตั้งเครือข่ายและการขยายผลเพื่อความยั่งยืน ด้วยการวิจัยกึ่งทดลอง ร่วมกับการวิจัยเชิงคุณภาพ ที่หมู่ 5 ตำบลโลกจี่หนอน อำเภอพานทอง จังหวัดชลบุรี กลุ่มตัวอย่าง ได้แก่ วิทยากรการเรียนรู้ 5 คน ที่ผ่านการอบรมแล้วทำหน้าที่พัฒนาศักยภาพให้แก่แกนนำสุขภาพประจำครอบครัว 36 คน ก่อนและหลังการอบรม วัดความรู้ความสามารถภาวะผู้นำและแรงจูงใจด้วยแบบทดสอบร่วมกับการสังเกตและการสนทนากลุ่ม ดำเนินการระหว่างกันยายน 2546 - มีนาคม 2547 สถิติที่ใช้ ได้แก่ ร้อยละ ค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน ซึ่งผลการวิจัยสรุปได้ดังนี้

แกนนำสุขภาพประจำครอบครัว 36 คน 3 ใน 4 เป็นหญิง อายุเฉลี่ย 40 ปี สถานภาพสมรสคู่ ร้อยละ 86.1 ร้อยละ 52.8 อาชีพค้าขาย รายได้ครอบครัวเฉลี่ย 10,116 บาท/เดือน ร้อยละ 89.9 จบชั้นประถมศึกษา ร้อยละ 58.3 เป็นผู้ดูแลสมาชิกในครอบครัวยามเจ็บป่วย พบว่า ความรู้ ความสามารถ ภาวะผู้นำและแรงจูงใจในการดูแลสุขภาพตนเองและครอบครัวและการส่งเสริมสุขภาพชุมชนของแกนนำสุขภาพประจำครอบครัวหลังการสร้างศักยภาพดีกว่าก่อนการสร้างศักยภาพอย่างมีนัยสำคัญทางสถิติ ($p < .05$) แกนนำ สุขภาพประจำครอบครัวร่วมกันกำหนดวิสัยทัศน์ด้านการส่งเสริมสุขภาพของชุมชน และเสนอแผนปฏิบัติการให้ อบต. จัดงบประมาณสนับสนุนให้จัดกิจกรรมส่งเสริมสุขภาพในชุมชน จัดการศึกษาดูงานหมู่บ้านที่มีกิจกรรม ส่งเสริมสุขภาพดีเด่น และนำบทเรียนที่ได้มาปรับปรุงแผนและกิจกรรมของกลุ่ม จากผลการศึกษาค้นคว้า สำนักงานสาธารณสุขจังหวัดจึงควรนำกระบวนการเรียนรู้แบบมีส่วนร่วม ผสานกับการสร้างพลังและการถ่ายทอดเทคโนโลยีระหว่างหมู่บ้านมาใช้พัฒนาศักยภาพของแกนนำสุขภาพประจำครอบครัวอย่างต่อเนื่อง ตลอดจนองค์กรปกครองท้องถิ่นควรกำหนดนโยบายส่งเสริมสุขภาพเชิงรุก สนับสนุนและขยายเครือข่ายส่งเสริมสุขภาพให้เกิดความยั่งยืนต่อไป

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CONTENTS

	Page
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
LIST OF TABLES	viii
LIST OF FIGURES	ix
CHAPTER	
1 INTRODUCTION	
1. Background and Justification.....	1
2. Research Objectives.....	7
3. Research hypotheses.....	7
4. Scope of study.....	7
5. Operation Definitions.....	8
2 LITERATURE REVIEW	
Part 1: Background and the development of family health leaders.....	12
Part 2: Concept of strengthening capability.....	16
Part 3: Concept of health promotion.....	44
Part 4: Concept of sustainable health promotion.....	47
Part 5: Concept of participatory learning.....	60
Part 6: Related research.....	65
3 MATERIALS AND METHODS	
Methodology.....	74
Phase One: Community and facilitator preparation.....	74
Phase Two: Strengthening capability of family health leaders.....	78
Phase Three: Establishment and expanding network.....	83
Ethical considerations.....	87

CONTENTS (CONT.)

CHAPTER	Page
4 RESULTS	
1. General characteristics of the studied village.....	88
2. Results of facilitator training.....	95
3. Results of strengthening the capability of family health leader.....	108
4. Results of establishment of network on community health promotion.....	129
5 DISCUSSIONS.....	136
6 CONCLUSION AND RECOMMENDATIONS.....	146
REFERENCES.....	149
APPENDIX.....	160
BIOGRAPHY.....	192

LIST OF TABLES

Table	Page
1 Training curriculum of participatory learning to increase knowledge and ability of facilitator.....	97
2 Training curriculum of participatory learning for family health leader on the first training.....	101
3 Curriculum of the second family health leader training.....	103
4 Knowledge about community health promotion and being facilitator of learning pre and post training as classified by item (n = 5 persons)	104
5 Number of facilitators as classified on ability pre and post training (n = 5 persons)	106
6 Comparison of mean score on knowledge and ability of facilitator's pre and post training.....	108
7 General characteristics of family health leaders (n=36 persons).....	116
8 Percentage of family health leaders as classified on level of knowledge and ability, pre and post-training (n=36 persons).....	120
9 Number and percentage of family health leader's corrected answers classified by item (n = 36 persons)	120
10 Percentage of family health leader's ability as classified by items (n= 36 persons)	123
11 Percentage of family health leader's leader behavior as classified by item before and after training (n = 36 persons).....	125
12 Percentage of motivation for being a family health leaders as classified by item (n = 36 persons).....	126
13 Comparison of mean score on knowledge, ability and motivation of being family health leaders during immediately pre and post-training, post-training 3 months and 6 months.....	128

LIST OF FIGURES

Figure		Page
1	Framework of strengthening capability of family health leaders on sustainable community-based health promotion.....	11
2	Managerial styles in Black & Mouton's Leadership Grid.....	31
3	The five Common networks.....	55
4	The cycle of experimental learning as proposed by Kolb's Model.....	61
5	Process of Experiential Learning.....	62
6	Blocks for information pyramid.....	78
7	The process of strengthening capability of family health leaders.....	86
8	Map of Village 5, Tambon Kok Keenon, Phanthong District, Chonburi Province.....	90

CHAPTER 1

INTRODUCTION

1. Background and Justification

The public health system consists of the following three elements: state public health system, private public health system and primary health care system. Each system has its own emphasis such as the state public health system delivers prevention and curative services, health promotion and rehabilitation to people. This management has been conducted in semi-social welfare and semi-business settings. Next, private public health emphasizes health care, curative services and rehabilitation for business. Primary health care strengthens people by promoting self-care, health promotion, and disease prevention more than cure (1), although there is an attempt to develop such systems for raising equilibrium and continuation. The resource allocation and technology from the government sectors have been directed to enlarge the health service centers and support their cure strategies creating an imbalance with health promotion programs, disease prevention and competency development on self-care. Thus, the expenditure trends of the national public health program are seen to increase every year. The increasing rate of curative expenditure, which is now more than 10 % per year, could not be decreased through control mechanisms and even if it were achieved, it would be a futile strategy in dealing with diseases and injuries which can be prevented. Furthermore, about 20 % of the population cannot properly access government public health services (2).

For optimum use, the Ministry of Public Health has revised their concepts and the policies of public health development by increasing the investment of health promotion, disease prevention through local technology and planning emphasis on primary health care system development (3) along with the health service system.

Primary health care means basic needs for health care delivery to all people and families in the community through participation at affordable expenditure (4). The concepts of primary health care have led to community action for health through cooperation and ownership by knowledgeable people and readiness in the family for self-care along with the coordination in health promotion and support in health service management. Furthermore, social mechanisms at the local level should be added (5, 6).

Primary health care in Thailand, implemented since the 4th Economic and Social Development Plan to the 6th Economic and Social Development Plan, involved the development of basic structure to cover all the villages such as manpower, organization and funding through village change agents or village health volunteers (VHV). From this development, it has been found that there were many problems affecting the efficiency of village health volunteer implementation; for example, lack of skill in working with the community, lack of continuous learning, lack of a cooperative plan, lack of support from concerned agencies and low participation level from the people (7).

In the 7th Public Health Development Plan, the direction of primary health care development was clear whereas the village health volunteer can cover all rural and city areas at an average of 1 VHV per 8-15 households. Primary health care activities have been classified into 14 elements according to the specific problem. There were "Community Primary Health Care Centers" (CPHCC) established in villages all over the country (8). The rural accelerating development project was set up to serve "health for all" programs motivating concerned agencies to strengthen these activities, which has effectively aroused the success of "health for all" programs by indicators set by the Ministry of Public Health in 1997.

Later, in the 8th Economic and Social Development Plan (9) the goal was set up with the "human as the center of development" for balancing economic growth. Then, the Ministry of Public Health launched a policy on human development at individual, family, and community levels for appropriate health behavior in health promotion, disease prevention and self-care in health by continuously supporting the relationship between family and community as an important basis for their members. This creates essential knowledge and skills for self-care and family health care

appropriateness and also calls for participation in all aspects of community development. Continuing to the 9th Economic and Social Development Plan (10) human resources were perceived as a development center emphasizing social strength and equilibrium. The health insurance policy for all the people by the Ministry of Public Health (11) also supported this by emphasizing health building (health promotion) more than health repairing (cure). In responding to this policy, the management system was adjusted seriously by building health to people, reducing the morbidity rate and government services dependence, supporting more self-care schemes and providing opportunities to participate as a partnership, which is aligned with the concept of family health leaders development created by the office of Primary Health Care. The family health leader is expected to have knowledge and capabilities in self-care and taking care of his family members in normal situations and mild illness. Participating in networks and other health activities of village health volunteers and other concerned agencies have been designed under the success of the village health volunteer development program. However, this success could not be stable according to the inconsistent levels of participation by village health volunteers (7). The family is the smallest unit in the community forced into many development activities and is the fundamental basis of societal values; whereas, if it could continuously develop itself, it may affect real strength in the society.

The ultimate goal of public health development is that the people can help themselves in health aspects, which will be successful if performed by active, cooperative people. Establishing targets and partnerships coincides with reports on the success of accelerated health for all of the Ministry of Public Health's indicator (8) and the study of people participation. After attaining health for all, it was found that the villages where people were exhibiting participation in health activities at the family level, would have more chance to stabilize village health for all compared to villages that passed the evaluation criteria supported by health officers and village health volunteer alone (12). In fact, all the development philosophy supported the responsibility of family level work through a more participatory process for which the target was to decentralize the system to the people and let them manipulate it (6).

As a result, the public health field had to emphasize family health leaders as a main mechanism of health promotion in the community. This is because the family

health leader is a representative of the family, which is the smallest unit of a community. It would be ideal if each family can take care of their own health and have good health behavior joining in public health problem solving and prevention that would have an effect on community health too. From this concept, the Office of Primary Health Care (6) was set up with the target to develop family health leaders covering 85 percent of all the families in the village and community. From this operation, the target not only supports the policy of assurance creation for all in health building but also supports the creation of a people health system which effectively modifies the Office of Primary Health Care mandate into a Division of Primary Health Care under the Department of Health Service Support, Ministry of Public Health (13). This organization has the duty to support community organizations to build up health programs parallel to curative services from the government.

Such mandate modification had little effect on the roles and duties of the Regional Training Center for Primary Health Care Development (CRTC) which still had to cover the old mission, especially concerning people support; that is, training and people's health development activities. CRTC takes responsibility in the target areas for 25 provinces in the central region of Thailand, except Bangkok. The main duty is to support the person responsible for primary health care at provincial, district and sub-district levels together with the village health volunteer organization and community organizations with technical know-how, materials and some funding for these people who can bring the policy into practice using the primary health care strategy most effectively. Moreover, the CRTC plays a role in the follow up and evaluation of achievements in each province including the development of the family health system.

At the end of the 8th Public Health Plan, the following results showed that the number of family health leaders, 2,206,413 persons (55.1%), had been created from every province and village in the central region. When compared to the target plan and coverage it was found far below the target (14). In each province, there were different patterns of development according to their needs and problems reflected from not having a clearly specified curriculum but only broad guidelines from the Ministry of Public Health. In general, most of them used training methods taking 3-6

hours by officers and village health volunteers for the training contents emphasizing policy and problem solving in the area of responsibility. Knowledge on self-health care and family members' care in illness, especially chronic disease was a second priority (14). The evaluation of knowledge on self-care of family health leaders in 25 provinces found that from the sample of 1,232 persons, 77.5% had knowledge on self-care at a good level. When classified by province it was indicated that family health leaders in Chonburi, Singburi, Prachinburi and Nakhon -nayok Provinces needed more improvement (15).

From that evaluation, covering both quantitative coverage of family health leaders and process of development, it was further emphasized that health self-care be introduced to boost practices on control, prevention and community health promotion. In the year 2002, an outbreak of Dengue Hemorrhagic Fever occurred in every area for the whole year and the morbidity rate of preventable disease witnessed an increasing trend (16). Such a situation implied a lack of awareness of the roles and duties regarding the self-health care of people who were depending on the government services more than participating in their own health problem solving as members in the community. This result may be the cause for family health leaders not to fully develop their capability and skill building for community health needs. Family health leaders didn't show additional understanding of their roles and there was an observed lack of motivation. Even when they possessed a sufficient level of knowledge, they seemed to have more difficulty in conducting the health promotion activities that people couldn't do by themselves and realize how the health promotion would effect their future. Motivation plays an important role to push the satisfaction of individuals to perform suitable act (17). Furthermore, one of the important roles of family health leaders is leadership, which is a characteristic for helping to motivate themselves in thinking, classifying problems and making conclusions. Leadership is a critical factor to motivate group work by creating suitable processes and leading to enlarged networks to control health hazards (18). From these points we can conclude that capability, motivation and leadership play important key factors to family health leader development.

Family health leaders focus on human development to attain a healthy condition at individual, family and community levels, and its mechanisms link people

health systems to government health services. It is a basic factor of development and outcome of development, too. The previous data reflects the picture of past family health leader development, which emphasized problem solving and looking after illness more than knowledge and capability building on health promotion. Refreshed training didn't revitalize the family health leader development program and continuous follow up, both from officers and village health volunteers, received no action. Family health leaders had no chance to participate in any health activities in the community (14). Thus, family health leaders lacked motivation and could not work as a team for community health promotion in order to extend the program in the form of networking.

Chonburi is one of the leading provinces in establishing the family health leader program. Since the year 1998 until the present time, the achievement target of family health leaders in Chonburi has shown a total number of 168,166 families (coverage 16.80%) at the end of the year 2000 when compared to the target set of 218,884 families from every village (677 villages). After reviewing each district, only 4 districts, Panthong, Nongyai, Kao Sichang, and Kao Chan could cover every village, however, Banglamung covered 99.84%, Pananikhom covered 95.63% and Bo Thong covered 89.8%. Consequently, the attainment of the program objectives according to the 8th Public Health Plan can still be considered a success because the planned target was not less than 85% of the number of villages (19).

Although the coverage could reach the ministry's set target there was still no evaluation for the whole province in the capability of family health leaders on and on how this program increased the health status of people. Furthermore, Chonburi is one of the provinces where the basic infrastructure has been developed the most and was the first that joined with the primary health care program. When the Ministry of Public Health announced the policy to strengthen community health promotion for enhancing the health insurance for all schemes, a clear model for implementing had not yet been approved. The researcher gave a great deal of attention to this point by looking for revisions for a more appropriate model and processing the mobilization of family health leaders in activating community health promotion and strengthening the capability of family health leaders of Chonburi Province. The implementation on community health promotion will be run through the participatory learning process.

For trial as a pilot project, family health leader capability will be investigated to use for learning, to adjust for self-care thinking, and to create awareness on community health promotion for achieving the objectives on strengthening the capability of family health leaders on sustainable community-based health promotion.

2. Research Objectives

2.1 General objective

To strengthen the capability of family health leaders in Chonburi Province for sustainable community-based health promotion and network establishment.

2.2 Specific objectives

1. To compare knowledge, ability, motivation and leadership of family health leaders before and after strengthening.
2. To compare self-care and health promotion of family health leaders before and after implementation.
3. To evaluate the process of network establishment for sustaining community health promotion.

3. Research hypotheses

1. Knowledge, ability, motivation and leadership of family health leaders after implementation will be better than before strengthening.
2. After implementation, self-care for family members and health promotion will be better than before.

4. Scope of study

The study population is family health leaders who live in Chonburi Province in fiscal year 2003. (not including family health leaders who also work outside Chonburi)

5. Operation Definitions

Family health leaders: family representatives who have been selected by public health officers, village health volunteers or community leaders to attend the training course on self-care and disease prevention, basic and first aid according to the family health leader's development project of Chonburi Province during the years 1999-2001.

Capability: knowledge and existing individual ability, which is a characteristic for the development of appropriate action in responding to the needs of individuals, groups and the community.

Strengthening capability of family health leaders: emphasizing the process to enhance knowledge, ability, leadership and motivation of family health leaders, which has been drawn into practice for supporting health promotion activities along with their life in the community.

Knowledge of family health leaders: facts and health profile that family health leaders can recall, and respond to consisting of knowledge in self-care and family health care in normal situations and incident cases. Knowledge covers health promotion for the aged group and community health promotion.

Capability of family health leaders: any activities done by themselves with willingness, knowledge, and skills for their life. The health and better living conditions of themselves and family are decided by daily action for health such as _ health self-care and family health care making a healthier life and by joining with others to act on community health promotion.

Leadership: Individual process of working together with others through appropriate ways to attain the target effectively and persuasive manners to allow them act with willingness, the process family health leaders use for themselves accepted by

family and community with valuable and participatory involvement for health promotion programs and mutual benefits in the group and in networking.

Motivation: motivating factors of individuals that express their knowledge, capability, leadership and skills for their goal, group and organization with satisfaction and willingness.

Motivation of family health headers: motivating factors consisting of acceptability as a family health leader, interest in health promotion, accountability in group work, which motivates them to express their knowledge, capability, leadership and willingness to participate in community health promotion activities.

Health promotion: the process enhancing the individual capability in promotion of various control factors which positively affects health and health self-care development for healthy conditions (body, mind and society) and healthy quality of life.

Community health promotion: the motivation process and working with the community to promote any activities for health and possible conditions for living with good health involving community members in every step for health promotion.

Community participation: motivating people to join activities enthusiastically for policy, plan, projects, etc. It is a social process calling on the motivation and enthusiasm of the group of people to cooperate in the decision making process for target setting, resource allocation and plan of operation leading to sustainable development.

Network: community members (family health leaders, village health volunteers, community leaders, public health officers in that area) join together with the goal of community health promotion by cooperation and drawing all resources to work for attaining a common goal.

Network expansion for sustainability: network of community health promotion joining the community health promotion activities continuously by using the community resources, maintenance of valuable things that are needed for health promotion and hazard control. Disseminating concepts and acting as a good model in health promotion directly to individuals interested groups and similarly, the community.

Participatory learning: the process arranged for generating learning experience among family health leaders, village health volunteers and concerned with people in the community, which call for groups to participate in every step of the learning process for public health problem solving and community health promotion.

Facilitators: people who complete the training course having knowledge and being able to develop the capability of family health leaders in a sustainable network.

Facilitators' knowledge: health self-care, community health care techniques; for example, group building, extending a sustainable network, techniques for the participatory learning process and participatory community study as well as follow up and evaluation.

Facilitators' capability: knowledge for practicing and developing skills in a variety of fields for facilitators that consist of capability in health promotion, communication, team building, and in problem solving.

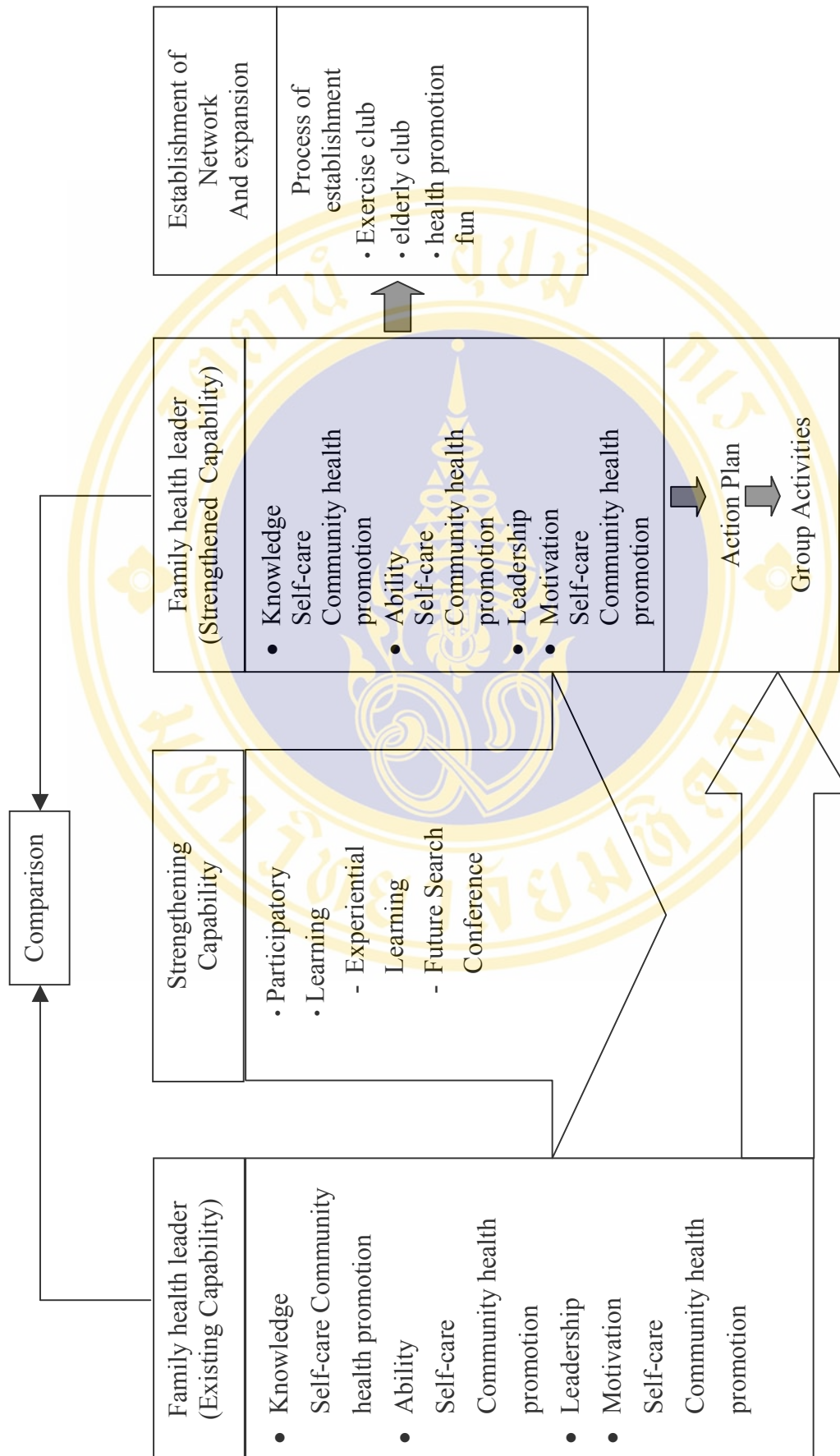


Figure 1 Framework of strengthening capability of family health leaders on sustainable community-based health promotion

CHAPTER 2

LITERATURE REVIEW

The objective of this research was to strengthen the capability of family health leaders for improving the community health which will be classified into 6 parts organized through the concept, theory and related research works as the following:

- Part 1 Background and the development of family health leaders
- Part 2 Concept of strengthening capability
- Part 3 Concept of health promotion
- Part 4 Concept of sustainable health promotion
- Part 5 Concept of participatory learning
- Part 6 Related research

Part 1 Background and the development of family health leaders

In the Eight Five-Years Plan of public Health had emphasized on “Human Development” to enhance the capability of people about self-care for good health in both body and spirit living happily in the society. Also participating in health problem prevention and disease control. The coverage about 85 percents of the village and community for the whole country. The strategy to attain the target had been established, were the promotion of role and potentiality of village health volunteer, health volunteer club, and community to transfer their knowledge and skill in self-care to family health leaders who plays an important by government officials or village health volunteers (20).

Family health leader is a model of people participation in the family level to support the village health volunteer works. The people will gradually learn how to

take care themselves on health for sustainability. The main issues for establishing the family health leader will be:

1. Form the Eight-Five Years Plan of Public Health aims to raise up knowledge and self-care capability corporate with their effort to solve the problem of community and clearly shows the target at least one person per family.
2. The primary qualifications of family health leader are:
 - The family has to pass the basic minimum needs (BMN)
 - Having good health behavior such as non alcoholism , non drug addict, best practice in self-care, be able to transfer knowledge to community, and natural leadership in the community which will be considered by health officers, village health volunteers and community leaders according to the criteria of primary health care elements falling 14 elements but isn't completed.
3. Family health leaders have to be good relationship with village health volunteer who acts as focal point of networking to transfer knowledge to community passed through family health leaders.

The family health leader who pass the training course and join the activities continuously would be changed his status to be village health volunteer which will be additionally trained according to the criteria of Ministry of Public Health under the consideration of public health officer who consider (21). Family health leader will work with the community, temple and school leading to sustainable health for all by starting from the family level and getting more knowledge through talking, meeting, training with village health volunteers more from book, television, radio or field trip as a key to approach to his family (22).

It could be summarized, the family member who was selected by public health officer and village health volunteer to act as the representative of his family to look after the health of family member in both body and spirit through knowledge transferred by health officer and village health volunteer and other source of information.

Chonburi is the province located in the central region of Thailand which has been developed on health according to the concept of primary health care continuously and had been announced to attain Health For All By The Year 2000. Nevertheless it doesn't mean that every family in the province can do self-care in the right way. Regarding to the health status report of Chonburi found that the high rate of morbidity and mortality of communicable diseases which is preventable still existed; for example hemorrhagic fever, diarrhea and pneumonia (19). Thus the policy on the development of family health leader will suit to improve the quality of health service development in Chonburi which has more detail as follows:

The development of family health leader project, Chonburi

Family health leader is the new target group of the provincial public health office for promoting the participation of the people from the family level strengthening the activities of village health volunteer but more flexibility (21).

Chonburi Provincial Health Office has started the family health leader training complied with the policy of Ministry of Public Health since March 1997 until the present. One person of family member chosen and having the following qualification:

1. Having a basic knowledge of self-care and family member on health promotion, disease prevention, basic treatment and first aid
2. Having the capability to apply knowledge of self-care into practice for his family such as fever release, faint aid, burn, and snake bite.
3. Having self-care behavior which will be the best practice model and joining the health activities in the community.

In the year 1999, it was set up target at least 50% of families in the village where health center located and expand to cover 35% of the households by the year 2000.

Family health leader means and person who has the knowledge and good behavior in self-care like a model in the family and can transfer knowledge to other family members. Family health leader comes from the selection of village health

volunteer or group house. Every family has been selected for one person who may be family leader, housewife, and other family member with the following requirement:

1. Not disability, deafness, blindness or chronic disease
2. Literacy for hearing radio, news, TV, newspaper, manual or talking with the village health volunteer.
3. Having good health behavior for being best model for family or neighborhoods.
4. Understanding and willing to be family health leader.
5. The age over 15 years

Project implementation

Provincial level: The meeting with the tambon health officer was set up to explain the policy of family health leader and to plan the teaching, producing manual for training to family health leader.

Tambon level: Community preparation has been done by tambon health officers. The meeting with village health volunteer has been done also to let them know about qualification and duty of family health leader and joining with village health volunteer to select the person in the family to act as family health leader.

Knowledge is transferred to family health leader by health officer together with health volunteer. The follow-up has been launched continuous to supervise and support the publication to family health leader.

Family health leader network establishment has been assigned by family health leader acting as a coordinator with village health volunteer and health officer for problem solving and local health development. Activities report and health knowledge evaluation of family health leader will be implemented to know the progress.

Budgeting: The Office of Primary Health Care supports the money to the village (Subsidize ฿ 7,500 per village)

Responsibility: Personnel Development and Primary Health Care subsections of Provincial Public Health Office, Chonburi Province.

Expectation: Every household in Chonburi has the personnel to do the duty of family health leader and family member can take care their health in proper way.

The project of family health leader of Chonburi has identified the family health leaders to have knowledge on health dealing with the basic health care, health promotion, disease prevention, basic treatment and first aid and to be the good model on health and to take care family member on health following the other health activities such as problem solving coordinating, family health development or health campaign.

Since the development of family health leader has been done from 1998 until present time the results found that the number of family target set up at 218,884 families from 67 villages. At the end of the year 2000, the family health leader development showed the number of success at 168,166 families cover 76.80% if considered at district level found that there were 4 districts (Panthong, Nongyai, Koksichang, and Ging Kokchang) covered all (100%) and Banglamong district covered 99.84% Panusnikhom covered 95.63% Bothong covered 89.8% attaining the Eight Five Year Plan of Public Health set indicator at 85% coverage of household and the rest of 6 districts under continuing on process (Chonburi Provincial Health Office: 2001).

In this research, the family health leader means the representative of family who has been selected from health officer, village health volunteer or community leader attended the training course on self-care, family health care, health promotion, disease prevention, basic treatment and first aids required by the family health leader development project of Chonburi between the fiscal year of 1999 – 2001.

Part 2 Concept of Strengthening Capability

2.1 Definition of capability

Any action of person leading to such required is the use of person's capability as the main factor where as capability state having continuous growth

specified to specific character of person. Capability has been generated from their learning and experience. The Royal Institute (1982) defines the meaning of capability as a latent state, power or competency immersed inside anything its may be developed or appeared to substantial state which is the same meaning identified in the Angus & Robertson Dictionary and Thesaurus (23) state that capability (n): 1.The quality of being capable practical ability, 2. a capacity for being used of developed, and 3. abilities, features, not yet develop or utilize, potential aptitude moreover it could be implied to the important element of explicit capability or to the development of appearing that is knowledge, ability and motivation of person who react to the personal requirement (24)

From above definition can conclude that capability means knowledge and ability of person which is existed inside, the character which can be developed for any action motivated to response to the personal requirement.

2.2 Strengthening capability

The term “strengthening capability” is used in many fields. Literature on strengthening capability within developing countries, describes strengthening capability as an approach to development that builds independence. Strengthening capability increases the range of people, organizations and communities who are able to address problems, and in particular, problems that arise out of social inequity and social exclusion. It can be a means to an end, enabling others to develop and sustain particular programs, or an end in itself, where the purpose is to enable others to have greater capability to problem solve together.

2.3 Definitions of strengthening capability

Strengthening capability is the development or promotion of specific knowledge sustainable skills, and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times (25). It is able to be the development of work that emphasis the ability of individual, community organizations and groups to build their structures, systems, and skills. So that they are

better able to define and achieve their objectives and engage in consultation and planning, manage community projects and take part in partnerships and community enterprises. It includes aspects of training, organizational and personal development and resource building organized in a planned, and self-conscious manner reflecting the principles of empowerment and equality (26). Strengthening capability is the activities which encourage people to determine their own values, priorities and to act on these, is the basis of development. It is an approach to development rather than a set of discrete or pre-packaged interventions (27). The conclusion of strengthening capability is the process of increase knowledge, ability, leadership and motivation of oneself to make decision and action properly for their lives.

2.4 Benefit of strengthening capability

Over the last few years there has been an increasing emphasis on the importance of addressing the social determinants of health. In addition, much work has been done to increase our understanding of working in partnership. Bush (26) notes that ‘social determinants’, ‘prevention’, ‘community’ and ‘partnerships’ are the substance of the language that is dominant in strengthening capability.

Strengthening capability is an important element of effective health promotion practice. It is sometimes described as the ‘invisible work’ of health promotion. It can include activities as diverse as canvassing the opportunities for a program, lobbying for support, developing skills, supporting policy development, negotiating with management, guiding the establishment of partnerships, or contributing to organizational planning.

There are a number of important reasons for the health system to focus on strengthening capability. These include:

1. Reorientation of health services: This is one of the main strategies advanced in the Ottawa Charter for Health Promotion. The message is that along with treating ill health, health services need also to take greater responsibility for improving the health of the communities they serve.

2. Multiplying health gains: A focus on strengthening capability will increase the likelihood that other people and organizations within health and

other sectors will also be able to promote health. This will multiply health gains many times over.

3. **Visibility:** A focus on strengthening capability increases the recognition given to the diverse efforts of practitioners working with other to take on and sustain programs. It gives a name to a large portion of work carried out by practitioners in developing effective programs.

4. **Accountability:** One of the difficulties of working invisibly is that practitioners are not readily accountable for this part of their work. Similarly, managers have lacked clear guidelines for assessing the quality of work purporting to build capacity for health promotion.

5. **Creating responsive systems:** Strengthening capability involves a focus on the processes that support change within organizations. It leads to systems which value critical problem solving and leadership across an organization. Responsive organizations are more likely to work in partnership to respond to new health challenges at a systems level. This is in contrast to a more traditional silo effect which results from organizations working on similar problems in isolation from each other.

2.5 Strengthening capability of family health leaders in health promotion

Health promotion is the hard core for health personnel because it is dealing with unseen problems. Thus people ignore changing. This approach is based on the realities of the current context, pre-existing capacities to support change, a practitioner's role in achieving change and their sphere of influence to effect change.

The domains of strengthening capability and develop indicators to guide health promotion strengthening capability practice, identified three distinctive dimensions to strengthening capability; (25)

1. **Health Infrastructure or service development:** Capability to deliver particular program responses to particular health problems. Usually refers to the establishment of minimum requirements in structures, organizations, skills and resources in the health sector, and community.

2. Program maintenance and sustainability: Capability to continue to deliver a particular program through a network of agencies, in addition to, or instead of, the agency which initiated the program.

3. Problem solving capability of organizations and communities: The capability of a more generic kind to identify health issues and develop appropriate mechanisms to address them either strengthens on the experience with a particular program or as an activity in its own right.

Strengthening capability can target varied levels: individuals, groups, communities, organizations, inter-organizations /coalitions. For practitioners who are strengthening capability at anytime they may be strengthening capability at many levels within a health promotion program. For example, a practitioner may be working with: An individual family health leader to develop particular health promotion skills, a manager, to negotiate allocation of resources to support the program, the project team to develop their skills to manage and support the program and identify opportunities to integrate the project into routine work practice, and people from other sectors to produce project champions in health and other sectors, and identify potential project partners, and people in a community to increase community participation and run to sustainability.

2.6 The principles of strengthening capability

1. Respect and value pre-existing capability: Before beginning to take on a strengthening capability function within a program, practitioners need to identify pre-existing skills, structures, partnerships and resources then work with and respect these. Effective strengthening capability practice links local people with content and context expertise with health promotion practitioners with technical and strengthening capability expertise, and uses processes that enable each group to contribute to an exchange of expertise among them. In addition, programs that are integrated into existing structures, and linked into existing positions and accountability processes, are more likely to be sustained. The establishment of separate vertical structures to maintain a program often duplicates the workload of the people expected to support the program. It may also suggest a lack of confidence in existing structures or

mechanisms. In the longer term this may undermine existing workplace relationships and contribute to a lack of support for a program.

2. Respond to context: Bush (26) has highlighted the importance of context and suggested that the field needs to work out more effective ways to monitor and assess context when evaluating programs. An evaluation method that focuses on the mechanisms only tells half the story only. Because context plus mechanism equals 'outcome'.

3. Develop well-planned and integrated strategies: To be the most effective, strengthening capability needs to work at a number of levels (e.g. with individuals, groups or across organizations) and use a combination of strategies from the key action areas of organizational development, workforce development and resource allocation.

4. Emphasis on customized developmental process (not a set of pre-determined activities) There is no single way to strengthen capability.

Thus, it is concluded that strengthening capability of family health leaders referred to the process which emphasis and enhance knowledge, ability, leadership and motivation of family health leaders, which has been drawn into practice for supporting health promotion activities along with their life in the community.

2.6.1 Knowledge Concept

Knowledge is the common word widely need in the technocrat group and general people. Knowledge is required by people for his various activities as follows:

Definition of Knowledge:

Education dictionary gives the meaning of knowledge that the fact discipline and varies detailed data collected as a structural research, observation, experiences or investigation report (28, 29). Bloom (30) thought that knowledge is the specific thing dealing with psychological process related to arranging the new memory and knowledge is intellectual competency.

The other points of view describe the knowledge in term of basic behaviors covering from vision, remembering, recalling which fact is. Theory,

regulation, structure, problem solving, comprehension all are generated from certain information which will be shown thought skill and competency in meaning interpretation and prediction (31)

Furthermore, knowledge can be classified into 3 perception according to the defined group that are knowledge of individual perception which is the perception and understanding of the event occurring in the nature and society found by themselves thought their individual competency. From technocrat opinions knowledge is the subjective concept, individual knowledge comes from his own learning but pragmatism gives the meaning as an understanding of event and various phenomena occurring in the nature and society which can be used by him (29).

This can be concluded that knowledge is fact, event and various details which can be remembered, recalled and interpreted into understanding to that thing.

Level of knowledge:

Knowledge or cognitive domain can be classified into 6 level started from simplicity to complexity that are: (22)

1. Remembering and recalling on thinking, object, and various event.
2. Comprehension on something which express thought behavior when confronting with the event.
3. Application which is the knowledge used to solve the problem in the real situation.
4. Analysis which is the competing to clarify the detail of subject linked by rationality.
5. Synthesis which is the competency to collect a thing component and to integrate thinking and planning for generating the new thing or new idea its required initiative thinking.
6. Evaluation which is the competency to decide on values, thinking, achievement, answering method and contents for some purpose based in rational justice criteria and valuable giving to others. Anyway, many technocrats have seen noticeable measuring of mentioned

Knowledge is normally measured in 2-3 beginning levels. The popular knowledge measuring is testing. It's most in choice which can measure in much dissension such as learning result in variety from basic intellectual process, cognition to super intellectual process, analysis, synthesis and evaluation (33).

Knowledge on self-care and community health promotion

Health care both in individual and family level is classified into 2 types, traditional and modern which are positive and negative for health. This individual and family have to have knowledge for selection to do or not to do any activities dealing positive health existence and negative health avoidance.

The activities of self-care will include external factors management and problem solving which is noticable action. The affective and emotional adjustment included self-care behaviors are generated from custom, culture of each groups. Adult will normally take care himself but baby, child, elder, patient or cripple may need to get help from related activities of care dealing with those are just on the beginning stage of physical, mental and social development. For elder needs help when his physical, intellectual deterioration appeared to obstruct his self-care ability. The cripple or patient needs to get help in some or all care depending on his health stage and present or future care requirement. Self-care is individual behavior of adult which will serve him to have a good health and will being family health care (34). Knowledge of self-care of family health leader consists of health promotion, disease prevention, basic treatment and first aids which is emphasized on health promotion as a key success.

Knowledge of health promotion: health promotion is related to many factors affected to various dimension of good health status adjusting to strengthen physical, mental abilities and to burden any risk of discusses.

The activities of health promotion have variety such as food, exercise, resting and stress releases as well as staying in well environment, endemic deceases control and prevention.

Health promotion of Thai family classified by ages is as follows:**(35)**

Preschool age (1-5 yrs): knowledge about growth caring, food for suitable age, nutritious food deficiency disease, illness free caring, prevention and control of communicable disease which it is prevented by vaccine as well as accident prevention.

School age (6-12 yrs): knowledge concerns with the promotion of the growth of school age child in personal hygiene, food buying and eating in corrective way of nutrition and food sanitation. Mouth cleanliness and regular dental check up are required, its also parental role and family health habit promotion.

Working age (13-59 yrs): on this age group, the knowledge covers on individual health promotion, personal hygiene, sex education, disease prevention and control, traffic safety, regular exercise promotion, behavior suggestion an disease avoiding, environmental hygiene and sanitation for living in a good condition customer protection realized on role and how to against the unfair goods and services.

Moreover, family health leaders have to have the knowledge on community health promotion that is the leading of community to participate in the activities of health promotion such as to promote the people having nutritious food and safety, to exercise regularly.

For ageing people above 60 yrs, knowledge will focus on physical and mental health for living in the family and community happily thought talking with the ageing people on nutritious food eating, meditation, exercise, leisure using for more benefit, participating in the ageing group activities and accident prevention.

In this study, knowledge of family health leader means the fact and any details of health contents which is recalled and answered from family health leader consisted of knowledge on self-care and family health care both in normal and mild illness, knowledge on age group health promotion and community health promotion.

2.6.2 Concept of ability

Personal ability is the readiness in action which is mostly considered in technique used to practice and skill on physical basic and learning. From the result of this field study showed the differentiation of those knowledge and ability in individual which will be used to consider the level of practice and success in individual.

Ability of competency means the existence of power to use knowledge, intellect in both physical and mental expression to do something (36). Furthermore, ability means knowledge and skill using to act for efficiency works or having value to solve the work problem of him according to the existing role. Some knowledge and ability are limited depending on each person but it's better in proved by specific training. Education and various experience provision can help to improve his ability through self learning in the house, school and past experience (37, 38, 39, 40, 41).

Each person has his own ability which is classified as follows: (42)

The ability to know rationality; Speaking, calculating in subtraction

The ability to see in wide range; Learning intellect, ability to imagination, ability to initiative

The ability to understand from the perception in correct way and high speed; ability for communication

The ability in physical properties; ability to work with mechanical instrument;

The ability to use hand for doing anything; ability to play musical instrument and artistry

For conclusion, ability means learning skill, learning usage and intelligent using to perceive, to think and to understand everything rationally which will express through any action for effectively working.

The ability in self-care and community health promotion:

The main factor affecting to respond the whole self-care requirement is self-care agency which including qualification, power and individual competency. Structure of competency in self-care consists of capabilities for self-care

operations, power components and foundational capabilities (34). The obvious potential self-care showed intended action falls in 2 periods:

Period 1: Data collection, interpretation, decision making on the existence or should be existence or should be change and on what to do in this period required knowledge and skill on considering and decision making.

Period 2: This period will be acting period which require the decision making application ability included evaluation and adjusting action (43, 44)

Competency power and basic qualification are included in self-care ability by structure. It is a foundation to help in doing of continuous self and family health care. That determines and directs self-care which are genetic and factors, affective perception, awareness, masonry, competency, learning skill, vision, value etc. These foundations will develop the memory competency for self-care which is competency power.

Competency power can empower the practice of self-care and act as a mediator between competency and basic qualification with the practice of self-care (45, 46, 47). There are consisted of these competency; active self caring intention, power usage control, rational posture control, self-care motivation, decision making on self-care, seeking, preserving, providing technical knowledge on self-care, collective skill for self-care, prioritized activities of self-care, self-care integration to life (48).

Self-care ability has been developed through learning process from intellectual curiosity, teaching and supervising from others as will as from self-care experience. Competency and basic qualification will be normally developed and based on the growth while there is learning on what should do or should not do according to own state, environment, social and culture. Learning creates competency power helping to decide on the target settling and to do self-care. Anyway, development of competency in various period of self-care practice may be unequal zed its depending on basic factor such as a few educational person may more act if compare to the rational and decision making usage (49, 34).

Self-care and family health care are sub-activities under self-care concept. As mentioned are the main strategic support for primary health care development and the widely interested issues for past 10 years.

World Health Organization defines “self-care” as an activity of individual, family, neighbor, colleague and community pass through decision making process for health. It is covered on treatment, disease prevention, health promotion, disease diagnosis, after service practice. Furthermore, many researchers express the concept of health care that is the initiative individual activities and pursuing on their own way for maintaining life, health promotion, and better living condition. Self-care is the specific action that means self-care having patterned, target, process and continuity if it is done on the correct way, completeness and efficiency supporting the functional structure and utmost working development of each person and each age group (50, 34).

Self-care has to generate from personal intention to take responsibility on self prevention, control or disease treatment. Every human has potential to learn and to develop skill in self-care which occurs from certain inside motivation or from outside (33). Thus the self-care is the important activities of human in both normal stage and illness because it is the issues of person directly. This can share the individual self-care to family and community following pattern, culture and belief which is raised up from his own community self-care, then, emphasizes in self-care in daily life which effects to good health such as food intake, sleeping, exercise, recreation, stress elimination (47).

Self-care in normal situation (52) are the activities to attain the healthy condition which is classified into 2 aspects:

1. Health maintenance is the ability to maintain the healthy condition, disease free, well living, and hazardous avoiding which is behavior regularly implemented.

2. Disease prevention is the action to do for disease and illness prevention such as immunized accessibility, moreover, it may imply to person who act for better health such as regular exercise for strengthening body muscle, enhancing more stress reduction (53, 54, 55). This will include regular health check, dental care, blood pressure measurement, cholesterol investigation. These activities

need to practice regularly for good health. The others important element affected to self-care are modern and tradition knowledge which concerns to health practice of person in that society (56).

For conclusion, the capability of family health leader means any activities which act by himself, his willingness, knowledge and skill for lively maintenance, health and better living condition to him and his family. He can do and make decision to practice on health daily as well as to cooperate with others for community health promotion.

Anyone who clearly shows the competency, more or less it is depended on knowledge and skill of that person. For participation development which is the key tools of sustainable development it is needed to motivate individual, group and community raising their competency. Thus, person must be provided to develop 3 basic skills (57).

1. Problem solving skill
2. Communication skill
3. Team Building skill

Furthermore, there are some basic skills when add up main basic skills helping to create more completed skills those are thinking skill, rational skill, emotional skill, learning skill, and managerial skill (58). At the end of the year 1992, World Health Organization and UNICEF (59,60) analyzed public health problem affected by globalization, which there is a rapid change, people could not cope with this change. They proposed to organization for taking responsibility to developing skill of people. Because they face with those situation and made himself, family, and society avoiding from hazard and danger through those basic skills development to various groups for competency promotion to fight with the problems effectively.

2.6.3 Leadership Concept:

The images associated with leadership have their roots in conflict. It is the stuff of generals who outwit their opponents, politicians who convince and channel groups into action, and people who take control of a crisis. A leader has a vision of what can, and should be done and can communicate this to others. Quality of

leadership is arguably, central to the survival and success of groups and organizations. There are almost as many definitions as there are commentators. Four things stand out in this respect. First, to lead involves influencing others. Second, where there are leaders there are followers. Third, leaders seem to come to the fore when there is a crisis or special problem. Fourth, leaders are people who have a clear idea of what they want to achieve and why. Thus, leaders are people who are able to think and act creatively in non-routine situations and who set out to influence the actions, beliefs and feelings of others.

In the recent literature of leadership there have been four main generations of theory: Trait, Behavioral, Contingency and transformational theories. It is important, as John van Maurik (61) has pointed out, to recognize that none of the four generations is mutually exclusive or totally time-bound.

For centuries, people have recognized that some persons perform very well as leaders, whereas others do not. Historically, the issue of leadership success has been studied from the perspective of the trait, behavioral contingency approaches to be discussed here. Each takes a slightly different tack in attempting to explain both leadership effectiveness and identify the pathway to leadership development.

Traits Theories

An early direction in leadership research involved the search for universal traits or distinguishing personal characteristics that would separate effective and ineffective leaders. The notion was to identify successful leaders and then determine what made them great. If a listing of definitive universal leadership traits could be made, it would then be easy to select for leadership positions only those people with the requisite characteristics. Historically, researchers struggled with their inability to find consistent patterns of leadership traits. More recent research indicates that certain personal traits may be important, but that they must be considered along with other situational factors. Briefly, the results can be summarized as follows: Physical characteristics such as a person's height, weight, and physical make no difference in determining leadership success. A study of over 3,400 managers, for example, found that followers rather consistently admired certain things about leaders.

Their followers as honest described the most respected leaders, competent, forward-looking, inspiring, and credible. Such positive feelings may enhance a leader's effectiveness, particularly with respect to creating vision and a sense of empowerment. In a comprehensive review of research to date, Shelley Kirkpatrick and Edwin Locke (62) further identify these personal traits as being common among successful leaders. Those personal traits are drive, self-confidence, successful leaders, creativity, cognitive ability, business knowledge, motivation, flexibility, honesty and integrity

Behaviors Theories

Recognizing that the possession of certain traits alone is not a guarantee of leadership success, researchers next turned their attention to examine how leaders behave when working with followers. Generally known as behavioral theories of leadership, work in this tradition sought to determine which leadership style the recurring pattern of behaviors exhibited by leader worked best. If the preferred style could be identified, the implications were straightforward and practical: train leaders to become skilled at using the ideal style to best advantage.

Most research in the leader behavior tradition focused on two dimensions of leadership style: 1) concern for the task to be accomplished and 2) concern for the people doing the work. But regardless of the terminology, the behaviors characteristic of each dimension are quite clear. A leader high in concern for task plans and defines work to be done, assigns task responsibilities, sets clear work standards, urges task completion, and monitors performance results (63). By contrast, a leader high in concern for people acts warm and supportive toward followers, maintains good social relations with them, respects their feeling, is sensitive to their needs, and shows trust in them (64).

The results of leader behavior research at first suggested that followers of people-oriented leaders would be more productive and satisfy than those working for more task-oriented leaders (65). Later results, however, suggested that truly effective leaders were high in both concern for people and concern for task. Figure 2 describes one of the popular versions of this conclusion the Leadership Grid of Robert Blake and Jane Mouton (66). This grid is designed too assess to first

determine where someone falls with respect to people and task concerns. Then a training program is designed to help shift the person’s style in the preferred direction of becoming strong on both dimensions. Blake and Mouton called this preferred style team management. This leader shares decisions with subordinates, encourages participation, and supports the teamwork needed for high levels of task accomplishment. In today’s terminology, this could also be a manager who “empowers” others.

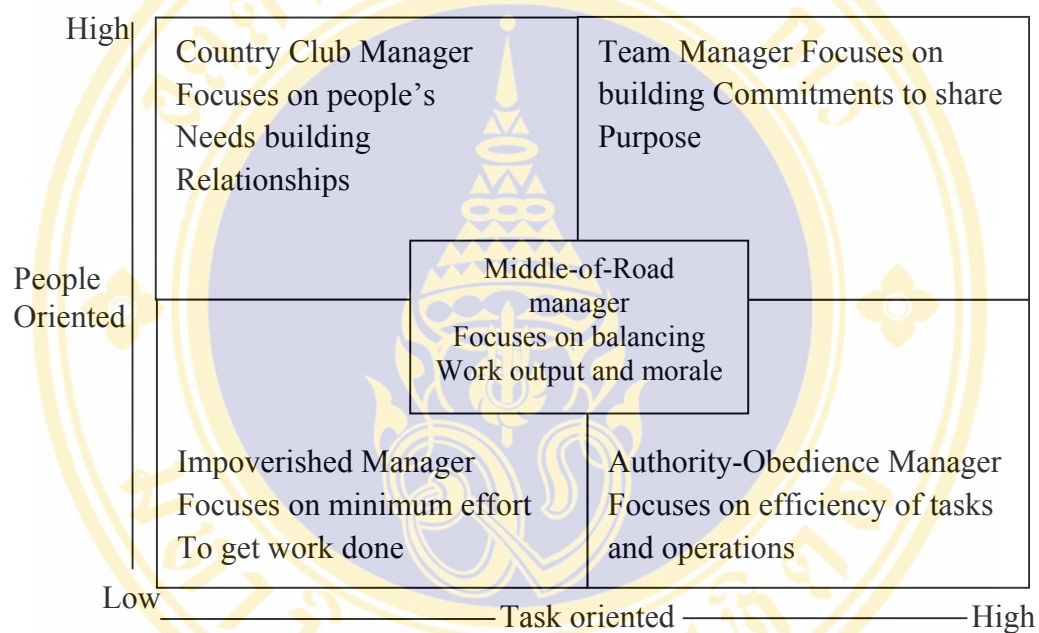


Figure 2 Managerial styles in Black & Mouton’s Leadership Grid.

Source: Applied from Blake and Mouton Grid Approaches for Managerial Leadership in Nursirg, 1981: 11.

Leader’s low concern for both people and tasks turn most decisions over to the work group and show little interest in the work process or its results. Leaders with high concern for the task and low concern for people make most of the decisions for the work group, give directions, and expect their orders to be followed. Leaders with high concern for people and low concern for tasks are warm in interpersonal relationships, avoid conflicts, and seek harmony in decision making. Middle of the road management is noncommittal in emphasizing both task and people

concerns. This leader puts forth-minimum required effort in balancing the task and people needs of the group to maintain adequate but not exemplary performance.

Contingency Theories

As leadership research continued to develop, scholars recognized the need to probe still further beyond leader behaviors alone and examine them in relationship to situational attributes. This is the essence of the following contingency approaches, which share the goal of understanding the conditions for leadership success in widely varying situations (67).

Fiedler's Contingency Model

An early contingency model developed by Fred Fiedler (67) was based on the premise that good leadership depends on a match between leadership style and situational demands. Fiedler believes that leadership style is part of one's personality; therefore, it is relatively enduring and difficult to change. He suggests that the key to leadership success is putting the existing styles to work in situations for which they are the best "fit." This is true contingency leadership thinking with the goal of successfully matching one's style with situational demands.

In Fiedler's theory (68); the amount of control a situation allows the leader is a critical issue in determining the correct style-situation fit. Three contingency variables are used to diagnose situational control. The quality of leader-member relations (good or poor) measures the degree to which the group supports the leader. The degree of task structure (high or low) measures the extent to which task goals, procedures, and guidelines are clearly spelled out. The amount of position power (strong or weak) measures the degree to which the position gives the leader power to reward and punish subordinates. Neither the task-oriented nor the relationship-oriented leadership style is effective all the time. Fiedler believes that leadership success depends on a good leader situation match.

Hersey-Blanchard Situational Leadership Model

The Hersey-Blanchard (69) situational leadership model suggests that successful leaders adjust their style depending on the maturity of

followers indicated by their readiness to perform in a given situation. “Readiness,” in this sense, is based on how able and willing or confident followers are to perform required tasks. The possible leadership styles that result from different combinations of task-oriented and relationship-oriented behaviors are as follows: delegating, participating, selling and telling. The delegating style works best in high-readiness situations of able and willing or confident followers; the telling style works best at the other extreme of low readiness, where followers are unable and unwilling or insecure. The participating style is recommended for low-to-moderate readiness and the selling style for moderate-to-high readiness. Hersey and Blanchard further believe that leadership styles should be adjusted as followers change over time.

House’s Path-Goal Leadership Theory

A third contingency leadership approach is the path-goal theory advanced by Robert House (70). This theory suggests that an effective leader is one who clarifies paths through which followers can achieve both task-related and personal goals. House identifies four leadership styles that may be used in this “path-goal” sense: directive leadership, supportive leadership, achievement and participative leadership.

Path-goal theory has also contributed to the recognition of what some theorists call substitutes for leadership. These are aspects of the work setting and the people involved that can reduce the need for a leader’s personal involvement. In effect, they make leadership from the “outside” unnecessary because leadership is already built into the situation.

Vroom-Jago Leader-Participation Model

The Vroom-Jago (71) leader-participation model is designed to help a leader choose the method of decision making that best fits the nature of the problem being faced. In this approach, an effective leader is someone able to consistently choose and implement from the following alternatives the most appropriate decision methods.

An authority decision is one made by the leader and then communicated to the group. Participation is minimized. No input is asked of group

members other than to provide specific information on request. The leader makes a consultative decision after asking group members for information, advice, or opinions. In a group decision, all members participate in making a decision and work together to achieve a consensus regarding the preferred course of action. This approach to decision making is a form of empowerment, and it is successful to the extent that each member is ultimately able to accept the logic and feasibility of the final group decision.

The Vroom-Jago model (71) is universally superior to any others considers no one-decision method. Rather, leadership success results when the decision method used correctly matches the characteristics of the problem to be solved. Each of the decision methods is appropriate in certain situations, and each has its advantages and disadvantages. The key rules guiding the choice relate to: 1) decision quality based on the location of information needed for problem solving and, 2) decision acceptance based on the importance of subordinate acceptance to eventual solution implementation. You may think of these in the context of an equation: Decision Effectiveness = Decision Quality * Decision Acceptance.

Current trends in leadership thinking seek to integrate and expand the insights discussed so far. This is the era of “super-leaders” who, through vision and strength of personality, have a truly inspirational impact on others. Their leadership efforts result in followers not only meeting performance expectations but performing above and beyond them. These are charismatic leaders who develop special leader-follower relationships and inspire others in extraordinary ways. The presence of charismatic leadership is reflected in followers who are enthusiastic about the leader and his or her ideas, who work very hard to support them, who remain loyal and devoted, and who seek superior performance accomplishments.

Transformational Leadership Theories

The term transformational leadership describes someone who is truly inspirational as a leader and who arouse others to seek extraordinary performance accomplishments. A transformational leader uses charisma and related qualities to raise aspirations and shift people and organizational systems into new high-performance patterns. Scholars differentiate this from transactional leadership,

which describes someone who is more methodical in keeping others focused on progress toward goal accomplishment (72).

Importantly, these are not mutually exclusive leadership approaches. Transactional leadership is a foundation or building blocks that help support transformational leadership. On its own, however, transactional leadership is acknowledged to be insufficient to meet the leadership challenges and demands of today's dynamic work environments. In settings where continuous and often large-scale change is often a high priority, the additional inspirational impact of transformational leadership is essential to achieve sustainable high-performance results (73).

The notion of transformational leadership offers a distinct management challenge, with important personal development implications. It is not enough to possess leadership traits, know the leadership behaviors, and understand leadership contingencies to act effectively from a transactional perspective. Any manager must also be prepared to lead in an inspirational way and with a compelling personality. The transformational leader provides a strong aura of vision and contagious enthusiasm that substantially raises the confidence, aspirations, and a commitment of followers to meet high-performance demands (74). The special qualities that are often characteristic of such transformational leader include the following:

Vision: having ideas and a clear sense of direction; communicating them to others; developing excitement about accomplishing shared “dreams.”

Charisma: arousing others' enthusiasm, faith, loyalty, prides, and trust in themselves through the power of personal reference and appeals to emotion.

Symbolism: identifying “heroes,” offering special rewards, and holding spontaneous and planned ceremonies to celebrate excellence and high achievement.

Empowerment: helping others develop, removing performance obstacles, sharing responsibilities, and delegating truly challenging work.

Intellectual stimulation: gaining the involvement of others by creating awareness of problems and stirring their imagination to create high-quality solutions.

Integrity – being honest and credible, acting consistently out of personal conviction, and following through commitments.

Emotional Intelligence

An area of leadership development that is currently very popular is emotional intelligence (EI) as an element of the essential human skill of managers. As popularized by the work of Daniel Goleman (75). EI is defined as the ability to manage us and our relationship effectively. Goleman breaks emotional intelligence down into five critical components. 1) The critical components of EI are the following. Self-awareness is an ability to understand our own moods and emotions, and understand their impact on our work and on others. 2) Self-regulation is the ability to think before we act, and to control otherwise disruptive impulses. 3) Motivation is the ability to work hard with persistence. 4) Empathy is the ability to understand the emotions of others, and to use this understanding to better relate to them. 5) Social skill is the ability to establish rapport with others, and to build good relationships and networks.

Gender and Leadership

The evidence clearly supports that both women and men can be effective leaders however; they may tend toward somewhat different styles. Victor Vroom and his colleagues have investigated gender differences in respect to the leader-participation model discussed earlier. Women may tend toward a style sometimes referred to as interactive leadership. This style focuses on the building of consensus and good interpersonal relations through communication and involvement. Leaders of this style display behaviors typically considered democratic and participative such as showing respect for others, caring for others, and sharing power and information with others. This interactive style also has qualities in common with the transformational leadership just discussed. Men, by contrast, may tend toward more

of a transactional approach to leadership relying more on directive and assertive behaviors, and using authority in a traditional “command and control” sense (67,73).

Drucker’s Old-Fashioned Leadership

Peter Drucker (76) offers another very pragmatic approach to leadership in the new workplace. It is based on what he refers to as a “good old-fashioned” view of the plain hard work it takes to be a successful leader. Drucker’s observations on leadership offer a useful complement to the transformational leadership ideas just discussed. He identifies the following three essentials of leadership. 1) The foundation of effective leadership is defining and establishing a sense of mission. 2) He believes in accepting leadership as a responsibility rather than a rank. 3) The importance of earning and keeping the trust of others. The key here is the leader’s personal integrity. The followers of good leaders trust them. This means that they believe the leader means what he or she says and that his or her actions will be consistent with what is said.

Ethical Aspects of Leadership

Firmly embedded in the concept of transformational leadership and good old-fashioned leadership is integrity the leader’s honesty, credibility, and consistency in putting values into action. Leaders have an undeniable responsibility to set high ethical standards to guide the behavior of followers. For managers, the ethical aspects of leadership are important and everyday concern (72, 73, 75). Concerned about what he perceives as a lack of momentum in organizational life. Leaders, according to Gardner (77), have a moral obligation to supply the necessary spark to awaken the potential of each individual to urge each person to take the initiative in performing leader like acts. It is the leader’s job to remove obstacles to our effective functioning to help individuals see and pursue shared purposes.

Gardner’s premise is that people with a sense of ownership of their jobs will naturally out perform those who feel they are outsiders. Moral leaders instill ownership by truly respecting others and helping them to do their best. By doing so they build organizations that consistently perform to society’s expectations.

Moral leadership, therefore, must be clearly and strongly anchored in a true commitment to people.

In the 21st century, the days of incremental improvement as the definitive improvement process are over. The capacity of leaders to generate new breakthroughs in organizational performance, technical excellence, and human and social capitalization is a requirement in today's marketplace. These breakthroughs in knowledge and performance occur most often in the context of community; learning communities that seek to leverage the unique capabilities and talents of all members. By fostering inclusion, diversity and shared-learning, the new leader can develop an organizational capacity for performance at all levels that is not easily matched by competitor organizations.

For this study leadership is individual process of working together with other through appropriate ways to attain the target effectively and persuasive manners to allow them to act with willingness, the process that use for acceptance by family and community with valuable and participatory involvement for health promotion programs and mutual benefits in the group and in network.

2.6.4 Motivation Concept

There are many factors to play the role for encouraging human to make decision and do or don't action. It is not only knowledge and ability to stimulate people for trying to achieve the goal but also their feeling (78). That is known as motivation. There are many motivation theories, which reveal the relationship among the need and variety factors. Those motivation theories can be grouped into 3 categories 1) Content theories, 2) Process Theories and 3) Reinforcement theory (79)

Content Theories of Motivation

Most discussions of motivation begin with the concept of individual needs the unfulfilled physiological or psychological desires of an individual. Content theories of motivation use individual needs to explain the behaviors and attitudes of people at work. The basic logic is straightforward. People have needs; these needs result in behaviors to satisfy them by obtaining extrinsic and intrinsic rewards. Although each of the following theories discusses a slightly

different set of needs, all agree that needs cause tensions that influence attitudes and behavior. Good managers and leaders establish conditions in which people are able to satisfy important needs through their work. They also take action to eliminate work obstacles that interfere with the satisfaction of important needs. The theories, which give more understanding, are as follow.

Hierarchy of Needs Theory

The theory of human needs developed by Abraham Maslow. According to his hierarchy of human needs, lower-order needs include physiological, safety, and social concerns, and higher-order needs include esteem and self-actualization concerns. Whereas lower-order needs are desires for social and physical well-being, the higher-order needs represent a person's desires for psychological development and growth. (80).

The two principles to describe how these needs affect human behavior are the deficit principle states that a satisfied need is not a motivator of behavior. 1) People are expected to act in ways that satisfy deprived needs that is, needs for which a "deficit" exists. The progression principle states that 2) a need at one level does not become activated until the next lower-level need is already satisfied. People are expected to advance step by step up the hierarchy in their search for need satisfactions. At the level of self-actualization, the more these needs are satisfied, the stronger they are supposed to grow. According to Maslow, a person should continue to be motivated by opportunities for self-fulfillment as long as the other needs remain satisfied.

Although research has not verified the strict deficit and progression principles just presented, Maslow's ideas are very helpful for understanding the needs of people at work and for determining what can be done to satisfy them. His theory advises managers to recognize that deprived needs may negatively influence attitudes and behaviors. By the same token, providing opportunities for need satisfaction may have positive motivational consequences.

Existence Relatedness and Growth (ERG Theory)

This theory developed by Clayton Alderfer (81). This theory collapses Maslow's five needs categories into three. Existence needs are desires for physiological and material well-being. Relatedness needs are desires for satisfying interpersonal relationships. Growth needs are desires for continued psychological growth and development. Alderfer's ERG theory does not assume that lower-level needs must be satisfied before higher-level needs become activated. According to ERG theory, any or all of these three types of needs can influence individual behavior at a given time. ERG theory thus contains a unique frustration-regression principle, according to which an already satisfied lower-level need can become reactivated and influence behavior when a higher-level need cannot be satisfied. Alderfer's approach offers an additional means for understanding human needs and their influence on people at work.

Two-Factor Theory

Frederick Herzberg developed the Two-Factor theory (82) from a pattern identified in the responses of almost 4,000 people to questions about their work. When questioned about what "turned them on," they tended to identify things relating to the nature of the job itself. Herzberg calls these satisfier factors. When questioned about what "turned them off," they tended to identify things relating more to the work setting. Herzberg calls these hygiene factors.

The two-factor theory associates hygiene factors, or sources of job dissatisfaction, with aspects of job context. That is, "dissatisfies" are considered more likely to be a part of the work setting than of the nature of the work itself. The hygiene factors include such things as working conditions, interpersonal relations, organizational policies and administration, technical quality of supervision, and base wage or salary.

To really improve motivation, the theory strengthens to the satisfier factors. As part of job content, the satisfier factors deal with what people actually do in their work. By making improvements in what people are asked to do in their jobs. Herzberg suggests that job satisfaction and performance can be raised. Satisfier factors include such things as a sense of achievement, feelings of

recognition, a sense of responsibility, the opportunity for advancement, and feelings of personal growth.

Acquired Needs Theory

In the late 1940s, David McClelland (83) and his colleagues identified three needs that are central to motivation. Need for Achievement is the desire to do something better or more efficiently, to solve problems, or to master complex tasks. Need for Power is the desire to control other people, to influence their behavior, or to be responsible for them. Need for Affiliation is the desire to establish and maintain friendly and warm relations with other people.

Process Theories of Motivation

The process theories, add to this understanding. The equity, expectancy, and goal-setting theories each offer advice and insight on how people actually make choices to work hard or not, based on their individual preferences, the available rewards, and possible work outcomes (78).

Equity Theory

The equity theory of motivation is best known through the work of Stacy Adams. (78) It is based on the logic of social comparisons and the notion that perceived inequity is a motivating state. That is, when people believe that they have been unfairly treated in comparison to others, they will be motivated to eliminate the discomfort and restore a perceived sense of equity to the situation.

Expectancy Theory

The expectancy theory of motivation which suggests that people will do what they can do when they want to do it (71,84). More specifically, The motivation to work depends on the relationships between the three expectancy factors, depicted and described here: 1) Expectancy or effect-performance expectancy: a person's belief that working hard will result in a desired level of task performance being achieved. 2) Instrumentality or performance-outcome expectancy: a person's belief that successful performance will be followed by rewards and other

potential outcomes and 3) Valence the value a person assigns to the possible rewards and other work-related outcomes. Thus, Expectancy theory implications include being willing to work with each individual to maximize expectancies, instrumentalities, and valences in ways that support organizational objectives.

Goal – Setting Theory

Goal-Setting Theory another process theory, as described by Edwin Locke (85). Focus on the motivational properties of task goals. The task goals can be highly motivating if they are properly set and well managed (86). Goal setting can enhance individual work performance and job satisfaction because goals provide direction, performance explanation, from of reference for tasks feedback and foundation for behavioral self-management.

Reinforcement Theory of Motivation

Reinforcement's theory views human behavior as determined by its environmental consequences. It focuses on the external environment and the consequences it holds for the individual. The basic premises of the theory are based on what Thorndike (87) called the law of effect: Behavior that results in a pleasant outcome is likely to be repeated; behavior that results in an unpleasant outcome is not likely to be repeated. (88).

Four strategies of reinforcement are used in operant conditioning. 1) Positive reinforcement strengthens the frequency of desirable behavior by making a pleasant consequence contingent on its occurrence. 2) Negative reinforcement increases the frequency of desirable behavior by making the avoidance of an unpleasant consequence contingent on its occurrence. 3) Punishment decreases the frequency of an undesirable behavior by making an unpleasant consequence contingent on its occurrence. 4) Extinction eliminates an undesirable behavior by making the removal of a pleasant consequence contingent on its occurrence.

From those theory concepts can conclude that incentive is the factor to motivate the person using knowledge and competency for showing leadership and skill to attain the aim of himself and group firmly.

For this research, motivating factors of Herzberg will be used as a guideline to create incentives for family health leader, which those factors will be a job contents creating more intention affection to change and to work more effectively.

Motivating factors consist of:

1. Recognition: There is recognized from family member, friend and group as a knowledgeable man. This recognition may imply in form of hearing, admiration, and cheer up, trusteeship or other expression to accept in competency.

2. Work Itself: That is the interesting work requiring initiative thinking to challenge to work or the uncomplexity work, which can be done from the beginning stage to the end, and the work enhancing knowledge and competency at the same time.

3. Responsibility: It is generated from new job assignment which creates the satisfaction. The community health promotion activities are the new thing for health leader and having authority to take full responsibility by no checking or close up control.

4. Achievement: It means the person can finish his job and getting success. The ability shows for solving problem and protecting any problem until the job success satisfied him on that job.

5. Advancement: That is a chance to study for earning more knowledge or training; meeting more participating included the ability to apply gaining knowledge for others work aspects.

It can say that family health leader motivation means motivating factors consisted of recognition in the status of family health leader, interested activities, responsibility receiving from trusted group, job achievement, and progress on his assigned duty motivated him to use his knowledge, competency, leadership and participating in community health promotion.

Part 3 Concept of Health Promotion

Very few causes engender more universal interest and appeal than the issue of health. The concern for the health of individuals transcends the boundaries of race, religion, culture, and national origin. Over the past decade, there has been an increased focus in the international community on the importance of maintaining or improving one's health status through the practice of health-enhancing activities. The rising popularity of the promotion of wellness and healthy lifestyles has been spurred by the participation of institutions from many different fields. Academic institutions, government authorities, private corporations, insurance companies, hospitals, medical groups, community groups as well as other significant individuals in health promotion have joined the universal effort to improve the quality of life. These developments have generated a global desire for intense networking and international collaboration in the area of health promotion.

3.1 Definition of Health Promotion

It is essential to examine what the terms "health" and "promotion" literally mean. Health has been defined in many different ways over history. The ancient Greek physicians believed health to be a condition of perfect body equilibrium. For the New World Indians being healthy was considered as being in harmony with nature. The ancient Chinese believed that health was a reflection of a vital body force called "Qi" (89). In contrast, Western medicine attempted to understand the construct of health by analyzing its single components rather than the interconnection of the various parts. The Western approach has been advocated throughout the world for years which led the medical field to primarily focus on disease and disability. Only recently has this medical outlook begun to gradually change towards a more holistic view. As far back as 1946, the World Health Organization (90) introduced a positive dimension of health to its definition: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Dubos (91) took a similar perspective: Health is a quality of life involving social, emotional, mental, spiritual and biological fitness on the part of

the individual, which results from adaptations to the environment. These definitions refer to health as a state of well-being. From this understanding the now common term "wellness" originated.

Health promotion is the process of enabling individuals and communities to increase control of the determinants of health and thereby improve their health. It needs for change in both the ways and conditions of living in order to promote health. Health promotion a mediating strategy between people and their environments, combining personal is choice with social responsibility for health to create a healthier future (90). And gain a stage of optimal health which means balance meant of people change physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices (92).

Health promotion means the total of support from education, environment effecting to practice in daily life state leading to health condition which occurs in individual, community or group (93). The agreement from the Ottawa Convention in 1986 defined the health promotion as the process to empower the people for controlling and genuine self health improving (90).

For conclusion, health promotion means the process of people competency building in the promotion or various control factors affected to health and self health development for physical, mental and social completion living in health condition.

3.2 Community-Based Health Promotion

Health promotion leads to change in behavior permanently and to enhance the total state of living. Personal skill development is not confined only in the education and living skill because he has to live in community and society which is not staying in the same community but also linking in culture and common goal and responsibility. Behavior of some people influences to others so needed to expose together on community health promotion leading to sustainable development in

healthy behavior through common controlling measures issued by community and society.

Community health promotion means the agent plans and identifies the activities of health promotion for people based on the problem and needs of community (94) such as the process, which is involved by health promotion personal who act as change agents better working together with the people to plan, to implement and to evaluation. It's a tactic on health education implemented continuously through the suitable system for personal behavior changes based on motivated support from community agency (94,95,96). Other implication shows the meaning of community health promotion as the supportive process to various groups in the community to be able analyzing on health problem for the whole pictures systematically leading to decision making on any problem solving according to community capability. The social, educational and political activities can help to motivate the public awareness on health in both individual and group empowering people to concern right and responsibility in arranging community environment to serve a better health and living condition (97, 98).

Considering those meaning found that community health promotion needs the cooperation between people and government which is the concept of ministry of public health attempting to push into practicing it's a proactive work for health promotion emphasized in enhancing self-care and involvement in health system management. Balancing on government and private role on health care has been changed.

Anyway, equilibrium changes have to consider between self help and service dependence regarding to the role and duty of health personal and people which is identified by Ottawa convention emphasized on the role of health personal in health promotion and protection of individual, family, and community as follows: (90).

1. Enabling people in self-care and environmental health management through the emphasis of competency development, health information searching, decision making on health problem solving and standing on various situation.

2. Acting as a mediate among interested group for the health purpose by suggesting, advocating to people in health and right on health.

The other side of the promotion and health protection process, people have to strictly involve the success can be met thus; people should have the sole on these (91).

1. Self-care by people must stand on awareness, good health reliance and concerning on various factors effect to health of individual, family and community searching for reliable knowledge and to be able selecting the information for helping in decision making dealing self-care and family member taker care. The right in health has been included together with skill development and risky behavior avoiding.

2. Family health care is the responsibility of all family members helping to create warm lovely climate, which is the basement of healthy condition.

3. Community health care based on the concern of people on environmental health. People have to join in preservation and maintenance of environment (physical, biological and social) and to build environmental conditions for serving a health promotion.

For conclusion, community health care means the process of motivation and works of family health leader together with community members in health activities promotion and possible condition in healthy living condition. The community members will involve in every procedure of health promotion.

Part 4 Concept of sustainable health promotion

Sustainable health promotion is the main target of health development (100). Community health promotion can be succeeded depending on cooperation from individual, family and community level through the using of local resource under participating of all concerned agency seriously. The successive measurement of sustainable health promotion in community must consider from community participation especially health promotion network which are many steps. The first step

will be shown under the condition of flexible small group building and expanding into network that is the key success factor to sustainable expansion.

Sustainability is the word to explain the continuity mentioned in Webster's dictionary. "Sustain" means "keep up prolong" which imply to the Subsistence or maintaining the existence without outside helping (101). In practice, there has been perceived the word "sustainability" as the project ability to maintain the centimeter of activities and to benefit to community even the outside support ended (102,103). And "sustainability" still means the capacity to carry on the successive pilot project gaiting acceptance and put into main mission of the group or organization which seem to be continuing development effected to enlarge it and sustainable acceptance when that project has been installed into the policy of the group or organization until it's become an organizational culture (97). Anyway, all sustainability needs highly community participation to built continuity (103) and networking establishment.

4.1 community participation concept

The concept of community participation in health development started up into practice when who announced the concept of primary health care as a main strategy in health development in the Alma Ata announcement 1978 (90) and alerted all member countries. It is an international motivation of community participation promotion (104). Its components are

1. The government views "people participation" will be a more effective strategy than others especially those countries with limited resources.
2. The trend to achieve more success of the project depending on the degree of participation of the people.
3. Community participation concept will correspond to equality and self reliance principles which form the development philosophy accepted by international agencies.

The definition of participation

There are many technocrats giving the word participation meaning in terms of resemblance and differences depend on the attitudes and backgrounds of those technocrats, which could be concluded as follows:

Participation means participating in the decision process of the activity development of implementation and evaluation (105).

The World Health Organization gives the meaning in 3 dimensions:

1. Participation is the voluntary collaboration.
2. Participation as the specific targeting of project benefits aim to cover neglected and groups lacking opportunity in the case of project beneficiaries.
3. Participation as empowerment that is highly recognized and disseminated in the present time.

From those meanings, participation has 2 aspects (106)

1. Participation as a means to assure the occurrence of collaboration in conducting an effective project.
2. Participation as an end which is the goal that in the empowerment of the people in terms of skill, knowledge and experience building for better responsibility guiding self development.

So, the participation means the spiritual and temperamental relationship of people in group situations affecting the motivation for the contribution of people to act for attaining the group objectives together with responsible feeling to the group (104).

“Community” means the group of people having a relationship, having continuous interaction, linking with living conditions, having common targets or interests and learning to be accepted as a member of community (104) that creates the community participation explanation as follows:

Community participation is the process to call for people to conduct development activities, thinking together, cooperate in decisions for solving the problem by themselves, creative thinking and knowledge and experience sharing

together with suitable technical knowledge and supporting the evaluation of organization and official concerns (107). It is also a social process for specific groups having a common requirement and living in the same geography willing a decision to set up the mechanism to succeed in those desires (108). Moreover, the community participation means the educational process and people empowerment in terms of partnership for any person who involves in helping to develop his community such as problem identification, motivating the people having mere responsibility in planning, managing, controlling and evaluating the needed activities which have been proved already (109).

In the present, community participation is the concept dealing with the decision process becoming a social ideal. It's a human right to transfer the authority from government to people who will bring benefit to people as in economically and socially disadvantaged groups for enthusiastic involvement in policy determination as well as taking action on implementation and evaluation of those projects.

Level of community participation

Rifkin (108) arranged community participation into 5 levels as follows:

Level 1: participating people receive benefit from the project.

Level 2: people participate in the activities of the project.

Level 3: people participate in managing and deciding.

Level 4: people participate in controlling and evaluating the activities.

Level 5: people participate in activities with planning concurring to the needs and desires of the community.

According to the American public health association, the 1983 concept on the level of participation is classified into 3 levels:

1. Decision - making level: in this level people have a chance to participate in planning and determining the self-development activities, which is the level of responsibility by themselves.

2. Cooperation: in this level, there are outside agencies playing a leading role in the community for calling people to devote themselves dealing with time, labor and sometimes in property to get the project successfully completed. Thus, participation in this level will be an acceptable level of participation.

3. Utilization: community accepts and takes advantages from services derived from the project.

Community participation model

The community participation model has been divided into 3 models (104).

1. Close participation: in this model, there is a parallel characteristic in work of the community with the counterpart in all topics and coaching at every step and sometimes leading to persuasion aimed at belief change or work acceptance by target group.

2. Cooperation/ collaboration model: this is an objective development attempt of community participation especially in local community. It regards the the previous health care belonging to the family community which takes care of each other by their existing local wisdom. The health development attempt in Thailand at the beginning stage is mainly based on the collaboration model shown in training, village health volunteer establishment, and village health communicator setting. Moreover, there is provided funding support such as drug funds, sanitation funds, and primary health care centers in the community. At the present time, there is a newly initiated activity that is named the family health leader. All of these come from the government directions that show participation in terms of collaboration.

3. Partnership model: this is a characteristic of equal treatment between community and counterparts not only government but also the private sector. It has the characteristics of equal respect, rights, practice that is based on the dignity of equal human beings with no division in social status.

In working with the community by using the partnership model one should consider the various community capabilities as follows:

1. Common ideas or common goal that is a motivation and the way to strengthen the capability of community to solve the problem.
2. Capabilities of the community to draw the participation of community members for generating health development projects.
3. Capabilities in management deal with the role and duty of community resource management in human, money and beneficial activities.
4. Capabilities to conduct fund raising from inner and outer resources leading to enhancing the self help capabilities.
5. Capabilities to bargain, which can play on making decisions to select and to bargain for bringing the highest benefit to the people of the community that will show off to the organization, funding agencies or any other supportive agencies. In working by partnership model, the leader has to have confidence in his capabilities on coordination, management, initiative thinking, be accepted by community members, show intuitive response to outside community situations and hearing and respecting other opinions.

In conclusion, community participation is the social process in a specific group having incentives and enthusiasm to join in the decision making process for determining target and resource allotment. It needs to take an action on the plan for meeting the target. Any activities have to be arranged in the community by participation models leading to sustainable development.

4.2 Concept of Networking

The participation of family health leaders in community health promotion affects continuous learning becoming sustainable development that is a new concept concentrating on humans as a center point of development equalized in objective and spiritual development by the attendance of people in the form of a variety of networks (110,111). That is the development, which is started from inner capabilities of different individuals joining in suitable management generating networks for cooperative work constantly. There are several meanings issued as follows:

A network is the initiative capability expression of individual to help the community members in attaining his and their goals with no expectation of reciprocation (112). Networks may be seen in the form of structure, which consists of individuals, groups or organization or agencies cooperating to work systematically by common objective to drive to common goals by a two-way relationship (113).

A network is the linkage by having similar goals (114). This network may occur from linkage of existing operation systems or linkage between the roles of individual, and various organizations under common objective of group members. Thus, networks imply links to many minor systems which is its own characteristic to be a new system or may imply that network is the work model which is generated from cooperation among concerned agencies through drawing all resources including manpower, intelligence, competency and working resource to cope up with obstacles and weaknesses of the work system. This idea corresponds to the present development concept which mentions area, function, participation (AFP) as a strategy for sustainable development. A network is the beginning stage to generate common goals of group members. Although concerned members will have different roles and duties if everybody perceives in the goal or common problem it is expected to show the role on their competencies and skill responding to network goals reflecting the real state which need not wait for direction from top levels (114, 115, 116).

A cooperation network is the process of collaboration for development or activities set from interested groups or agencies. A cooperation network brings about power to solve the problem both in local and society levels. This kind of cooperation will lead to movement and is widely expands; for example, the agriculturist network, aids network, and environment network.

The network meaning implies the following characteristics: 1) having a group of organizations or persons more than 2 joining to attain the common objective. 2) Having interaction among each other. 3) Cooperation process arranging to implement the common objective and goal attaining the success.

Those network characteristics empower the organization. Instead of doing and thinking alone, networks can help to initiate the collaborative activities according to their interest and to exchange information, experience and to build

experts in their work, pulling resources, cooperative organization structure, processing under cooperation, ordering movement for more powerful actions, exchanging ideas, information access opportunity, and processing of development participation. This development process is needed in the present and future time because the collective group leads to participation doing benefit (115). By this concept, ordinary people will come to exchange their own problems and to share learning under their own context (117). The successful people have to have self reliance or independence which will be a model of people serving others who are facing the same problem, getting to solve the problem, earning experience to control themselves become a unity of good health. In this concept we will see ordinary people not facing the problem alone but sharing with others. The result of exchange affects people to use their own capabilities to solve the problem and prevent it by themselves among the facing situation. The self-help system is a way to provide a chance for group members to interact in thinking and skill-building among each other affecting the confidence level to drive the group relation to have more strength and motivation to do the collaborative activities especially for complex activities that can't be done alone or the activities which require social support such as community health promotion.

Network development needs a communication process to enhance communication related to the structure of networks in individuals with individuals and individuals with groups or organizations and groups with groups or organizations (118). Communication, which includes coordination, will be in both horizontal and vertical channels increasing efficiency and widening exchanges. In addition, due to globalization, network models in the society have high complexity regarding the use of many model integrated to appear as a complex network as follow.

Communication Networks

The channels by which information flows are critical once we move beyond groups of two or three individuals. The way a group structures itself will determine the ease and availability with which members can transmit information.

Most studies of communication networks have taken place in groups created in a laboratory setting. As a result, the research conclusions tend to be

constrained by the artificial setting and limited to small groups. Five common networks are shown in Figure 10-4: these are the chain, all-channel, wheel, “Y” and circle. For our discussion purposes, let us think in an organizational context, and assume that the organization has only five members. We can then translate the networks in following Figure into their organizational equivalent (119).

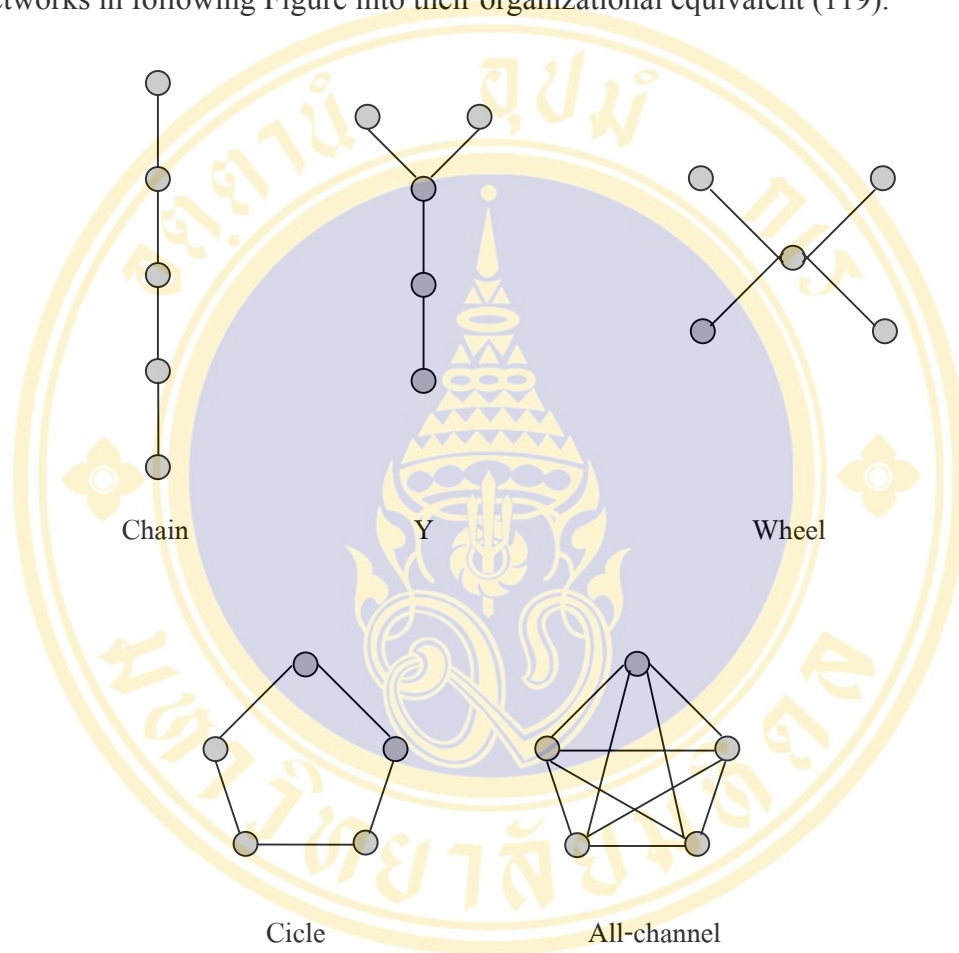


Figure 3 The five Common networks

Source: Robbins; JC. Organization Behavior in Private; 1983.

The chain would represent a five-level hierarchy where communications cannot move laterally, only upward and downward. In a formal organization, this type of network would be found in direct-line authority relations with no deviations. For example, the payroll clerk reports to the payroll supervisor, who in turn reports to the general accounting manager, who reports to the plant

controller, who reports to the plant manager. These five individuals would represent a chain network.

If we turn the “Y” network upside down, we can see two subordinates reporting to a supervisor, with two levels of hierarchy still above the supervisor. This is, in effect, a four-level hierarchy. If we look at the wheel diagram as if we were standing above the network, it becomes obvious that the wheel represents a supervisor with four subordinates. However, there is no interaction between the subordinates. All communications are channeled through the supervisor.

The circle network allows members to interact with adjoining members, but no further. It would represent a three-level hierarchy in which there is communication between superiors and subordinates, and cross communication at the lowest level.

Finally, the all-channel network allows each of the subjects to communicate freely with the other four. Of the network discussed, it is the least structured. While it is like the circle, in some respects, the all-channel network has no central position. However, there are no restrictions; all members are equal. A committee best illustrates this network, where no one member either formally or informally assumes a dominant or take – charge position. All members are free to share their viewpoints.

Certain communication networks foster speed of decision-making. Some are more effective in ensuring that directions are followed and for control purposes. Others have demonstrated success in maintaining high levels of morale. No single network will be best for all group efforts; rather, the network used should reflect the goals of the group.

Laboratory experiments have found that the circle is considerably slower than either the chain or the wheel for transmitting information among all members, and that the circle rates poorest in accuracy of communication flows, As a result, the wheel and chain are rated as the most effective in terms of high job performance. However, morale is significantly higher in the circle, and, for complex problems, the circle and all-channel networks are faster and more effective. The “Y” shares advantages and disadvantages of the wheel and chain. It is fast, generated high performance, but with lower satisfaction.

From this complex network, there are many networks connected and communicating between central areas of each organization and all members of the network when they want to develop will cooperate and promote to create a joint organization to act as a coordinator for all networks or the place where members can be accessible to operation.

Network establishment can be done in many ways, which can be classified in 3 types (7).

Type 1: natural network, this network normally occurs from people who have the same thinking, working style and problem coming to join together for exchanging idea, experiences and seeking a better way to survive among their members. It is generated from inside the group and this kind of network usually happens in the community, which has a similar culture and has previously joined as a group or club. It will form a network by passing through the increasing number of members, area of work or target expansion. The developments of this network will be made stronger depending on time, area coverage and ability to respond to the needs of members.

Type 2: established network, an established network comes from the policy or the activities of the government sector. It is needed to motivate and push through the mechanisms of government affecting progress and the number of members is not generated from basic needs, thinking, or a common understanding of people. This type of network has temporary characteristics, specific jobs, and lacks continuity. It will eventually disappear except that its beginning development is through good advice until people gain realization and set routines into practice to develop it as a network. Nevertheless, if the group can maintain its network, downsizing still remains compared to the beginning network establishment.

Type 3: evolutionary network, evolutionary networks originate from a development process started by people joining with wide objectives, supporting each other, learning together. This is not a naturally innate network and with direct establishment. There are no specific objectives or goals motivated by outside agencies through hearing, facing to another network and then starting to think in combination, and treaty forming into networks for promoting self development. Although this kind of network does not originated directly from inner motivation at

the beginning stage if members have strong attention, good attitude, appropriate motivation, clear goal arrangement and serve the needs of members it is expected to continue the process of development until it will be strong enough like a natural network as well.

The structure of the organization of a network will show the communication process and decision making of network members which could be classified as follows (120).

1. The communication process must have continuity exchange promotion on information, technique, experience, continuous development and implementation progressing to a conclusion informed to members and networks.
2. The needs of network members, idea exchange, point of views on the activity targets including the decision making process on cooperation in goal and objective setting for all members adapting into practice resulting continuous cooperation.
3. A cooperative organization with effective structure network responding to cooperation and reducing conflict as well as building equal participation.
4. Giving the importance to role promotion and decision-making in the implementation stage of members for new initiation.
5. Roles of network and members are published for pooling cooperation and awareness in working of members and people including continuous expansion culminating in sustainable development.

Community health promotion is a continuous process. It requires a longer time to show the effect clearly such as mortality rate, morbidity rate, disability reduction rate, quality of life of people, and good environment. If there is no activity generalizing from experiences learning, the community health promotion process can be achieved in a short period and in some specific areas then the expansion for sustaining of community health promotion is needed.

The expansion is the most important part of the development process of a pilot project brought to its conclusion on concepts, process and

recommendations from those projects to implement in the same or other areas (Jumroon Mekhanon, 1990). From the implementers' experience transfer of interested people make people, groups, or organizations to participate and to increase the number of members leading to expand the size of the group and coverage of responsibility (121). The result expansion includes the applied main concept of pilot projects to other concerned concepts.

The result of an expansion that has been done at any dimension will be connected to each network expanding further such as the pilot project starting with the skill development project to community leaders in water pollution prevention and later expanding to the concept of fire prevention for water source forest and then expanding to an ecology group emphasizing ecology preservation and food chain of water source forest passing through the community education system (122).

The achievement of various projects after implementation to the due date is not only a means of measuring all activities, spending the budget, and using resource in time but it has to concern about the following results in the long periods including the sustainability of such result.

Concepts of sustainability can be explained with people's participation concept, group joining, and network establishment regarding all concepts supporting reciprocal exchange that is the result of expansion for sustainability brought to the group setting and network linkage to generate continuous activities for attaining the target and objectives. In other words it can be stated that strong groups and networks arrange a variety of activities continuously stimulating connections to other groups and networks near-by brought to sustainable expansion.

Thus, it can be stated that the sustainable expansion means the community health promotion network joining to implement the activities of community health promotion continuously through the community resources and maintaining beneficial health promotion to encounter any health problems that might occur. The concept dissemination and modeling in health promotion to a person or interested group is needed to bring about this concept including the way of practice to implement in the community with the same context.

Part 5 Participatory Learning

In the building of the family health leader capabilities, the accepted process for efficient learning for adults is participatory learning (123,124). The learning process of villagers comes from the villager's capabilities on "intellectual" or "wisdom" accepted and respected according to their capabilities in analyzing, inventing, experimenting and forming conclusions from local wisdom integrating knowledge and outside technology introduced into the community, and if people access to data and appropriate method for better learning of people.

5.1 Definition of Participatory Learning

Participatory learning is a learning process to reproduce working in community in the form of joining learning experience between developers with the community for using participation in every procedure of public health problem solving in the community (125). This concept is concerned mainly with the importance of interaction between people owners of the community with developers from outside the community. This is similar to Barab (126) who gave the definition of participatory learning, which means the experience exchange with each other not only teacher and learner but also interaction in various levels of the learner group and learning concerning the learner to determine the context, process, environment and required output.

Educational philosophers have developed many adult learning models in the nonformal education system. This is a foundation, which can bring the learner capabilities to participate in various activities motivating the continuous intelligence synthesis process (121). It is believed that participatory learning is the most effective teaching-learning model in human development for knowledge, attitude and skill. This model passes the synthesis from many analyses of research on learning models creating the basic structure of participatory learning consisting of experience learning cycle integrating group process. In each element in the experiential learning cycle, every experiential learner uses his experience for highest benefit through opinion exchange, reproducing knowledge into practice passing through a group process. Regarding human limitations on power and differential intelligence and depending on

each other it is needed to work in group affecting the learning exchange with each other and helping to does the difficult work or work never done before with confidence that is particularly useful in the time limits set by training (128).

From those concept it could be concluded that participatory learning consist of 2 elements: Experiential learning and Group participation or group process

5.2 experiential learning concepts

Learning processes have been developed since the 18th century. The new model is called experiential learning in which Kolb (121) proposed that experience is the source of learning and development. The kolb model is the cycle of learning to earn knowledge, attitude and skill falling into 4 elements as follows:

- Concrete experience
- Reflective observation
- Abstract conceptualization
- Active experimentation

From those elements can make the diagram as below:

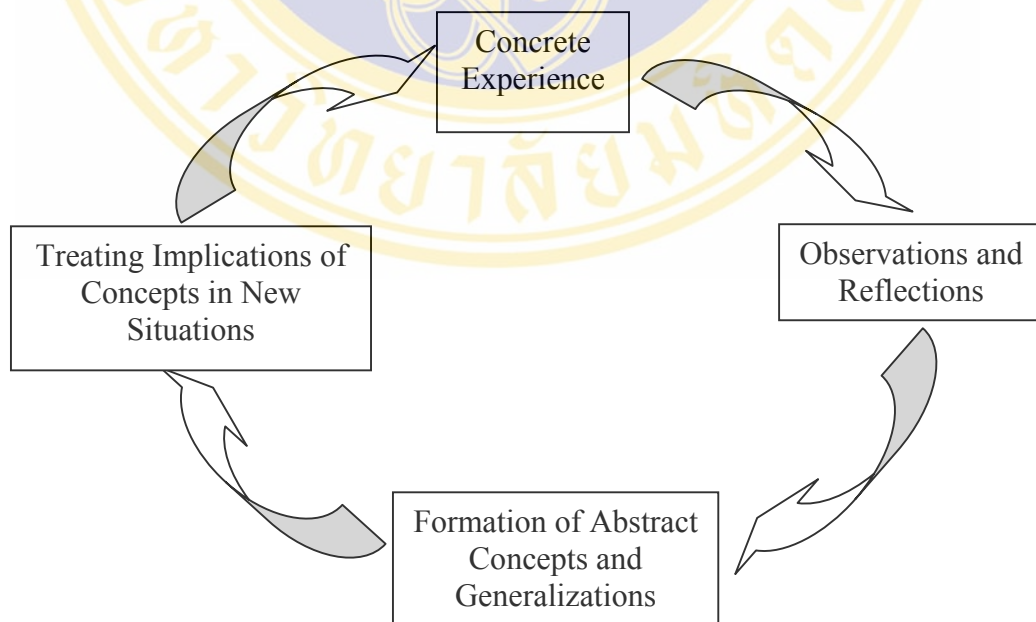


Figure 4 The cycle of experimental learning as proposed by Kolb’s Model

Source: Kolb, DA. Experimental Learning: Experience as the Source of Learning and Development, 1984: 29-31.

Experiential learning is generated from a learner who has a chance to think, review past experience appearing objectively to him or others with awareness to generate thinking or knowledge, and clear understanding.

Experiential learning gives a chance to learners to integrate feeling including temper, imagination, foresight, guesses and valuable evaluation with experiential learning emphasized in the concentrated participation of learners and analyzing the context from those experiences which can be explained by the process as shown below:

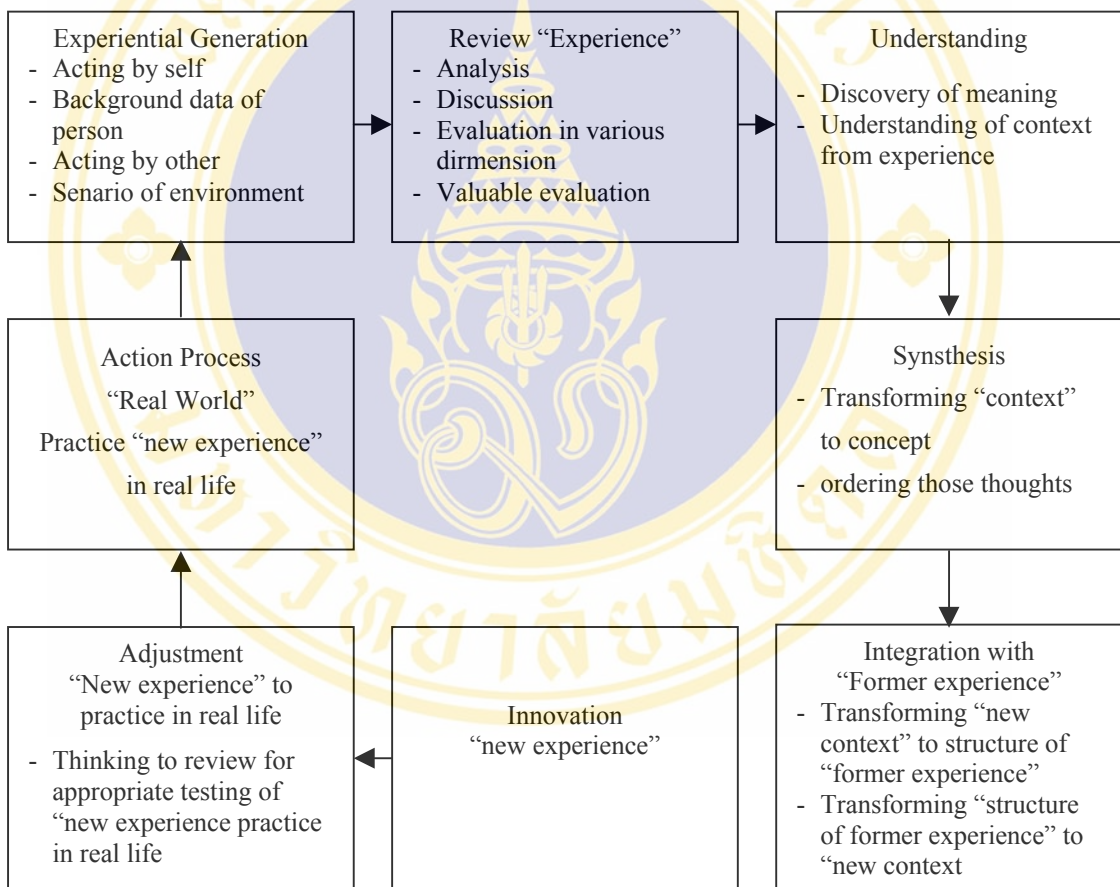


Figure 5 Process of Experiential Learning

Source: Process To Promote The Strengthening Of Community, Society, Theraphong Kaewhawong, Northeastern Regional Training Center for Primary Health Care Development, Khon Kaen, 2000.

Experiential learning will make active participation from target groups then in building experience to family health leaders depending on the provision of various experiential learning models that will be accepted in different degree according to their capabilities and interests. Experiential learning will be the foundation of the development in helping family health leaders to establish experience, knowledge, skill and learning exchange with each other leading to appropriate selected development in the practice of further daily life.

Participatory learning emphasizes a group learning process from joining to work the learner has to participate in the learning activities by himself brought to make fun, stimulation, and activation. Learning is generated from experience brought to high value for the learner. Participation in the activities of learning as a member of the group is more effective as a member of the group has a chance to implement, show his thinking, having feeling and express his emotion in his work brought to start a concept and to remember a context longer. Moreover, the group process pays attention on the free interaction of members attaining to meet the set target of the group (130). In addition, the group process will help group members developing in attitude, value and behavior because the group process involves the activities leading to real practice for analysis creating better understanding of himself and others. The member will accept his error and be ready to correct at helping member to have experience on democratic living, to take responsibility in his role, to take a rational problem solving, to have sympathy to others, and to work together with others (57, 129, 131, 132).

Technique to arrange participatory learning process

The participatory learning process is developed on the principal of adult learning arrangement and experiential learning process as mentioned earlier. The technique to arrange the learning process is divided into 2 types mainly:

1. Workshop based, which is the workshop arranged for target groups to participate in the development project beginning with building the acquaintance to relate leading to sustainable cooperation further. The learning facilitator will help to arrange activities and learning climate to exchange experience, knowledge, and interests of different members to consensus. Some of the most

popular techniques used in this type are appreciation influence control (AIC), future search conference (FSC), objectives oriented project planning (ZOPP) and team up etc.

2. Field based, which is the joining to understand community context under the condition of belief in community members who know best in the story of their community. This technique can help to motivate participation and local wisdom acceptance leading to working together well. Some of the main techniques of field based methods are rapid participatory appraisal (RPA), participatory rural appraisal (PRA), self-esteem, associative strength, resourcefulness, action plan and responsibility (SARAR), and field visit or technical cooperation among developing village (TCDV) etc.

This second type technique uses many methods to integrate for generating group learning together such as pictures, exchange in opinions, information, and intelligence of stakeholders to share learning; for example, art invention, desired community picture, mind mapping, problem map to link cause and effect for community analysis and to propose it by villager wisdom etc. It is used very often in humanity study (125).

In this study, participatory learning is the process providing to generate experiential learning together among family health leaders, village health volunteers and concerned people in the community through the participation in every procedure of learning for public health problem solving and health promotion in the community. The researcher will use various techniques to forge appropriate integration for the group and situation and to get the most effective participatory learning. For workshop-based methods, F.S.C. technique will be mainly used with other techniques involved and field-based methods employed will be RPA technique as a core mixed with other techniques. And for expanding the network to be sustainable, the researcher will use TCDV Technique.

Part 6 Related Studies

From reviewing any research concerns to capability development of family health leaders to sustain community health promotion, it was found that there are so many related studies but it is not completed in all elements of the capabilities of family health leaders. For some studies, which are similar, divide capability development of self-care and family care, health promotion and the achievement of the general view of family health leader project evaluation that could be concluded in each dimension as follows:

Capability Building Dimension

The study of capability development of family health leaders for aging health promotion, Yasothon Province (123) aimed at family health leaders having knowledge to promote aging health groups by using participatory learning process to motivate family health leaders to have a positive attitude and skill by using AIC and FSC. Techniques. The result of training found that knowledge in aging health promotion of family health leaders were better than before attending the training course. They can do problem analysis and search the appropriate ways to help aging groups by doing health promotion activities joining with aging groups such as Thi-Chi exercise, Pa Bun Mee stick dance and to demonstrate this exercise in the Red Cross Fair (RCF) in the year 2002, pouring water for paying respect to aging groups on Songkran Day, entertainment arranging, villager forums for transferring of experience, learning and exchanging their experience.

This study showed that capability building of family health leaders by participatory training together with suitable following support for increasing higher capabilities. It was similar to the study result of Somchai Jirarotwattana (133) on the study of empowering building tambon youth leader for social mobilization in prevention and solving the problem of aids in Bang Khla, Chachoengsao Province by using participatory training process thorough the principle of life skill building and aic technique for 3 days then follow up periodically for support. Later evaluation found

that tambon youth leaders had good attitude and awareness of aids prevention including higher skill in decision-making on sexual context.

Prathana Sooksun, (134) studied effectiveness of participatory learning programs about consumer protection in school. It was a program to enhance the knowledge on consumer protection and food intake selection, attitude in food intake, and behavior in food selection of students in primary school, Nakhon Nayok, Province with a sample size 64 persons divided into an experimental group of 32 and control group of 32. The experimental group had been provided the participatory learning program in consumer protection in school but the control group had not been provided the program. Both groups had been supported by the consumer protection project in health promoting school and provided learning on consumer protection from regular teaching in class levels 5 and 6. In this study, participatory learning program in consumer protection consisted of teaching 4 times and each time spending 3 hours including the context of consumer protection, food toxin, food labels and food selection. The study result showed that before experiment there was no differentiation of average score on knowledge, attitude, and behavior of food selection but after implementation the average score on the experimental group was higher than the control group on behavior of food selection.

It was noticed that the participatory learning program increased better knowledge, attitude and behavior similar to the way of life in health promotion that goes along with the study of on the application of participatory learning in controlling of aedes larva passing through family health leaders, Pak Kret Distriet, Nonthaburi Province (135). The objective was to study the effectiveness of participatory learning in controlling the aedes larva. The 77 family health leaders participating in this study provided the activities of experience exchange, lecture, discussion, brainstorming, demonstration and real practice, using media of slide, exhibition, poster and pamphlet. The study result showed that after experiment and follow up, the experiment group had higher knowledge on haemorrhagic fever and controlling of aedes larva, perception on risk and severity of haemorrhagic fever, perception on effective ways of controlling aedes larva and breeding places of the aedes mosquito compared to the

control group including the household indicators of aedes larva in family health leaders' houses decreased in number significantly.

The above study showed that participatory training process gives results in capability building. Additionally, it is found that up to the present time, the health leader training process development has been less emphasized. It mostly uses the old method that is transferring knowledge training by tambon health officers and some areas joining with village health volunteers (134) and some areas delivering to village health volunteers to set up their own training course in the house in the vicinity (136). The content will emphasize self-care, family health care when sick, and control and prevention of disease; for example, haemorrhagic fever, diarrhea and leptospirosis moreover, there was dissemination of self-care manuals and helping family members by the provincial public health office of Nongkhai, Phetchaburi, and ratchaburi as a document of training (137,138).

The studies showed that most of family health leader training still used the traditional method emphasizing knowledge in specific problem areas and no variety in terms of method to push into real practice and also concentrated in the content of self-care and family care when illness occurred as a first priority and prevention, promotion falling into second priority.

Health Promotion Dimension

Pelletier (139) reviewed about community health promotion from 1980 to 2001; there were 24 published studies evaluating the health and, in some cases, cost benefits of comprehensive health promotion and disease prevention programs in the community. All of them indicated positive health benefits and every study that examined cost benefits demonstrated a positive effect. Of the 23 studies conducted since 1991, all but one evidenced positive health outcomes and positive return. According to a prior report, the Singapore government's recent emphasis on healthy life style and health campaigns for public. The result indicates that people have more positive attitudes towards their living, express higher job satisfaction and are healthier (140).

Knowledge of Family Health Leader Dimension

Knowledge on self-care and family care when getting illness stay in the middle to high level (135, 141, 142), which is different from the study of Pannarai Pitakcharoen, (142) that showed knowledge in self-care of family health leaders needed to be improved. Moreover, knowledge in health promotion and disease prevention, first aid and basic treatment mostly needed to be improved also. Although most of the result of the studies of family health leaders have a good level of knowledge on health care, in practice still remains under target and needs to be improved (141, 142, 143).

Self-care and Health promotion Dimension

Most of the studies aim to study models of practice while becoming ill more than health promotion and disease prevention such as Pimpawan Penchan (144) whose study found that self-care and family members care of local people in the Northeastern region could be divided into 3 levels as follows

1. In the family level they will take care of each other according to rationality of family member's discussion.
2. In the cousin level they will follow the suggestion of elders such as father or mother-in-law usually using herbal medicine, traditional treatment.
3. In the community level it will be similar to cousin level regarding the relationship in the locals effecting good health care in the community.

This study is similarly with Nongpun Piriyanuphong (144) who found that fertile women in the village Southern region have self-care in maternal and child health in traditional perspective having cousins to closely take care of them in suggestion and making decisions for long following practice such as giving birth with a traditional doctor and after delivery warming which is different from Suwat Thienthong, (145). He mentioned in his finding in self-care of people in 9 provinces of central region, people pay more attention on western medical treatment preferring modern technology required over self-care.

From the above studies, it can be concluded that self-care of people is the part of the life style of Thai people relating to cousin association, which is a strength to promote better self-care. For the self-care model, when people get sick it is

needed to use either traditional and modern medical treatment or a mix for the result of recovery of people.

From the follow up of the activities of family health leader project in 25 provinces it was found that there are two provinces only which launched the training activity to family health leaders and evaluated it, Phetchabuti, Nakhon Nayok as shown in the result below:

The achievement evaluation of family health leader project in phetchaburi province (137) found that most of family health leaders have the activities on self-care and can be the best practice to family, and neighbor in health perspective. More than half of the sample used to give suggestion on health care in normal situations and in getting illness to family member and neighbor. The family health leaders have developed their own knowledge by talking to village health volunteers in health content and joining together for village development.

This evaluation showed that family health leaders who passed the training and received higher capabilities reflected on the success of the project while the result of evaluation of family health leaders of Nakhon Nayok (142) found that the objectives of project did not succeed regarding the achievement of family health leaders in self-care and family members care on basic practice for most illness treatment existing in the middle level and knowledge on health promotion for disease prevention, basic treatment, which showed that the basic treatment was achieved mostly at a needed improvement level.

Barke (146) studied life style to promote worker's health in the workplace by using reproductive models of health promotion behavior that belong to Pender, by selecting the variable of knowledge-perception 4 variables, giving the definition of health status and self ability. There were two covariables, population characteristic and behavior. The sample came from 6 factories that have health promotion projects consisting of exercise, nutrition, and relaxation activities. The result showed that the health promotion behaviors were attaining the life goal an exercise, and responsibility on health and stress management. Three months later they had been measured the behavior of worker's health promotion again and found that the whole picture of the health promotion behavior of workers were still increased,

joined with variable on knowledge perception and covariable that could predict a variation in health promotion behavior of 41.0 percents.

Suttinit Huntasarn (147) studied menopausal women for health promotion behavior by using the reproductive model of health promotion behavior of Pender, with 380 samples of women aged between 40-59 years old living in the village of Nonthaburi Province. The result of this study found that the women who were trained had more confidence to cope with their menopause symptoms and the level of health promotion behavior was 57.10 percent higher than before.

Supavarinth Hunkittikun (148) studied on aging health promotion behavior in Lampang Province using an evaluation of health promotion by measuring life style following Walker Sechrist and Pender in 6 dimensions: food eating, health responsibility, stress management, self understanding, helping each other by studying the associations of leading factors, related factors, supported factors and predicting the ability of those 3 factors to health promotion behavior. The study sample was 380 aging people above 60 living in Lampang. The study result showed that most aging people had health promotion behavior at the middle level, 81%, and best level on health promotion behavior in helping each other, 59.0% and food eating 39%. Leading factors such as knowledge on health promotion, perception of health status, sex, age, marital status and family status had an association with health promotion behavior of aging significantly. Related factors, occupation and accession of various service sources had an association with health promotion behavior as well. For support factors such as receiving support from family members, cousins and neighbors and health personnel club officer, aging people had an association with health promotion behavior. In health promotion behavior prediction it was found that all independent variable had influence to health promotion behavior prediction at 42% and the most influential variable was knowledge on health promotion.

Saovanee Kunsomboon (149) studied community power and health association to know the source of working, learning and coordination of networks in community organization and the result of movement of association process. The study analyzed social context factor affecting the movement of associations and the result of development affecting community health. It was conducted by qualitative research in 4 regions of Thailand in October 1999 - September 2000. This study found that the

source and community management had 3 types 1) Network and community organization in natural style affecting social relationship. 2) Network and community organization promoted by government affecting government policy, management structure and similar type of activities directed making lack of quality and continuous. 3) Network and community organization empowered by private development organization targeted for sustainable development and moving to push public policy and law. These 4 case study movements began from community awareness and community problem. There was a generating of main movement from inside the community having movement in two ways, various movements of activities and joining learning bettering health status. Moreover it helped to make the strength of village health volunteers sharing their work with other communities for building happiness of individual, family and community.

Yanun Jaiarthan, (150) studied the learning process for participatory building of community leaders in implementation of health activities in the community. Community leaders consisted of people, members of occupation groups in the community, village committee, village health volunteers and members of tambon administrative organization (subdistrict administrative organization) who applied to participate in the learning process. The study result found that community leaders had the capabilities to work together were hearing skill, speaking, problem analysis, resource utilization, and change of leader in the village. The learning process of community leaders brought health development in individual, family and community level. The community could help itself in planning that were occupational promotion plan in community, haemorrhagic fever prevention and control plan, traditional medicine promotion and development plan and education and human development plan. Then, it was needed to support and motivate people in the community to have a chance to join in the learning process to build the activities in the community continuously for sustainability.

Seri Pongpit (151) studied community network and people association and introduced that network building would be the most important factor of sustainable development promotion because network member had the important role to work together such as target and criteria setting, made every section to participate in the activities, role and duty assignment and doing something together. The

important activities had been done together by every network that included learning, information exchange, experience exchange leading to making a plan and doing the activities together for synergy in resource using economy and efficacy especially various campaigns done by network effected more efficient results. It was found that the responsibilities of network coordinator of community organization involved 3 roles, facilitator, catalyst, and networker.

From the revision of literature and related research it can be concluded that the health promotion process in various group studies reflected many aspects of network and community organization and health association guiding the study of working movements in health promotion. In this study, the researcher will bring all the past experiences to adapt into the study.

However, the past researches did not show clearly dealing the capabilities building of family health leader in self-care and health promotion. There are no studies on knowledge and health promotion at the individual and community level including no coverage of the main variables reflecting the capabilities of family health leaders such as knowledge, capabilities in health promotion, disease prevention, community health promotion, leadership of family health leaders, appropriate incentives, and the most important thing is no studies on networks and its expansion for sustainable community health promotion building including the method of family health leader development in the past, which emphasized training with giving knowledge by lecture with document and manual concentrating on illness treatment with practice only. However, this method is not suitable for adult learning especially without follow up and continuous support, from health officers and village health volunteers.

The researcher, will pay attention to initiating capability building of family health leaders for chonburi province to enhance knowledge, ability, leadership and motivation affecting to community health promotion including network establishment and expanding sustainable community health promotion through questioning on how to do.

Then, the sustainable community health promotion building, researcher will select to build capabilities of family health leaders of Chonburi Province, the participatory process emphasizing enhancing knowledge and ability to create

community health promotion, leadership, motivation, networking process and expanding for sustainability through transferring of technology learning process.



CHAPTER 3

MATERIALS AND METHODS

Strengthening capability of family health leaders on community-based health promotion had been designed. The objectives of this research is to compare knowledge about self-care and health promotion, ability, leadership and motivation of family health leaders in Chonburi Province. This chapter describes design, sample, research instrument, data collection, and data analysis of Phase One, Phase Two and Phase Three used in this study. The details of the study are given below.

Methodology

The research design is quasi-experimental study. It was divided into three phases.

Phase One: Community and facilitator preparation

Phase Two: Strengthening capability of family health leaders

Phase Three: Establishment and expanding network

Phase One: Community and facilitator preparation

The objectives of this phase were to study base-line data of target village, improve the knowledge and ability of facilitators, to develop curriculum and manual for family health leaders training and to plan for facilitators activities.

Population and sample size

The 5 facilitators were purposive selected. Among facilitators consisted of 3 public health officers who worked in Kok Keenon Health Center (PCU), Panthong Hospital and 2 village health volunteers who live in Ban Nern Phi.

1. Community preparation

1.1 Researcher cooperated with Chonburi Public Health Office and community leaders in the study area for study clarification, asking for study permission and asking for personal cooperation in joining the study team.

1.2 Facilitator was selected and involved a meeting in order to understanding the study objectives and procedure in detail as for determining the participation roles.

2. Facilitators preparation

2.1 The facilitators were trained for 3 days by experts focused on facilitator team development for improving their knowledge and skill, group dynamic process, and necessary skills for participant motivation and community study process through participatory learning.

2.2 Community situation study according to health, health promotion, disease prevention and related data dealing with the family health leader activities. The facilitators and the researcher studied data from the secondary data and indices of primary health care program of Chonburi Provincial Health Office's Annual Report and research documents related to this study were included to view the whole picture.

2.3 The data on situation of health, health promotion disease prevention and evaluation of Chonburi family health leader project were presented by the researcher to the facilitator team. The facilitator team joined to study the data of Village 5, Ban Nern Phi by Rapid Participation Appraisals Technique (RPA). It covered the main elements of community which are the structure of community organization, the various capabilities of community such as environment, social status, culture and economic factors, endemic diseases, health problems, environmental health, health services, social service accessibility and health policy of local authority.

3. Manual and Course development

3.1 Operation meetings was set up for 3 days training course initiation. The facilitator team worked together with the researcher making a draft of

family health leader development manual which consisted of contents and guidelines from situation analysis combined with related theory.

3.2 The draft of manual was submitted to 3 experts in family health leader development for appropriate consideration in contents. The experts who approved the manual were Gen. Sonthaya Mahothan (The President of Central Village Health Volunteer Association), Mr. Mathee Chanjaruporn (Director, Primary Health Care Division) Ms. Ganitta Rakmanee (Deputy Director, Primary Health Care Division). Any suggestion from experts was given back to the facilitator team for consideration.

Data collecting instruments

Instruments used to assess the community

1. Rapid participation appraisals (RPA) survey form was a semi-constructed guideline to interview key informants and to collect data from health center record, the Tambon Administrative Office (TAO) and district health office.

2. Pre-test and post-test form for the facilitators which consisted of three parts:

Part 1: General characteristics e.g. sex, age, education marital status, family status, family member, and exposure to training (all this data collected before training only).

Part 2: Knowledge on self care, community health promotion and being facilitator

Part 3: Ability of facilitator according to being facilitator

3. Checklist for observation about facilitator's ability

Data collection

1. **For community assessment: Quantitative data** was collected to search the total population, bio-statistics from records and report of the health center, district health office, and TAO. **Qualitative data** was collected from key informants interview such as community leader, village headman, village fund chairperson, health center personnel, chief of village health volunteer etc.

2. For facilitator ability assessment: Pre-test and post-test was collected before and after training. Observation was done during they practice. Scores obtained from using the knowledge and ability assessment forms were divided into three levels.

80 % or more is a good level of facilitator knowledge and ability

60-79 % is a fair level of facilitator knowledge and ability

60 % or less is facilitator knowledge and ability need improving

Data analysis of community assessment:

The facilitator team together with community leaders were conducted a SWOT analysis seeking the strengths and weaknesses of the community; leadership, structure and various group activities. Capabilities would be identified as well as health development obstructions such as causes of health problem, and disabilities. Beliefs and attitudes of people also have been analyzed in the field of health promotion, funding agencies and other resources. Public services would be covered regarding accessibility and acceptability of the people as well as the policy of local authority on health promotion. The analysis will use the Information Pyramid Technique which is classified in 4 level described in the figure 3. (details attached).

Data analysis of facilitator ability assessment:

Data analysis was performed by statistics as follows:

1. Descriptive statistics including frequency, mean, standard deviation, maximum and minimum was used to explain the general information of facilitators including age, gender, educational qualification, position held and work experience.

2. Inferential statistics used the Wilcoxon Signed Ranks Test for the comparison of knowledge and ability of facilitators before and after training. The level of significance was set at $\alpha = 0.05$.

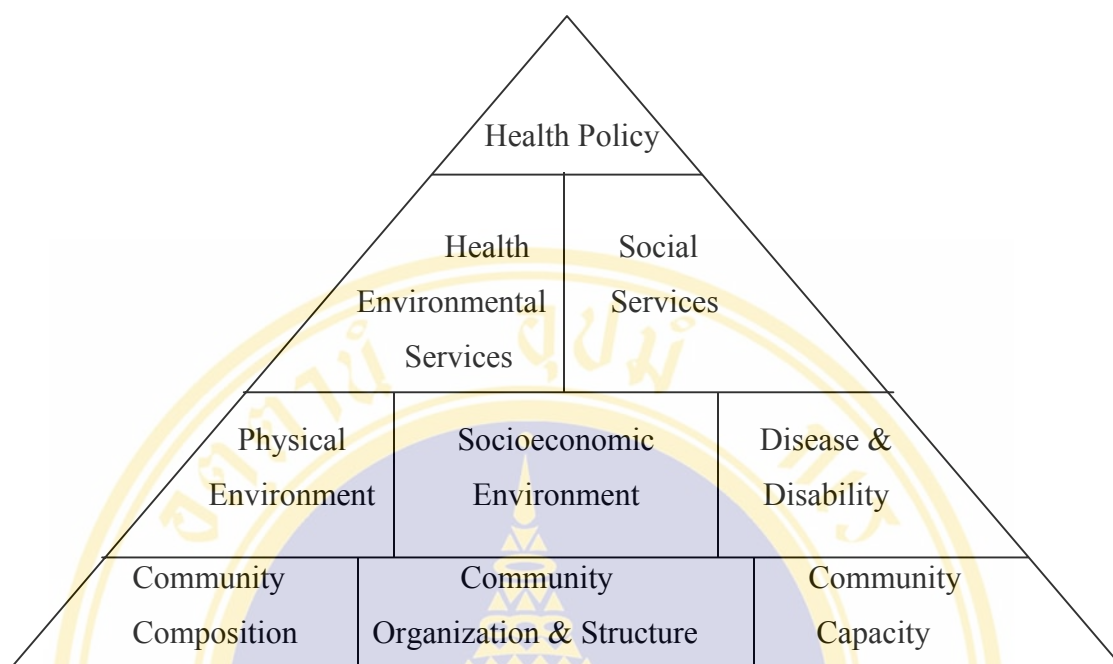


Figure 6 Blocks for information pyramid

Source: Annett M. and Rifkin SB. Guidelines for rapid participation appraisals to assess community health needs. Geneva, 1995. (152)

Phase Two: Strengthening capability of family health leaders

The objective of this phase was to enhance knowledge, ability, leadership and motivation of family health leaders and to motivate family health leaders acting in self-care, family health care and sustainable community health promotion

Population and sample size

Population was the family health leaders in Chonburi Province. There were about 168,166 persons who were identified to be family health leaders.

The sample selection involved purposive sampling on a voluntary basis as the criteria of: during the past 3 years (between October 2000-september 2002), the smallest occurrence of Hemorrhagic fever outbreak in the province meant that the people had the existing capability to prevent and control this epidemic disease. For Chonburi province there are 11 districts, and the statistical outbreak of hemorrhagic fever showed that Panthong District had the least cases and when considered at the

tambon level of this district it was found that tambon Kok Keenon had less cases which was the least within 3 years. Village 5, Ban Nern Phi, tambon Kok Keenon, Panthong District, Chonburi Province had 112 families from 91 households with a total population of 386 persons. The precious preliminary study found that there were 36 family representatives who identified themselves to be family health leaders and were willing to participate in this study.

The sample group also met the inclusion criteria selection as follows:

1. Family health leaders who passed the training course between the years 1999-2001.
2. Family health leaders who still stay in their home town and have not moved out in the period of one year (the year of 2003-2004) or along study period.
3. Family health leaders who still accept themselves to be the family health leaders in this village.

Exclusion criterias are as follows:

1. Family health leader who has a health problem such as illness from chronic disease or having a disease which could make an obstacle to working continually.
2. Family health leader who was a village health volunteer.

The phase of strengthening capability of family health leaders was conducted as the following:

Preparation

1. The facilitator team invited family health leaders participating in study project orientation.
2. The existing capability assessment was done.
3. To arrange the group process activities for preparing readiness of the participants involved in this study aiming to build up the learning climate.

Participatory training program to strengthen the capability of family health leaders

The participatory training program placed emphasis on the participants. The course comprised two basic principles: experiential learning approach, based on the concepts by Kolb, and maximum participation and maximum performance approach (121). The steps of the learning process were as follows:

Step One: Concrete experience

Step Two: Reflection/ discussion

Step Three: Conceptual context

Step Four: Experimentation/application

Five days operation training set up by using a guideline of family health leaders and participatory learning process by facilitators. The course divided into 2 training as follows:

First training:

Knowledge enhancement: three days participatory training was arranged through self-care manual and community health promotion program which were included all four steps as mentioned:

1. To review knowledge on self and family health care including community health promotion by each person sharing his experience practicing both when normal and illness.
2. To discuss and exchange experiences on self-care and community health promotion.
3. To educate them about community health promotion according to the course contents and others requirement knowledge.
4. To wrap up and add up knowledge in health care on the manual if needed.

Second training:

Ability building: to emphasize in practice during the training for gaining more experience and skills through 3 basic skills, problem solving skill, communication skill and team building skill.

Leadership building: to use motivation process to let them express their leadership in leading the group enforced by a climate of mutual respect.

Continual motivation was done through learning climate such as conditional activities, question from community information for initiative thinking affecting self development. The appropriate assignment was also created acceptance of each others. By this motivating approach, family health leaders would be satisfied with their jobs which had a continual effect on their performance.

These training process produced a group of family health leaders who interested in the same issues, and operation plan for each group which accepted by group members.

Data collecting instruments

In this phase the instrument consist of:

1. Manual of family health leader capabilities building and participatory leaning guideline. (developed in phase 1 and apart of that was attach in appendix D).

2. Family health leader capability assessment form which consist of:

Part 1: General characteristics e.g. sex, age, education marital status, family status, family member, duration of working as a family health leader (all this data collected before training only).

Part 2: Knowledge on self health care and family health care during normal and illness, prevention and control of disease, and community health promotion

Part 3: Ability of family health leader in self-care and family health care, including community health promotion

Part 4: Leadership of family health leader

Part 5: Motivation of family health leader

The scores obtained from using the knowledge and ability assessment forms were divided into three levels.

80 % or more is a good level of facilitator knowledge and ability

60-79 % is a fair level of facilitator knowledge and ability

60 % or less is facilitator knowledge and ability need improving

Validity and Reliability

1. Content validity of the research instrument: The content validity were examined by three experts from Associate Professor Dr.Rana Pongreungpun (Deputy of President, Burapha University), Dr.Amorn Nontasuta (Former Permanent Secretary, Ministry of Public Health), and Mr. Mathee Chanjaruporn (Director, Primary Health Care Division).

2. Trial of the research instrument: The research instrument were tried out with 30 persons of family health leaders in Panasnikom District. The reliability of the research instrument was determined using Cronbach's alpha coefficient. The reliability of the instruments were as follows: $\alpha = 0.83$ for knowledge, $\alpha = 0.91$ for the ability, $\alpha = 0.74$ for leadership and $\alpha = 0.80$ of facilitators.

Data collection

Data was collected from the sample group which was done before training and after training at the end of the training course and after training 3 times: immediately post-training, 3 months post-training, and 6 months post-training as follow:

Data analysis of family health leaders capability:

Data analysis was performed by statistics as follows:

1. Descriptive statistics including frequency, mean, standard deviation, maximum and minimum was used to explain the general information of family health leaders including age, gender, educational qualification, position held and work experience.

2. Inferential statistics used the Repeated Measure of ANOVA for the comparison of knowledge, ability, leadership and motivation of family health leaders among before training, immediately after training, 3 months after training and 6 months after training. The level of significance was set at $\alpha = 0.05$.

Phase 3: Establishment and Expanding of Network

The objective of this phase was to assess the process of network establishment and its expansion

The researcher and facilitator team joined to discuss with each group every 2 weeks 4 times continuously for motivation and mental support in acting by the plan. For observation the change in individual and group there were several ways to observe such as group process, participation, number of group members, transferring experience, motivation and satisfaction in the group.

For 2 days of community health promotion network meeting set up after a particular group worked for 1 month. The participants in the meeting come from the particular group representative and facilitator. The representatives of each group have to inform about the activities they have done at the meeting including what and how of the result, obstruction and the proceeding activities. The suggestions from other group members will be accepted, which the system is as described in the technical co-operation among developing village: TCDV. For using as a guideline to group and network extension occurred from individual and various group learning under a friendly climate (for details in attachment).

Data collecting instruments

1. Observation record form for recording the activities in the family and community level according to the agreement of operation plan. Self-care when a person becomes sick and activities of community health promotion, continuous learning process in the community, model for participation in the activities of the group and activities of health promotion such as physical exercise club and aging club were also recorded.

2. Group discussion guidelines with specific interested group which identify as the following up issues in community health proposition and establishment of health promotion club.

3. Club establishment evaluation form; the networking establishment process and the expansion of community health promotion network from group or club in the village to other villages in the same tambon or other tambon.

4. Participatory observation guidelines for recording any activities such as group meeting, study tour and the progress of network establishment and the sustainable expansion.

The researcher and facilitator team will observe field information, arrange group discussions and interview experts following the specific question on qualitative research principle.

Data analysis

1. The data of final process of this research was analyzed by descriptive statistics e.g. frequency, percentage, mean, and standing deviation for knowledge, capability, leadership, motivation analysis on self health care and community health promotion.

2. A comparison was made of knowledge, capability and motivation in self-care, family health care and community health care of family health leader before and after by using Repeated Measure ANOVA.

3. Qualitative data was obtained from interviews, group discussion and field observation were classified and analyzed according to contents issued in the objectives and hypothesis.

Evaluation

The objective of this evaluation was to identify the progress of research from the beginning to the end of the project. Evaluation was a process undertaken from phase 1 for explanation of the project situation by various details as follows:

1. Participation and partial participant observation in every activity which is implemented by family health leader in the community. There are records of activities, varieties in the individual, family, group, community and networks of knowledge, capability, leadership and motivation utilization for community health promotion.

2. Follow-up and support will be done to specific interested group for initiating activities in technical know how, coordination, outer resource seeking

and operation plan adjustment fitting time and group limitation as well as hearing the problems and various obstacles.

3. To learn the network process, related discussion was conducted in the community, which concerns economic, social, local politic with sustainable community health promotion.

4. The researcher brought all data to classify and analyze in quantity and quality information.

5. To present the results of analysis to the facilitator team for validation (cross check or triangulation test). The facilitator team concluded in terms of sustainable community health promotion and lessons learns.

6. To empower the facilitator team this would be implemented any time by participatory principle and motivating enforcement for strengthening the continuous action and the expansion capability.

7. To present the results of sustainable community health promotion to the Primary Health Care Division, Health Service Support Department and any health service network to broaden expansion.

STRENGTHENING CAPABILITY OF FAMILY HEALTH LEADERSON SUSTAINABLE COMMUNITY – BASED HEALTH PROMOTION

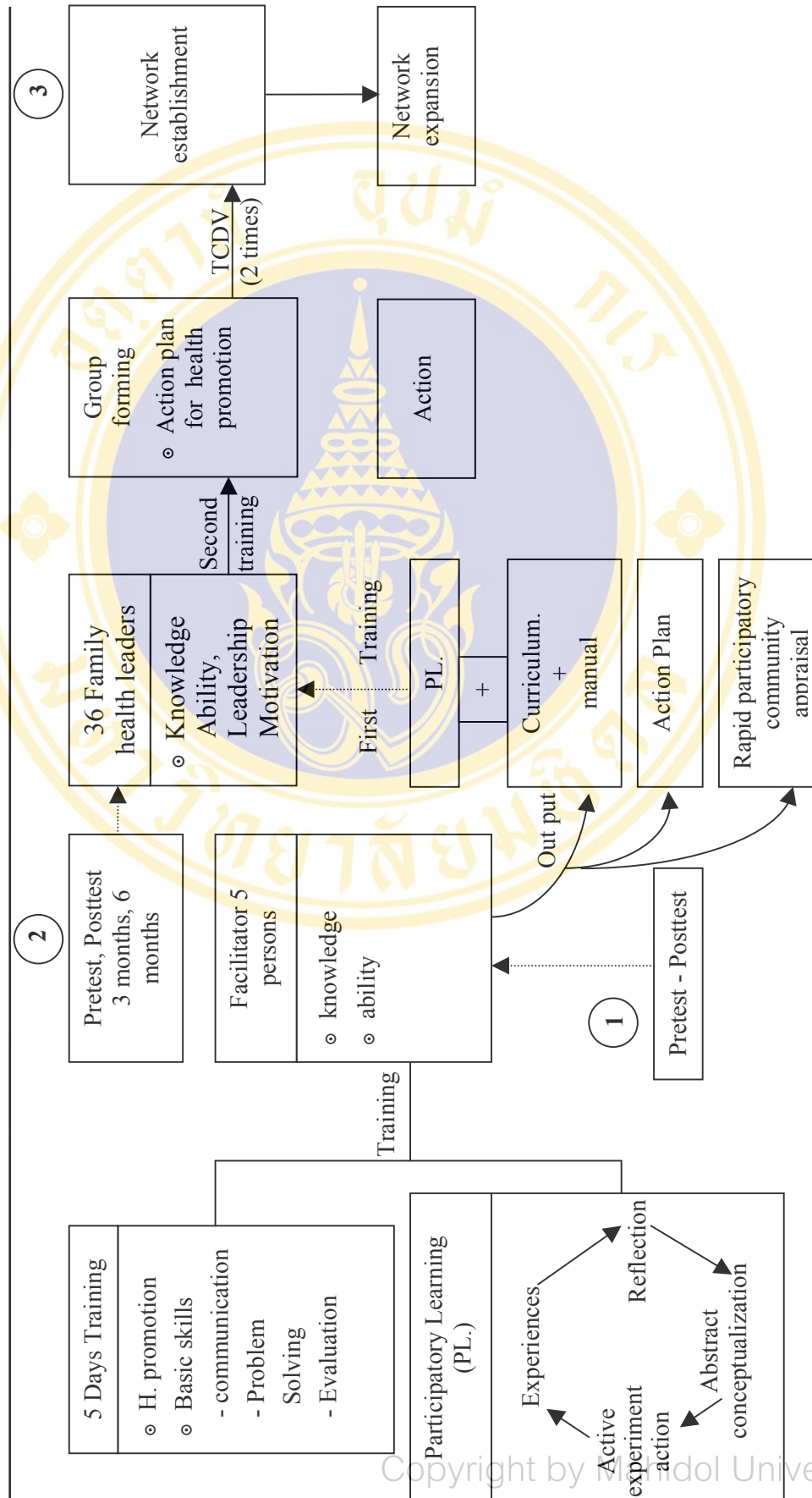


Figure 7 The process of strengthening capability of family health leaders.

Ethical considerations

Permission to carry out the study was obtained from the Documentary Proof of Ethical Clearance, The Committee on Human Rights Related to Human Experimentation , Mahidol University. (Appendix)

Consent to conduct this study was obtained from the Provincial Chief Medical Office, Chonburi Provincial, Panthong District Health Officer.

All facilitators and family health leaders signed the consent form. This study performed base on the respect of facilitators' and family leaders' decision for participating in the training workshop activities. Objectives were clearly informed to the participated family health leaders. Researcher asks for a permission of family leaders every time, regarding to the research information and personal information is kept in confidential.

CHAPTER 4

RESULTS

This quasi-experimental study of strengthening the capability of family health leaders aimed to study 1) comparison on knowledge, capability, leadership and motivation on self-care and family including community health promotion among family health leaders pre and post training and 2) to appraise the process of establishing community health networks and sustainable extension after strengthening their capability, for which these processes were conducted in 3 phases following: The phase of community preparation, strengthening capability of family health leader and evaluation. The period of intervention was 7 months during September 2003 to March 2004. The results of this study were shown as follows:

1. General characteristics of the studied village
2. Results of facilitator training
3. Results of strengthening the capability of family health leader
4. Results of establishment of network on community health promotion

1. General characteristics

A general information of Village 5, Ban Nern Phi, Tambon Kok Keenon, Phanthong District, Chonburi Province was conducted by method of rapid participatory appraisal (RPA.) that included the following procedures:

1. A team of facilitators and researchers studied the general information in Village5, Tambon Kok Keenon from various documents such as 1) annual report of Kok Keenon Health Center 2) family health folder 3) service record of Kok Keenon health center 4) a copy of the basic needs in each family, which then recorded the number of family members, family size, information on health status,

information on service management of the health center and illness density among villagers in Ban Nern Phi village.

2. Setting the group for rapid participatory appraisal that gathered information of the community by key informants related to Village5 Ban Nern Phi. This activity had 6 participants such as the head of the health center, owner of the village grocery, community development worker, chairman of village fund and village health volunteer (VHV). These persons participated in the focus group by the author, who performed the role of facilitator and the team of members were recorder. The topic of group discussion comprised the basic structure and strengthening the capability of community, social and economic environment in the village, services, including health problems in the community and policy on community health promotion.

3. Data analysis a participatory involvement of the community so that the and information analysis was conducted by the facilitator, and community leaders, which consisted of the Tambon chief (Kamna) at Kok Keenon, village leader at Village5, member of the Tambon (sub-district) Administration Organization (TAO) in Village 5, leader of the village health volunteers and the representative of family leaders numbering 15 persons. The author submitted first and second collected information to the experts who verified its content validity and precision and then the information would be categorized in the group using the method of information pyramid and cooperation to analyze the strengths and weaknesses of the community that showed the results as follows:

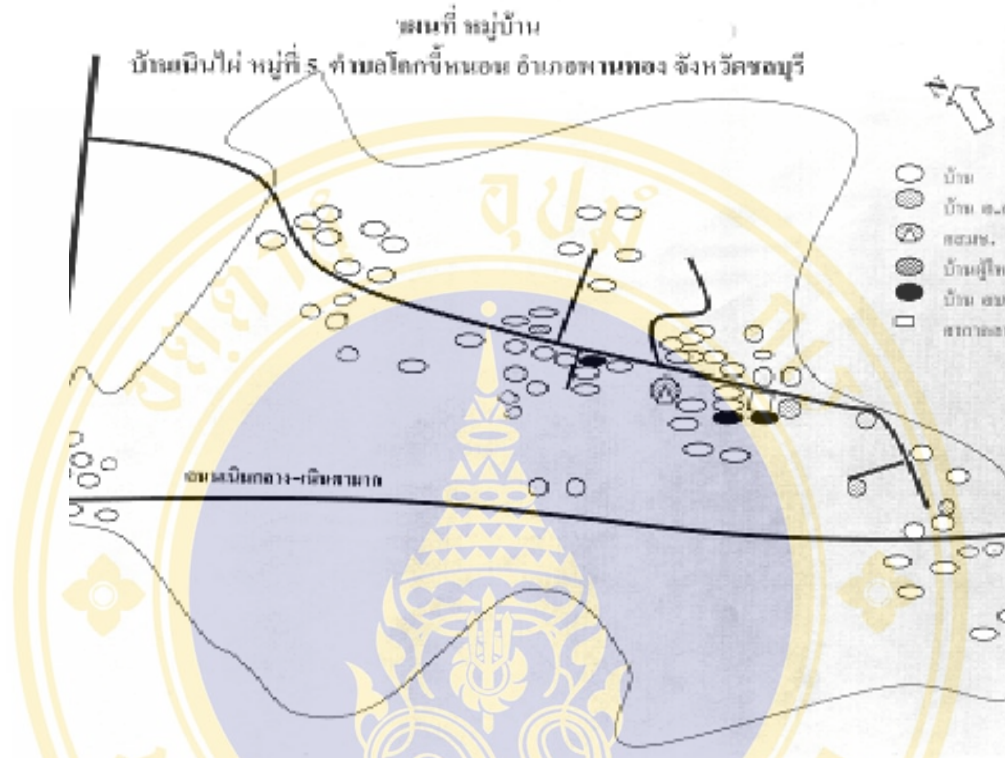


Figure 8 Map of Village 5, Tambon Kok Keenon, Phanthong District, Chonburi Province

Ban Nern Phi, Kok Keenon sub-district, Phanthong District, and Chonburi province with the boundaries as follows:

- North near Village4, Kok Keenon sub-district, Phanthong District, and Chonburi province
- South near Village 6, Tambon Phanthong, and Chonburi Province
- East near Village 3 Phanthong District, Chonburi Province
- West near Village 3 Tambon Kohloy, Phanthong District, Chonburi Province

The topography of Ban Nern Phi village consists of lowlands with enriched minerals and has 2 natural canals that provide water throughout the whole year.

Communication lines existed between this village and Phanthong District about 13 kilometers away and transportation was available to go back and forth with all vehicles in about 10 -20 minutes. The route to this village consisted of a concrete and asphalt road that accessed the heart of the village. The length of the road was 3 kilometers and continued in 4 lines of the road that served as branches of the main road. Thus, communication in this village was easily facilitated. The characteristics of the households was scattered in groups within their areas.

Structure and organization in community

Village5 Ban Nern Phi was governed by a village leader who has started in this position about 7 years ago. This village had a proxy of Kok Keenon TAO of about 3 persons and the village committee comprised 11 persons

In Ban Nern Phi village there were various groups which continually conducted activities such as:

1. Village health volunteers comprising 8 members.
2. Group of agriculturists raising fish comprising 38 families.
3. Community fund (1 million) comprising 91 families
4. Poor elderly group comprising 21 persons.
5. Group of one tambon one product comprising 16 members (member of sub-district level)

There was one primary health center at Ban Nern Phi which was constructed in 256 and located at the VHV's house, one place of the civil welfare center, 3 grocery stores, no temple, no school or health center. The results of the basic needs survey in 2536 found that this village had passed all the criteria of the basic needs.

General Characteristics

There were 91 households, 112 families, 171 males and 182 females totaling 353 persons in Ban Nern Phi. The rate of literacy was 97.0%, Buddhist 97.0% and Christian, 3.0%. Most of the people raised animals such as ducks, chickens and fish.

Culture and values among villagers at Ban Nern - Phi

In addition, the Songkran festival, great sermon ceremony and making rituals have appeared for a long time period in the history of Ban Nern Phi. Many members of this village would come back to make merit when the festival met. They would give food and fruit to the monk and listen to sermons on Buddhism days and it was found that there were many practices that affected the unity in the village as follows:

1. The canal making merit ceremony was the activity that pays thankfulness to the god who provides plenty of water for the farmers. This ceremony will be done on the first full moon night in February of every year. But nowadays most of the old men who served as the master of ceremony have died and the big tree that formed the place of ceremony had died too. As a result, in each of the following years the number of persons to make merit has decreased.

2. The cremation ceremony to give respect to those who died is a ritual that would be conducted during Chinese New Year by Chinese people. It was begun in the last march that was called "Chuhun Day". On this day whoever was a relative, daughter-in-law or related person would bring food, sweetmeat, and fruits place on the burial place and later eat together. This ritual serves as a memorial to family ancestors and affects the unity in the family strongly.

3. Several ritual ceremonies involve participating in cooperative activities such as making food in a new house, ordination, marriage etc. However the ceremony of cooperating to make sweetmeat in several rituals has become more of a business.

4. Cooperation ceremonies for working and rotating help in another village.

5. Local wisdom involved in occupations such as weaving a round bamboo-basket, making local food such as Buan Curry, Thai fried noodles, making desert; e.g., Thong Muan (crispy pancakes), Mor Kang (bake custards) and Khanom Ping (scented crumble sweetmeat). These were steeped in local wisdom and considered to be a noteworthy skill and even a marketable ability. At present Ban Nern Phi village was interested to transfer some local folk wisdom such as making

desert to students and to promote products to be part of the one Tambon one product scheme.

Health status

There were 353 people in Ban Nern Phi under the health insurance system with about 332 persons or 94.5% who were under the gold card of the health insurance project with about 260 persons. The main service location for this project was Kok Keenon health center and Phanthong hospital. There were social insurance cards numbering 49 persons and the civil servant cards and public state were 23 persons.

One year past (information on December 31, 2546) there were 3 child births, 2 deaths with old disease and there was a patient with chronic disease such as 2 patients had diabetes mellitus and 13 patients had hypertension and born disability (down syndrome) including one patient whose disability was due to accident from vehicle (paralyzed)

Regarding people's illness in community, it was found that they were minor illnesses such as upper respiratory disease; e.g., common cold, peptic ulcer, diarrhea, food poisoning, stress and accidents in the household; e.g., a knife cuts, falling from a high place, and burns, etc.

Kok Keenon Health Center (Primary Care Unit: PCU.) was located around 3-5 kilometers from village. Thus, when villagers in the community were ill it would be service available there. Where there was a nurse and physician regular working on Monday, Wednesday and Friday.

Whereas, in the village there were village health volunteers who had undergone continually training numbering 8 persons and they always participated in activities of the health center and Community Primary Health Care Center (CPHCC). This center was located at the one of VHV's house and provided simple treatment services such as taking blood pressure test, urine tests for primary screening of Diabetes Mellitus (DM.) and wound dressing to client. This VHV of this center would be a key person who providing service; whereas, others would rotate to practice in the center.

Service on public health

Villagers who were the proxy of a family numbered 60 persons and participated in training being a family health leader in 2542. The period of training was one day only one time and they had never participated in retraining and never participated in health activities in the community. But in this sample it was found that most of them continued to cooperate and participate in activities.

Not only the health promotion activities in the community such as activity on surveillance and disease prevention but also these village health volunteers maintained cooperation with villagers and Sub district or Tambon Administration Organization (TAO) campaigns and prevented DHF disease by eradicating dengue mosquitoes and larvae and developing sanitary environments in households.

Village capability analysis

The facilitator team and village leaders analyzed the capability of the village regarding strengths and challenges and the results were shown as follows:

The strengths of this village included 1) most of villagers being relatives and familiar to each other. The symbol of society in village that was peaceful. 2) Kamnan, members of TAO and VHV who were active leaders are living in this village. So, people were able to continually access service, information including benefits from supporting resources. 3) this village was near the city, communication and transportation were convenient, various medias were accessed in the community. In this village also has a place of information distribution such as at the grocery store, where was located in a suitable area, and the positive characteristics of geography that enabled the completion of infrastructure. 4) health and public services were unified and strengthened providing from Kok Keenon Health Center where nurses and physicians had regularly in practice at least one time / week. Thus, villagers were better able to take advantage of available services in that place. 5) there was a Community Primary Health Care Center (CPHCC) that provided basic service and primary screening such as taking blood pressure, and weighing under the supervision of the public health staff 6) policy of local governing organization as regard to health promotion among people in the community must be obvious and had a supporting budget and materials under the community's plan. 7) having conferences

of civil society about one time/ month that increased the sharing of experience among people in the community 8) there was a combined community organization and had continued practice. 9) villagers continued to adhere to culture practices and customs that continued so long time and it also affected the unity and cooperation among them.

For challenges there were many factors as the following: 1) having industry and factories scattered near the community thus they would have many more people working in the industry. Although, they had more income but they did not have enough free time to participate in the community developing. 2) family health leaders who had undergone training lacked of proper stimulations or incentives to being a good family health leader. 3) there was no obvious health promoting activity in the community although the policy of local governing organization would support it and 4) in this community there were many groups of leader that would have responsibility to their groups but still lacked the integration of networks that influenced empowerment of the community.

2. Results of training facilitators

Training facilitators were selected and conducted training at Central Regional training Center for Primary Health Care Development, Chonburi Province.

2.1 Facilitator selection conducted on purposive selection. These facilitators were close to family health leaders and accepted by people in the community and they volunteered to participate in this implementation. There were about 5 persons selected as facilitators that comprised 3 personnel and 2 village health volunteers in Ban Nern Phi.

2.2 The training of facilitators was established at the Regional Training Center for Primary Health Care Development (CRTC-PHC) during 11-15 September 2003 for 5 days. The objective of implementation was to develop the knowledge and capability of facilitators to create strengthening capability for family health leader under a structure of curriculum that comprised of 5 major principles 1) roles of facilitator 2) characteristic of facilitator 3) technique and process of participatory learning 4) designing and planning participatory learning and 5) follow-up and

evaluating implementation of family health leader (structure of curriculum in appendix 5) these activities were conducted by experts from a project of integrating community plan against poverty in Chonburi Province. The schedule of training facilitators in each day is shown as follows:

The first day of training was to review about existing knowledge and capability of facilitators about self-care and health promotion in the community via participatory learning that emphasized on sharing experience and stimulated participating in various activities.

The second day was a learning process management to create basic skills such as communication, problem solving and teamwork through the skill of being a facilitator by doing group activity, brainstorming and preliminary demonstration. The participants responded with enthusiasm and participated in the program; they were able to analyze and solve their deficiency and able to act by teamwork.

The third day witnessed a performance for being facilitator to train and create family health leader's skill from Tambon Samet, Muang District, Chonburi Province numbering 12 persons and it was intended that this activity would create skills for being facilitators who would be able to transfer knowledge and benefit to the community. This performance kept the time of each person to 30 minutes whereas, another group would act as recommenders to develop and take photographs, record video. Then facilitator reviewed it from video and developed their performances. During practice, it was found that the VHV facilitators were worried because they were not familiar to being facilitators but after they explained their stress, and the rest gave psycho support then their anxiety were decrease whereas, other facilitators had more confidence.

In addition, there was a study on community participation including pyramid information analysis. The facilitators would be interested in this activity such as brainstorming and sharing experience until they were able to diagnose community and prepare studying community participation of all steps.

On the fourth day the facilitators studied community participation in Village 5, Tambon Kok Keenon by studying the documents and reports of the health center. An activity of the focus group was conducted at the village welfare center in

Village5 and analyzed information together with village leaders until it was completed.

On the fifth day the facilitators reviewed all details that were studied and analyzed transformation and what was not studied under the key topic.

At the end of training course, the facilitator made a group activity and brainstorming to plan for family health leader training and determined the scope of details of the family health leader's handbook by emphasizing self-care and promoting community participation. The facilitators were separated and were assigned duties to conduct in each detail to make the family health leader handbook and formulated implementation plan to be consistent with the next plan. The whole details are shown in table 1.

Table 1 Training curriculum of participatory learning to increase knowledge and ability of facilitator

Time	Topic	Activity
First day		
1 hour	Prepare readiness for facilitators - created acquaintance - Expectancy	Group activities
1 hour	Concept on health self-care and community health promotion	Lecture
5 hours	Self-care <ul style="list-style-type: none"> • Food • Recreation • Exercise • Accident prevention • Minor illness Community health promotion Participation	<ul style="list-style-type: none"> • Group activity and sharing experience as reflected idea and concept including learning by one self (Walk rally) • Practice

Table 1 Training curriculum of participatory learning to increase knowledge and ability of facilitator (Cont.).

Time	Topic	Activity
Second day		
30 Minutes	Reviewed and reflected idea of learning and what would learn go on	<ul style="list-style-type: none"> • Activity of representative of participants
3 hours	Participatory learning to created strengthening capability of family health leader	<ul style="list-style-type: none"> • Idea reflected activity, lecture and summarized on concept
4 hours	Being facilitators <ul style="list-style-type: none"> • Characteristics • Communication skill • problem Solving skill Team work designing and planning to trained family health leader Evaluating achievement of family health leader	<ul style="list-style-type: none"> • Lecture • Group activity • Summarized concepts
Third day		
1 hour	Reviewing and reflecting idea and experience after underwent training	
4 hours	Trained being facilitator	<ul style="list-style-type: none"> • Group activity • Trained by one self, reflected idea and summarized concept
3 hours	Participatory learning process	<ul style="list-style-type: none"> • Lecture

Table 1 Training curriculum of participatory learning to increase knowledge and ability of facilitator (Cont.).

Time	Topic	Activity
Forth day		
6 hours	Participatory learning community study	<ul style="list-style-type: none"> • Studied on baseline data in area • Activity on focus group and on participatory community analysis with village leader
Fifth day		
2 hours	Summarize characteristics, roles and duties and skills of facilitators	<ul style="list-style-type: none"> • Group activity as reflected idea
3 hours	Family health leader training plan	<ul style="list-style-type: none"> • Group activity • Summarized
1 hour	Evaluated achievement of training	<ul style="list-style-type: none"> • Grab bag activity

2.3 General characteristics of facilitators

Facilitators participating in the project numbering 5 persons had characteristics as follows:

First person: male, 43 years old, married, graduated from Burapha University majoring in public health (continuation course) and his position was public health technician and practiced at Phanthong District Public Health Office.

Second person: male, 36 years old, graduated from Sukhothai University majoring in public health (continuation course) and his position was public health officer and practiced at Kok Keenon Health Center and responsible for the Village 5, Tambon Kok Keenon.

Third person: female, a 33-year-old, graduated from Chonburi Nursing College majoring in nursing (continued) and her position was technical nurse

works in Phanthong Hospital. But she practiced at Kok Keenon Community Health Center (PCU) about 3 days per week.

Fourth person: female, 41 years old, graduated from informal education level of high school; she was a merchant and agency purchaser. She was selected to be a village health volunteer (VHV) since 1988. Currently, she worked in a chief of VHV in Tambon Kok Keenon.

Fifth person: female, 33 years old, bachelor degree of human resource development from Burapha University, she was a voluntary teacher of informal education and selected to be a village health volunteer in 2000. Currently, she was working as a secretary of the VHV's club in Phanthong District.

2.4 An apparent result during implementation of facilitator training

All participants were interested in participating in every activity of training during the 5 days of implementation. They would attend to repeat practice until they could perform confidentially. All this they still studied on various games and focus groups that were consistent with the context of Ban Nern Phi.

The facilitators found that during implementation they were able to practice at positive levels as evidenced by the following 1) creating warm atmosphere during training such as giving familiarity, unity of trainees, entertainment during workshop 2) stimulating for sharing experience among participants by questioning and expressing ideas on the topic as implementing and linking together various topics. 3) promoting family health leader participation in the program such as asking questions to stimulate participation, provide more detailed explanations including demonstrate participants in practicing activities. 4) using various media for transferring to family health leaders such as handbooks, documents and equipment 5) perceiving and responding to the participants reflection and 6) supporting together among facilitator's team members.

2.5 Continually appearance results

During training on the last day, they had brainstorm to design the curriculum of the family health leader's training including making a draft of the family health leader's handbook. After one week, they continually worked on the

handbook to be the instrument for training and the entire curriculum had the structure as follows:

2.5.1 curriculum for strengthening the capability of family health leader was divided into 2 periods as follows: The first period was about 3 days and the second was about 2 days. The details of its structure comprised self-care and community health promotion by applying participatory learning to enhance knowledge, ability, leadership and motivation for the participants. Whereas, a plan to create the potential of self-care and participation in health promotion and establishing a network was summarized in table 2.

Table 2 Training curriculum of participatory learning for family health leader on the first training.

Time	Topic	Activities	Expected Outcome
First day			
2 hours	Activity of preparing readiness of participants	Group activities	Getting acquainted/ building familiarity and creating friendly atmosphere to reduce pressure.
2 hours	Concept on self-care and community health promotion.	Lecture Group activities	knowledge
4 hours	self-care and health promotion previous experience practice	group activities set as a station of knowledge and lecture including summarization	knowledge, ability and skill of the leader

Table 2 Training curriculum of participatory learning for family health leader on the first training (Cont.).

Time	Topic	Activities	Expected Outcome
second day			
6 hours	leadership development and motivation	video, group activity and sharing experience that reflected concepts practice lecture on concepts	family health leader had leadership and motivation better than before training
third day			
3 hours	activity of self-analysis and family members about self-care and community health promotion	group activities - sharing experience - reflecting idea - lecture and - summarization on concepts	- health status of each family health leader a guidance of practice by group
3 hours	planned health self care and family members and community health promotion	group activities by integration process	adjusting plan of family health leader

After the first training for one week the training was continued to the second training as shown in table 3.

Table 3 Curriculum of the second family health leader training

Time	Topic	Expected Outcome
First day		
1 hour	reviewing knowledge and ability to care for one's self and community health promotion.	group activity summarized topics
5 hours	established an action plan about community health promotion Image analysis of past, present and future - recruiting alternatives	activities
second day		
½ hour	reviewing image and alternative way	lecture
1 hour	way analysis	group activities
2 hour	making project and assigned responsibility	group activities

2.5.2 The family health leader's handbook formulated the scope of details under the objective of strengthening capability from participatory community study and family health leader's needs. While studying the general information of the community and trying out instruments in Phanasnikom district the facilitators would collect information from various resources to make records and distributed them to family health leaders. This handbook contained content details covering food, relaxation, exercise and participating in community health promotion

2.6 Facilitators' knowledge about community health promotion and being a facilitator

The result of knowledge evaluation among facilitators before and after training found that before training 5 facilitators had knowledge about health promotion that was positive but the knowledge about being a facilitator was positive for only one and there was a need to develop 4 facilitators. But after training they had knowledge about being a facilitator that was positive for 5 facilitators.

When considering knowledge about community health promotion in details, it was found that before training all participants had knowledge about proper practice regarding taking meal, food requirements according to age, relaxation, first aid for joint painful and fever reducing. There were 4 participants answered about benefit of incorrectly but after training, all participants could have correct answers regarding all items.

For knowledge on being a facilitator before training it was found that only one participant answered correctly regarding participatory learning process and participatory persuasion, 2 participants know about techniques of participatory community study and 4 persons could answered correctly about the components of interpersonal communication. After training, most of them were made more correct answers than before in all items which details were shown in table 4.

Table 4 Knowledge about community health promotion and being facilitator of learning pre and post training as classified by item (n = 5 persons)

Knowledge Items	Correct answer (Person)	
	Pre-training	Post-training
Health promotion		
Proper practice for taking meals	5	5
Food requirements by age	5	5
Proper and correct relaxation	5	5
Exercise	4	5
First aid for joint pain	5	5
Reducing fever	5	5
Being facilitators		
Characteristic of participatory learning	1	4
Components of interpersonal communication	4	5
Participatory studying community	2	5
Techniques for increasing participation	1	4

2.7 Ability of facilitators

Regarding the ability of the five facilitators about self-care, health promotion and facilitating skill before training, it was found that their ability in all aspects should be developed. But after training it was found that there were 4 participants whose ability level were better. For the rest one participant who could not get confidence, she willing to practice frequently until her ability was at an accepted level.

When considering the ability of the facilitator on type of practice it was found that before training the majority of participants were able to practice following all activities if receive recommendation but after training most of them were able to practice without recommendation as follows:

When considering the ability of facilitator by item before and after training it was found that only one item for the 5 participants was able to immediately practiced without recommendation that was demonstrating how to eliminate dengue larvae in the household and surrounding environment to family health leaders. Before training there were 4 participants who were able to practice without recommendation as regards to advising on proper taking meal by age and demonstrating tepid sponge for family health leaders. There were many things that only one facilitator was able to practice without recommendation including motivating family health leaders to share experience with others and reviewing all things received and approved for which there a problem was including that there was an evaluation of family health. All facilitators were unable to immediately practice certain topics if they were not advised which were; demonstrating exercise to family health leaders, summarizing main topics of group discussion and rapidly perceiving the reaction of family health leaders to transfer details. As for post training it was found that facilitators had more ability in all activities that all facilitators were able to practice without recommendation as regard to introducing on taking meal, tepid sponge, explaining to family health leaders knowledge about releasing stress, rapidly perceiving details and evaluation among family health leaders as shown in detail in table 5.

Table 5 Number of facilitators as classified on ability pre and post training (n = 5 persons)

Items	Pre-training		Post- training	
	Immediately practiced without recommendation	Practiced if received recommendation	Immediately practiced without recommendation	Practiced if received recommendation
Made positive feeling of family health leader	3	2	4	1
Created positive atmosphere and no pressure	2	3	3	2
Gave recommendation on taking meal as suited for age.	4	1	5	-
Demonstrated exercise to family health leader	-	5	3	2
Demonstrated use of tepid sponge to family health leader	4	1	5	-
Explained how to relieve stress to family health leader.	2	3	5	-
Demonstrated how to eliminate dengue larvae in and around household to family health leader.	5	-	5	-
Motivating family health leader and family members to participate in DHF prevention campaign activity in community.	2	3	4	1
Coordinate with various groups in community to allocate exercise equipment.	3	2	3	2

Table 5 Number of facilitators as classified on ability pre and post training (n = 5 persons) (Cont.).

Items	Pre-training		Post- training	
	Immediately practiced without recommendation	Practiced if received recommendation	Immediately practiced without recommendation	Practiced if received recommendation
Motivating family health leader to share experience with others.	1	4	3	2
Summarizing main topic of group's agreement.	-	4	3	2
Rapidly perceiving reaction of family health leader to all activities transmitting details as how to transmit	-	5	5	-
Motivating group review of all activities of learning to improve understanding and adding its deficiency	3	2	3	2
Evaluation of family health leader training	1	4	4	1
	1	4	5	-

2.8 Comparison on knowledge and ability of facilitators before and after training

Regarding the comparison on knowledge and ability of facilitators during pre and post- training by using Wilcoxon Signed Ranks Test, it was found that mean score on knowledge pre and post-training was different with statistical significance ($p = .033$) and post-training knowledge was more than pre-training. As for the ability of facilitators, it was significant different ability between pre and post training ($p = .021$) and post-training ability was more than pre-training as shown in the table 6.

Table 6 Comparison of mean score on knowledge and ability of facilitator's pre and post training

Variable	Pre-training	Post-training	Z	P-value
	$\bar{X} \pm S.D$	$\bar{X} \pm S.D$		
Knowledge	6.20 \pm 2.28	9.00 \pm .00	- 1.841	.033
Ability	2.40 \pm .11	2.73 \pm .09	-2.023	.021

P = value by Wilcoxon Signed Ranks Test

3. Results of strengthening the capability of family health leaders

There were 36 family health leaders underwent participatory training by facilitators that led to enhance knowledge, ability, leadership and motivation for self-care and health promotion.

Curriculum for training of family health leaders was formulated by facilitators which designing related to documentary reviews and agreements from family health leaders who cooperated in community analyzing event. The formulated curriculum took for implementation 2 times. The details of training were described as follows:

First training:

Participatory learning curriculum in first training about 3 days emphasized on participation by sharing the previous experience of each person. The facilitators picked some important detail of experiences to encourage participant participation. The family health leaders were able to reflect their ideas on each topic via the process of critical thinking and trial basis conducting step by step. These affected the learning of family health leaders at the beginning. Thus, at the first day of the course they were prepared the readiness before going through the process. The facilitators created a friendly atmosphere during the procedures including relieving stress among participants. The group discussion was the means for this process. The

participants were assigned a topic of activity involving a concept on self-care and community health promotion that was comprised of details and objectives, targets and essential elements of self-care and after that, facilitators divided the participants into 6 groups and rotate to participate in activities that comprised 6 stations. Each station emphasized the following details:

- First station: our body and mind
- Second station: food for health
- Third station: exercise
- Fourth station: first aid and accident prevention
- Fifth station: mental health
- Sixth station: hygiene regulation

In each station of knowledge took 45 minutes. The activities within that station comprised family health leaders' existing experience reflection; for knowing about basic knowledge and ability among family health leaders. After that there were experience sharing and reflecting ideas focusing on topic assigned. In addition, the facilitators discussed to gain correct concepts. The participants practiced much as much as they can that emphasized group discussion and skill development. According to training process the participants enjoyed playing games and group activities. The family health leaders participated in satisfaction assessment of those activities including the process of participatory learning in each station. When they turned all stations, they had to cooperate summarizing their lesson learned while participating in the station with the facilitators.

For the entire result of evaluation it was found that family health leaders were satisfied with the learning atmosphere because they were excited and not bored, the facilitators performed well with them and especially they were able to do the self-care activities by themselves. Each station of learning had relevant benefits to them. The details were suitable, not excessive, and not difficult to understand practice at all bases. The most popular station for family health leaders were the station of physical exercise and first aid those were needed in the community.

On the second day of training, they were able to learn about participation and various leadership styles including motivation by watching the video

“Sam Kok” followed by group discussion and summarized together with facilitators. The family health leaders learned that the quality of leadership had several characteristics and each of those would be different importance and they further analyzed what leadership style was suited for the family health leader. Then, they participated in conclusion session.

On the third day of training, family health leaders considered by themselves that they were able to care for themselves and participate in community health promotion. As for the analysis that was conducted by the facilitators they had questions to stimulate the family health leaders to understand and continually followed what activities were involved or not involved in daily life. Moreover, they were able to explain that taking food was a benefit to the persons who took it by themselves but it was not a benefit to others if they did not take by their own including self-care. Afterwards the family health leaders would plan to develop their skills regarding self-care, leadership and motivation.

Second training:

The second training of family health leaders spent 2 days. The first day of participatory training included topics of reviewing knowledge and abilities of family health leaders regarding self-care and health promotion in the last training. Topics of health promotion action plan would comprise of many activities about making a vision of the community. These activities concerned about current situation of health promotion, future expectation that related to health promotion in the community and comparing to the previous vision. On the second day by using brainstorming in groups analyzed the alternatives of probable methods for attaining the settle vision. After that they planned and assigned function and responsibility to their members for implementation. The results of each activity were shown as follow:

For target and community development needs; it was found that the vision of the community was “the community were able to care for ourselves without communicable diseases, having a good environment and peaceful”. This vision, then posted this statement in front of the entry gate of the village 5. There was an exercise area in the village such as a football field, area for aerobic dance, place for reading the

newspaper and all families in the village access to a sanitary water supply. Most of the family in this village plant vegetables free from chemicals.

Regarding the community analysis in the past, present, and future about village problems, it was found that small group of villagers participate in various activities because there was no conference about health and the lifestyle in village. The villagers were not interested in physical exercise and didn't know about selecting food, had stress about their illness including economic problems and uncomfortable community infrastructure. They more concerned about treatment than health promotion. There was no broadcasting hall, villagers did not access information and lacked knowledge about health care. Currently, the villagers in the community get better information about health promotion which concentrated on nutrition, how to select safety food, disease control, and how to self-care. The villagers had group physical exercise for which the TAO was a supplier in this program. They received more information from the VHV and through a variety of media. It was mentioned that their mental health were better because the accessibility of community facility.

According to the family health leaders need for supporting their health promotion activities in community were revealed as follow: the facilitator transferred proper knowledge and to be their partners for a period of time, they would like to establish promotion club in this community and motivated villagers to joining and in the future villagers had knowledge about food selection, disease prevention and established social networks to other villages. The villagers still needed the government sector support the sport equipment. It was further envisioned that there would be no narcotics in the village, vegetables and fruits would be free chemical and the promotion of occupation for all villagers in community would exist. After they had learned and shared experience on many problems, which occurred in the community, they would cooperate and study the factors for successful implementation. It was found that the first successful factor on health promotion was the cooperation of people in the community, as they needed to have committees, strength leaders, building unity in the village and the collaboration among all sectors related to community development. The second factor was an establishment community fund such as low interest loaning fund, supported financially by the TAO

and the private sector. The third factor noted was information administration, published information covering all people. The fourth factor was place, equipment, knowledge and various modern technologies.

To attain the needs as mentioned, family health leaders planned to change villagers' behavior in the community. There were 3 projects within their plan. From brainstorming among family health leaders during the training, it was agreed that the plan would submit to TAO for considering financial support.

3.1 The entire results of participatory learning

From continual notice of those participating in group discussion with family health leaders at Ban Nern Phi during implementation about 6 months by the researcher and facilitators the results of the qualitative study can be shown as follows:

3.1.1 Results during training

During training it was found that family health leaders were enthusiastic to participate in this training and intended to repeat the practices until assured that they could do well such as practicing how to measure temperature, tepid sponge, provide first aid to patients who fainted, etc. They asked questions, expressed their ideas and shared their experience. But it was still found that some of the family health leaders lacked skill in using the guideline book and thought that handbook was not interesting because it was not colorful if compared to some which produced from Division of Health Education. However, some of them reflected that having handbook was better nothing because while they were participating with the class, they could not take notes because of their writing skill. Another reason of handbook usefulness was that they kept to review at home.

The results during the training of 4 items included 1) establishing an exercise club that was comprised of family health leaders who were members; they would have a public relations role and select a secretary of the club 2) action plan of family health leader group 3) dividing areas of community to be cluster for selecting an agency of family health leaders to participate in activities with

facilitators during the evaluation and 4) plan of study tour on community health promotion and establishing networks.

3.1.2 Results after training

After training, the family health leaders were given assignments to conduct activities regarding to an action plan. But it was found an error of time and from meeting every 2 weeks the researcher and facilitators would continually motivate them to practice on self-care activity and community health promotion by oral transferring and practice being a model for members in family and neighbors.

An informal conference about 3 hours among family health leaders and facilitators one time per month was set up. The family health leaders in each area acted as the hosts of training including giving opportunity to general people who participated in the activity. As for the topic of the conference it was emphasized that talking about health problems in the family was important and that all participants had to narrate about their problem around one month ago. The narration was presented about what was a health problem or if they had any health problem in the family. If they had, how did they cope with it, how did they assign jobs by group, what were their problems and obstacles and what activities were done next?

From observing and participating in activities it was found that in each meeting, there was 2-3 family health leaders participating in meeting and was satisfied with these activities. Most family health leaders were well morality because each activity used interactive communication and each participant was able to share experience and ask questions, and express their feeling to the group. In this activity, it found that many things occurred such as a change at the family, personal and community levels that could be seen from self-assessment in recorded books of family health leaders about health promotion activity in family and according to facilitators' observation during 3 months after training was summarized as follows:

Results occurred at the individual level among family health leaders after they continually participated in the program that was divided in to 5 items as follow:

1) Practicing follow the criteria of health promotion under national health regulation especially washing hands before taking meals and after excreting, taking cooked clean food, etc.

2) Having ability on first aid focused on joint pain due to accidents until receiving aid from the physician.

3) Family health leaders numbering 22 persons were actively exercise. There were 15 persons who always exercised by aerobic dancing and 4 people who practiced brisk walking and 3 people exercise by Chinese Tai Chi (Thai-kek).

4) Family health leaders especially the chief of each cluster would attend public conferences held in the village every time and express their opinion in order to involved physical health.

5) Family health leaders would be satisfied to develop knowledge and were proud to take care of members in the family about disease prevention and health promotion.

3.1.3 Results at the family level among family health leaders

Family health leaders transfer knowledge to members in the family such as the spouse would emphasize reducing various risk behaviors such as drinking alcohol and smoking and exercise instead. It was found that male family health leaders were able to motivate their spouse to exercise and be members of the assembly numbered 4 persons and others were making decisions. Most of the activities implemented by family health leaders after training are shown in detail as follows: 1) talked to members in the family to know that he or she underwent health care training 2) stimulated members in the family to reduce various risk behaviors such as taking highly seasoned food, drinking alcoholic beverages and not wearing a head guard, etc. 3) Members in the family health leader's family cooperated in various activities such as exercise and DHF prevention. 4) Members in the family attended meetings with the family health leader when there was a conference in his or her community.

3.1.4 Results appearance at the village level

As a result of the family health leader being more interested, it affected the action plan that the family health leader and the VHV cooperated on and accepted by community leaders as follow 1) TAO supported with equipment for aerobic activity 2) the VHV assembly financially supported and promoted the agency of family health leaders to participate in exercise training.

Activities for all villagers in the community were practiced such as campaigning to eradicate dengue larvae under local folk wisdoms by adding salt into storage containers without using chemical and using plastic to cover on top of the jar and tied. These activities were the best thing to prevent this disease. All villagers and family health leaders were able to practice by themselves that was different from the last year when the VHV was a taker.

In addition to the above results mentioned were changing knowledge, ability, leadership and motivation among family health leaders that was evaluated before and after training by using same instruments that showed quantitative results as follows:

3.2 General characteristics of the family health leader

Most of the family health leaders were female about 75.0% and aged between 36-66 years with an average of 40.1 years about 86.1%, marital status was 52.8%, and occupation was merchant with an income between 3,600-50,000 Baht / month. Whereas, the average income was about 10,116 Baht/month. Most of them, 89.9%, completed education at the primary school level and had members in the family from 3-8 people with an average of 4.6 persons.

Family health leaders, about 36.1%, were care takers of members in their family when they were ill. Most of them were elected by village health volunteers (VHV), about 58.3%, followed by selected by public health officer, about 41.7%. After they were selected, about a half of them were trained by the public health officer and village health volunteer and that period of time was one day about 47.2 %.

As for the past operation of learning process, group discussion was about 91.7%, lecture was 86.1%, distribution of a handbook was 47.2% and study tour was 41.7%. Whereas, details of training were ranked from high to low as exercise, self health-care, aids, nutrition, health regulation and others. Most family health leaders, 91.7%, liked to get knowledge on rehabilitation that was listed by interest such as exercise, DHF and first aid as shown in detail in table 7.

Table 7 General characteristics of family health leaders (n =36 persons)

Variables	Number	Percentage
Gender		
Male	9	25.0
Female	27	75.0
Age (years)		
Lower than 40	4	11.1
40-44	13	36.1
45-49	5	13.9
50-54	6	16.7
55-59	2	5.6
60-64	1	2.8
65 years and over	5	13.9
$\bar{X} \pm S.D = 40.1 \pm 6.4$ Min = 36 Max = 66		
Marital status		
Single	4	11.1
Married	31	86.1
Widowed divorced /Separated	1	2.8
Occupation		
Agriculturist	11	30.6
Self-employee	19	52.8
Employee	6	16.7

Table 7 General characteristics of family health leaders (n =36 persons) (Cont.).

Variables	Number	Percentage
Income (Baht)		
Lower than 10,000	9	25.0
10,001-20,000	22	61.2
20,001-30,000	3	8.4
More than 30,000	2	5.6
$\bar{X} \pm S.D = 10,116.67 \pm 9,398.19$ Min = 3,600 Max = 50,000		
Education		
Primary school	32	89.9
Secondary school	4	11.1
Family members (persons)		
1-3	7	19.4
4-5	28	77.8
5 ⁺	1	2.8
$\bar{X} \pm S.D = 4.6 \pm 1.4$ Min = 2 Max = 8		
Care taker of family when member was ill		
Family health leader	13	36.1
Spouse	7	19.4
Offspring	3	8.3
Parents	9	25.0
VHV.	2	5.6
Public Health Officer	2	5.6
Selected to be family health leader by whom		
VHV	21	58.3
Public Health Officer	15	41.7
Number of member in family (persons)		
1-3	7	19.4
4-5	28	77.8
5 ⁺	1	2.8
$\bar{X} \pm S.D = 4.6 \pm 1.4$ Min = 2 Max = 8		

Table 7 General characteristics of family health leaders (n =36 persons) (Cont.).

Variables	Number	Percentage
Care taker of family when member was ill		
Family health leader	13	36.1
Spouse	7	19.4
Offspring	3	8.3
Parents	9	25.0
VHV	2	5.6
Public Health Officer	2	5.6
Selected to be family health leader by whom		
VHV	21	58.3
Public Health Officer	15	41.7
Family health leaders who underwent training from ^a		
Public Health Officer	36	100.0
VHV	18	50.0
Period of training		
1/2 day	15	14.7
1 day	21	58.3
Training process ^a		
Lecture	31	86.1
Study tour	15	41.7
Group discussion	33	91.7
Self study	17	47.2
Subject of training ^a		
Exercise	26	72.2
Hemorrhagic Fever	25	69.4
Self-care	24	66.7
AIDS	23	63.9
Health regulation	19	52.8

Table 7 General characteristics of family health leaders (n =36 persons) (Cont.).

Variables	Number	Percentage
Rehabilitation training Needs		
Yes	33	91.7
No	3	8.3
Subject that should rehab ^a		
Exercise	32	88.9
Hemorrhage fever	30	83.3
First aid	25	69.5
Hypertension	14	38.9
Health regulation	14	38.9

^a Multiresponse

3.3 Knowledge, ability, leadership and motivation of family health leader

After training it was found that the level of knowledge, ability, leadership and family health leader's motivation were at a more positive level as follows:

Before training it was found that the family health leaders were at 19.4% at a positive level and 80.6% should improve but after training it was found that 94.4% of them were also at a positive level.

Family health leaders at 50.05 % had positive ability more than pre-training but after training was found that they had a more positive ability at 88.9%

Before training it was found that 30.6% of family health leaders had a positive level and 69.4% should develop but after training was found that about 61.1% of family health leaders had good leadership and 38.9% should develop.

As for family health leader's motivation before training it was found that those of family health leaders at 88.9% were at a positive level and after training it was higher at 91.7% as shown detail in table 8.

Table 8 Percentage of family health leaders as classified on level of knowledge and ability, pre and post-training (n=36 persons)

Variables	Pre-training		Post-training	
	Good	Need for improvement	Good	Need for improvement
Knowledge	19.4	80.6	94.4	5.6
Ability	50.0	50.0	88.9	11.1
Leadership	30.6	69.4	61.1	38.9
Motivation	88.9	11.1	91.7	8.3

The family health leader's knowledge about health promotion pre and post-training classifying by items, it was found that for pre-training, all family health leaders (100.0%) had good knowledge about improper food for children, method of cooking and usefulness of vegetables and fruits that were a benefit to the digestive system and it was also found that all family health leaders didn't have knowledge about taking care of a patient with high fever. After training it was found that most of the family health leaders had knowledge about health promotion that was better than before, as shown in table 9.

Table 9 Number and percentage of family health leader's corrected answers classified by item (n = 36 persons)

Statement	Correct answer			
	Pre-training		Post-training	
	Number	Percent	Number	Percent
Child about 1-2 years of age should take mother's milk was sufficient ^a	34	94.4	36	100.0
Ice-cream and aerated water were favorite things for children thus it should be given them ^a	36	100.0	36	100.0

Table 9 Number and percentage of family health leader's corrected answers classified by item (n = 36 persons) (Cont.).

Statement	Correct answer			
	Pre-training		Post-training	
	Number	Percent	Number	Percent
Food suitable for childhood should emphasize flavor and sugar because they had to use energy ^a	31	86.1	33	91.7
Seniors should eat fish more than other meats due to easy digestion and low fat	34	94.4	36	100.0
Eating more vegetables and fresh fruit affected the digestive system well	36	100.0	36	100.0
Adding water lemon into spiced minced meat eaten vegetable was one method of killing parasite. ^a	36	100.0	36	100.0
Continue exercise for about 20-30 minutes until tired and had excretion about 3-5 times was good exercise	35	97.2	36	100.0
Deep sleep and relaxation means having to sleep at least 6-8 hours	35	97.2	36	100.0
Singing karaoke was one kind of relaxation that promoted psychosocial health	31	86.1	36	100.0
Taking care of patients who had high temperature was done as follows				
Tepid sponge with warm water along arms, legs and put on various joints	3	8.3	22	61.1
Drink much cool water ^a	0	0	35	97.2
Give aspirin tab. ^a	0	0	36	100.0
More sleep	0	0	36	100.0

Table 9 Number and percentage of family health leader's corrected answers classified by item (n = 36 persons) (Cont.).

Statement	Correct answer			
	Pre-training		Post-training	
	Number	Percent	Number	Percent
The following is how to take care of patients who have joint pain				
Cool compress on pained area	22	61.1	36	100.0
Strongly massage at pained area ^a	32	88.9	36	100.0
Bandage at pained joint protects moving	31	86.1	35	97.2
First aid to burned patient is as follows				
Apply on a wound with tooth paste ^a	2	5.6	35	97.2
Used fish sauce to apply on a wound ^a	28	77.8	34	94.4
Use cool water to rinse on a wound	17	47.2	34	94.4
First aid to stroke patients is as follows				
Loosen clothes and lie down face up	35	97.2	36	100.0
Dilute heart-stimulant and immediately drink ^a	27	75.0	35	97.2
Call many peers support to empower mind ^a	31	86.1	35	97.2
Curcuma Longa Linn is able to cure intestine infection ^a	5	13.9	2	5.6
Faa Tha Lai Joan is able to cure sore throat	33	91.7	33	91.7
Aloe Vera is able to cure peptic ulcer.	20	55.60	31	86.1

^a Negative statement

When considering health promotion ability among family health leaders pre and post training, it was found that for the entire length of post training they were able to practice all activities more than pre training. When considering by item it was found that in pre training the most immediately practiced was about motivating members in the family participating in DHF prevention campaigns 52.8%

followed by tepid sponge, motivating villagers in community to stop using unsafe drugs, expressing ideas about health problems in public conferences and requesting support from village committee (50%) respectively. As for activities that were able to practice if received recommendation, the most 69.4% were able to demonstrate how to exercise. After training it was found the increasing to 91.7% could immediately practiced about motivating members in the family to participate in DHF prevention activities. It was noticed that ability which not changed both pre and post training was motivating members in the family to quit using package drugs and requested financial support from the committee of villagers or members of TAO. The details were shown in table 10.

Table 10 Percentage of family health leader's ability as classified by items (n= 36 persons)

Statement	Pre-training			Post-training		
	Practice	Practice if receive supper vision	Practice if closely controlled	Practice	Practice if receive supper vision	Practice if closely controlled
Prepared food for family that covers flavor, meat, fat, vegetables and fruits of each day	19.4	66.7	13.9	55.6	33.3	11.1
Demonstrated correct tooth - brushing	36.1	25.0	38.9	61.1	30.6	8.3
Demonstrated exercise on neighbors	25.0	69.4	5.6	77.8	19.4	2.8
Motivated neighbors in exercise that fit their age	19.4	52.8	27.8	63.9	77.8	8.3
Tepid sponge for members in the family with fever until reduced	50.0	41.7	8.3	75.0	25.0	0.0
Provided drug remedy for use when it was necessary	44.7	50.0	5.6	72.2	27.8	0.0
Motivated members in family to participate in activity of village about DHF prevention campaign	52.8	41.7	5.6	91.7	8.3	0.0

Table 10 Percentage of family health leader's ability as classified by items (n= 36 persons) (Cont.).

Statement	Pre-training			Post-training		
	Practice	Practice if receive supervision	Practice if closely controlled	Practice	Practice if receive supervision	Practice if closely controlled
Motivated members in family and neighbor to stop sacked drug.	50.0	44.4	5.6	50.0	44.4	5.6
Cleaned lacerated wound with sterilized water and dressed with Povidine iodine.	47.2	41.7	11.1	44.4	38.9	16.7
Explained health problems in community during meeting in village	50.0	44.4	5.6	88.9	8.3	2.8
Established group of family health leaders to continually make health promotion in community.	47.2	47.2	5.6	86.1	8.3	5.6
Requested support from village committee or TAO to practice following activity of health promotion.	50.0	44.4	5.6	50.0	44.4	5.6
Explained to nearby neighbors to understand benefits of community health promotion for recruitment.	47.2	47.2	5.6	63.9	33.3	2.8

Leadership of family health leaders was investigated on leader behavior as classified by item before and after training. It was found that, before training the family health leader's behavior was the most practice at about 58.3% which was opening opportunity to peers for expressing their ideas and plan before implementation. There were 50.0% of the samples liked to learn new things and be able to control their emotion when conflict appeared. As for leader behavior, it was

the lowest at about 11.1% which was that they volunteered to act as agency of a group doing activity and 33.3% responded that they liked to express their idea in group discussion. As for training, it was found that they had leader behavior as the highest at about 77.8% and that they gave opportunity to their peers to express ideas; whereas, leader behavior was the lowest at about 16.7% which was being an agent of a group that was more than before training as shown details in table 11.

Table 11 Percentage of family health leader's leader behavior as classified by item before and after training (n = 36 persons)

Items	Pre-training			Post-training		
	Regularly practice	Some time practice	Never practice	Regularly practice	Some time practice	Never practice
Expressed idea in a conference	33.3	61.1	5.6	33.3	66.6	0.0
to train using thermometer	11.1	83.3	5.6	16.7	83.3	0.0
Volunteered to be agent of group to take activity						
Liked to learn a new things	50.0	47.2	2.8	72.2	27.8	0.0
Advised your friend working	44.4	52.8	2.8	69.4	30.6	0.0
Before any working should plan to do	58.3	36.1	5.6	75.0	25.0	0.0
When in a group will accept reason more than taking side a friend	36.1	58.3	5.6	36.1	63.9	0.0
Gave equal importance to member	47.2	50.0	2.8	75.0	25.0	0.0
Opened opportunities to peers to express their idea.	58.3	38.9	2.8	77.8	22.2	0.0
Able to control one self when conflict in group	50.0	50.0	0.0	75.0	25.0	0.0
Being role model to family and group for self-care	47.2	52.8	0.0	75.0	25.0	0.0

Regarding the whole of family health leader's motivation before and after training it was found that after training family health leaders had more motivation and when considered by item it was found that before training the highest of their motivation was shown in being family health leaders would be able to learn about new models of self-care and prevent by themselves at 72% followed by taking care of a member's health in family at 69.4%. As for after training it was found that the highest motivation was being a family health leader which would make them have more peers and learn new things at 100.0% as shown in table 12.

Table 12 Percentage of motivation for being a family health leaders as classified by item (n = 36 persons)

Items	Pre-training		Post-training	
	more	less	more	less
Proud to be family health leader	63.9	36.1	69.4	30.6
Family health leader was a challenging job	41.7	58.3	69.4	30.6
Being family health leader would have more peers.	44.4	55.6	100.0	0.0
Being family health leader benefit to one self and family	66.7	33.3	94.4	5.6
Being family health leader would b able to learn new thins about self-care when was ill.	72.2	27.8	100.0	0.0
Being family health leader would make one self have proper care taking of member's health in family.	69.4	30.6	72.2	27.8

3.4 Comparison of knowledge, ability, leadership and motivation on self-care, and community health promotion among family health leaders

Comparison knowledge of family health leaders

A comparison health leader's knowledge, ability, leadership and motivation was made by periodical of time between pre-training with immediate post-training, 3 months and 6 months post-training by using Repeated Measure ANOVA. It was found that all the family health leader's knowledge was increased when compared to the mean score. It was found that the family health leader's knowledge at 3 months after training higher than immediate post-training, 6 months post-training and pre-training by $\bar{X} = 22.92, 22.81, 19.67$ and 16.50 respectively. There was significance different of the family health leader's knowledge between pre and post training ($p < .001$). That was supported hypothesis 1.

Comparison of family health leader's ability

The ability of family health leader after training was higher than before training. It was found that the family health leader's ability which measured at 6 months after training higher than 3 months after training, immediate after training and before training with $\bar{X} = 3.67, 3.60, 3.54$ and 3.26 respectively. And there was significance different of family health leader's ability between before and after training ($p < .05$).

Comparison of family health leader's leadership

When comparing family health leader's leadership during pre-training and post-training, it found the increasing of leadership. It was found the family health leader's leadership which measured at 6 months after training higher than immediate after training, 3 months after training, and before training with $\bar{X} = 1.89, 1.60, 1.56$ and 1.40 respectively. And there was significance different of family health leader's leadership between pre and post-training ($p < .001$).

Comparison of family health leader's motivation

Measurement of family health leader's motivation before and after training was from the different time and it was found that the mean of motivation at 3 months after training higher than 6 months post-training, immediate post-training and pre-training by $\bar{X} = 4.77, 4.68, 4.56$ and 4.50 respectively. Those of measurement was found that the mean of motivation at the different time had a difference with statistical significance at ($p < .05$)

From these results, knowledge, ability, leadership, and motivation of family health leaders after strengthening were better than before. These results were supported hypothesis 1 as shown details in table 13.

Table 13 Comparison of mean score on knowledge, ability and motivation of being family health leaders during immediately pre and post-training, post-training 3 months and 6 months

Variables	Time for measured	$\bar{X} \pm S.D$	Difference	S.D	p-value ^a
			Mean		
Knowledge	Pre-training	16.5 ± 0.50	6.306	.347	<.001
	Immediate pre- training	22.81 ± .24	-6.306	.347	<.001
	Post-training 3 months	22.92 ± .27	-6.417	.370	<.001
	Post-training 6 months	19.67 ± .55	-3.167	.205	<.001
Ability	Pre-training	3.26 ± .09	.280	.039	<.001
	Immediate post-training	3.54 ± .06	-.280	.039	<.001
	Post-training 3 months	3.67 ± .04	-.410	.055	<.001
	Post-training 6 months	3.60 ± .06	-.342	.043	<.09
Leadership	Pre-training	1.40 ± .62	.200	.045	<.001
	Immediate post-training	1.60 ± .06	-.200	.045	<.001
	Post-training 3 months	1.56 ± .07	.053	.030	.043
	Post-training 6 months	1.89 ± .03	-.486	.053	<.001

Table 13 Comparison of mean score on knowledge, ability and motivation of being family health leaders during immediately pre and post-training, post-training 3 months and 6 months (Cont.).

Variables	Time for measured	$\bar{X} \pm S.D$	Difference	S.D	p-value ^a
			Mean		
Motivation	Pre-training	4.50 ± .10	.065	.035	.038
	Post-training immediate	4.56 ± .07	-.065	.035	.038
	Post-training 3 months	4.77 ± .04	-.278	.078	.000
	Post-training 6 months	4.68 ± .03	-.190	.090	.021

^a Within factor Repeated Measure ANOVA

4. Establishment of network on community health promotion

Originating networks on community health promotion was begun by trained family health leaders who participated in vision setting. Ban Nern Phi was a Health For All (HFA) village by the year 1998, and during past 3 years there was no communicable, endemic and chronic diseases. So, health problems in this village was not clearly evidence. However, the trained family health leaders analyzed on risk conditions to health by beginning at self-analysis. Finally, if concerning the elements of health promotion it was found that self-practice related to food intake and relaxation were at a satisfactory level whereas, physical exercise should be improved. Thus, all members of the group had agreement that they should establish an exercise group.

During 6 months of study, there were many activities conducted by family health leader group in community. From evaluation of establishment and expansion of networks on community health promotion by observation and group discussion, the process of establishment network on health promotion were as follows:

4.1 Community health promotion network initiation:

Health promotion network establishment was started from the community vision “the community were able to care for ourselves without communicable diseases, having a good environment and peaceful”. The family health leaders and VHVs planned to transfer knowledge and ability to their family members, relatives and neighbor as well. The process of establishing and expanding health promotion network were as follows:

Step 1. The family health leaders improve their health behavior as a model of family members, such as washing hands before meal and after using toilet, made cleanliness house and surrounding, physical exercise and sport playing etc. Those activities were integrated into their everyday life, and at the same time they encouraged family members and relatives to do so.

Step 2. The family health leaders looked for their relatives and neighbors who had health problems. It was found 14 persons with chronic illness, 9 Hypertensions and 5 Diabetes Mellitus. Among this group, 8 of them have to take medicine and monthly follow up by physician. The family health leaders gave advice about daily life self-care to them by following procedure in provided handbook. It was not only self-care strengthened but encouraged then to do proper exercise also. Later, it was found that 6 patients participated in the activity and 3 patients selected to exercise following their familiar method, 3 patients participated in aerobic dance activity and other 2 patients exercised by Thi-kek.

Step 3. Family health leaders liaison with chief of village health volunteer supported this program by taking blood pressure of members of exercise groups every 2 weeks to know about changing physical conditions and to control severity of disease. The village health volunteers gave good cooperation to do activity and the health center provided a sphygmomanometer for the group.

Step 4. Family health leaders divided household of Ban Nern Phi into 6 clusters according to the characteristics of location and based on responsibility of village health volunteers at about 8-9 households per cluster and in each area they held group meetings twice a month including participating in various ceremonies of the village. Family health leaders cooperated with village health volunteers for

distributing brochures and leaflets to neighbors covering all households and every time of meeting such as meeting about breeding chickens, many participants would be interested in the activity and raise the questions. They integrated health promotion topic in every meeting even those activities were held would lead to managing occupation or others.

4.2 Health promotion networks expansion:

In Village 5 Ban Nern Phi, had many existing groups those were linked to variety groups both in and close villages under the mission of their own. The results of expanding health promotion networks were as follow:

At tambon level, TAO has fully responsible for management to develop the quality of people's life. The members of TAO came from every village. The monthly meeting of tambon which called "civil society" was the channel for community participation in the process of tambon management. The representative of family health leaders participated with civil society every month and raised topic of community health promotion frequently. And after civil society conference about 3 times, it was found that Village 5, has been financially supported from Kok Keenon TAO in fiscal year 2004. In this case, the village health volunteer club and family health leaders conducted together with members of TAO. They set up 3 projects those were 1) project of promoting exercise. 2) Project of washing hands without diseases that this project was to investigate on cleaning household and clean food good taste campaign. Especially household that was a reservoir of diseases such as spreading food borne diseases if any household was clean the food would be safe including emphasizing on washing hands and 3) Project of family health leader training in Ban Nern Phi.

In the case of TAO supported exercise equipment such as radio with mini-amplifier used for activity of aerobic and supported sport equipment for youth such as football, volleyball, and net including skipping rope. Whereas, the second project was unnecessary to use budget funds thus, all families were able to immediately use and community leaders should practice to be the exercised models and after that there should be propagation to other places going on. As for the third

project, it had been conducted by TAO and it was considered in the third month of fiscal year 2004. Moreover, it was expected that it would probably expand to all villages in Tambon Kok Keenon.

Groups of family health leaders cooperated with VHV clubs, youths and older group establishing a health promoting assembly. All interested people were able to participate in this assembly. The example of the activities such as health promoting assembly contest, campaigning exercise against drug dependence that was conducted by the Governor including an activity of “eating egg-chicken fry that stimulated a sense against bird flu” that was implemented in February 2004.

In addition, there was a meeting between a group of family health leaders and facilitators in various conferences such as on the tenth of every month, during New Year, and Chunhun Day would have a conference of VHVs at the health center.

Family health leaders, village committees, members of TAO and facilitators had a study tour about two times, that was technical cooperation among developing village (TCDV) which was an effective network expansion method. The first TCDV studied at Village2, Tambon Tha-kham, Phansarikom District, Chonburi Province. This village received a reward on community health promotion in the year 2003. The second TCDV, they studied at Bang-phra TAO, Chachoung Sao Province. This village's outstanding point was health management that was conducted by the village's cooperation committee.

Whoever conducted study tours had a meeting to prepare a topic of study that was determined as 3 topics that were investigated: how was the situation in the community before development, how was it implemented and how would they solve the problem? Family health leaders were assigned responsibility for recording and formulating questions, and sharing during study tours including cooperating to analyze information. After that they summarized information collected during study tours both times. They concerned about cooperating to determine targets and willingness to continually conduct and encouraging establishment networks, efficient communication, continual follow-up, real supports and specifying that health promotion was a major policy of local governing organization that this policy affected the sustainability of networks and support community health promotion. During

study tours, family health leaders were interested in seeing real situation and liked to share their experience for being family health leaders with the host.

An implementing project at the tambon level with the cooperation of family health leaders, VHV, TAO and public health sector which was a responsibility of 5 villages such as Kok Keenon health center had a leader of exercise training for selecting 3 representatives from 39 persons. This activity was supported budget by TAO. The health promoting officer and facilitator of Phanthong Hospital and this program received cooperation by people, VHV and the secretary of TAO that made leaders have more proper knowledge about basic exercise in each village. After that they had meetings about setting activities in their villages that concerned about equipment and types of exercise including motivating people to participate in that activity. The health promoting leader who had undergone training would motivate and invite villagers to join the activities including giving knowledge about nutrition and distributing documents, pamphlets, leaflets with detail knowledge about food safety, exercise, taking meals with 9 nutrition regulations to family health leaders.

Regarding the group discussion during 3 months after development it was found that there was a group for exercise in the community at Village 4, 1, and 2. The village jointed in group exercise by aerobics that was conducted at the health center whereas, the children played volleyball and football but before development there was no existing group acting as present. As for this activity, the school supported loudspeakers, TV for exercise and members of that group donated their money about 20 Baht/person for electricity charge monthly. Even with all this, there still was a lack of some equipment such as a compact disk player, and etc. It was found that 60-80 participants established a health promotion assembly in the area of Village 1 but some areas of Village 3 and 2 were under TAO control. This area would lack of cooperation and coordination from village health volunteers because there were many conflicts to each other so, people in this area prefer to join exercise at Phanthong Hospital.

Obvious assembly base-committees were established that consisted of facilitators who were coordinator. As for other villagers that began to exercise in village. There were 10-25 people per village using an area that was in front of the

village health volunteer's house, head of village, in school or other public places. But the sport equipment was insufficient for the number of exercise groups and lacked of a compact disk for aerobic dance, amplifier and the model to lead aerobic exercise. Family health leaders motivated each household to exercise in household area by community radio broadcasting from 17.30 to 18.30 p.m. everyday. Each village was able to manage by community itself.

From group discussion with family health leaders, it was found that there were 15- 30 villagers exercising in their households during the time mentioned. As the village level, there was an implementation of health promotion activities in each village but it did not cover all villagers. Some villages lacked of many things for support especially, the cooperation of government officers who were an important factor to inform and advise health promotion among the people in the community because some people would believe the public health officer more than family health leaders. Family health leaders had, however, intention to continually development

Evaluation of lessons learned

After training about 6 months the author and facilitators summarized the lessons learned with the agency of family health leaders, deputy of TAO, Kok Keenon Health Center, Phanthong district public health office by overall implementation. It was found that those who were involved in strengthening capability of family health leaders revealed that coordination between unit sections had satisfaction, community leaders had learning about the critical thinking process and had power to promote their health and community. Villagers in the community participated in several activities and were able to solve their problems in the village. They were able to express their feelings and ideas by being leaders who motivated people in the community to participate in exercise in the community. As for consuming healthy food without toxin, many family health leaders were interested and concentrated on buying food but some of them had no awareness because they had limitation of economy in family. Even with all this they still had intention to continually practice and motivated entire villagers in this district to participate in this

program for their health. In addition, they shared their experiences about study tours of the community where there were gone successes in consumer protection to develop the community further.



CHAPTER 5

DISCUSSIONS

This chapter covers the discussion of strengthening the capability of family health leaders IN sustainable community-based health promotion. The discussion is based-on the knowledge and ability of facilitators, the capability of family health leaders, implementation by family health leaders and establishment of a community health promotion network. The details are as follow:

1. Knowledge and ability of facilitator

Five facilitators were trained to empower the family health leaders. The training curriculum for the facilitator emphasized knowledge and ability for self-care, health promotion and facilitation techniques and roles of a facilitator. After a five-day training, the knowledge of the facilitator was better than before training. The result was in agreement with the study of Theerapong Keawhawong (120), Nittaya Phensirinapa (153), Makus Hund (139), and the World Bank (59). The knowledge level that changed significantly was the knowledge of being a facilitator, especially, characteristics of participatory learning and techniques for increasing participation. It was possibly due to the fact that most of the facilitator were well educated and worked in a health-related field as the level of health promotion knowledge did not change much, but facilitator techniques were enhance as it is needed for the interactive learning process.

Dealing with the ability of facilitator, before training, most facilitators had the ability at the level of needs improvement. There were some activities that they could not practice without recommendation from the expert, especially demonstrating exercise, and motivating family health leaders to share experiences with others. After training about participatory learning, the ability of facilitators increased significantly.

This study result goes along with Winch (154), Bhattacharyya, Freund, Amde, and Teshome (155), (41) and Theerapong Keawhaeong (120), who found that participants' learning was an empowering stimulation for participants to improve their skills. The study of Nuttamon Yimyam (157) at Rachaburi Province revealed that increasing the skill of facilitators, continual practice, close supervision, participatory consulting and moral support were needed. Therefore, it could explain that the ability to be a facilitator was reflected with skills such as communication, teambuilding, and problem-solving skills. Thus, the curriculum was set to strengthen all these skills. It was observed that all facilitators were interested in all processes assigned, they shared their experiences with others, repeated demonstrations and practices and discussed more about lessons learned, which might be another reason explaining the increase of facilitator ability.

2. Strengthening capability of family health leaders: knowledge ability, leadership and motivation

Each component of capability was strengthened. There was a significant difference of these components when comparing knowledge, ability, leadership, and motivation before and after training.

Knowledge: family health leader's knowledge about self-care and health promotion after training was significantly higher than before training ($p < 0.05$). The information showed that 80.6 % of family health leaders had knowledge at the level of needs improvement, which was similar to Thawin Lerkchaiyapoom and Wanida Wirakul (138), Sawai khoheng (142) and Phannaray Pitakchareon (143). It can be explained that the majority of family health leaders were selected and trained since 1998, and most of them attended only one training. There was no continuous training or retraining at all. Thus, their knowledge about health care and health promotion declined. However, it differed from the study of Penpimol Siripachoti (156) who found that the existing knowledge of family health leaders in the municipal areas of Samuth Sakorn Province were at satisfactory levels. This might be explained by the fact that the family health leader lived in the municipal area and could access information about health from various sources both directly and indirectly (137).

However, after training, family health leaders knowledge was higher as mentioned before. The majority, 94.4 % had a good level of knowledge and the rest, 5.6 %, needed improvement. This result was also consistent with the study of Nittaya Phensirinapa (153), and Nattamon Yimyam (157) who researched the potential of health promotion leaders in order to achieve health promoting villages. This study result confirmed the trend that the level of knowledge development of family health leaders was still higher than before training even after a time lapse of 6 months, when it was found to have slightly declined, which might due to the pandemic of Bird Flu. This trend can be explained because the facilitator conducted continuous participatory learning and group discussion within their village frequently.

Ability: It was found that before training, 50% of family health leaders had the need to improve their ability, especially first aid for burn patients (95%) and using herbs to treat stomach ache (86%). These abilities could reflect less practice among family health leader after the required training from the past 4 years and lack of continuing practice in everyday life. Focusing on the specific abilities of family health leaders that could be practiced as recommended were food preparation (71%), exercise demonstration to neighbors (69%), motivating neighbors to join exercise (52%), and providing drug remedies when necessary. The results are in accordance with the study of Penpimol Siripachoti (156) and Pisut Kongkum (164).

After training, the ability of family health leaders was significantly better than before training ($p < .001$). It was consistent with the studies of Pannaray Pitakchareon (143) and Theerapong Keawhaeong (120). This result also showed that 3-6 months after training, their ability level was still maintained. It might be due to the opportunities for participation, which motivated them to join such as group exercise and any activities held by their group accompanied by the facilitator. They practiced frequently and gained more skills.

Leadership: In the present study, 69.4% needed to improve leadership behavior before training, but after training the leadership behavior was better and the remaining number needing to improve was reduced to only 38.9%. This can be explained by the fact that the training process affected the family health leader performance. By observation, family health leaders fully participated in all activities assigned so, they could practice and fully utilize the time, gain more confidence to

make decision, giving opportunity to others to express opinion and accept with equity including planning before working. They were better able to control their emotions when a conflict occurred within the group. In addition, they were still held up as positive models to family and neighbors regarding self-care. This might be caused by the participatory learning process that was able to motivate participants to do activities by themselves. They were able to accept recommendations from others. This activity would produce great results gradually changing behavior and they were willing to participate in the program. Similarly, Olga Epitropaki (163) found that a person would express his/her leadership when he/she had suitable opportunity especially, if there was no pressure and if members in the group supported and accepted him/her. This was also consistent with the study of Baling and Kelloway (88) who found that transformational leadership was better able to develop skills regarding participatory learning which Bennis and Nanus (63) explained in that training means to build self-confidence to flow together with formulating new guidelines and that it was a process of developing commitment and trust by building and generating short-term wins such as submitting projects to civil society assemblies at the tambon level FOR WHICH the TAO supported both materials and budget, etc.

Motivation: It was found that before training 88.9% had motivation at a good level, because most family health leaders were proud of being assigned this position. The main reason was this local position gave a benefit to them and their community including the fact that they would gain more knowledge as related to health. Thus, after training, 91.7% gained a good level of motivation. In addition, they were able to learn by doing, which created more self-confidence and skill. All participants accepted the program and indicated that this program was a benefit to the community. This was in accordance with Herzberg (82) who introduced the motivating factors. The result mentioned is also consistent with the study of Chot Girdbundhit (159) who found that students in secondary school who were selected to be health youth leaders and their performance on peer health care was at a good level especially, first aid.

3. Family health leader implementation: Self-care, community-based health promotion

After training, family health leaders formed in groups and conducted activities related to their action plans. The implementation plans of family health leaders could be exhibited as self-care activity and community-based health promotion.

Self-care: It was observed that family health leaders paid attention to the practice of first aid especially on helping fainting and injured persons, which they frequently encountered. The self-care practice places an emphasis on food for different ages, relaxation and recreation, minor illness management, and first aid. The results indicated that most family leaders transferred health knowledge among family members, encouraged them to join group exercise and changed some risk behaviors such as the reduction of smoking. It was found that 22 persons of the family health leaders regularly exercise since their training and have continued more than 6 months. Most of the respondents follow the hygiene regulations especially washing hands before meals and after using the toilet. It might be explained that this resulted because family health leaders were motivated to consider the benefit of self-care for their family in economic aspects; even though most of them have health insurance. The conclusion of Chotip Boromthanarat (160) was that self-care enables family members to identify and seek their own health agenda, Because self-care rests in the ability of individuals to meet their needs, maximize personal strengths and become autonomous. Moreover, the strengthening process and continuous facilitation might be additional reason.

Community-based health promotion: It was found that family health leaders could cooperate with community leaders such as the Kamnan, TAO members and other local wisdom sources for support. At the beginning phase, family health leaders proposed their plan, then initiated activities to motivate villagers' participation. This movement of family health leaders goes along with the study of Nuttamon YimYam, (157) It is possible that all of the family health leaders who

participated in this program need to be accepted as leaders in the aspect of health from the villagers point of view.

4. Establishment of community health promotion network

Regarding the results of the establishment of a community health promotion network, it was found that the network was begun from sharing experience and viewing the same benefit and opportunity of development. This was consistent with the study of Powell (115) who revealed that a person would share his/her experience and learn together within a self-context and he/she would make himself/herself become familiar with the group and make a support system. Additionally, Seri Phongpit (153) found that building a network was the most important factor to sustainable development because members worked together and shared experience and information. These would affect the creation of empowerment and especially, if they were done by network, several campaigns would succeed more easily. The coordinator of a network group has to have the ability to coordinate as a facilitator, catalyst and networker.

Networks in different levels are established naturally but it is not always obvious such as when public health officers link an activity to various organizations in the community, and when VHVs coordinate with several groups, etc. However, the network among the families and neighbors would form close relationships making it easy to communicate. Thus, the linkage would be strengthened more than other networks. Gilchrist (161) stated that the “community is derived from looser networks of neighborhood colleagues and fellow activists or associates, rather than a more traditional family connection” and it was often found that public health officers worked in these cross networks more than using local resources for strengthening the network.

From the present study, it was found that networks initiated from family health leaders as mentioned was started from informal communication then plans were made to make the activity flow together. Network structure had various models but it was less important than the multi-channel communication process by members in that network. They had to exchange information between persons by using a variety

of communication channels such as seminars or meetings and acting together, etc. All this indicated that the Ban Nern Phi health promotion network might be continued if family health leaders are encouraged and supported by the local authority including health personnel. Supports could be in terms of technical support as required.

Lessons learned and limitations

During the 6 month-period, the researcher and facilitators trained family health leaders by informal discussion and documentation conducted parallel with partial observation. After this period, the researcher and facilitators concluded about lessons learned and limitations of this study.

Lessons learned:

The process of community-based health promotion network establishment for sustainable development is composed of four phases: 1) forming networks, 2) maintaining the family health leader's role, 3) establishing networks and 4) expanding networks. It was developed through continuous participatory learning, empowerment, and TCDV. It can be verified as follows.

Group forming: The group begins forming during the training conducted by facilitators. It should flavor the climate of participatory learning, including meeting strategy, activities and the local community network to gear the group of family health leaders in the direction of appreciation. Thus, the facilitators should consider being key persons who bring together different aspects of group activities in a community without any influence on the community system. It was not difficult for them to share experience and seek for commitment because most of them are familiar to each other. The activities in this period should be both tangible and intangible rewards for family health care. These activities helped to motivate family health leaders to participate with the group and facilitator as well. It was learned that rapid participatory community appraisal (RPA) was employed to involve stakeholders to be concerned in the community information, which was far from their awareness. It assisted stakeholders' comprehension and understanding of the relationships of information and development, which in turn, affected their living. It helped them to

have a vision of community health promotion under their community context, and to know the strengths and weaknesses of their community.

This was consistent with the suggestion of Kanjana Keawtep that community diagnosis led the people to have more power from their knowledge in setting priorities, and to understand the method of analyzing the true causes of the problem and the method of analyzing themselves. This method helped the stakeholders to accept that they were important persons in the community. On the other hand, the roles of community committees and local authorities affected the community environments as a whole.

Maintain family health leader's role: The family health leaders' roles were gradually transferred from the facilitator. Family health leaders advocated group members, organized groups and developed networks for promoting health. In this period, the facilitator is still an important person by coordinating among family health leader groups, health providers and the TAO to run group activities.

The most important lesson learned from this study was the way to maintain the roles of family health leaders. They might maintain their self-care and health promotion activities along with their daily life if they realized the benefits of those behaviors. They could play important roles with confidence from being a family health leader. Thus, the strengthening capability for enhancing knowledge, ability, leadership, and motivation required this factor. The strengthening capability curriculum was constructed in appropriate consideration of the status of family health leaders knowledge, basic health promotion capacity, and availability of their contribution. The participatory learning process was endorsed for turning their existing experiences to new experiences following the principles of adult learning.

Establishment of network: Facilitators regularly empowered groups of family health leader members to develop group activities in the appropriate direction both at the individual and group levels. It was in accord with the evidence of Penpimol Siripachoti (156), reporting the starting point of the community development group was the effort to empower people in the community which traditionally maintained their members as a group of closely connected and prolonged relationships. Due to an increase of self-care and health promotion activities at the group and community levels, group members specified the responsibilities to organize

activities. Although the group relied on the knowledge of other persons, group members selected the responsibilities by emphasizing the distribution of responsibilities in the community. To facilitate the group to be active in establishing a network, it has to employ the empowerment process.

Network expansion: This period was the last and took the most time. It was observed that the family health leaders group had a better understanding of their roles and participated with others regularly. The family health leaders group operated independently in this period. Group members were mostly stable. Most of them were the leaders of a community-health promotion committee, and were interested in health related activities. Some of them became key persons in creating and running group activities and also facilitators. All of the stakeholders maintained alliances. They intensely cooperated to nurture community health activities, tried to mobilize resources and negotiated with their networks by themselves. The family health leaders group became the mechanism of community activity for which stakeholders in the community participated to join the activities. The activities among groups happened from their experience sharing. This process aided them to have cognitive complexity, critical thinking, content knowledge, and motivation to work.

Simultaneously, networks were expanded and resources were constantly mobilized for the group. To expand the network, exposure to evidence followed an appropriate process. On the other hand, the group of family health leaders could apply what they learned from other communities through TCDV as well.

Limitations of the study:

1. During the study period, there were some influential incidents that might have affected the process of the study such as national narcotics eradication campaign, TAO election, SARS and Bird Flu epidemic. These caused a prolong process, and lowered participation from health officers and other government employees including community leaders. The researcher and facilitators worked with them as a partner of those projects.

2. The Ministry of Public Health's policy regarding nationwide "exercise for health" was launched in the communities during the same period. As a result, the study might reflect that either community-based health promotion outcome

went along with that policy or that the success of the promotion came from beyond the project.

3. The network establishment for community health promotion was time consuming. Health promotion activities were far from the community concerned. Some successful activities may not have been obvious during such a short period. They gradually emerged and were evident when the family health leader group had its own power. Moreover, community awareness needed the effort and patience of all of the stakeholders not only from the family health leader. Also, experiential participatory learning about self-care and community health promotion continuously empowered them and was in close accord with the health problems concerning their daily lives. Facilitators acted as key persons in the vigorous coordination of all of the stakeholders to help their groups to direct themselves. Facilitators necessarily had a profound understanding about the implementation process regularly involving stakeholders to create awareness in this issue.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

This research was a study of strengthening capability of family health leaders on sustainable community based-health promotion with the stated purpose to compare knowledge and ability of family health leaders having health promotion before and after participating in a participatory learning program and assessing the network establishing process and sustainable extension of the community. The study was the quasi-experimental research that assessed one sample together with a qualitative study by studying before and after implementation. The sample comprised villagers in Village 5 Ban Nern Phi, Tambon Kok Keenon, Phanthong District, Chonburi Province. The sample comprised facilitators who included 3 public health officers, 2 village health volunteers and family health leader numbering 36 persons. The questionnaire was used for quantitative data collection before and after training and qualitative data was gained by observation and group discussion. The period of implementation was 7 months from September 2003 to March 2004.

Conclusion

Facilitators comprised 2 males and 3 females, 4 persons were graduated bachelor degree, 3 persons were public health officers and 2 village health volunteers. Facilitators' knowledge and ability before training needed improving. After training their knowledge and ability were higher with statistical significance ($p < .05$).

Thirty-six family health leaders were recruited in the study. There were females 3 of 4 among them, aged between 36-60 years. The average age was 40 years old, married 86.1%, merchants and had incomes about 3,600-50,000 Baht with an

average per month of 10,116 Baht at 89.9%, graduated primary school at 58.3%, and 50.0% were care taker of family .

The family health leader's knowledge at 3 months after training higher than immediate post-training, 6 months post training, and pre training. The ability that measured at 6 months after training was higher than 3 months after training, immediate after training and before training. The increasing of leadership which measured at 6 months after training higher than immediate after training, 3 months after training, and before training. The motivation at 3 months after training higher than 6 months after training, immediate after training and before training respectively.

From these results, knowledge, ability, leadership, and motivation of family health leaders after strengthening were better than before. These results were supported hypothesis 1

The mean score on motivation before training was lower than immediately after training, after training 3 months, and at 6 months with statistical significance ($p < .05$) that was according to the hypothesis.

Regarding establishing health promotion network and sustainable extension it was found that after training family health leaders were able to expand health promotion networks to the family their family member and neighbor in the community.

Recommendations

Recommendations for policy implication

1. The Central Regional Training Center for Primary Health Care Development should convince the regional policy for Provincial Health Offices to strengthen the capability of health personnel to be facilitator.

2. The local authority, TAO should encourage the local policy for community-based health promotion network establishment. The process should consist of strengthening capability of family health leaders, funding support, empowering the group, and provide opportunity for fully participation in all community activities so, it could support the decentralization policy.

Recommendations for Implementation

1. The Central Regional Training Center for Primary Health Care Development should develop participatory learning curriculum which appropriate for facilitator by emphasizing on building ability and motivation to work proactively with the family health leaders. Training for the trainers should be held and provided to health personnel and the leader of village health volunteers.

2. Provincial Health Office, District Health Office, and Community Health Center should encourage the family health leader groups to establish, and expand network for sustainable community health promotion. The process should consist of: 1) Group forming by encouraging more participation in term of self-awareness, 2) maintain family health leader's role by strengthening capability for enhancing knowledge, ability leadership and motivation, 3) establishment of network by continuous empowerment and 4) network expansion by multi-channels communication and TCDV.

Recommendations for further Study

1. Qualitative methods should be applied more in follow up studies to explicit the process of community health promotion network expansion, and health impacts of community.

2. Action research should be used to develop proactive health promotion skills of the facilitators and family health leaders as well.

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APPENDIX A

Test Form No.....

Pre-test and Post-test of Training of Facilitators For Strengthening the Capability of Family Health Leaders in Community-based Health Promotion

Part 1: General Information

Direction: Please answer the questions and fill in the blanks completely

1. First Name Family Name
2. Age Years
3. Sex 1. Male 2. Female
4. Educational Attainment

<input type="checkbox"/> Secondary education / Vocational school	<input type="checkbox"/> Diploma/ Certificate
<input type="checkbox"/> Bachelor degree	<input type="checkbox"/> Other (specify)
5. Marital status

<input type="checkbox"/> Single	<input type="checkbox"/> Married
<input type="checkbox"/> Widowed, divorced, separated	
6. During the past two weeks, did you participate in any training?

<input type="checkbox"/> No
<input type="checkbox"/> Yes

 1. .courseduration
 2. courseduration
 3. courseduration
7. What kinds of knowledge and capability do you want to enhance and strengthen?

<input type="checkbox"/> 1. Participatory community analysis
<input type="checkbox"/> 2. Participatory planning
<input type="checkbox"/> 3. Participatory evaluation
<input type="checkbox"/> 4. Community empowerment
<input type="checkbox"/> 5. Resources mobilization techniques

Part 2: Knowledge of facilitator

Direction: Please choose the best answer of the following questions.

1. Which item is the correct practice about taking meals?
 - A. Eating 3 meals and 2 snack per day.
 - B. Hypertension patients don't eat high cholesterol food.
 - C. Eating flour, meat, fat, vegetable and fruit in each day.
 - D. Drinking coffee when you don't have meal.
2. Which item is the appropriate meal for each person?
 - A. Only breast feeding in the first 4 months old.
 - B. In adolescent should eat a lot of vegetable for prevent obesity.
 - C. School child should drink sweat water instead of pure water to have enough energy.
 - D. Elderly should have high protein for retrieving.
3. Which item is the correct practice about enough resting?
 - A. Going to see the first round of the movie with family.
 - B. Sleeping 6-8 hours per day.
 - C. Going to party.
 - D. Reading the favorite novel until end.
4. Which item is the correct practice exercise?
 - A. Labor working such as continue dig some grasses 6-8 hours/day.
 - B. Fast walking for 30-40 minutes or until feeling tired, sweat and having more heart rate.
 - C. Jogging for 3-5 minutes for sweating.
 - D. Continue aerobic activity 2 hours.
5. Which item is the correct first aid about sprain?
 - A. Suddenly hot compress.
 - B. Suddenly cold compress.
 - C. Strangely massage with balm.
 - D. Softly rotate the injured joint.

6. Which item is the correct method for relief fever?
 - A. Keep warm with the thicken blanket.
 - B. Increasing drinking warm water.
 - C. Take mixed amphetamine drink for preventing fatigue from fever.
 - D. Do exercise for 10 –15 minutes to sweat for relief fever.
7. Which item is the correct about participation training?
 - A. Training with expert trainer in each item.
 - B. Training that participants are familiar.
 - C. Training that learning from integrates learner's experience with group process.
 - D. Training that strengthen questions from learner more than lecture by trainer.
8. Which item is the main component of interpersonal communication?
 - A. messenger, channel, and interpretation
 - B. messenger, message, and receiver
 - C. messenger, channel, interpretation, and feedback.
 - D. messenger, message, channel, receiver and feedback
9. Which item is the Participatory Learning Process for community study?
 - A. Interview family representative every house in the village.
 - B. Collect data from District Health Office.
 - C. Questionnaires about health status from primary care unit.
 - D. Group discussion with women group, teachers, health care providers, local government official about nutrition in school child

Part 3: Ability of facilitator

Please choose (√) your extent of practice of being facilitator

Statement	Immediately practiced without recommendation	Practiced if received recommendation	Immediately practiced without recommendation	Practiced if received recommendation
1. Made positive feeling of family health leader.				
2. Created positive atmosphere and no pressure.				
3. Gave recommendation on taking meal as suit for age.				
4. Demonstrated exercise to family health leader.				
5. Demonstrated how to tepid sponge to family health leader.				
6. Explained how to relieve stress to family health leader.				
7. Demonstrated how to eliminating Dengue Larvae in and around household to family health leader.				
8. Stimulated on family health leader and member in family participated in DHF prevention campaign activity in community.				
9. Coordinated to various groups in community to allocate exercise's equipment.				
10. Stimulated on family health leader had sharing experience to others.				
11. Summarized on main topic of group's agreement.				

Questionnaire for Family Health Leaders

Part 1: General Information

Direction: Please answer the questions and fill in the blanks completely.

1. Sex 1. Male 2. female
2. Age..... Years
3. Marital status
 - 1. Single 2. Married
 - 3. Widowed, divorced, separated
4. Occupation
 - 1. agriculture 2. domesticate animals
 - 3. seller 4. Employee
 - 5. government officer 6. others.....
5. Educational Attainment
 - 1. did not attain school 2. Primary school
 - 3. secondary school 4. Vocational school
 - 5. Diploma/ Certificate 6. Bachelor degree
6. Average income..... Bath/ month
7. Number of members in the family.....persons.
8. Who is the caregiver in your family?
 - 1. yourself 2. wife / husband
 - 3. son /daughter 4. father / mother / relative
 - 5. village health volunteer 6. health care provider
9. When did you be family health leader? year.....
10. Who did select you to family health leader?
 - 1. Village health volunteer 2. Health care provider
 - 3. Village committee 4. Head of the village
 - 5. By yourself 6. Other.....

11. After you have been selected to family health leader. Whom did you train?
- 1. health care provider
 - 2. village health volunteer
 - 3. other ministry official
 - 4. head of the village/ trainer from TAO
12. You were trained fordays.
13. How did you be trained?
- 1. lecture, demonstrate, practice
 - 2. field trip among villages
 - 3. group conference and give document
 - 4. give document for self study
14. What subject did you learnt from training? (can choose more than one)
- 1. self care
 - 2. exercise
 - 3. nutrition
 - 4. Dengue hemologic fever
 - 5. AIDs
 - 6. hygiene regulation
 - 7. Other.....
15. Have you got revisable training?
- 1. no
 - 2. yestimes
16. What subjects do you want to learn? (can choose more than one)
- 1. first aid
 - 2. Exercise
 - 3. nutrition
 - 4. hygiene regulation
 - 5. Dengue hemologic fever
 - 6. Other.....

Part 2 Knowledge of Family health leader

Please choose and mark the box which you agree

Statement	Yes	No
1. Child about 1-2 years of age should take mother' milk was sufficiency		
2. Ice-cream and aerated water were favorite thing for children thus there should give it for them		
3. Food was suitable for childhood should emphasized on flavor and sugar due to they had to use energy		
4. Senior should eat a fish more than other meats due to easily digested and low fat		
5. Eating more vegetables and fresh fruits affected digestive system was good		
6. Adding water lemon into spiced minced meat eaten vegetable was one method of killing parasite		
7. Continue exercise about 20-30 minutes until be tired and had excrete about 3-5 times was good exercise		
8. Dept sleepy and relaxation had to sleep at least 6-8 hours		
9. Singing Karaoke was one kind of relaxation that promoted psychosocial health		
10. Taking care patient who was high temperature was done as follows Tepid sponge with warm water along arms, legs and put on various joints More drink cool water Took aspirin tab More sleep		

Statement	Yes	No
11. This following was how to take care patient who was joint pain Compressed on pained area with cool Strongly massaged at pained area Bandaged at pained joint protect moving		
12. First aid to burned patient as follows Apply on a wound with tooth paste Used fish sauce apply on a wound Used cool water pour on a wound		
13. First aid to stroked patient as follows Loosed clothes and lie down face up Diluted heart-stimulant and immediately drink Called many peers to psycho support		
14. Curcuma longa linn was able to cure intestine infected Acanthacea was able to cure sore throat Aloe vera was able to cure peptic ulcer		

Part 3 Ability of family health leader

Please choose (√) your extent of practice

Statement	Immediately practiced without recommendation	Practiced if received recommendation	Immediately practiced without recommendation	Practiced if received recommendation
1. Prepared food for family that cover on flavor, meat, fat, vegetables and fruits of each day				
2. Demonstrated exercise on neighbors				
3. Motivated neighbors exercise that suit for their age				
4. Tepid sponge for member in family who was fever until reduce				
5. Provided dung remedy for use when it was necessary				
6. Motivated member in family participate in activity of village about DHF prevention campaign				
7. Motivated member in family and neighbor stopped sacked drug				
8. Cleaned lacerated wound with sterilize water and dressed with Providine Iodine				
9. Expressed on health problem in community at civil conference in village				
10. Established group of family health leader to continually make health promotion in community				

Statement	Immediately practiced without recommendation	Practiced if received recommendation	Immediately practiced without recommendation	Practiced if received recommendation
11. Requested supporting from village committee or SAO to practiced follow activity of health promotion				
12. Explained to neared neighbor understand to benefit of community health promotion for recruitment				
13. Expressed idea in a conference				
14. Volunteered to be agency of group to take activity such as trained using termometer				
15. Liked to learn a new things				
16. Advised your friend working				
17. Before any working should plan to do				
18. When be in group will accept a reason more than take side friend				
19. Gave equally an importance to member				
20. Opened opportunities to peers express their idea				
21. Be able to control one self when had confliction in group				
22. Being positive model to family and group for self health care				

Part 4 Leadership of family health leader

Please choose (√) your extent of practice

Statement	Always	Sometime	Never
1. Expressed idea in a conference			
2. Advised your friend working			
3. Before any working should plan to do			
4. When be in group will accept a reason more than Take friend's side			
5. Gave equally an importance to member			
6. Opened opportunities to peers express their idea.			
7. Be able to control one self when had confliction in group			
8. Being positive model to family and group for self health care			

Part 5 Motivation of family health leader

Please rate (√) your extent of behavior

Items	more	Less
1. Proud to being family health leader		
2. Family health leader was a challenged job		
3. Being family health leader would have more peers		
4. Being family health leader would be benefit to one self and family		
5. Being family health leader would b able to learn new thins about self health care when was ill		
6. Being family health leader would make one self had proper taking care member's health in family		

INTERVIEW GUIDE
INTERVIEW GUIDE FOR FOCUS GROUP TO FOLLOW UP THE
ACTIVITIES OF FAMILY HEALTH LEADERS

1. After training, family health leaders have something change or not and what are your change in these topics?
 - Self care yourself and your family both wellness and illness condition
 - Cooperate with the community for health promotion
 - To be the leader of change for health promotion
2. After training, do family health leaders have meeting themselves? How do they do? Who is the coordinator? What is the process of activities? How do you assign responsibility?
3. Do family health leaders have group activity? Do your group enlarge? How do you do and what are your activities?
4. Do you see anything changed in your group and how?

INTERVIEW GUIDE
GUIDELINE FOR OBSERVE THE ACTIVITIES OF FAMILY HEALTH
LEADERS IN HEALTH PROMOTION PLAN

1. Activities as follow plan
2. Place
3. Participant
4. Participation and activities of family health leaders as well as participants (give opinion, suggestion, information, critique, willing to do activities etc.)
5. Out put of their activities



INTERVIEW GUIDE
INTERVIEW GUIDE FOR FOCUS GROUP TO FOLLOW UP THE
ACTIVITIES OF FAMILY HEALTH LEADERS

1. After training, family health leaders have something change or not and what are your change in these topics?
 - Self care yourself and your family both wellness and illness condition.
 - Cooperate with the community for health promotion.
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INTERVIEW GUIDE
INTERVIEW GUIDE FOR OBSERVE THE ACTIVITIES OF FAMILY
HEALTH LEADERS IN HEALTH PROMOTION PLAN

1. Activities as follow plan
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4. Participation and activities of family health leaders as well as participants (give opinion, suggestion, information, critique, willing to do activities etc.)
5. Out put of their activities



APPENDIX B

CURRICULUM STRUCTURE (FACILITATOR)

1. The kinds of learning process to enhance and strengthen family health leader.
2. Participatory Learning Process
3. Facilitator's role
4. Facilitator's qualifications
 - 4.1 knowledge about the potential of the family health leader, self care, health promotion, participation technique, group construction, and net work extension for sustainable development
 - 4.2 basic skill as follow:
 - communication skill
 - observation skill
 - trust construction skill
 - problem solving skill
 - team work skill
 - conclusion, analysis, interpret, and synthesis skill
5. Design and plan for Participatory Learning Process
6. Evaluation and follow up

ตัวอย่าง หลักสูตรวิทยากรการเรียนรู้

กิจกรรมที่ 1

จิตสำนึกและบทบาทของผู้นำการเปลี่ยนแปลง

กิจกรรมที่ 1.1 จิตสำนึกผู้นำการเปลี่ยนแปลง

วัตถุประสงค์

1. เพื่อให้ผู้เข้าอบรมทุกคนได้วิเคราะห์ว่าจิตสำนึกของคนมีอะไรบ้าง
2. เพื่อให้ผู้เข้าอบรมทุกคนได้ให้คำจำกัดความคำว่า “จิตสำนึก” ในความหมายของตนเองนั้น คือ อะไร
3. เพื่อให้ผู้เข้าอบรมฝึกทักษะสนทนา ได้แก่ การเป็นผู้พูดและผู้ฟังที่ดี เพื่อสร้างจิตสำนึกพื้นฐานของการเป็นผู้นำการเปลี่ยนแปลง

ระยะเวลา 30 นาที

เวลา	กิจกรรมการเรียนการสอน	วิธีการ	สื่อ	ผลที่คาดว่าจะได้รับ
5 นาที	<p>1. วิทยากรเกริ่นนำเพื่อให้ผู้เข้าอบรมเห็นความสำคัญของคุณค่าของคนต่อการสร้างจิตสำนึก</p> <p>2. แบ่งกลุ่มผู้เข้าประชุมคละกลุ่ม (ตามจำนวนผู้เข้าอบรม แต่ละกลุ่ม ประมาณ 10 – 15 คน</p> <p>2.1 แจกใบงานที่ 1 ให้กลุ่มวิเคราะห์ และ สรุปประเด็นต่อไปนี้</p> <ul style="list-style-type: none"> ▪ จิตสำนึก คืออะไร ▪ เกิดขึ้นจากอะไร 	<p>: กระบวนการกลุ่ม</p> <p>: บรรยาย</p> <p>: อภิปรายสรุป</p>	<ul style="list-style-type: none"> ● บัตรคำ ● กระดาษปรีฟ ● ปากกาเคมี 	<p>ผู้เข้าอบรม ทราบและเข้าใจถึงความสำคัญของการมีจิตสำนึกที่ดีที่มีต่อการพัฒนาสุขภาพและเข้าใจถึง ผลการเป็นนักฟังและนักพูดที่ดีต่อการสร้างจิตสำนึกของผู้นำการเปลี่ยนแปลง</p>

เวลา	กิจกรรมการเรียนการสอน	วิธีการ	สื่อ	ผลที่คาดว่าจะได้รับ
	<ul style="list-style-type: none"> ▪ การฟังและการพูดที่ดี มีผลต่อการสร้างจิตสำนึกอย่างไร ▪ จิตสำนึกที่ส่งผลต่อการพัฒนาด้านสุขภาพ มีอะไร 			
	2.2 ...			
	2.3 ...			

กิจกรรมที่ 2

ภาพฟังประสงค์ของหมู่บ้านสุขภาพดีและแนวทางสร้างหมู่บ้านสุขภาพดี

วัตถุประสงค์

เพื่อร่วมกันกำหนดคุณลักษณะของหมู่บ้านสุขภาพดี และนำไปกำหนดตัวชี้วัดและแนวทางการพัฒนารวมทั้งการประเมิน ที่เหมาะสมตามหลักวิชาการ นโยบายและบริบทของท้องถิ่น

ความคิดรวบยอด

แนวทางในการพัฒนาและประเมินผล “หมู่บ้านสุขภาพดี” ควรเกิดจากระบวนการมีส่วนร่วมของชุมชน และเป็นไปตามหลักวิชาการ สอดคล้องกับนโยบายและบริบทของท้องถิ่น

ระยะเวลา 1 ชั่วโมง 30 นาที

กิจกรรมที่ 2.1 หมู่บ้านสุขภาพดี ดูที่ไหน อย่างไร

เวลา	กิจกรรมการเรียนการสอน	วิธีการ	สื่อ	ผลที่คาดว่าจะได้รับ
10 นาที	1. วิทยากร(หลัก)กลุ่ม ชี้แจง กิจกรรม และตั้งประเด็นคำถาม 5 ข้อ ต่อไปนี้ (1) หมู่บ้านสุขภาพดี ควรมี ลักษณะอย่างไรบ้าง?(มี องค์ประกอบอะไร บ้าง?) (2) ลักษณะเหล่านั้นจะดูได้จากอะไรที่ไหน (3) ลักษณะเหล่านั้น จะต้องมีจำนวน/ขนาด มากน้อยแค่ไหน จึงจะถือว่าเป็น “หมู่บ้านสุขภาพดี” (4) ใครบ้างที่จะเป็นผู้ดู/พิจารณาประเมิน (5) ควรจะดู/พิจารณาเมื่อไร/ช่วงไหนบ้าง	1. ประชุม กลุ่ม 2. บรรยาย 3. อภิปราย สรุป	- กระดาษ ปรู๊ฟ หรือ แผ่นใส ที่มีเนื้อหา ประเด็น คำถาม 5 ข้อ	- สมาชิกกลุ่มเข้าใจคำถาม และมีประสบการณ์ในการกำหนดตัวชี้วัดเพื่อการประเมิน
30 นาที	2. แบ่งกลุ่มย่อย 2 – 3 กลุ่ม แบบคละ(ให้มีหลายพื้นที่ หลายกลุ่มคน) ให้แต่ละกลุ่มย่อยเลือกประธาน เลขานุการและโฆษกกลุ่มย่อยและ พิจารณาตามประเด็นคำถาม			- สมาชิกกลุ่มคุ้นเคยกับการเลือก/สมัครเป็นตัวแทนเพื่อทำหน้าที่ต่าง ๆ ในกลุ่ม
15 นาที	3. ให้โฆษกกลุ่ม นำเสนอคำตอบของกลุ่ม โดยสรุปกลุ่มละ 5 นาที		- กระดาษ/ แผ่นใส	

เวลา	กิจกรรมการเรียนการสอน	วิธีการ	สื่อ	ผลที่คาดว่าจะได้รับ
5 นาที	4. วิทยากรกลุ่ม สรุปคำตอบของกลุ่ม และชี้แจงเพิ่มเติมถึง ตัวชี้วัดในระดับนโยบาย แล้วปรับรวมเนื้อหาให้สอดคล้องกันและกัน (เช่น ข้อนี้ ตรงกันกับ ข้อนี้ ตัวเลขเกณฑ์น่าจะไม่น้อยกว่าของกระทรวง หรือ ข้อนี้ของกลุ่มมี/ไม่มีของกระทรวงมี/ไม่มี เป็นต้น) ส่วนกระบวนการประเมินควรสรุปตามแนวทางของกลุ่ม		- กระดาษ/ แผ่นใส เสนอ - เอกสาร ตัวชี้วัด หมู่บ้าน สุขภาพดี	- ได้คุณลักษณะ ตัวชี้วัด และกระบวนการ ประเมินหมู่บ้านสุขภาพ ดี ที่ปรับแล้ว พร้อมนำไปใช้ในพื้นที่

หมายเหตุ ถ้ามีเวลาไม่มากพอ อาจจะดำเนินกิจกรรมโดยไม่แยกกลุ่มย่อย อาจจะประชุมกลุ่มรวม (20 – 50) คนได้ แต่ควรเพิ่มเลขานุการกลุ่มขึ้นอีก

APPENDIX C

STRUCTURE OF TRAINING CURUCULUM FOR FAMILY HEALTH LEADERS

Curriculum Objectives:

1. To enhance knowledge, ability, leadership, and motivation of family health leaders.
2. To develop skills of family health leaders about self-care and health promotion.

Participatory Training Course to Enhance the Knowledge Ability Leadership and Motivation of Family Health Leaders

Objectives of the Training

After the training, the participants will be able to

1. Apply the learning into the effective self-care and health promotion practice.
2. Improve health promotion knowledge, skill of family health leaders

Duration of the First Training 3 days

Method of the Training by using group processes to encourage the exchange of ideas, also reflect and conclude the conceptual thoughts.

Contents of the Training

First day

- | | |
|------------------|--|
| 8.30 – 9.00 am. | Test for the knowledge and ability of the before the training. |
| 9.00 – 10.00 am. | Preparation for readiness of the supervisors |

by.....

Objectives In order that the participants will

1. Get to know each other and build up relations among each other
2. Relax and be ready for the training course.
3. Evaluate themselves and be ready to learn.

Activities

1. The participants would learn that the factors of success in any practice are up to both physical and mental power and they would receive the test for physical and mental power.'
2. Introduction of oneself was done by drawing a picture on a paper with the detail of the character, their likes and dislikes before handed it to the lecturer. The lecturer then mixed up the drawings and handed it back to the participants in order to let them follow and take care of each other throughout the training.
3. Self-analysis was evaluated by drawing a bean shown by the lecturer and the participants had to score their drawings. Later, the lecturer peeled the bean and asked the participants to correct the score with explanation.
4. The participants wrote their names on the envelopes and kept it in the meeting room in order that the participants would be able to write a letter to each other.

10.00 – 12.00	Course orientation
12.00 – 13.00	Lunch
13.00 – 17.00	6 Knowledge Station
	Station 1
	Station 2
	Station 3



No. 85/2003

Documentary Proof of Ethical Clearance
The Committee on Human Rights Related to
Human Experimentation
Mahidol University, Bangkok

Title of Project : **Strengthening Capability of Family Health Leaders on Sustainable Community-based Health Promotion**

Principal Investigator : **Mrs. Wanasara Chaoniyom**

Name of Institution : **Faculty of Public Health**

Approved by the Committee on Human Rights Related to Human Experimentation

Signature of Chairman : 

(Professor Dr. Srisin Khusmith)

Signature of Head of Institute : 

(Professor Dr. Pornchai Matangkasombut)

Date of Approval : 9 MAY 2002

APPENDIX E

คำอธิบายต่อแก่นนำสุขภาพประจำครอบครัว ผู้ยินยอมตนให้ทำการวิจัย

ด้วยดิฉัน นางวนัสรา เซาว์นนิม นักศึกษาระดับปริญญาเอก วิชาเอกบริหารสาธารณสุข คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล จะทำการวิจัยเรื่อง การสร้างเสริมศักยภาพแก่นนำสุขภาพประจำครอบครัวในการส่งเสริมชุมชนอย่างยั่งยืน ความสนใจครั้งนี้ เนื่องจากแก่นนำสุขภาพประจำครอบครัว คือตัวแทนของสังคมระดับครอบครัว ที่มีบทบาทสำคัญที่สุดในการดูแลสุขภาพของสมาชิกครอบครัวทั้งยามปกติและยามเจ็บป่วย เป็นผู้ที่บริหารจัดการทรัพยากรให้สอดคล้องกับสถานภาพของครอบครัว นอกจากนี้แก่นนำสุขภาพประจำครอบครัว ยังเป็นตัวแทนของสมาชิกในครอบครัวที่จะเข้ามามีส่วนร่วมในการพัฒนาสถานะสุขภาพของประชาชนในระดับชุมชนและสังคม ดังนั้นจึงนับว่าแก่นนำสุขภาพประจำครอบครัวเป็นบุคคลสำคัญอย่างยิ่งของชุมชนที่มีต่อการพัฒนาทุกด้าน โดยเฉพาะอย่างยิ่งด้านการส่งเสริมสุขภาพซึ่งเป็นพื้นฐานของการสร้างสุขภาวะ ลดปัญหาการเจ็บป่วยด้วยสาเหตุที่สามารถป้องกันได้ ลดความพิการ อันเนื่องจากการเจ็บป่วยเรื้อรัง เป็นต้น ซึ่งหากมีการส่งเสริมสุขภาพกันอย่างจริงจังในระดับชุมชนแล้วจะเกิดผลดีหลายประการตามมาทั้งด้านสังคมและเศรษฐกิจ ดังนั้นผู้วิจัยจึงจะสร้างเสริมศักยภาพของแก่นนำสุขภาพประจำครอบครัวในการส่งเสริมสุขภาพชุมชนอย่างยั่งยืนด้วยกระบวนการเรียนรู้อย่างมีส่วนร่วมเพื่อเป็นโครงการนำร่องที่จะกระตุ้นให้แก่นนำสุขภาพประจำครอบครัวนำศักยภาพที่มีอยู่มาเป็นประโยชน์ต่อการเรียนรู้รับวิธีการดูแลสุขภาพไปสู่การสร้างสุขภาพตลอดจนมีจิตสำนึกในการส่งเสริมสุขภาพชุมชน และสร้างเครือข่ายตลอดจนการขยายผลเพื่อให้เกิดพลังการพัฒนาที่ต่อเนื่องและยั่งยืนต่อไป โดยการวิจัยมีวัตถุประสงค์ ดังนี้

1. เพื่อเพิ่มพูนความรู้ ความสามารถ แรงจูงใจ และภาวะผู้นำ ของแก่นนำสุขภาพประจำครอบครัวในการดูแลสุขภาพตนเองครอบครัว และการส่งเสริมสุขภาพชุมชน
2. เพื่อส่งเสริมให้เกิดกระบวนการจัดตั้งเครือข่ายการส่งเสริมสุขภาพชุมชนและการขยายผลเพื่อความยั่งยืน

ในการครั้งนี้แก่นนำสุขภาพประจำครอบครัวที่เข้าร่วมในโครงการจะมีส่วนร่วมในการวิจัย ดังนี้

1. แคนนำสุขภาพประจำครอบครัวเข้ารับการอบรมแบบมีส่วนร่วม ตามเนื้อหาในหลักสูตรและคู่มือที่นักวิจัยและวิทยากรการเรียนรู้ร่วมกันจัดทำขึ้น
2. การร่วมกิจกรรมของชุมชนตามแผนซึ่งกลุ่มแกนนำสุขภาพประจำครอบครัวและทีมวิทยากรการเรียนรู้ร่วมกันจัดทำขึ้นหรือตามที่อาสาจะทำ ตลอดจนตามที่กลุ่มมอบหมาย
3. การให้ข้อมูลที่เป็นประโยชน์ต่อการทำวิจัย ด้วยการตอบคำถามทั้งด้วยวาจาและการเขียน การร่วมสนทนากลุ่มเพื่อประเมินความก้าวหน้าของโครงการ ตลอดจนการร่วมประเมินกระบวนการสร้างเครือข่ายการส่งเสริมสุขภาพชุมชน ด้วยวิธีการสังเกตและบันทึกกิจกรรมด้านสุขภาพที่ปฏิบัติด้วยตนเองปฏิบัติต่อสมาชิกในครอบครัวและสมาชิกชุมชน

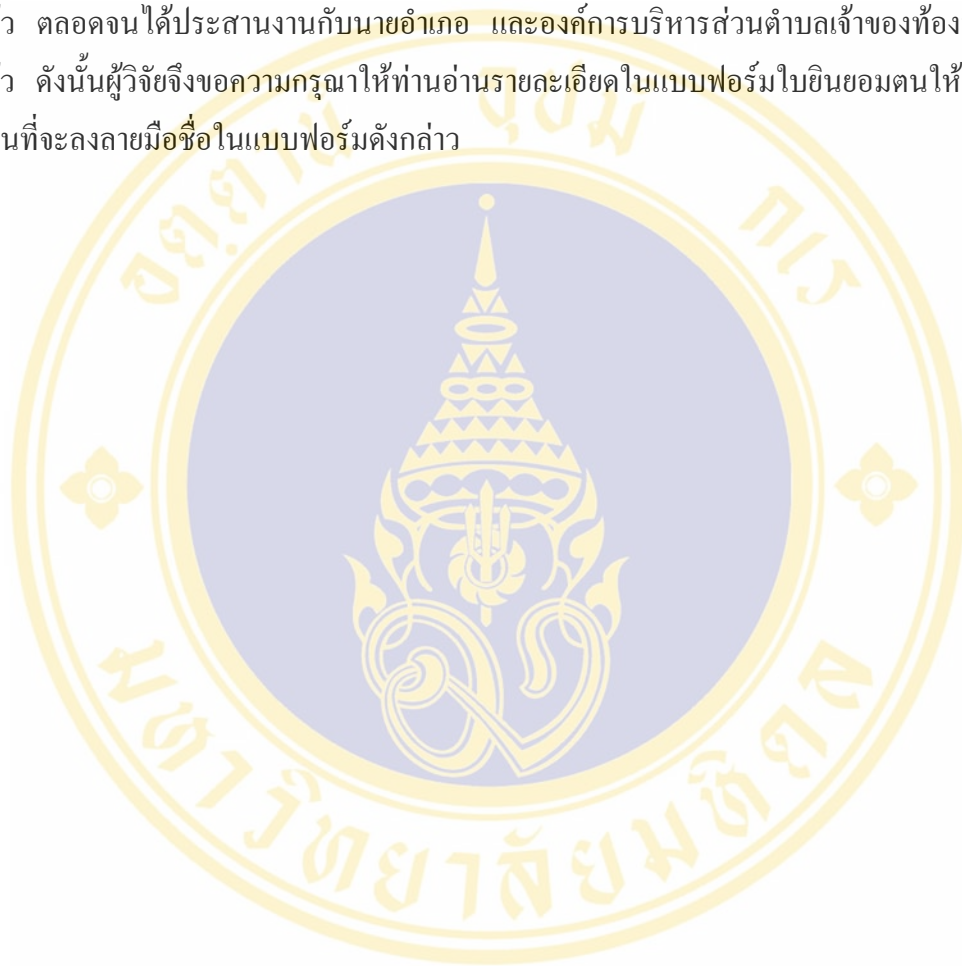
ประโยชน์ที่คาดว่าจะได้รับการวิจัย

ประโยชน์ที่คาดว่าจะได้รับหากเสร็จสิ้นการวิจัยแล้ว มีหลายประการ ได้แก่

1. ประโยชน์ต่อประชาชนในหมู่บ้านที่ศึกษา กล่าวคือประชาชนมีโอกาสที่จะมีส่วนร่วมทุกขั้นตอนในการส่งเสริมสุขภาพชุมชนของตน โดยปราศจากการบังคับจากส่วนราชการ สามารถร่วมกันกำหนดทิศทางการพัฒนาและควบคุมปัจจัยที่คุกคามต่อสุขภาพในระดับครอบครัว ชุมชน และสังคมโดยภาพรวมได้
2. ประโยชน์ต่อแกนนำสุขภาพประจำครอบครัว ที่ได้รับการเพิ่มพูนความรู้ ความสามารถ ได้รับการพัฒนาภาวะผู้นำและการสร้างแรงจูงใจ เพื่อให้สามารถดูแลสุขภาพของตนเอง ครอบครัว และการส่งเสริมสุขภาพชุมชนได้ ตลอดจนสามารถจัดตั้งเครือข่ายการส่งเสริมสุขภาพได้อย่างต่อเนื่อง ซึ่งจะนำไปสู่การมีสุขภาพดีถ้วนหน้าและชุมชนเข้มแข็งได้อย่างยั่งยืน
3. ประโยชน์ต่อเจ้าหน้าที่สาธารณสุขและผู้นำชุมชน กล่าวคือ ประชาชนเข้ามามีส่วนร่วมในกิจกรรมต่าง ๆ ของชุมชนอย่างเป็นระบบ อีกทั้งได้รูปแบบในการพัฒนาด้วยกระบวนการเรียนรู้แบบมีส่วนร่วม อีกทั้งมีโอกาสได้รับการพัฒนาให้เป็นวิทยากรการเรียนรู้ ตลอดจนเทคนิควิธีการทำให้เกิดการมีส่วนร่วมอย่างมีประสิทธิภาพ
4. ประโยชน์ทางด้านวิชาการ และการบริหารจัดการ ได้แก่
 - 4.1 หลักสูตรการอบรมสร้างเสริมศักยภาพแกนนำสุขภาพประจำครอบครัว เรื่องการสร้างสุขภาพชุมชนอย่างยั่งยืน
 - 4.2 คู่มือการอบรมแบบมีส่วนร่วม
 - 4.3 รูปแบบการสร้างเสริมศักยภาพแกนนำสุขภาพประจำครอบครัวที่มีประสิทธิภาพ

4.4 รูปแบบและกระบวนการจัดตั้งและขยายเครือข่ายการส่งเสริมสุขภาพที่สามารถดำเนินการได้อย่างมีประสิทธิภาพ

โครงการวิจัยเรื่อง การสร้างเสริมศักยภาพของแกนนำสุขภาพประจำครอบครัวในการสร้างเสริมสุขภาพอย่างยั่งยืนนี้ ได้รับอนุญาตให้มาดำเนินการวิจัยโดยนายแพทย์สาธารณสุขจังหวัดแล้ว ตลอดจนได้ประสานงานกับนายอำเภอ และองค์การบริหารส่วนตำบลเจ้าของท้องที่เรียบร้อยแล้ว ดังนั้นผู้วิจัยจึงขอความกรุณาให้ท่านอ่านรายละเอียดในแบบฟอร์มใบยินยอมตนให้ทำการวิจัยก่อนที่จะลงลายมือชื่อในแบบฟอร์มดังกล่าว



APPENDIX F

THE PICTURES OF THE ACTIVITIES

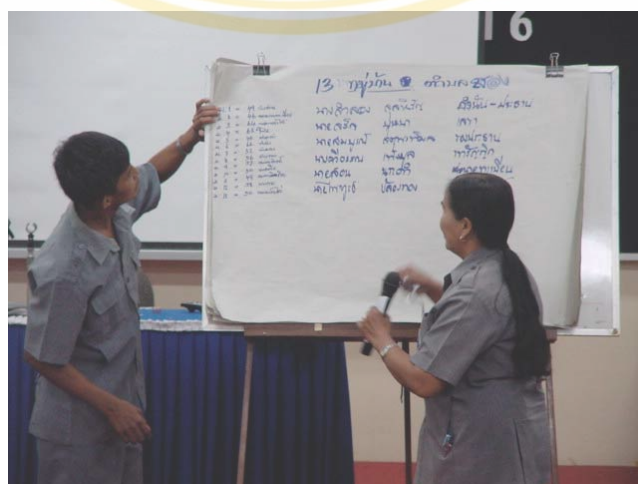
1. Training of the facilitators



2. The First training of family health leaders



3. The second Training of family health leaders



4. Technology Cooperation among Developing Village





BIOGRAPHY

NAME	Mrs. Wanasara Chaoniyom
DATE OF BIRTH	20 February 1960
PLACE OF BIRTH	Chonburi, Thailand
INSTITUTION ATTENDED	Chonburi Nursing College, 1982: Certificate of Nursing Equivalent to Bachelor Mahidol University, 1992: Master of Primary Health Care Management Mahidol University, 2004: Doctor of Public Health
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