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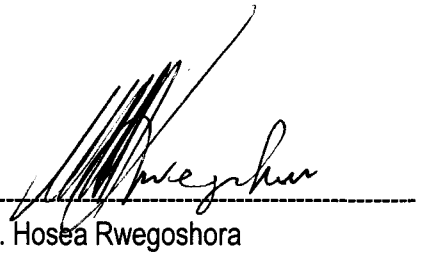
A TRAINING MANUAL FOR OLDER PEOPLE'S CAREGIVERS IN THE COMMUNTY

DANIEL SMART RWEGASILA

SUPERVISOR CERTIFICATION.

This is to certify that I have gone through the project for Daniel Smart Rwegasila and found it in a form acceptable for the partial fulfilment of the requirement for the Master's of Science in Community Economic Development of the Southern New Hampshire University and Open University of Tanzania.



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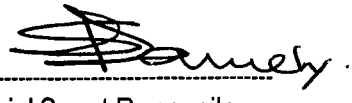

Daniel Smart Rwegasila

DEDICATION

This project is dedicated to my wife Lilian, my daughter Doreen, and my son Wilbroad, whose love and inspiration encouraged me to complete this work.

ABSTRACT

The population of older people is increasing dramatically. The greatest increase is taking place in the developing countries. Tanzania is among the countries whose number of older people has increased considerably. According to the 2002 population census, Tanzania has 1,952,041 people of 60 years and above. This is 5.7 % of the total population. While the number of older people is on increase, the quality of care provided to them by the family, community and the government has continued to decline due to modernization, urbanization, industrialization and impact of HIV/ AIDS.

The limited age care skills among older people's care providers have made the situation worse, as they are unable to provide the needed care to older people. (Forester, 1998). Poor quality of care to older people within the family and the community has made older people to have poor health thus limiting their contribution not only on their own life but also to their families and communities they live in (Kiwala, 2000). Recognising the needs to address the challenge that has been brought about by the fast increase of the older people in Tanzania, and the limited age care knowledge and skills that exist in different communities in Tanzania, an age care training manual has been developed aimed at building the age care skills of caregivers and other people who work with elderly in order to improve the quality of care they provide for senior citizens.

The manual has been developed based on the survey that was carried out in Chanzulu and Mikocheni wards in Kilosa and Kinondoni district respectively. It is a real working tool for age care organizations, social workers, community workers and other practitioners in the area of ageing. It is expected that by going through all modules in this manual participants will be able to broaden their knowledge on ageing and improve and sharpen their age care skills, and more importantly be able to design local interventions for improvement of age care practice in their respective communities.

ACKNOWLEDGEMENT

This training manual is the result of survey that was conducted in Mikocheni and Chanzulu wards and practical experience of Vumilia. I appreciate the valuable input I received from the leadership of Vumilia Women Cooperative Society and all 240 people who were interviewed. Their active participation and contribution of ideas have added considerably to making this manual a working tool for practitioners to use.

I greatly appreciate the advice I received from my supervisor Dr Hosea Rwegoshora, Director of Studies at Institute of Social Work, Dar es Salaam. His advice enabled me to sharpen my thinking. I also express my sincere thanks to the management of HelpAge International who gave me moral and material support, and more importantly granted me a permission to pursue this course.

Furthermore I am grateful to Michel Adjibodou, the Director of CED programme, his teaching and guidance, laid foundation of my knowledge in research work.

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CHAPTER ONE: BACKGROUND INFORMATION

1.1 INTRODUCTION

The rapid ageing of population has become a challenge not only to Africa, but globally. However, what is of special concern in African countries like Tanzania is the declining of the quality of care provided to older people (Rwega, 2002). Various researchers in Tanzania such as (Forester 1998), (O'Donoghue, 1999) and (Kiwala, 2000) have identified the limited understanding of ageing issues and age care skills on the part of the general public and care providers and those organisations working with older people. This has made older people rights in respect to care to be severely violated in the family and the community they live in.

For the United Nations (UN) care for older person does not only encompass physical care but also social and psychological care. According to UN, things that are covered under care include; right to access basic needs such as shelter, clothes and food, right to access health, right to make decision about their care, right to use their rich experience and enjoy basic human rights, respect and privacy. It is this UN definition that has been adopted in the current study.

When a basic need such as shelter, and clothes is not accessible for older people, then a fundamental human right is being denied to older people. When a basic right such as nutrition is being denied to older people, their health and well-being are severely compromised, with tremendous effect on their lives. When the right of older person to live in safe environment is not accorded, the life of older people is being severely affected. When older person is being butchered just because he or she has red eyes, it reflects acute violation of the fundament human right, the right to live.

When an ill older person visits a healthcare centre in search of treatment and is told that he/she is not sick but is just suffering from old age, then that older person is being denied appropriate treatment. When an older person is denied the right to participate and make decision in activities that affect their well being, his or her dignity and respect are being rubbed off and made to feel as worthless. Such incidents are often manifested in our communities, and it is the true reflection of little understanding of ageing among general public and vivid indicator of poor care provided to our senior citizens in our society.

Since the UN International Year of Older Persons in 1999, which received a lot of attention in Tanzania, many organisations have been formed to support older people. Many of these organisations are still at infancy stage, lacking effective strategies on how to deal effectively with elderly people. Unfortunately, there is no institution in the country that provided such training. It is this gap that triggered Vumilia Women Cooperative Society (VWCS) to ask me to support the process of developing a training manual for older people's caregivers.

In collaboration with VWCS a survey was conducted in Chanzulu ward Kilosa, as the representative sample of rural area, and Mikocheni ward in Kinondoni, which represented urban area. It is the finding from this survey that has led to the development of this age care training manual.

The Age care training course (based on the developed manual) is community focused and has been designed to support and complement initiatives that are being done by emerging age care

organization across the country. The course raise the awareness of the key issues facing older people and the national policies that exist to protect them. The training targets diverse audience, from caregivers, primary school teachers to community leaders including local government officials. It is envisaged that the training will lead to positive change in age care practice in the community and set in motion the implementation of the National Ageing Policy (NAP), which so far has remained on paper.

As we think of improvement of quality of care for older people, it is worth recalling the words of the Secretary General of United Nations in October, 2001 that

"Promotion of healthy life styles and supportive environment to older people within the families and the communities do not only reduce disability levels associated with old age, but also enable older people to keep on contributing to their own families, community they live in and their nations.... In this respect forward thinking call us to embrace their potentials and give them necessary support as a basis for future development of society as a whole."

1.2 STATEMENT OF THE PROJECT ASSIGNMENT

The challenge brought about by the rapid increase of older people is a great development concern that every country has to address in this century. The United Nations report (1999) shows that there has been a drastic increase in the number of older people in the world in this century, which has never been experienced before. This increase has been demonstrated more in the developing countries where the social economic changes have already weakened the traditional family and community mechanism that was the basis for effective care for older people. Worse still, even the formal social security system in these developing countries is underdeveloped with minimum coverage, and very little effect even for the older people who are covered.

In Tanzania like any African country, it was often believed that traditional family structures and norms of respect means that all older people were well cared for, as such, violations of their rights including right for decent care was not an issue. However, different studies including the recent research on the Impact of HIV/AIDS on older people by (Sangale, 2004), have proved that this is not the case. The system has been severely weakened by social economic changes and the impact of HIV/ AIDS to the extent that it is no longer capable of providing adequate care for older people.

While modernization, industrialization and urbanization have led families to live great distance apart, different studies have also indicated limited knowledge on ageing and inadequacy skills among care providers and other people including leaders of community support structures such

as religious institutions and village governments. These shortcomings have made the life of older people who are 5.7 % of the total population to continue to deteriorate following acute violation of their rights within the family and the community they live in.

Whilst it is true that abuse of older people's rights have always taken place, recent research reports such as ***The Situation of Older People in Magu*** **by** (Forester, 1999) and ***Safety net for Vulnerable Groups*** by (Geffy, 2000) have revealed an increase in the number of reported cases about violations of the rights of senior citizens, which are attributed to poor understanding of ageing process and lack of basic age care skills among older people's caregivers.

In Sukumaland for example older people are being killed just because they have wrinkles and red eyes, thus regarded to be witches. Quoting the work of TAMWA, Kate Forester,(1999) indicated that about 500 older women are murdered in Tanzania every year after being accused of witchcraft. Some of the suspected killers are their own sons and daughters who are expected to protect them. If such evil acts are allowed to continue without public intervention the majority of today's older women and men in Tanzania, who are 1,952,041 and those reaching old age in the future, are likely to become subject of further humiliation and abuse irrespective of the valuable contributions they will have made to their families and beloved country.

What is even worse is the fact that, although it is clearly known that as the people grow old the more physically weak they become, the whole medical system in Tanzania have not been oriented to the needs of older people (Kiwala, 2000). Medical personnel have not been oriented

to gerontology or medicine of older person, and so far this is not featured as an important specialization in the medical profession the way it is for paediatric and gynaecology for children and women respectively. There are no public health care for elderly and the essential drugs pay little attention to older people (Mongula, 2002).

In recognition of difficult life facing elderly, some CBOs and local NGOs have been formed to support older people. Records from HelpAge International indicate that, there are about 200 CBOs and NGOs across the country that has been established recently to work with older people. Some of them are; Vumilia Women Cooperative Society, SAWATA Dodoma, Mtwara Retired, MAPERECE Magu, Good Samaritan Social Service Trust and Songea Older Person Forum, just to mention a few. Many of these organisations are still at infancy stage, with very limited skills and knowledge on ageing and age care. Unfortunately there is no institution in East and Central Africa where age care training is provided, and none of the Universities in this part of Africa that offers gerontology. Consequently many age care organizations in Tanzania operate without training in the area of ageing and age care.

Problems associated with lack of institutions to deliver age care skills compelled Vumilia Women Cooperative Society (Organization I have worked with in this project) to initiate the study that will lead to broadening of understanding of ageing issues and improvement of age care practice in the society. The study therefore intends to collect the views of older people, caregivers and community leaders that will lead to formulation of age care training manual. The manual to be developed will be an important tool for those who will be involved in the sentization of the

community to understand on ageing issues and more importantly be able to design local interventions for improvement of age care practice in their respective communities.

1.3 PURPOSE OF THE STUDY

- To build the capacity of older people's caregivers both in rural and urban areas

1.4 OBJECTIVES OF THE STUDY

- Identify the age care skills gaps among people who provide care to elderly in the family and the communities.
- Establish chronic health problems affecting older people in urban and rural areas.
- Explore the level of involvement and support provided by existing community structures to older people
- Develop an age care training manual for caregivers and local community leaders who work with older people

CHAPTER TWO: LITERATURE REVIEW

2.1 CONCEPTUALIZATION OF AGEING

Indeed ideas about ageing and reality of growing older have both positive and negative elements. More importantly ageing is not predictable as it is sometimes a positive force and sometimes a negative one even in the same individual. It is therefore not surprising to see some writers emphasising on the positive quality that ageing can bring, whereas others emphasising on the negative image of aging. For example, Aristotle argued that older people are small-minded because they have been ambled by life: their desire are set upon nothing more exalted or unusual than what will help them keep alive (Mckee, 1982:11). In contrast, Cicero (McKee, 1982: 26) said "Older persons may not be doing what the younger members of the community are doing, but what they do is better and much more important."

In many traditions African societies, ageing was perceived positively. Traditional African words used to describe an old man or an old woman as neither demeaning nor derogative. Literal translations of old age in many African languages define it synonymously with wisdom. Common expressions in West African languages refer an older person as a person who knows and who has vision. The Malians for example, perceive the tree as a symbol of old age; a mighty tree with deep spreading roots which cling to the ground with its shade-giving branches of leaves spreading high to the sky. (Nana, 1999). This same symbolism is reflected in Zimbabwe's Ndebele people's reference to the elderly as " shade of the children" (Cox and Mberia, 1977).

In Tanzania like any other African country, the word older person commonly known as "mzee" had a very positive meaning. In most cases, it was linked with wisdom. An older person was also

seen as a centre of unity in a society. No wonder, the father of the nation, the late Mwalimu Nyerere used to meet with elderly before announcing major decision that were seen to have a big impact to the nation. (Mongula, 2001)

In the context of this study, ageing should be seen as a broad concept that includes physical change in our bodies over adult life, psychological change in our mind and mental capacities, and social change in how we are viewed, what we can expect and what is expected of us. While we cannot ignore negative elements associated with ageing, it is important to underscore that wisdom nurtured by life experience tends to increase as the person grow old. This is probably the most precious element embedded in ageing which we need to look at in order to have realistic conceptualization of the value of older people in our community. As Cicero said, it is not by muscle, speed, or physical dexterity that great things are achieved, but by reflection, force of character, and judgement; in these qualities old age is not only not poorer, but is even richer (Atchley, 1991: 47)

2.2 THEORETICAL FRAMEWORK OF AGEING

There are many theories which attempt to explain the why and when of ageing. The social psychological literature of aging depicts two general viewpoints with regards to optimum patterns of aging. Both views are based on the observation that as people grow older, their social interactions decrease (Cumming and Henry, 1961). The activity theory of Havinghurst (1968) and others whilst disagreeing with the 'disengagement theory' stress the inevitable changes in biology and health. In their view, the decreased social interaction that characterises old age results from

the withdrawal of the society from the aged person and that the decrease in interaction proceeds against the desires of most ageing persons.

It is generally accepted that in old age, the loss and decline be it physiological. Psychological, economical and social are greater than at any other stage in a person's life. Such losses, however, are not always due to biological factors but might also be due to social, economic and environmental and cultural factors (Derricourt and Miller, 1992).

The problems facing older people today could be comprehended when modernization theory is used to analyse dominant social, economic and technological changes, which culminate into the contemporary problems facing elderly. The central thesis of modernization theory is that the processes that cause societies to evolve from rural to agrarian social and economic systems to urban and industrial ones also cause change in the positions that older people occupy in the society and the esteem afforded to them. The direction of change is usually assumed to be for the worse.

Simmons (1945) was probably one of the first researchers to address the issue of modernization's effect on older people. Based on a cross-cultural study of 71 societies, he concluded that in relatively stable agricultural societies, elders usually occupy positions of favour and power, mainly because of the concept of seniority rights. But when the rate of change increases, Simmons said, older people lose their advantaged status. He did not specify how or why this happened.

Cottrell (1960b) viewed modernization as a result of the growing use of fossil fuels and technology to increase human productivity. To Cottrell, the most significant aspect of the historical shift from agrarian to high-energy industrial forms of production had its effect on the organization of the society. Agrarian societies revolved around the village, which itself was a collection of families. The power of the elderly men, and occasionally elder women, in the agrarian system stemmed from their positions as heads of families, which in turn admitted them to the council of elders that ran the community. In addition, tradition was the main way that people decided issues in agrarian societies, which gave elders value as keepers of knowledge and tradition. Heads of families made decisions in all realms of life: economic, political, religious, and social.

Fischer (1978:108-112) advanced the notion that for the new egalitarian type of society to emerge, the traditional hierarchical type had to be undercut. In the process, because they were usually in control of traditional societies, older people as a category came under attack by those who wanted to change the system. Thus it was not their capacities or a lack of them that caused older people to lose their advanced positions, but that they were symbols of an outdated social order. All these are plausible explanations of why elders lost their hold on the privileged positions in industrialized society. But older people did not become merely equal to everyone else; they became less valued than other age categories. Unfortunately the above scholars could not explain the reasons behind.

Cowgill (1972, 1974b, 1986) developed a theory to explain why older people were devalued by the process of modernization. He felt that several factors associated with modernization combined to reduce the desirability of elders participants in society. First, demographic trends which indicates stead increase of proportion of older people in the population both in the rich and poor countries. This, coupled with a lower demand for workers because of the increased use of technology, heightened the competition between the young for jobs. In addition, the growing number of new kinds of jobs reduced the value of experience and practiced skills, which were older people's main ways of offsetting their relative lack of physical dexterity.

Retirement lowered the value of elders because it was based on the assumption that they were no longer capable and because it dropped them into a less desirable income category. Rapid social change and child-centred education outside the family made obsolete much of the knowledge that had formerly been a foundation of esteem for elders. Finally, urbanization often left older people behind, causing them to be viewed as "backward". For these reasons, older people presumably lost a great deal of power and prestige in the process of modernization.

As we continue to analyse progressive changes in all structures and functions of the social, technological, economical and cultural environment, and the direct impact they have to the capacity of the family, clan and the entire community, it makes more sense when the analysis is also linked with the impact of HIV/AIDS to many communities particularly in the sub-Saharan Africa (which has been hardly hit by this disease). The disease has killed and continues to kill many young people who were expected to provide care to their old parents. Worse still, many

older people are now compelled to support young orphans whose parent have died of HIV/AIDS at the age when themselves are actually in desperate need of support. What this boils down to is that, it is important to analyse the problems of older people in the context of all changes that surround them, and policies and programmes to address the problems of ageing in country like Tanzania should be the products of our particular environment.

Based on these facts, it is clear that any meaningful effort made to improve the lives of older people in Tanzania should go hand in hand with the effort of reviving the spirit of helping old people in the community and strengthening the weaker social structures we have in our communities to resume their tradition role of caring for older persons Moreover they should also aim at empowering old people themselves to cope effectively with the challenges of modern world. This is the main thrust of this study.

2.3 EMPIRICAL LITERATURE REVIEW

Ageing in developing countries has not been attractive sphere of research for long time. This was probably contributed by the assumption that older people particularly in Africa are still receiving adequate cared from their families. It is until recently when some scholars started to undertake specific studies in this area. It is therefore a subject, which has limited literature. The literature below represents some of the studies that have been done in the area, their main findings and recommendations.

Nyangulu et al (1994) studied the level of support children provide to their parents in Zimbabwe. In his study titled ***Family Support For the Elderly in Zimbabwe***, Nyangulu highlighted the growing problem in Zimbabwe whereby children are no longer providing adequate support to their parents. He recommended policy options for encouraging family support of the elderly.

In a study by Rwega (2002) which was conduced in the northern part of Tanzania, titled ***Situation of Older people in Bukoba District,*** Rwega commented that the families in buhaya have been weakened by HIV pandemic, low price of coffee and declining of banana production, (a staple food for the people of that area). All of these factors point to an increasingly fragile situation of older people in the area. He advised the government to set up the systems that will ensure that families are given economic back up to enable them to deliver effective care to older people.

Forester (1998): in her research study on Situation of Older People in Tanzania which was conducted in five regions of Tanzania namely; Mbeya, Kagera, Mwanza, Dares salaam and Zanzibar, indicated how older people in Tanzania are being mistreated even by their own sons and daughters. She revealed that older people particularly vulnerable older people are excluded from the social services such as access to health service just because they are old. This aspect of excluding older people and its associated impact was also highlighted by Townsend (1985:665), as the source of the growing inferiority complex among older people.

Conversely a study in Magu, Tanzania titled ***Older People in Magu Tanzania; The Killing and Victimization of Older Women"*** again by Forrester (1999), exposed the problem of older

women being beaten or murdered following accusations of witchcraft just because they have wrinkles and red eyes. Forester recommended for the government to adopt appropriate measures that will enable the society to change their negative attitude toward older people.

Analysing the reason as why older people in Tanzania are not well cared for, O'Donoghue, (2000) on his research ***Safety Nets for Vulnerable Group in Tanzania*** associated this with little public awareness on ageing or information about older people's contributions, situations, issues and needs. According to him, the negative images and assumptions commonly held about older people tends to increase their 'invisibility' and marginal position which in turn feeds the impression that they are just a burden to other sections of the population, hence they do not deserve decent care. He recommended for public awareness on ageing as the means of addressing the problem.

Commenting on the role of older people in the society, Maya (2001) in his study on ***Contribution of Older People in African Societies*** narrated that in times of social upheaval and crisis older people often provide a 'cultural reservoir' of experience, history, stories and guidance that is essential to the preservation of cultural identity and the social reconstruction that will follow. Similar view from older people themselves appears in the work of O'Donoghue (1999) when he summarised the discussion he had with the group of older people in Rwanda

" ***The best thing about older people is that we work as advisers in our own communities, we are able to settle misunderstandings and help to keep things running smoothly. Whatever you think you mustn't think that older people are finished – we still have such a lot to offer***"

In another study conducted in 13 regions of Tanzania titled ***The Social and Economic Conditions of the Elderly People.*** Safari. J. F. (1992) explained that older people generate income through farming, brewing, fishing, metalworking and casual labour. He argued that older people are as likely to give as to receive support provided that the society offers supportive environment for them to realize their potentials. Similar comment was made by Bossert (1987) who reported that many older people in developing world are engaged in farming, livestock keeping and fishing, and that many are engaged in petty trading and have started small businesses. However they lack support from their society to make their activities a success.

It is very clear that, the above studies attempt to explain the value of older people and some of the key problems older people face in the developing countries particularly Africa. More importantly most of them seem to agree that educating the family and the community to understand ageing is an important step toward solving older people's problems. Unfortunately non of the study has been able to establish the training needs of older people care givers, community leaders and other people who work closely to older people.

The current study therefore endeavour to fill the gap by studying the existing knowledge in the area of ageing and the age care skills gaps among older people themselves, older people's caregivers, and community leaders. Based on the gaps to be identified an age care training manual will be developed with the aim of improving quality of care for older people in this country

2. 4 POLICY STATEMENTS AND THEIR EFFECTS ON THE LIVES OF OLDER PEOPLE IN TANZANIA

Tanzania is a signatory to all United Nations' and Africa Unions' policy frameworks and conventions regarding ageing. Tanzania is also the second country in Africa after Mauritius to enact National Ageing Policy. That means care for older people in Tanzania could be analyzed with reference to both international and national policy guidelines.

Older person's care is among the five United Nations principles of older person that were adopted by United Nations General Assembly (resolution 46/91) on 16th December 1991. Other principles are; independence, participation, self-fulfilment and dignity. For United Nations care for older person do not only encompass physical care but also social and psychological care. Things that are covered under care include; rights to access to basic needs such as shelter, clothes and food, rights to access to health, rights to make decision about their care and enjoyment of basic human rights, respect and privacy.

Looking at this comprehensive UN concept of care, it is obvious that Tanzania, which is a signatory to the United Nations charter that endorsed these principles, has done very little in a practical sense, to ensure that these principles are being enforced as it was agreed. What is disappointing is the fact that even in the areas where specific policy statements have been made, older people have not benefited. For example, under Tanzania Health Policy, older persons have been allowed free medical service, however no system has been put in place by the government to ensure that they get any service at all that corresponds to their complaint let alone

free. As the result, reports from across the country indicate that older people continue to suffer from poor health service contrary to what is stated in the health policy. (HAI, 2002)

Tanzania is a signatory to Madrid International Plan of Action of Ageing (IPAA), which sets out a strategy to combat poverty among older people. The IPAA was agree upon in Madrid during the Second World Assembly on ageing in April 2002. In addition, Tanzania also endorsed Africa Union Policy Framework and Plan of Action on Ageing in Africa that received the final seal of approval during the 38 Ordinary Session of the Assembly of African Heads of States and Government in Durban, South Africa in July 2002. Likewise the Africa Union Policy Framework and Plan of Action on Ageing require member states to design, implement appropriate programmes to meet individual and collective needs of older people particularly the whole issues of poverty. Despite of the effort to endorse all these International Policy Guidelines, the fact on the ground depicts that no practical action has been implemented to address older people's poverty and to set sustainable mechanism to improve their wellbeing.

In 2003, Tanzania enacted a National Ageing Policy (NAP), which sets out concrete commitments to improve quality of life of senior citizens. NAP recognises age as the sole criterion to determine an older person. The cut of age stipulated in this policy is 60 years. NAP put special emphasis to health service to older people, assurance of basic needs for vulnerable old people, support to older headed household dealing with HIV/AIDS and orphans, enactment of law safe guarding the rights of older people and promoting awareness and preparedness for ageing in all sections of the society. In order to improve the quality of life of older people, NAP recognise the

prime role of the family and the communities they live in, and state categorically the need to enhance the capacity of families and communities (in terms of resources, knowledge and skills) to be able to deliver effective care to older people. However, so far the practical application of these policies has been patchy.

The current study is therefore an innovative initiative geared at developing the manual that will support the government to take forward its commitment of improving the quality of life of elderly as stipulated on National Ageing Policy and other international Ageing policy guidelines which it has endorsed. .

CHAPTER 3: RESEARCH METHODOLOGY.

3.1 COVERAGE.

The study was conducted in Chanzulu ward in Kilosa district, which is one of the six districts in Morogoro region, and Mikocheni ward in Kinondoni district, which is one of the three districts of Dar es Salaam region. While Chanzulu ward represents the typical rural area, Mikocheni represents the urban area. In this sense, the information that has been gathered in this study encompasses views of rural and urban-based respondents.

Another factor that was considered in the selection of Chanzulu and Mikocheni wards was knowledge and familiarity of the areas by Vumilia Women Cooperative Society (the organization I worked with). This organization has been implementing projects in these two wards. It was therefore relatively ease to gather information from these wards as community leaders and substantial numbers of older people in those areas were aware of the work of Vumilia Women Cooperative Society. So the interviews and questionnaires administered were seen as the continuation of Vumilia Women Cooperative Society engagement with older people in their area and not something new.

3.2 POPULATION.

The total number of people in Chanzulu and Mikocheni wards were 13,631 and 11860 respectively (WEO's offices Chanzulu and Mikocheni, November 2004). However, the actual number of the respondents in this research was 240. These are categorised as follow; 100 older people of which 50 were from Chanzulu and 50 from Mikocheni, 100 older people's caregivers 50

from each area. Others were 40 community leaders of which 21 were from Chanzulu and 19 from Mikocheni. The table below summarises the distribution of respondents

Table 1: THE DISTRIBUTION OF STUDY POPULATION BY AREA, GENDER AND CATEGORY

AREA	CATEGORY OF RESPONDENTS		MALE	FEMALE	TOTAL
MIKOCHENI-KINONDONI	**Older people**		**25**	**25**	**50**
	Older people's caregivers		**25**	**25**	**50**
	Community leaders	*Religious*	*1*	*3*	
		Village/mtaa	*2*	*5*	
		Ward	*3*	*1*	
		NGOs/CBOs	*0*	*1*	
		Other	*3*	*0*	
	Sub total community leaders		**9**	**10**	**19**
CHANZULU-KILOSA	**Older people**		**25**	**25**	**50**
	Older people's caregivers		**25**	**25**	**50**
	Community leaders	*Religious*	*2*	*4*	
		Village	*2*	*4*	
		Ward	*2*	*1*	
		NGOs/CBOs	*3*	*1*	
		Other	*1*	*1*	
	Subtotal community leaders		**10**	**11**	**21**
TOTAL RESPONDENTS			**119**	**121**	**240**

Source- Survey report, December, 2004

3.3 SAMPLING TECHNIQUES USED.

3.3.1Stratified sampling:

Under stratified the population is divided into several sub-populations that are individually more homogeneous than the total population. The method enabled the research to get 119 respondents from the urban area, Mikocheni- Kinondoni and 121 respondents from rural area , Chanzulu - Kilosa district. The methods were also used to get 60 female and 59 male respondents at Mikocheni and 60 male and 61 female respondents at Chanzulu. In this way

the information collected had fair representations of rural and urban residents with balanced gender.

3.3.2 Multiplestage sampling

The selection of caregivers and older people to be interviewed passed through several stages , in the first stage simple random sampling was used in the selection of three villages out of six villages in Chanzulu ward and one Mtaa/ street out of three Mitaa in Mikocheni ward to be involved in the study. In the second stage of selecting 100 caregivers and 100 older people to be interviewed, convenience sampling was used. Criteria that were considered were age, willingness of the caregivers and older person concern to spare time for interview, accessibility and gender balance.

3.3.3 Quota sampling

The methods ensure that that certain number of sample unit from different categories with specific characteristics appears in the sample, so that all these characteristics are represented. This method was used in the selection of community leaders to be interviewed. The method enabled the study to reach 6 village leaders, 6 religious leaders, 4 CBOs/ NGOs leaders and 3 ward leaders from Chanzulu. In Mikocheni the methods enabled the study to get 4 religious leaders, 7 street/ Mtaa leaders, 4 ward leaders and 1 CBOs/ NGOs leader

3.4 DATA COLLECTION.

3.4.1 Individual interview (face to face)

Interview technique was employed to extract the views of 100 older people, and 100 caregivers. As Brownlee (1991) put it, this method permits clarification of the questions and

has high respond rate than self-administering questionnaire. The method is also suitable for use with community with illiterate persons. These reasons made me to select it as the suitable method to gather information from these respondents.

3.4.2 Key informant Interviews

The technique was employed to extract the views of community leaders and talk about other people's knowledge , attitude and practice beside their own. In carrying out the interview Standardise open-ended questions were used. As stated by Kothari (1990), the aim was to increase comparability of responses and facilitate organization and analysis of data. This method allowed community leaders to talk freely about the involvement of their organizations/institutions in supporting older people.

3.4.3 Observation

Kenneth (1978) argues that methods eliminates subjective element, which might influence finding. In this study the method was used to study observable aspect such as physical health status and personal hygiene of older people who were interviewed.

3.4.4 Review of secondary sources

Substantial time was located for prior documentary studies such as researches and other official and unofficial studies and reports. Most of these documents were easily accessible in HelpAge International resource centre in Dar es Salaam. The method enable me to collect information on the situation of older people in Tanzania, problem associated with care of older people, and national and world statistics on older people which could be very difficult to establish or get by other means in such a short period of time.

3.5 DATA TREATMENT

- Performing quality control checks

  The information checked again before and during data processing for completeness and internal consistency.

- Data processing and analysis

I processed and analysed the data by computer using SPSS programme. Table were used to present frequencies and percentage of finding. Cross- tabulation methods were also used to explore relationship between variables.

CHAPTER FOUR: ANALYSIS OF THE RESEARCH DATA: (TRAINING NEED ASSESSMENT)

The aim of this chapter is to establish the training needs among older people's caregivers and community leaders that will form the basis for the training manual to be developed in chapter five. For this reason, collected data have been analyzed in reference to:

- Major problems facing older people and their relation to care
- Chronic health problems affecting older people
- Understanding of appropriate diet for older people among caregivers
- Awareness on the National Ageing Policy (NAP) among community leaders
- Community structure's involvement in the care for older people and
- Necessary skills and knowledge required by caregivers and community leaders to perform their caring roles

The chapter ends by drawing recommendations and highlighting key topics the training manual should cover.

4.1 MAJOR PROBLEMS FACING OLDER PEOPLE AND THEIR RELATION TO CARE.

The lack of the most basic need was the subject that came up in almost all encounters in both Chanzulu and Mikocheni. In Chanzulu 97% of all older people interviewed raised this as the issue of concern. On the side of Mikocheni the number was slightly lower (96%). Older people say they are finding it more difficult to satisfy their basic needs, such as food, clothes and shelter. This again is connected to the decline family and community care for elderly. The difficult older people experience in accessing the basic needs and the lack of support, both affect the health of older people (Forester, 2000)

All these problems are magnified for vulnerable older people, the house bound, the sick who are forced to be highly dependant, but who are suffering more acutely from withdraw of family and community care. 65% of older people who were interviewed in Chanzulu said they were not getting adequate care from their family relatives including their own children. The number of older people with this views increased in Mikocheni to 70 %. Concerning community support and care, only 3 % and 6% of the older people who were interviewed in Mikocheni and Chanzulu respectively, said they have already received some kind of support from non-family members. The direct interpretation of the above percent tells us that the community is no longer reliable in supporting poor older people. A lot of effort is required to bring it back into its traditional role of supporting older people.

4.2 CHRONIC HEALTH PROBLEMS AFFECTING OLDER PEOPLE

The study wanted to establish the most health problems affecting older people. This question was posed to 100 older people of which 50 were from Chanzulu ward and 50 from Mikocheni in Kinondoni.

Table 2: Distribution of different diseases of older people in Mikocheni and Chanzulu wards

Health status for older people	Frequency	Percent
Not having chronic diseases	11	11
Eye problem	21	21
Hear problem	6	6
Lower extremities	23	23
Diabetes	8	8
Cardiac complication	10	10
Backache	10	10
Other	11	11
Total	100	100

Source- finding from field survey, December, 2004

Six chronic conditions were repeatedly mentioned; these are lower extremities pains, 23 (23%), eye 21(21%), backache 10(10%) and cardiac problems including blood pressure 10 (10%). Others were diabetic, 8 (8%) and hear problems 6 (6%).

Although in general the above six health problems were frequently mentioned in both Chanzulu (rural) and Mikocheni (urban) , the highest percentage of older people interviewed in Chanzulu 13 (26%) complained of lower extremities pains including joint pains and leg swelling. Women represented large number of complaints 16% against 10 % of men. Lower extremities pains were followed closely by eye problem, which was mentioned by 10 (20%) of all older people who were interviewed in Chanzulu.

In Mikocheni the number of older people who complained of eye related problems was the highest. 11(22%) older people mentioned it. Older men in Mikocheni constituted a large portion of respondents who complained of eye problem of older people. They were 9(18%) whereas older women were 2 (4%). Lower extremities pains ranked the second in Mikocheni with 10 (20 %) of all respondents out of which older women were 2 (4%). The difference in ranking between lower extremities pains and eye problems observed in Chanzulu and Mikocheni is due to the fact that majority of people in Chanzulu depend on agricultural activities. They are therefore walking on foot for not less than 7 kilometres daily to attend their shamba. This is not the case for older people in Mikocheni. Majority of older people who are still energetic in this area depend on either employment or petty business like selling charcoals and food items. In this way they spend most of their time sitting on one place. Even when they have to move there is the possibility of using

commuter bus. That means older people in Mikocheni could still cope with lower extremities pains without being forced to abandon their activities completely.

Although all caregivers interviewed associated the above ailments with ageing only 12% were aware of what they were supposed to do to support their older people to manage those problems. ***"It is because of advanced age she has been loosing sight ... I don't think there is something we can do to manage further complications, as she is now approaching 70 years."*** One of the caregiver in Chanzulu whose mother was about to become blind completely because of cataract commented. Such despairing statement from the caregiver for the problem, which could be easily treated, implies lack of knowledge of different diseases affecting older people among caregivers. More seriously, even problems, which need immediate medical attention from the physician, are confused with other normal age related ailments that can be managed at home. In this way older people are denied access to see the doctor, hence worsening their health conditions or sometimes causing death.

4.3 UNDERSTANDING OF APPROPRIATE DIET FOR OLDER PEOPLE AMONG CAREGIVERS.

Without proper diet efforts to care for older people are likely to bear minimum results. Healthy diet remains vital for elderly people to maintain activity and resistance to illness, and to prevent other disabling conditions too. With this in mind the study wanted to explore the understanding of caregivers concerning appropriate food and how it should be provided to older people they care for. It was revealed that the concept of balance diets for older persons was not an issue of importance to 70% (12) and 50% (10) of caregivers who were interviewed in Chanzulu and

Mikocheni respectively. "***We have been trained in the clinic that balanced diet is important for children as they are still growing, I therefore don't see why we have to talk of the balance diet again for older people who have already reached the end of their maturity".*** A woman at Chanzulu living with her mother aged 80 years rebuked.

The other aspect of nutrition practice, which the study explored, was the number of meal taken by older people in a day. Out of 100 older people interviewed 8% said they take one meal in a day, 57% get two meals, that means lunch and dinners, 32% take three meals, which are lunch, tea and dinner. Only 3% all from Mikocheni indicated that they eat more than three times in a day.

Explaining why they eat less than three times, 44 (67%) of older people who were interviewed attributed the tendency to economic reasons, 13 (20%) associated the tendency to mere habit, 4 (6%) linked it to lack of appetite because food becomes monotonous as they are compelled all the time to eat one type of food which they could afford . For most families it is "Ugali". 3 (5%) said they lack a person who can prepare food frequently.

Looking at the low importance attached to balanced diet to older people by the majority of the caregivers and other associated nutrition practices for older people like taking one or two monotonous (similar) meals in a day, it is not surprising to see the health condition of older people declining day after day. This is because their body lacks nutrients, which are needed for providing immunity and strength to fight diseases that might attack him or her. Table 3 gives the picture of meal taken by older people in a day.

Table 3: Distribution of meals taken in a day and reasons given by respondents (OP) in Mikocheni and Chanzulu

Location of the respondents			Reason for less than 3 meal						
			economic reasons	lack of appetate	no one to prepare	habit	not applicable	Other	Total
mikocheni	Meal taken daily	1	3	1		1			5
		% of Total	6.0%	2.0%		2.0%			10.0%
		2	16	2	2	4			24
		% of Total	32.0%	4.0%	4.0%	8.0%			48.0%
		3	1				17		18
		% of Total	2.0%				34.0%		36.0%
		more than 3					3		3
		% of Total					6.0%		6.0%
	Total		20	3	2	5	20		50
		% of Total	40.0%	6.0%	4.0%	10.0%	40.0%		100.0%
chanzulu-kilosa	Meal taken daily	1	1			2			3
		% of Total	2.0%			4.0%			6.0%
		2	23	1	1	6		2	33
		% of Total	46.0%	2.0%	2.0%	12.0%		4.0%	66.0%
		3					14		14
		% of Total					28.0%		28.0%
	Total		24	1	1	8	14	2	50
		% of Total	48.0%	2.0%	2.0%	16.0%	28.0%	4.0%	100.0%

Source – finding from field survey, December 2004

4.4 AWARENESS ON THE NATIONAL AGEING POLICY (NAP) AMONG COMMUNITY LEADERS

The other thing, which the survey explored, was the awareness of the community leaders on the National Ageing Policy (NAP). The policy state categorical and clarify roles pertaining to care for different stakeholders including district council, village government, CSOs and family. Table 4 summarises the responses of the community leaders.

Table 4: Awareness on the National Ageing Policy by the community leaders

Location				organization they .work with					Total
				village government	ward government	religious institution	NGO/CBO	other	
Chanzuru	awareness on NAP	yes	Count	3	1	1	1		6
			% of Total	14.3%	4.8%	4.8%	4.8%		28.6%
		no	Count	3	2	5	3	2	15
			% of Total	14.3%	9.5%	23.8%	14.3%	9.5%	71.4%
	Total		Count	6	3	6	4	2	21
			% of Total	28.6%	14.3%	28.6%	19.0%	9.5%	100.0%
Mikocheni	awareness on NAP	yes	Count	1	1	1		1	4
			% of Total	5.3%	5.3%	5.3%		5.3%	21.1%
		no	Count	6	3	3	1	2	15
			% of Total	31.6%	15.8%	15.8%	5.3%	10.5%	78.9%
	Total		Count	7	4	4	1	3	19
			% of Total	36.8%	21.1%	21.1%	5.3%	15.8%	100.0%

Source – Finding from field survey, December 2004

The above table indicates that majority of community leaders who were interviewed in Chanzulu and Mikocheni were not aware of the presence of NAP, which was launched in 2003. In Chanzulu out of 21 community leaders interviewed 15 (71%) were not aware of the presence of NAP, only 6 (29%) were aware of its presence. In Mikocheni where 19 community leaders responded to the question, the situation was worse as 15 (79%) of the respondents were not aware of NAP, so only 4 (21%) were aware of the presence of NAP. This implies that out of 40 community leaders who were interviewed, only 10 (25%) were aware of NAP. That means 30(75%) were not aware of it, so they should not be expected to make reference to this policy in their day-to-day works and planning.

4.5 COMMUNITY STRUCTURES INVOLVEMENT IN THE CARE FOR OLDER PEOPLE.

While the family is expected to assume the primary responsibility of caring for older person, in African traditions the role of caring and supporting older people is believed to be in the hands of the entire community. This reality has been re-emphasised by NAP. In this regards the study collected opinion of community leaders in Chanzulu and Mikocheni pertaining the involvement of

the organizations or community structures they belong to in caring and supporting older people. The table below summarises the findings

TABLE 5: community structures and level of involvement and support to older people

Location				organization they .work with					Total
				village government	ward government	religious institution	NGO/CBO	other	
Chanzuru	involvement of org./institution	not at all	Count	2			2	2	6
			% of Total	9.5%			9.5%	9.5%	28.6%
		rare	Count	4	3	3	2		12
			% of Total	19.0%	14.3%	14.3%	9.5%		57.1%
		fully	Count			3			3
			% of Total			14.3%			14.3%
	Total		Count	6	3	6	4	2	21
			% of Total	28.6%	14.3%	28.6%	19.0%	9.5%	100.0%
Mikocheni	involvement of org./institution	not at all	Count	3	2	2		1	8
			% of Total	15.8%	10.5%	10.5%		5.3%	42.1%
		rare	Count	3	2	2	1	1	9
			% of Total	15.8%	10.5%	10.5%	5.3%	5.3%	47.4%
		fully	Count	1				1	2
			% of Total	5.3%				5.3%	10.5%
	Total		Count	7	4	4	1	3	19
			% of Total	36.8%	21.1%	21.1%	5.3%	15.8%	100.0%

Source – Survey finding, December 2004

The table indicates that 6 (29%) of the 21 community leaders who responded in Chanzulu ward admitted that the community structures they represent are not involved in any way with activities that support or facilitate care for older people. 12 (57%) said that the community structures they represent are superficially involved with activities that support older people. So, only 3 (14%) said the organizations they represent had activities that facilitate care and support to older people.

In Mikocheni, 8 (42%) of all 19 community leaders who responded, confirmed that the organizations/ community structures they represent have no activities that support senior citizen in their areas. 9(47%) said the organizations they represent are partially involved in the activities

that support and facilitate care for elderly in their community. Only 2 (11%) said their organizations include activities that support older people in their areas. This means that the level of support from the available community structures like religious institutions, CBOs, village and ward governments which are expected and thought to be very close to vulnerable groups in any community is very little. Owing to this situation, older people who have no relatives for providing support are suffering and their lives are at high risk.

4.6 NECESSARY SKILLS AND KNOWLEDGE REQUIRED TO PERFORM CARING ROLE

In total 100 older people's caregivers of which 50 (50%) were women and the remaining 50 (50%) were men, responded to the question that wanted to know the kind of skills they require to enable them to perform their caring role of older people effectively. Table 6 summarises the responses.

Table 6: Types of skills and knowledge required by caregivers to enhance their caring role

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Conselling skills OP	20	20.0	20.0	20.0
	nutrition in old age	22	22.0	22.0	42.0
	phisiological changes associated with old age	26	26.0	26.0	68.0
	Ageing associated diseases	17	17.0	17.0	85.0
	working with vulnerable older people	10	10.0	10.0	95.0
	Other	5	5.0	5.0	100.0
	Total	100	100.0	100.0	

Source – Survey finding, December 2004

Table six shows that understanding physiological changes associated with ageing (ageing process) was mentioned by 26%, 22% wanted to know nutrition in old age. Those who wanted to be trained on counselling skills for older persons were 20%, management of diseases associated with ageing were mentioned by 17% whereas working with vulnerable older people were mentioned by 10%

Community leaders including religious leaders, CBOS leaders, village and ward leaders were also asked to suggest the type of training they need to make them more supportive to older people. Out of 40 community leaders responded to this question, 19 were from Mikocheni and 21 were from Chanzulu. Although generally the list of issues they would like to learn was not very much different from the list made by caregivers, the percentage of community leaders in need of certain training differed from that of the caregivers as follow; skills of working with vulnerable older person were mentioned by 27.9 %, physiological changes associated with ageing 24.5% counselling skills 19.8% and those who mentioned nutrition were 7.5%.

Difference in responsibilities and level of engagement with older people could be explained as the main reasons that caused different weight given between community leaders and caregivers to the list of issues they would need to learn to enable them to provide effective care and support to older people. For instance while training on nutrition in old age was favoured by 22% of care givers interviewed, only 7.5 % of the community leaders mentioned nutrition as the important topic they would like to learn. The fact that community leaders are not necessarily direct involved in the preparation of food for older people contributed greatly to the difference observed.

4.7 RECOMMENDATIONS

Basing on the findings the following recommendations are made

i. The manual to be developed should address the knowledge and skills gaps that have been identified. Suggested modules are;

- Physiologically changes associated with ageing and management of old age related diseases.
- Nutrition in old age
- Working with vulnerable older people in the community
- Counselling skills for elderly people

ii. Declining of quality of care for older people is "a community problem" it should not be seen as the problem of caregivers alone. The course to be developed therefore should target a wide range of people who work with and for older people. These include; care providers, community workers, social workers, religious leaders, NGOs and CBOs. Others to be targeted are village and ward leaders, influential older people, teachers and local government officials. With good training these people are able to design appropriate community interventions for improvement of age care practice in their respective communities.

iii. Community leaders who will attend age care training should be given facilitation skills as well, to enable them to impart the skills they will acquire from this training to other community members. This will enable age care skills to reach as many people as

possible. In this context, facilitation skills has to be added to the manual as the fifth module.

iv. Where possible, participants of age care training should get a copy of National Ageing Policy. If this is not forthcoming because of limited resources, a summarised version should be provided to participants. This will enable them to be aware of the policy and to use it to support their works with older people, and avoid confusion that might arise because of not being aware of this policy that guides older people's issues in the country.

v. Training of Trainer (TOT) course is recommended to Vumilia Women Cooperative Society to enable the organization to be conversant on how to use the manual.

CHAPTER FIVE: TRAINING MANUAL FOR OLDER PEOPLE'S CAREGIVERS IN THE COMMUNITY

5.1 ABOUT THE MANUAL

5.1.1 Introduction

The manual contains two main parts. The first part is a guide to the facilitator on how to run the training. The second part comprises background information, notes and the reference to use as resource material to enable the facilitator to effectively run the sessions. There is also recommended literature for facilitators and trainees.

The manual has been designed in consideration of people using it with varying levels of education and different professional backgrounds. I believe they can all benefit from the training. In this context, materials are simple and have been presented in ordinary language. "The language of the common people"

The course targets a wide range of people who work with and for older people. These include care providers, community workers, social workers, religious leaders, NGOs and CBOs. Others are village and ward leaders, influential older people, teachers and local government officials. It is expected that such people are able to design local interventions for improvement of age care practice that can involve everyone in their respective communities.

5.1. 2 Overall aim of the manual

To build the age care skills of the caregivers and other people who work with the elderly in order to improve the quality of care provided for older people.

5.1.3 Manual objectives

The main objectives of the training manual are three folds namely:

- Enable caregivers to understand the most common health related problems associated with ageing.
- Enable participants to acquire skills of working with vulnerable older people.
- Devise strategies for supporting vulnerable older people in communities.

5. 1. 4 How to use the training manual

This manual contains five complete workshop packages on:

- Physical and physiological changes with ageing
- Nutrition in old age
- Working with vulnerable older people
- Counselling elderly people
- Facilitation skills.

There is also a sub topic on how to prevent pressure sores for the bed ridden. Each of the five topics follows the same pattern.

Part one	Part two
In part one you will find • Aim • Objectives • Methodology • Materials to use • Lesson plan	In part two you will find • Background information • A set of notes

Background information gives a general overview of the subject discussed and its relevancy to the trainee, whereas notes informs about the topic being dealt with in more detail.

Background Information and notes have been arranged in such a way that they can be used as the facilitator's input. Facilitators should feel free to add materials on the contained topics. It should be noted that conditions differ from area to area. So facilitators should adapt the content to meet their own needs and situation. It is therefore recommended that before conducting the training the facilitator should try to be familiar with the prevailing age care practice in the area and the situation of older people.

5.1.5 Duration of the course

You will need five full days to go through all five modules. If participants are still energetic enough, you can also accommodate the collaborative development of a plan of action. If this is not the case, you are advised to use a few hours on the following day to help your participants to come up with their own plan of action. Remember this is very important section, which will guide participants in using their knowledge and skills for the benefit of older people.

The course must be evaluated at the end to get the reaction of the participants. Both oral and written evaluation will be done. Remember, having an 'end of training programme' review does not mean that the facilitator should not administer 'topic by topic', or 'day by day' reviews.

5. 1. 6 Getting started

The programme for the first day will slightly differ from the rest of the days because participants will want to know each other and become familiar with what will be happening throughout the course. So for the first day the facilitator will take participants through the following procedures:

Welcome words and getting to know each other - 20 minutes

- Say a few words to welcome participants
- Explain to the participants the services provided in the area e.g. telephone, toilets etc, and how accessible they are.
- Ask participants to introduce themselves.

Introduction to the Workshop - 10 minutes

Facilitator to explain the:

- Aim and objectives of the course
- Topics that will be covered
- Approach and training methodologies to be used
- Duration of the course
- Range of participants invited.

Expectations - 25 minutes

- Ask participants to list their expectations
- Go through the list and sort out what will and will not be met
- Explain to the participants why some of their expectations will not be met.

Drawing of timetable and participants contract

Discuss the timetable to be used. Things to be agreed by participants include:

- Time to start
- Break for tea/drinks
- Lunch time

- Closing time.

Ask participants to list down sets of behaviour that will help the training be a success. These behaviours will form a **participants contract**. Pin them on the wall for easy reference during the course.

5.2 PART ONE- GUIDE TO FACILITATOR TO PREPARE LESSON PLAN

5.2.1 MODULE ONE: PHYSICAL AND PHYSIOLOGICAL CHANGES WITH AGEING

AIM

To enable caregivers to broaden their understanding of common physical and physiological changes associated with ageing and related health problems and their management, for the purpose of improving age care practice in the community.

LEARNING OBJECTIVES

Participants will be able to:

- Understand physical and physiological changes that take place in the body as we age
- Understand common health related complications associated with ageing
- Design locally implementable interventions to counteract the negative aspect of these physical and physiological changes.

METHODOLOGY

- Mini lecture
- Group discussion
- Brainstorming
- Experience sharing
- Demonstration – depending on availability of time and if a good case study arises during the session

MATERIALS

- Flip chart

- Marker pen
- Masking tape
- Handouts

LESSON PLAN

INTRODUCTION - 20 minutes

To introduce the session the facilitator briefly identifies the relevancy of the topic to the participants. Suggested ideas to use are as follows:

Growing old is a reality. We are all ageing. We may begin to feel less agile, to tire more easily and to develop more aches and pain as we grow old. If people live long enough nearly everyone becomes frail, hence requires help or care from other people. The reason is that most of us are affected by changes in our body in one way or another. These changes affect us throughout our life but as we get older they become more obvious and can start to cause health complications.

It is not possible to prevent the signs and symptoms of old age. However if they are properly managed most older people can continue to be active, self supporting and comfortable. It therefore helps if caregivers of the elderly understand the sources of physiological changes that take place as we grow old and how best these changes can be managed to minimize their negative effects. This knowledge also enables the caregivers to be able to distinguish the natural effects of ageing which the caregivers with age care skills can handle, and the medical problems for which referral to hospital is recommended.

- Through brainstorming, ask trainees to give their views about the physical and physiological characteristics of an older person. They are likely to mix physical, social and psychological characteristics. Don't interrupt at this stage. Record every thing.

- Work together with the trainees to separate physical, social and psychological characteristics and features. Sum up introduction by emphasizing that only physical characteristics and features will be covered in the session. The others (social and psychological) will be covered later within the same training course.

GROUP DISCUSSION - 30 minutes

Once you are sure that trainees are aware of the difference between physical, social, and psychological features, divide them into 4 groups. Maximum number of trainees in each group should not exceed 6 people. Factors such as gender, level of education, age and location of the trainees need to be observed and balanced in the formation of the groups. The discussion of these four groups will be guided by the following questions:

i) What are the most common five health related complications of the older people in your community?

ii) What do you do to help older people with the above mentioned health complications?

Let the trainees stand up, walk around a bit before starting the discussion - remind the groups to choose someone who will take notes and report back, flip chart will be used.

PLENARY SESSION - 25 minutes
When the groups have finished their discussions they come back into the bigger group and they report back.

During report back and discussion, the facilitator will be able to identify areas that need to be emphasised in the next session of the facilitator's input.

FACILITATOR'S INPUT - 30 Minutes
Before facilitator starts to give her/his input bring to people's attention the good contribution made by the entire group.

Talk about the physiological changes that take place, as we grow old and some health related complications, which may happen. Explain recommended measures to help OP with these complications, using the notes called 'physiological and physiological changes with ageing'.

If the facilitator wants to correct the contribution made by one of the group, do it effectively without embarrassing the person. Make sure that the following areas have been properly touched/discussed

i. Decreased function of cardiovascular and respiratory systems
ii. Decreased functioning of the nervous and sensory systems
iii. Decreased function of urinary system.
iv. Decreased function of the musculoskeletal system
v. Decreased functioning of intergumentary (skin and nails)
vi. Decreased functioning of digestive system

vii. Prevention of pressure sores for the bed ridden OP.

Make sure that after 20 minutes of lecture there is a short break or any other event that will allow people to relax. Facilitator should indicate how the mentioned changes in the above system affect older men and older women. Give trainees time to comment and ask questions.

BREAK

SMALL GROUP DISCUSSION – 1 Hour

The group is again divided into small groups of five to six people to discuss the following questions.

Based on the actual situation of your community / older people explain how you will use the acquired skills to help or take care of OP in order to address the following:

- Maintain good and healthy skin
- Take care of OP with urinary problems (dribbling)
- Be able to talk to OP with hearing problem
- Create a safe environment for OP with eye problems
- Prevent occurrence of pressure sores to the bedridden older person.
- Avoid constipation

More conditions can be added to be discussed by the trainees. Use the practical conditions, which are existing in the community. Each group should have maximum of 3 conditions to discuss to enable them to exhaust their ideas about those conditions. Use the flip chart to record the points.

PLENARY SESSION - 1 Hour
Each group will be given 7 minutes to give their presentation. Five minutes for discussion. If information is given which may mislead the trainees, the facilitator should reflect the point again and ask other trainees to correct it. The facilitator will sum up the key points, which can be elaborated on before closing the session.

5.2.2 MODULE TWO: NUTRITION AND OLD AGE

AIM
To enable caregivers to understand the dietary needs of older people for the purpose of improving their nutrition status.

LEARNING OBJECTIVES

Participants will be able to:

- Broaden their knowledge of a healthy diet for older people.
- Understand the common age-related problems, which prevent older people maintaining a healthy diet.
- Recognise strategies to improve the nutrition status of older people in their area.

METHODOLOGY

- Group discussion
- Brainstorming.

MATERIALS

- Flip chart
- Marker pens

- Masking tape

LESSON PLAN

INTRODUCTION - 10 Minutes

Briefly introduce the topic. Suggested words to use in the introduction:

The proper functioning of the body systems depends on many factors however, of all the factors involved, the quality and the quantity of the food we eat is paramount. We need food to live regardless of our age. Without proper diet efforts to care for older people are likely to bear minimum results. Caregivers therefore need to understand properly how older people can sustain a healthy diet.

GROUP DISCUSSION - 40 minutes

Divide participants in small groups of five to six people.

Discussion in these small groups will be guided by the following questions

i. What is 'balanced' diet?

ii. Is it necessary for the older person to eat a balanced/healthy diet? If yes why?

iii. What are the physiological, economic, psychological, social and gender factors that prevent older people from having access to a balanced diet in your community? How can you overcome these?

iv. What constitutes a healthy diet for older people?

v. What are you going to do to ensure that older people in your community eat a balanced diet? Suggest ways of improving the nutrition status of older people in your community.

PLENARY SESSION - 1 Hour

Every group will present their work for seven minutes. Ask participants to preserve their comments/questions till all groups have finished their presentations. Encourage general discussion at the end of the presentation. Observe the gaps in their presentations and discussion. Use notes on 'nutrition in old age' to cover identified gaps.

SUMMARY 15 Minutes

Before closing the session summarise the key points discussed with much emphasise on what participants have recognised they can do to improve the nutrition status of older people in their area.

2.2.3 MODULE THREE: WORKING WITH VULNERABLE OLDER PEOPLE

AIM

Encourage caregivers and the community to extend their support to the vulnerable older people who are currently not supported.

LEARNING OBJECTIVES

Participants will be able to:

- Identify vulnerable older persons using set criteria.

- Acquire skills of working with vulnerable older people.
- Device strategies of supporting vulnerable older people in their community.

METHODOLOGY

- Brain storming.
- Experience sharing.
- Group discussion.
- Home visiting -this will depend on the availability of time.

MATERIALS

- Flip chart
- Mark pens
- Note books
- Pens

LESSON PLAN

INTRODUCTION - 10 minutes
Facilitator introduces the topic, explaining what will be covered and the relevance of the topic to the trainees (caregivers).

INPUT FROM FACILITATOR–SEMI LECTURE - 25 minutes
Use background information to give participants the general situation of older people in Tanzania with particular emphasis on the decreased care available to vulnerable older people.

To give participants a good base for their discussion, the facilitator covers the following;

- Explain briefly how social economic change in Tanzania has affected the care of older people.
- Talk about the current position of older people with particular emphasis on vulnerable older people.
- Talk about National Ageing Policy and Health Policy
- Without embarrassing anyone use experience and practical examples you have to challenge the quality of support to older people delivered by various institutions including the government at various level, religious institutions, NGOs, families, individuals and the community at large.
- Work with them to identify untapped resources that can be utilised to support vulnerable older people.

GROUP DISCUSSION - 45 minutes

Participants to form small groups of six people. They will use these groups to discuss the following questions.

i. Who is the vulnerable person?
ii. What are the causes of vulnerability among OP
iii. What does care for an OP mean to you?
iv. Why is it necessary to care for vulnerable older people?
v. Who should be involved in the care of vulnerable older people?

vi. As the caregiver what are you going to do to ensure that all vulnerable older people in our communities are well cared for?

All answers to be recorded on the flip chart.

FEEDBACK SESSION - 80 minutes.

Allow groups presentation of the first question then discuss points presented by all groups before moving on the next question.

Question number six is intended to get the commitment of the trainees and their plan of action on what will be done to extend care to all vulnerable older people in their community/village. For this to happen, trainees must have enough time to discuss and agree on the common approach to be adopted on their plan of action. Keep that on separate flip chart, as they will be very useful at the end of the course to enable participants to prepare their overall plan of action.

CLOSURE - 10 minutes

Facilitator summarizes all-important points raised and encourages the participants to put their plan of action into practice.

5.2 4 MODULE FOUR: COUNSELING ELDERLY PEOPLE

AIM

To increase the ability of caregivers to handle emotional and psychological problems of vulnerable older people in their communities.

LEARNING OBJECTIVES

Participants will be able to:

- Understanding emotional and psychological problems facing older people.
- Acquire basic counselling skills for older people
- Identify vulnerable older people in their community whose problem needs counselling service.

METHODOLOGY

- Semi lecturing
- Group discussion
- Brainstorming

MATERIALS

- Flip chart
- Marker pen
- Handouts

LESSON PLAN

INTRODUCTION - 5 minutes

Without going into detail, facilitator to explain what the topic will cover.

BRAINSTORMING - 15 minutes

Facilitator request trainees through brainstorming to give the definition of counselling and its relevance to care givers. List their answers without going into deep discussion.

FACILITATORS INPUT – 1 Hour

Use background information and notes on counselling to:

- Cover the gaps in the definition of counselling and the relevance of counselling for the caregivers.

- Explain how psychological problem affects the health of an older person. - Make sure you have enough examples of both older women and older men. Explain the effects.
- Explain the three phases of counselling.

GROUP DISCUSSION - 30 minutes

Participants to form four groups for discussion. Their discussion will be guided by the following questions:

i. What will you do to build a good working relationship with your counsellee?

ii. How will you help your counsellee in the counselling session?

iii. What needs to be done to enable the counsellee to explore alternative solutions?

iv. Mention five emotional and psychological problems affecting older people in your community, which may require counselling services.

All group to record their answers on the flip chart.

FEEDBACK - 40 minutes

Each group to be given seven minutes to present their views. During presentation other participants to be encouraged to ask questions or to make addition contributions.

CLOSURE - 10 minutes

Facilitator will sum up all-important points discussed. S/he will also try to fill gaps that will be detected in the presentation.

5.2.5 MODULE FIVE: FACILIATATION SKILLS

AIM

To increase the ability of care giver to impart age care skills to other members of the community.

LEARNING OBJECTIVES

Participants will be able to:

- Acquire basic facilitation skills
- Understand how to prepare a lesson plan

- Facilitate a training workshop

METHODOLOGY

- Lecturing
- Brainstorming
- Practical demonstration

MATERIALS

- Flip chart
- Marker pen
- Exercise book.

LESSON PLAN

INTRODUCTION - 10 minutes

Facilitator will explain briefly what the session will cover. S/he will use background information to explain the importance of the topic to the caregiver.

DEFINING THE TERM - 20 minutes

Through brainstorming facilitator will ask the participants to define the term ***training*** and ***facilitation***. This will enable the facilitator to check the general understanding of the participants about the topic.

FACILITATOR'S INPUT - 2 Hours

Facilitator will start the session by filling the gaps on the definition of training. S/he will later explain the five principles of training adults. Refer the background information available.

The facilitator will cover a range of skills:

- How to speak
- Questioning skills
- Feedback
- Avoiding empty space
- Facing participants

The facilitator will also mention how to select the right methods. Different facilitation methods will be covered. These include lecturing, role-play, brainstorming, guided discussion, and demonstration/practice. The advantages and disadvantages of each method should be mentioned.

Cover information on how to develop a good lesson plan. All three sections of a lesson plan i.e. Introduction, main body, and conclusion need to be explained thoroughly.

DEMONSTRATION/PRACTICE - 2 hours

Trainees will be grouped in to three groups of 8 people each. They will be asked to prepare a simple training session and deliver it. They will be free to choose one of the topics taught in the

workshop. After each presentation, the participants will be asked to comment starting from what went well followed by what could have been done differently.

Facilitator to make general comments after the presentation of all groups.

CLOSING - 15 Minutes

Facilitator to summarize important points discussed before closing the training.

5.2. 6 DEVELOPING A PLAN OF ACTION AFTER THE TRAINING -1:30 Minutes

Participants need guidance and support in developing a **plan of action**. This will be their plan on how they will put into practise what they will have learnt from the workshop for the purpose of improving the lives of older people in their community. In doing so, the emphasis is on their role in enabling the full utilisation of the available and potential resources to support the elderly in their communities.

Steps to follow

Explore with participants through brainstorming, the different activities which can be done to ensure that older people, particularly vulnerable older people in their community or area of operation are well cared for (physically, socially, psychological and nutritional-wise). Exhaust participant's ideas and record all answers on the flip chart.

Formation of functional groups

Group participants into possible functional groups (for example members who are able to plan and execute plans together e.g. participants from the same villages/wards, NGOs/CBOs with similar interest areas, or institutions such as schools. Check from participants if the groups formed represent realistic functional groups.

Each group will consider the following in order to prepare their plan of action.

Based on the knowledge and the skills you have after this training and the other realities around you, explain the types of activities you are going to do to make your organisation/institution/ community more effective in caring for older people particularly vulnerable ones. To answer this question, participants will follow the format below, which in turn will enable them to make a proper plan of action.

FORMAT TO FOLLOW

What activities will you do:

i. .....

ii. .....

iii. .....

iv. .....

v. .....

a) Explain how you are going to implement each activity you have just listed and the method you will use.

b) Who will be involved and what will be their specific role in that particular activity.

c) When are you expecting to start and finish each activity?

d) What are the likely obstacles and how will you overcome them.

e) Who else will you need to consult/involve and for what purpose.

f) How are you going to co-ordinate and manage these activities

g) How will you know that you have succeeded or failed to meet your objectives

It is important to ensure that all these questions have clear answers.

Avoid unrealistic plans that cannot be met.

5.2.7 COURSE REVIEW

Finally, the training programme now needs to be reviewed. Immediately after finishing the last topic the facilitator will administer written and oral evaluations to seek the reaction of the participants.

Written evaluation 10 Minutes

Ask participants to be as honest as possible as they will be reacting to the following questions:

i. What did you enjoy/not enjoy about the programme

ii. What did you learn this week

iii. How will you apply what you learned

iv. What was not included which you think should have been

v. Have you in anyway become more effective as the result of this training programme

vi. What challenges are you likely to face in implementing what you have learned

vii. How can your institution/organisation/community become more effective as the result of this training course

viii. What additional comment do you have?

Oral evaluation - 10 minutes

i. What went well

ii. What would have been done differently

iii. What issues did you pick up for implementation

iv. Recommendations

5.3 PART TWO: RESOURCE MATERIALS

5.3.1: RESOURCE MATERIALS FOR MODULE ONE: PHYSIOLOGICAL CHANGES WITH AGEING

BACKGROUND INFORMATION

Ageing is an individual process that occurs at different rates in different people, and social psychological factors may retard or accelerate the physiological changes. Also the rate of change in various body process affected by ageing vary among people. Visible sign of ageing include the appearance of wrinkled skin, greying and thinning of hair and shortened posture from compressed spiral discs.

As a person ages, blood vessels, tendons, the skin and connective tissues lose their elasticity. Hardening of blood vessels and stiffening of joints occurs. Bones become brittle and thin; hormonal activity and reflexes decrease.

As the person ages, there is general decline of the circulatory system with reduced blood supply, impaired mental sharpness, interference with balance, and reduced effectiveness of muscles and body organs. The probability of stroke and heart attack also increases.

As the person ages, the muscles lose some of their strength and co-ordination, and endurance become more difficult. There is also a decline in the functioning of organs such as the lung, the kidney and to the lesser extent, the brain. As ageing continues, hearing and vision capacities decline, food may not taste the same, the sense of touch may become less acute and there may

be a loss of memory of recent and past events. The degree to which one's body loses its vitality can be influenced by, one's life style.

People who are mentally and physically active throughout their youth and adult years remain more alert and vigorous in their late years.

Although many of the effects of ageing are irreversible, several of the supposed effects of ageing are due to largely to the inactivity that is often associated with ageing. Learning to reduce stress along with exercising and maintaining a healthful diet can reverse or at least hold in abeyance many of the effects caused by ageing.

NOTES

Growing old is a natural process. We are all growing older everyday. As we grow older certain change takes place in our body. Although many elderly people remain vigorous beyond 80 years there is a general decline in all our bodily systems and a reduction of normally functioning cells caused by ageing. This leads to decreased ability of older people to withstand and adapt to physical or emotional stress. Consequently older people start to be dependent on others who may find this a burden especially if the necessary adjustment has not been made. Some of the physiological changes with ageing are:

DECREASED CARDIOVASCULAR AND RESPIRATORY FUNCTION (HEART AND RESPIRATION)

Food, oxygen and water are carried to various body tissues through blood. The heart pumps the blood, which is carried in arteries and veins. When we get old the blood circulation gradually slows down because of changes in the arteries and veins. This may result in high blood pressure and hardening of arteries.

The rib cage, which helps in the process of breathing in and out become more rigid and the small tube in the lungs, lose their elasticity. Lower respiratory tract also become potentially vulnerable to infection due to decreased immunity.

There can therefore be decreased endurance, fatigue and getting out of breath more easily. To manage:

- Encourage rest in between movement
- Do breathing exercise. (Top right positions recommend to prevent pneumonia)
- Eat balanced meals to improve immunity.

DECREASED FUNCTION OF URINARY SYSTEM

The urinary system removes waste product from the blood and passes them out of the body in the form of urine. Some older people pass urine more often because the muscles around the

opening get weaker with age. However, drinking less water in order to avoid going to the toilet may cause harm to the kidney.

Older men sometimes have difficult in passing urine due to a swelling of a gland (prostate), which lies, between the bladder and the urine tube. It may help to sit in the bath of hot water. If this does not help see the doctor or nurse as incontinence can be treated. When someone suffering from this problem goes for a walk, devise some kind of urinary or incontinence pads to avoid embarrassment in case of dribbling.

Older women may also experience urinary tract problems resulting from disease or multiple births. Treatment is advisable as soon as the problem is identified. The carer should keep in mind that this situation is embarrassing to the patient who thus may refuse medication. Persuasion, mentioning the benefits, may be needed.

DECREASED FUNCTIONING OF DIGESTION SYSTEM

The digestive system break down the food we eat. Food is grounded by the teeth and moisture with saliva. With old age people can loose their teeth and produce less saliva as well as loose their sense of taste. This may cause indigestion and constipation because waste product takes longer to be excreted. Decreased stomach and intestine gastric acid production, which is vital in the digestion process, can also cause this problem.

Caregivers should give elderly soft and nutritious food because of difficult in chewing and swallowing especial in supine position. Avoid too much starchy food. Fruit, vegetable and drinking plenty of water is highly recommended.

Daily exercise can also help. A nurse or doctor should attend to bad cases of constipation. Loosing control of bowels can also be experienced. In this case the person and the bedding must be kept clean. Healthy diet and regular bowel movement can help.

Malnutrition and food intolerance are very common to older person because of the above reason, so care provider need to be aware to prevent further complications.

DECREASED FUNCTION OF THE MUSCULOSKELETAL SYSTEM

(bones, muscles and joints)

MUSCLES

Help us to move and protect internal organs. As we grow old muscles become weaker, they decrease in mass, adipose replaces muscle cells, which lead to decreased strength and endurance. No wonder some old people require help in lifting even light things. Exercise is important to make them strong.

BONES

As we grow older bone become weaker and weaker and more brittle. They break more easily and take longer to heal if there is a fracture especially if there is an inadequate supply of calcium and

other mineral. The discs in between the bones shorten. This is why people seem to shrink when they grow older. Elderly women can suffer bone loss due to the changes taking place in their hormones. Care providers must ensure safety of old people by:

- Helping them to avoid slippery floors
- Environment must be free from things on their way
- Enough light for them to see clearly.

JOINTS

As we grow old cartilage (gristle) which cover the ends of bone get roughened (erode) and then worn away. The exposed bone ends grate on one another and the tissue round the joint become inflamed. This lead to pain and limitation of movement, which can be very disabling. Older women are more affected. Usually it affects the weight-bearing joint of the backs, the hip and the knee. Some of the recommendations to the caregiver to address this are:

- Weight reduction - old people avoid carrying access weight, which puts a great deal of unnecessary strains on the joint especially knees.
- Old people should exercise so that they do not get stiff but they should avoid becoming over tired.

DECREASED FUNCTION OF INTEGUMENTARY

SKIN

With ageing the skin loses some of its elasticity so that there is wrinkling and sagging. This is due to decreased sub-cutaneus fat sweat glands, extracellular water, melania receptors and blood circulation to extremities. Other outcomes of these conditions are that skin easily bruises, there is decreased pain sensitivity hence OP can easily burn and may get non-healing skin lesions. Caregiver should help old people to apply Vaseline on their bodies after washing and drying.

Protect OP from injury and burns

Remember the elderly may not be sensitive to heat and they like sitting near fire. Care providers should cover them and encourage them to sit far from fire.

NAILS

Ageing cause decreased peripheral blood supply and increased keratin. The outcome is thickened brittle nails, ridging called privation. Due to this the nail become hard to cut. Elderly people therefore need someone to carefully cut these brittle thick nails, as they cannot bend because of stiff joints.

DECREASED FUNCTION OF THE NERVOUS SYSTEM

The brain spinal cord and nerves form part of the nervous system. The nervous system is the form of communication between the various parts of the body sending messages to the body tissue.

BRAIN

Ageing can cause decreased number of cells in the brain, decreased blood flow, and oxygen utilization. These lead to decreased mental processing, loss of balance and co-ordination, slower response reaction to time. This is the potential condition, which can lead to depression. Care givers therefore has to make sure that elderly do not cross roads alone especially the high way where cars move fast as old people are slow in responding. Care provider must be patient with them. It is tempting to do all things for the elderly because they are slow. This takes away their autonomy and self esteem. For the best result therefore caregiver are advised to be patient.

VISION

Older people may become increasingly blind. From the age of 40 years onwards reading or close work such as sewing may be difficult because the vision blurred. This is because the lenses responsible for focusing on near or distant objects become harder a condition known as presbyopia. Spectacle helps this condition.

Macular deterioration is the common eye; eye decease affecting part of the retina of old people a part which enable us to see the detail. Hence old people with such problem cannot read print and recognize faces although they are not to totally blind. If one or both eye become cloudy and cause problem with sight there may be cataract. Light cannot enter the eye. Sometime operation helps a person to see again.

In general many old people cannot see well, especially in the dark. Care providers should ensure enough light, and remove objects in the elderly person way. Remember older people's eye problems can be treated or corrected by the provision of spectacle, drugs or operation. So old people should be encouraged to see the doctor or nurses. Day-to-day cleanness of old people eye is also encouraged.

HEARING

Deafness can be another problem. Some older people who are slightly deaf may also feel dizzy and hear ringing or buzzing noises in their ears. They may feel unsure of their step when walking. They can look as if they are drunk even though they have not had alcohol. In this situation a doctor may be seen as medicine may help. Moreover there are many ways to help the older people with hearing problem to improve communication. These are:

- Attract the person attention before starting to speak (e.g. touching their shoulder).
- Make sure your face can be seen, keep hands away from the mouth as you speak.
- Keep distraction at minimum e.g. turn off radio
- Speak up but don't shout.
- Speak more slowly than usual.

TASTE

Ageing causes decreased number and functions of taste buds. Food must be extra tasty; otherwise older people may suffer from malnutrition.

SMELL

With ageing, there is a diminished sense of smell. Food is not as pleasing as it is supposed to be. Old people's food therefore should be appetizing.

PRESSURE SORES

Many illnesses and disabilities limit an older person's ability to move about unaided - they may be confined to be on chair for long periods of time, perhaps permanently in some situations. Indeed rest in itself may be used as a treatment in some conditions such as in serious joint pain. However, having to lie or sit for a long time can be dangerous for older people for a number of reasons and one of these is the risk of pressure sores.

WHAT ARE PRESSURE SORES?

Pressure sores are areas of damage to the skin and often the underlying tissues, caused by continuous pressure between bony parts of the body and firm surfaces (such as beds or chairs) on which the older person is resting. The older term 'bed sores' gives the impression that they only occur in people confined to bed; this is certainly not the case as people lying or sitting in any position for a long time can develop them. The term 'pressure sore' is therefore far more accurate.

Pressure sores can be the source of much discomfort to the older person, and deep ones - although less painful than the shallower variety because nerve endings have been destroyed -

can be dangerous enough to threaten the person's life. Infection is an ever-present risk, especially when deep body tissue and perhaps the bone is exposed.

HOW DO THEY DEVELOP?

There are several places on the body where parts of the skeleton lie just beneath the skin with very little padding of fat and muscle over them. As with the rest of the body, the skin requires oxygen and nutrients to stay healthy; it obtains these from its blood supply, which also takes away waste products. When continuous pressure is put upon the skin however, because the older person cannot change their position, the tiny blood vessels are squashed and the blood flow is blocked. Eventually the skin cells will die and a pressure sore will form. At first the skin may simply look dark and sore but unless rapid action is taken it will break open and expose the under lying tissues. In extreme cases it may continue to enlarge until a deep hole appears and the actual bone may be exposed.

In addition to pressure damage, the older person's skin is at risk from shearing forces' or friction if they slip down in a chair or bed or if they are dragged rather than lifted into a good position. The skin surface becomes grazed on the sheet or the chair surface beneath them, damaging the small blood vessels, with sores then developing on the grazed area. Sores can also develop where folds of skin are in constant contact with each other. This may happen in the folds on the buttocks for example or in women with large breasts.

PREVENTION OF PRESSURE SORES

To prevent pressure sores there are some very straightforward 'Do's' and 'Don'ts' to follow:

DO

- Regularly move the person at risk and put them in different positions, thus altering the areas under pressure. For people sitting in chairs: Lift them clear of the chair for a few minutes every two hours. If they can stand with support and carry out some gentle movement, encourage them. Reposition them slightly differently if possible (e.g. facing the opposite direction supported by pillows or cushions).

- People in bed: They should be turned and repositioned every two hours. (During a day and ideally at night too). They can be moved from their right side to their left, then on to their backs, then on to their right again for these two hours periods. Many older people find it difficult to lie flat on their stomachs but when they can tolerate this it gives another option. Where the older person finds it difficult to stay on their side, rolling back on their buttocks a pillow behind their back to support them often helps.

- Give a good mixed diet and a good fluid intake to help to keep the skin healthy.

- Deal with loss of bladder and bowel control promptly and thoroughly. Ensure that the skin is washed and dried and a barrier cream gently applied if available.

- Do treat anaemia promptly.

- Place sheepskin or other soft pads if they are available under the areas at risk. The wool contains lanolin, which lubricates the skin and reduces friction because it does not wrinkle. They are no substitute for regular turning and changing position. Problems of washing and disinfecting are avoided if small pieces are used and thrown away when they are no longer needed.

DON'T

- Wash the skin excessively except following loss of bladder or bowel control. Washing removes the skin's natural oils and dries it out making pressure sores more likely.

- Massage the skin; it used to be thought that vigorous rubbing promoted the circulation but it is now realised that the friction this causes damages the skin even more and encourages the development of pressure sores.

IMPROVING A PERSON'S ABILITY TO MOVE ABOUT

The prevention and treatment of pressure sores cannot be carried out without finding the cause for the person being unable to move about on their own. Every effort needs to be made to help older people regain their ability to move about after an illness or injury. Sometimes very basic problems such as bad feet can be the cause of the trouble and can be fairly easily be dealt with. At other times, perhaps permanent, far more serious conditions such as paralysis or widespread muscle weakness make help much more difficult to give. But care giver always need to

remember the difficulties long periods at rest can bring; even in the early stages of an illness there should be exercise as much as possible to help the older person to be mobile.

CONCLUSION

It is important to remember that much of our health in later life is determined by our habit and lifestyles in earlier years and so care in younger days should not seem as specific to that time but a proportion for a life time of healthy development. Good eating habit, exercise and careful personal hygiene can make a big difference to health in later life.

5.3. 2 RESOURCE MATERIALS FOR MODULE TWO: NUTRITION AND OLD AGE

IMPORTANCE OF HEALTHY DIET TO OLDER PEOPLE

Food is a basic human necessity. Older people like any other human beings need food to live. A healthy diet not only have to provide all necessary nutrients to support life and body activities, it must also contain them in the correct proportion to one another and exclude substances known to be harmful to health.

IMPORTANCE OF A HEALTHY DIET TO OLDER PEOPLE.

Healthy diet remains vital for elderly people to maintain activity and resistance to illness, and to prevent other disabling conditions too. Older people makes valuable contributions to their families and community, they may be wage earners in the city or do house tasks such as caring for young children or work on the farm. Good nutrition status means that an older person is more able to carry out these activities. It also means that a person become ill less often and that s/he can

continue to bathe, dress and look after themselves thus avoiding embarrassment that would have happen if the different would be the case.

WHAT CONSTITUTES HEALTHY FOOD FOR OLDER PEOPLE

A good diet for older people consists of small frequent meals containing many different foods. These foods should be affordable, easily available, easily prepared and easy to chew. They should also provide all nutrients which older person needs.

Protein – This is for body growth and repair suggested foods are: fish, meat, beans, groundnuts milk and eggs.

Carbohydrate – This is for energy and heat. These are food like rice, ugali, banana and potatoes etc. (remember any of these food items or a mixture can serve the purpose).

Vitamins - Protective food for all body functions in vitamins. Vegetable and fresh fruits are very rich in vitamins

Liquid – this is in the form of fresh water, juice, soup, and soda. etc. Minimum intake per day for an older person should not be less than 8 cups.

Minerals – for maintaining healthy blood bone and teeth. – Food like milk and eggs are very rich in calcium.

AGE RELATED CHANGE AFFECTING DIET

Physiological change

- Decreased sense of test and smell. Food may need to be more strongly spiced or seasoned to obtain appetite.
- Slowing down of the digestion process. More frequent meals may be more manageable than larger ones.
- Loss of teeth. Encourage older people to use their false teeth
- Physical frailty, Unable to prepare his/her food. Improved cooking facilities and encourage practical support from neighbours.

Social change

- Poverty - low income, lack of productive plots of share unable to get the right food at the right time.
- Tradition beliefs food choice and segregation.
- Loneliness and isolation especial after bereavement.
- Gender barriers.

INTERVENTIONS

The right intervention should aim to address:

- Improve the diet food intake of older people, both male and female.
- Improve physical ability of to obtain, prepare, and eat meal.
- Improve availability of food for older people.

- Reduce social and emotional risk factors of nutrition vulnerability.

IMPORTANT THINGS TO CONSIDER.

- Food like liver, and vegetable need very short time to prepare - long preparation leads to loss of nutrients.
- Exercise is important to older people. It increases appetite.
- Avoid cigarette and drinking too much alcohol as this also affect OP appetite.
- OP need to be exposed outside for Vitamin D from the sunlight.

5.3 3 RESOURCE MATERIALS FOR MODULE THREE: WORKING WITH VULNERABLE OLDER PERSONS (VOP)

BACKGROUND INFORMATION

Like many other developing countries the number of older people in Tanzania is on the increase. It is estimated that Tanzania has 1,952,041 million older people who are above 60 years. While statistical data show a higher number of older people at this time than in the past, older people themselves are loosing their social importance, they are neglected, isolated and subjected to different kinds of abuse by the community.

In the past, older people were valued and respected. They were seen to have the wisdom, experience and deep knowledge of culture and tradition. Elderly people therefore had responsibility for advising the younger generation and for making sure that they grew up fully conversant in the tribes mores and ethics. Elderly people were the guardians of all traditions and culture.

Traditional societies on their side did not only respect old people but also had responsibility of providing adequate care to elderly people up to the end of their lives. In fact it was a shame for the family, clan and the entire community to see their senior citizens wondering on the street without support or dying because of the failure to have an access to basic needs. However as time went by, the world started to experience social, technological and economical changes, the impact of which weakened the traditional system of caring old people in the community.

In the fast changing world and the money oriented economy of today, there is less family support as sons and daughters leave their villages to seek employment elsewhere. The support of the community for old people has also declined tremendously because people are concentrating on making ends meet on their own lives and they have no resources to spare for others especially old people.

Reports from different parts of Tanzania indicate that older persons receive less support in areas such as cultivation of their shamba, fetching of water, collection of fire wood, washing, cooking and other day-to-day activities.

While the traditional systems which used to care and protect senior citizen continues to disintegrate, the modern social security schemes in Tanzania like PPF and NSSF are still providing inadequate services to their beneficiaries and do not allow them to meet their basic needs.

Another major shortcoming of the modern social security schemes in Tanzania is the number of elderly people covered. So far the services of these schemes are extended only to older persons who were employed by formal sectors. e.g. retired civil servants etc. (about 2% of OP). This means that the majority of older persons in this country (about 98%) are excluded.

Based on these facts, it is clear that any meaningful effort made to improve the lives of older people in Tanzania should go hand in hand with the effort of reviving the spirit of helping old people in the community and strengthening the weaker social structures we have in our communities to resume their tradition role of caring for older persons Moreover they should also aim at empowering old people themselves to cope effectively with the challenges of modern world.

The recent research on the situation of older people in Tanzania undertaken by HelpAge International showed that to survive, old people have to work harder to get food for themselves and their dependants, enduring bad conditions and in some cases, begging on the streets.

While life has become more difficult for the majority of old people, such difficulty tends to be magnified for vulnerable older people (e.g. the bed ridden) who are armed with few coping mechanisms and hence making their survival quite uncertain. It is therefore this group which require special attention not only from the family members but also from other members of the community.

Where a vulnerable older person has a family, that family should take primary responsibility for caring for the older person. If this is not done, they should be persuaded and educated to do it. Where this is not possible because of different circumstances, a system need to be developed to ensure that neighbours and other social support structures (institutions churches, mosques, youth groups, women's groups, voluntary associations) and the elderly themselves are well mobilised to derived adequate care to vulnerable older persons, and to take it as part of their day to day obligations.

It is therefore important for the caregivers to know most, if not all, older persons in their village and not simply their relatives or those old people who appears to be important. Caregivers should also know what other people could do to help in different ways and be able to link the VOP with those resources.

Some of the main problems affecting older persons include; failure to meet their basic needs, lack of access to medical services hence enduring permanent pain, being oppressed and denied of their rights e.g. possession of properties, and being isolated, neglected and dishonoured by the communities some times including their own children.

Some of the activities which the community can best do to help VOP are; help with practical tasks such as fetching water, fire wood, house repair; and cooking or providing some meals. They may be able to sit and talk to an older person while doing some household tasks, or even support in the preparation of older person's shamba. Neighbours including children could be encouraged to

spend time with elders who live near. This increased social contact will also help to ensure that elders who develop health problems receive timely community attention hence taken to the hospital or dispensary without delay.

In the whole process of supporting VOP it is important to remember that although they are very poor they deserve respect and they should not be treated like children. They need to be consulted, be given opportunity to give their idea, and express their feelings. The ideal service to VOP should therefore avoid removing respect, dignity and self-esteem of an older person but rather promoting them.

VULNERABLE OLDER PERSON (VOP)

An older person is called a vulnerable older person when s/he becomes physically weak and unable to perform their own important activities for survival, economically poor to the extent that he/she can not have an access to basic needs and his/her social relation is dwindled to the extent that she/he can not interact freely with other people or get basic support from them. It is the state where an older person is physically, economically and socially incapacitated to such an extent that he/she cannot manage on his/her own to cope up with the challenge of life.

CAUSES OF VULNERABILITY

Causes of vulnerability can be categorized in the following groups.

i) Physical Weakness

An older person becomes weak, sometimes unable to move from one point to another. At this stage support of another person is essential for the survival of that VOP. Diseases like stroke,

disability, and accident and advanced age e.g. (100 years old) are some of the likely cause to physical frailty.

ii) Lack of income

This is the most common problem. Older people lack reliable source of income. Consequently majority of them have meager income, which can no enable them to have access to their basic needs including food. Moreover, due to AIDS pandemic some older people whose economies are already in shamble are forced to care for their younger orphans.

iii) Poor social relation

Human being is a social creature. We all depend on other people to survive. When social relation of an older persons is badly damaged, they becomes automatically vulnerable as they cannot continue to enjoy the support from the community e.g. victims of witchcraft allegation.

PROBLEM FACING VULNERABLE OLDER PERSONS

Problem of vulnerable older people appear in all aspect of life i.e. socially economically and physically. Some of their specific problems include: -

- Failure to meet their basic needs e.g. Food, shelter water etc.
- Lack of access to medical service hence enduring pain
- Loneliness and neglect
- Oppression and humiliation

SUPPORTING VULNERABLE OLDER PEOPLE (VOP)

Vulnerable older people need to be supported to over come all obstacles that make their final lives quite uncomfortable.

To get ideal solution of OP's problems you will need to consult them and work together with them to find the solution. It is important to remember that vulnerable older people like any other person deserve respect. In this sense the process aimed at helping them should not make VOP to feel that they are useless but rather a process of empowering them to own their destiny. Some of the activities that the community can do to support VOP are:

Practical help

Assist them to perform daily tasks of living like fetching water and firewood, cleaning laundry, cooking, provision of food and house repair.

Physical Care

Together with practical help sick older people require physical care like being washed, shifted to and from the toilet etc.

Companionship to maintain their morale

Visit them, talk to them so that they are not lonely. Value their contribution and make them feel wanted. Do some simple exercises with them all these activities will make VOP to feel that life is still interesting and worth living.

Promotion of their income

Where possible VOP can be supported to start simple activities like small garden chicken and goat project that will make them more active and earn some income.

Linking them with resources

Assist them (VOP) to have an access to available resources e.g. village dispensary etc. You will always find that most of OP's problems do not need special project as they can be solved by using existing resources in the community if there will be someone to link VOP with those resources.

INVOLVEMENT OF THE FAMILY AND THE COMMUNITY IN THE CARE OF VOP

Where VOP has relative effort has to be done to ensure that the family is fully involved in the care. When this is not possible (no family members) neighbours and other social structures including CBOs like women groups, youth groups, and other volunteer's associations will have to fill the gaps. Religious institutions and village government will also be involved to ensure that VOP receive adequate care.

Successful age care programme should not only be determined by service rendered to VOP but also how sustainable the programme is, this can only be seen by looking on the way families and entire community have been mobilised to be actively involved in the care of their older people.

PROBLEMS ENCOUNTERED IN WORKING WITH VOP

There are several problems, which any person working with older people is likely to face. Most of them are centred on two areas.

A. Inadequate resources

Resources are always inadequate to meet the needs. However most of the service, which VOP needs, involves resources, which are available in the community. For instance provision of practical help like washing, cleaning and fetching of water can be organised without requiring external support provided that all social structures and institutions in the village see the importance of assisting them.

Moreover a thorough identification of the most needy basing on the agreed criteria will enable the community to know exactly where scarce resources is needed most.

B. Negative attitudes of the community toward older people

Most people do not see older people as the group that need to be supported. They see them as unproductive. Some other people regard VOP as the witch who should be eliminated so they don't see the reason of supporting them. To tackle this problem requires patience and a well-planned awareness raising campaign and mass education on the rights and contribution of older people. Public meetings, drama groups, schools and religious institutions are some of the potential entry point for fighting against these negative attitudes.

VULNERABILITY AND GENDER - Its Effects in Old Age

High life expectancy

Women above 60 years outnumber men. In most parts of the world women live longer than men. The difference between male and female life expectance is the result of a combination of biological differences, such as a lower susceptibility to heart disease in women before menopause, and cultural influences, such as greater male exposure to occupational hazards.

Unfortunately as they advance in age most of them find themselves lonely, weak and without sufficient support from their family and the community at large. This situation can lead them into absolute poverty.

Negative attitude toward older women

Women without old age support are more likely than men to be blamed for their circumstance. Those with support face more precarious situations. Though women tend to live longer than men older women often receive less support from their families and there is often an underlying assumption that they do not deserve supporting. Older women are much more likely to be accused of being witches often with violent results in some parts of Tanzania.

Witchcraft

An estimated 500 older women are murdered every year after being accused of witchcraft. Many more are driven from their home and communities becoming destitute as a result - A recent study in Tanzania by HAI found widowhood exposed many older women to the charge of witchcraft.

This was typically related to their solitude. If she is not seen much around the village, an air of mystery may group up around her, which contributes strongly to accusations of being a witch.

Widowhood

Widowhood is more prevalent among women because they live longer and marry men older than themselves. Whether by choice or custom women are less likely than men to remarry after the death of a spouse and often live alone.

High rate of disability

Women suffer from high rate of disability at older ages, reflecting burden that accumulate over their life cycle. Older women health status is affected by their lack of health care, education and nutrition.

Lack of education and access to information

Older women in Tanzania are less likely than any other group in the society to have been educated and many do not speak the national language, Kiswahili. They are therefore excluded from the official life of communities and access to information restricted, and even if legally she is entitled to land or resource, lack of access to information about rights means older women, particularly widows can be thrown off land and made homeless.

5.3.4 RESOURCE MATERIALS FOR MODULE FOUR: COUNSELLING ELDERLY PEOPLE BACKGROUND INFORMATION

It is indisputable fact that the physical process of ageing contributes to health problems. However most of the health problem in old age are either accelerated or associated with social and personal stress, which calls for psychotherapy or counselling services.

The elderly in our community face a wide range of stressful situation many of them created by our society making them to feel useless. Some of the stressful situations which older people encounter are; loss of social status, retirement, reduced income, and loneliness. Other are; death of friends and family members, decline in physical energy and physical capacities and being neglected by even their own children.

When there is no proper adjustment to cope up with these problems, elderly find themselves psychologically overwhelmed and totally despaired. At this stage life become meaningless to an older person no wonder some older people refuse to follow medical advise, refuse to eat, decide to hide themselves inside the house and become reluctant to participate in any activities which are crucial for their survival etc. If the problem of older people at this stage is not attended properly there is drastic decline of both physiological and mental function of an older people, which might result into death.

Although some psychological situations require highly qualified psychotherapist to intervene, most of the stressful conditions which older people face in our community can be properly handled with the person with basic counselling skills. In this context therefore it is important for

the caregiver to be equipped not only with physical age care skills but also social and psychological skills that involve counselling skills.

Counselling is not giving and telling people what to do or what they ought to do as most of us do especially when we are working with vulnerable old people. It is helping them to make their own decisions, and to take their own action to solve problems that are worrying them. Counselling skills will help the caregiver to assist older people to solve their problem by helping them to

- See the problem in different ways and to understand them better.
- Explore their feeling about problems and express their feeling.
- Understand how other older people may see the problem.
- Identify what could be done to solve the problem
- Understand type of adjustment needed to be able to cope effectively with the problem that cannot be solved.
- Find out who or which organization could help them.

Counselling an older person is quite a process it is not something that can be achieved in a day. Counselling involve three important phases which will have to be passed through to attain the intended goals these are building a relationship, exploring problem in depth and exploring alternative solution. Successful counselling gradually proceeds from one phase to another, however, in most case you will find that these stages are overlapping.

If you are counselling your parent or your relative there is the danger that because you are emotionally involved you may get upset or into argument with him/her. It may be best to refer that counselling to some one else.

NOTES ON COUNSELLING ELDERLY PEOPLE

WHAT IS COUNSELLING?

Counselling should not be confused with giving advice or telling a person what you think he/she must do to solve the problem. Counselling then is a face-to-face service provided to enable or help a person realize the problem then make decision and take action to solve it. Counselling process becomes successful when it is done with the counsellee not to or for the counsellee. It increases person's capacity motivation and opportunity to look the problem in depth and come up with meaningful solutions.

COUNSELLING PROCESS

Counselling is process not an over night issue. Effective counselling gradually proceeds from one phase to another. These phases in counselling involve.

i. Building a relationship
ii. Exploring problems in depth
iii. And exploring alternative solutions

HOW TO BUILD RELATIONSHIP

In initial contacts with the counsellee you need to establish a non - threatening atmosphere in which the counsellee feel safe to communicate fully his or her troubles while feeling accepted as

a person. Introduce your self as a knowledgeable, understanding person who may be able to help and who want to try.

Do not laugh or express shock emotional out bursts will lead to the OP to believe that your are not going to understand his or her difficulties and she/he will usually stop discussing. Be non-judgmental and non-moralistic. Show respect for the counsellee's values and do not try to sell your values. The values that work for you may be not best for some one else in a different situation.

Avoid superior/inferior relationship counsellee will be less motivated to reveal and discuss personal difficulties if they feel that they are treated as inferior. Usually use non-offensive words, do not use words that are strange to the counsellee.

Keep all that you discuss with your client confidential. Working relationship may be quickly destroyed if the counselee discovers that confidentiality has been violated.

If you are counselling an OP who is your relative there is a danger, that because you are emotionally involved, you may get upset or into argument with the other person. If that happen refer the counselee to some one else.

EXPLORING PROBLEMS IN DEPTH

Do not suggest a solution as soon as a problem is identified. Have time to explore the problem in depth before working on the solution. In exploring problem in depth examine extent of the

problem, its duration, its causes, the counselee's feelings about the problem and the physical and mental capacities and strength of counselee to cope with the problem before exploring the alternative solutions.

When a problem area is identified a number of smaller problems may occur, explore all these problems. In such situation the best way to decide which problem to handle first is to ask the counselee which she/he perceive as most pressing. Develop together the strategy toward the solution of sub problems. The success in solution to sub problems will increase confidence and strengthen the working relationship.

Show empathy not sympathy. Empathy is the capacity to show that you are aware and to some extent feel what the counselee is saying. Sympathy is also sharing feeling but it has the connotation of pity for an older person who is lonely depressed and they will continue to tell you of sad story over and over supported by your sympathetic feelings.

When you believe that the client has touched on an important area of concern you can encourage further communication by: non-verbal signs that you are paying interest. Use neutral-probing questions e.g. could you tell me more about that? Why do you feel that way?

Ask questions of the counselee tactfully as answering may put him/her in an embarrassing situation. Suppose for instance you are counselling an older person who has been discharged from his job (where he was working as the gate keeper) because of poor personal hygiene. You

as a counsellor you may tactfully say I am wondering if your personal appearance and hygiene may be a reason for the dismissal.

HOW TO EXPLORE ALTERNATIVE SOLUTIONS

After exploring the problem in depth, the next step is for the counsellor and the counselee to consider alternative solutions. In exploring alternative solution start by asking something like "Have you thought about way to solve this. The merits short comings and consequences of the alternatives thoughts should be thoroughly examined.

As the counsellor avoid selecting the alternative for the older person because if the alternative is undesirable for the counselee your future relationship will be seriously hampered. On the other side if alternative may prove to be desirable for the counselee it will make him/her to become overly dependent on the counsellor.

When a counsellor believes a client should take a certain course of action, this idea should be phrased as suggestion. (Have you thought about...? rather than advice I think you should.) The counselee's right to self-determination should be taken away only if the selected course or action has a high probability of seriously hurting other or the counselee e.g. when the old person decide to commit suicide.

Perhaps the biggest single factor in determining whether the counselee's situation will improve is the motivation to carry out essential tasks. A counsellor should seek to motivate apathetic

counselees. One way to increase motivation is to clarify what will be gained by meeting commitment.

Counsellor should refer the counselee to someone else or at least seek a professional counsellor to discuss the case with for any of the following situations. If the counsellor feels that she/he is unable to empathize with the counsellee; if the counsellor feels that the problem is of such a nature that she or he will not be able to help; if the counsellor feels that the counselee is choosing alternatives that conflict with the counsellors basic value system, and if a working relationship is not established. Remember you can help some people but not all.

5.3 5 RESOURCE MATERIALS FOR MODULE FIVE: FACILITATION SKILLS

BACKGROUND INFORMATION

As we are talking of more than 1.9 million Tanzanians above 60 years, it is becoming quite clear that the care of older people cannot be left to a few caregivers. In fact it is the responsibility of the entire community. Families, neighbours, religious Institutions, CBOs and NGOs ought to play major role to ensure that older people, especial vulnerable ones, are well cared.

However this is not the thinking of some people as they are dominated by negative altitude toward older persons. So they comment negatively when they hear of something good concerning older people. There is another group of people who would like to help the senior citizen but they don't know how this could be organised within the community. This has made some of them to suspect that perhaps the solution is to construct many centres where all

vulnerable older people should be cared until the end of their lives. Unfortunately our social and economic realities have proved to be against this solution.

In this sense the need for age care training for caregivers and the rest of the population is paramount. This training will not only change their negative altitude toward older people but also provide skills on how to provide affective care to older persons within the community. It is therefore expected that people who have attended age care training will also impart the skills to others, no wonder the section on facilitator has been added.

NOTES ON TRAINING

Training is a planned and systematic effort to modify or develop individual through learning experience. Training enables an individual to perform adequately a given task. This happens when people acquire knowledge skills and attitude through experience, reflection study and instruction. An ideal training helps the learner to diagnose the gap between their aspiration and their presence level of performance.

TRAINING MATURED PEOPLE

In order to have a successful training of the matured trainees, trainer should be aware of some principle of adult learning, which must be considered in the designing of the course materials and in the delivering process.

The most important principles are:
A. Problem centred

Adult learners prefer to focus on current, existing problem rather than abstracts concepts you course design should comprise topics, which can be converted into use to solve the existing problem.

B Immediate Application

Adults will view learning as a benefit only if it can be quickly applied to all life problems.

C. Building on previous experience

Adult understands a lot so they should be given times to share their experience in relation to the topic.

D. Learner control

Adult want control over their learning and prefer to have trainer as a facilitator rather than a teacher or expert.

E Active participation

Adults learn best when they are involved hence course design should include a number of activities.

FACILITATION SKILLS

Facilitation is defined as the process of making things easy for the people to enable them to make progress. Facilitation's skills therefore are instructional skills that enable the trainer to run the training programme while assuming the role of helper rather than a teacher. Training programme can be a success or a disaster depending on how well it is facilitated

Good and successful facilitation depends on three important factors.

i. Ability of the facilitator to capture the audience and motivate them to learn
ii. Good selection of the method to use
iii. Good preparation of the lesson plan.

a) CAPTURING AND MOTIVATING THE TRAINEES

It is crucial for the facilitator to ensure that his/her style of facilitation continues to make trainees active, interested and motivated to learn and their mind are on the subject through out the delivery process. To attain this level, the facilitator will need to consider the following: -

HOW TO SPEAK

A well-prepared voice will go a long way towards creating interest and reducing monotony and boredom. You are therefore advised to be: -

- Eloquent enough that your words are easily captured by the audience.
- Vary tone and pitch. Be dramatic, confidential and sometimes triumphant depending on what message you are delivering.
- Over emphasize where this is necessary and accentuate syllables.
- Repeat key phrases with different vocal emphasis
- Use delivery speed to manipulate the audience. Fast delivery will excite and stimulate slow delivery will emphasize.

QUESTIONING SKILLS

One good way to gain your trainee participation is by asking them questions. Ask the right kind of question to elicit the best possible response. Below are various types of questions and the ways in which they can be used.

Open question

Allow respondent to give detailed response without any restriction. Such question requires thinking before answering so they are good for stimulating participants e.g. What did you learn from the exercise?

Direct questions

They are often aimed at one person. The respondent may feel embarrassed if he does not know the answer e.g. Mabula, what can we do to stop the killing of older person in Magu?

Indirect questions

Question presented to the whole group and is open to anyone in the group to answer, if the answer is not for the coming, revert to direct question.

Subject/attitude questions

These questions allow participants to express their own feeling, prejudice and biases e.g. Why do you think Mr. Rwegasira was wrong. Since there is no right or wrong answer they encourage comments from other member of the group.

Double check questions

Allow facilitator to assess participant, understanding e.g. so what you mean is. It is a non-threatening way to get feedback and to make sure you are talking the same.

Objective questions

Require respondent to think and give a non-biased answer e.g. What are necessary to set good community based age care programme.

Summary questions

Allow participants to recap the key part of the session e.g. So what we have agreed on is.

Closed questions

Require yes or no answer. They can be used to confirm certain details.

FEEDBACK

It is important after every exercise that participants do to give them feedback. A non-threatening way to do this is to ask the group to give feedback to their colleagues especially after group presentation. Facilitator should ensure that feedback is objective, non-personalized and educative. As the facilitator avoid being defensive, explaining and attacking some one.

FACING PARTICIPANTS

Facilitator should face participant rather than flip chart. Instead of reading from the flip chart, use small card.

AVOID EMPTY SPACE

Empty space makes participant to start thinking something out of the topic so they loose concentration. These gaps are likely to happen when facilitator starts to write detailed information the flip chart. You are therefore advised to do most of the writing before starting the session. Where possible have a co-facilitator.

b) GOOD SELECTION OF THE METHOD TO USE

There are various methods, which are used to facilitate training programme. However a good facilitator knows where to employ a certain method to ensure that trainee get maximum benefit out of the training delivered.

HOW TO SELECT THE RIGHT METHOD

Before selecting a method to use on facilitation be aware of:

Resources at your disposal

Different methods require different resources. So unless you have all the required materials for that method do not choose it.

Nature of your audience

The selection of the method should also look at specific audience. Age, knowledge of the trainees over the topic is one of the things that can help the facilitator to select a certain method. For instance adult learner would normally have knowledge of certain issue hence the need for careful selection of the methodology to enhance their participation.

Time

Some methods consume more time than other so you need to know the time you have before selecting the method.

SOME COMMON METHODOLOGIES USED TO FACILITATE TRAINING

Lecture

In this method facilitator talk alone before the trainees. There is very little or no opportunity at all for the group to interact. This is an ideal method for large group it allows material to be covered in a structured way in a relative short time. It also allows the facilitator to have a full control of the topic hence able to repeat key points for emphasize. After 20 minutes of lecture, make sure that there is a pause or change of style e.g. asking questions. This is particular important when you are working with older people. Lecture should be presented dramatically to capture the audience e.g. this is an interesting issue.

Role Play

It is a way of extending trainee's experience by presenting them with a common encountered situation and asking them to place themselves in the position of role play of the parties involved and act out. Situation selected for acting should be realistic as much as possible to make role play meaningful. Role-play is a memorable enjoyable create understanding and involve active participation of the trainees. If it is well planned and monitored it can generate solution, which can be used for future programme.

Brainstorming

It is a loosely structured form of discussion. It provides a practical means of generating ideas without too much involvement into unproductive analysis. The method encourages creativity, overcome limited thinking and remove fear of criticism among trainees. If it is not properly managed it may bring incomplete ideas and be time consuming.

Guided Discussion

This is a free verbal exchange of knowledge ideas or opinion between trainer and trainees. For a discussion to be effective it is necessary for the participants to have a certain measure of knowledge. This knowledge might be acquired through instruction or experience gained prior to the course or by information provided on the course. Questions can be used to guide the discussion. The method is very interactive and helps the facilitator to monitor understanding and gain commitment of the trainees.

Demonstration / practice

This involves the performance of a particular action or explanation of a procedure before participants to enable them to perform the same action under guidance. It is an ideal method for enabling trainee to acquire particular skills and to introduce a new technique as it affords the opportunity to use real object or model. However the method is suitable for small group where every participant would have the opportunity to practice the skills.

c) LESSON PLAN

Definition

Is a guideline which specifies in detail what the facilitator will be expected to do during the delivery process. It is a blue print, which outline; what will be covered; what will be done by the facilitator and by participant; time spent on each learning activity and the methods to be used in the delivery process. It should be noted that however conversant a trainer is on the topic he will still make the session a disaster if the lesson plan was not well prepared.

Information to be delivery to the participant concerned with a specific topic will have to be categorised into three categories.

- Must know - The most important information which participant must know. This information should be given first priority.
- Should know - This information is also important and participant should know them though they are not as important as the must know information.
- Could know - Information that could be shared by the trainees in order to broaden their understanding or help to clarify the must and should know information. This can only be covered if time allow and participant seem to be motivate and capable to understand it.

Arranging your materials in these three categories will help the facilitator to know what point need to be emphasized and how much time should be allocated to a certain point.

MAIN SECTIONS OF A LESSON PLAN

Lesson plan is divided into three important sections, which are: Introduction; Main body, and conclusion.

Introduction

This is the first section of your lesson it is therefore expected that the facilitator will be able to cover the following: -

- Introduce the topic to the trainees
- Show the relevance of the lesson to the participant
- Arise interest
- Give her/his background
- Give the course direction.

Main body

This is the core of the lesson plan set out the detailed subject matter of the course. This is the most important section of the lesson plan, so a thorough thinking is needed to get what to include and how to present i.e.

Some of the hints that can assist you to have main body section well planned are:

- Have time to research the subject
- Establish the main elements
- Categorize the information you have into must know, should know and could know.

- Allocate time to each area.
- Have all material well organized before starting the training
- Review the plan.

Conclusion

This is the ending section of your lesson plan facilitator will use this section to fill gap, to emphasize important point and to review point covered. Question can be answered doubt clarified and pointing the way to the future. The lesson should end in such a way as to leave the group feeling motivated and confident.