CHAPTER III

PROPOSAL

Participatory Learning: A strategy to Improve Knowledge, Attitude and Practice in Tuberculosis Prevention and Care Among HIV Self-Help Group in Bangkok.

3.1 TITLE PAGE

A. Project Location : Wednesday Friends' Club(WFC), Thai Red Cross Society, Bangkok

B. Target Group : 80 cases of People living with HIV/AIDS (PHA) who are Wednesday Friend Club's(WFC) member

C. Project Duration : September, 2001-August,2002 (12 months)

D. Funding Support in Baht

Total project cost	:	1,150,620
TB division contribute in kind	:	400,000 (34.76)
Researcher contributed in kind	:	40,000 (3.48%)
Request from Donor	:	710,620 (61.76%)

E. Implementing Organization: Non-governmental organization, and TB division cooperate with WFC.

3.2 Rationale of the study

Tuberculosis (TB) remains a major public health problem in many countries worldwide despite scientists discovered drugs that can cure nearly 100% of people with TB more than 50 years ago(WHO,1999, p.p. 4,11). The resurgence of TB is increasing severity especially in developing countries(Davies,1994, p 245) include Thailand as the result of HIV epidemic a condition which facilitates the spread of TB and inadequate efforts made in the past for TB control in the Region (Rojanapithayakorn & Narian, 1999, p10). The severity has made the World Health Organization declare TB is a global emergency in April 1993.

Everyday approximately 2,000 people die of TB in the South East Asia (WHO, n.d., p4). Thailand is one of the countries most severely affected both infections of TB and HIV(WHO,1999, p. 3). One-third of the Thai's population was infected by TB bacillus(Walaisathien, 1999, p.p. 40-42). Nationwide about 40% of the People living with HIV/AIDS (PHA)suffer from TB either as the result of reactivate of previously latent TB infections or as a fast progression disease after a new infection(GTP & WHO, 1998, p. 61). There is estimated that Thailand has 100,000 people develop TB annually-the 13th infection rate of the world and there are 42,000 sputum smear positive. The infection rate of HIV- positive persons with TB, is 15% overall of country, particular in

the upper north of Thailand is high to 40% . Within this condition and the treatment system in the past is not good enough cause 1 case multi drug resistance in every 40 cases (Walaisthien, 1999, p. 42).

About one-sixth of the population in Thailand lives within the Bangkok metropolis area(estimated around 10 million). About twenty percent of people in Thailand with TB live in the capital city. It is estimated that about 15,000 people develop TB annually in Bangkok(Walaisathien,1999, p. 41). In 1995,under the surveillance in Bangkok found that the TB is one of the ten leading causes of disease. In 1996,the respiratory disease is the first of the ten leading causes of illness of out patient for all BMA medical services department hospital, 126,843 patients or 13.02% (Bangkok Metropolitan Administration, 1997, p.p. 40,42). The TB bacillus infects is one of the most significant communicable diseases threatening the health of the people in Bangkok.

People living with HIV/AIDS's (PHA) immune system become dysfunctional and vulnerable to attack from opportunistic infections (OIs). About 88% of death related to HIV infection and AIDS cause by OIs (Stine, 1996, p.p. 40-80). **TB** is an important OIs of HIV infection, which a **leading cause of death** from a single infectious agents of PHA worldwide(WHO, 1998, p. 7). In Asia, about 60% of AIDS patients, respectively, had TB. This clearly indicates that TB is the most important life-threatening opportunistic infection associated with HIV (Rojanapithayakorn & Narian,1999, p. 13). In addition, the emergence of multi drug – resistant (MDR-TB) strains has increased the morbidity and mortality associated with TB. Treatment of

MDR-TB is **expensive, toxic**, and **few patients are cured** (Rigsby & Friedland, 1997, p. 245)

TB is the only major OIs which can **spread through** the air to **HIV-negative people**(Rojanapithayakorn & Narian,1999, p. 13). When a person is sick with TB –and not properly treated-that person will likely infect ten to fifteen people in a year (WHO,1996, p. 2).

In parts of Thailand, up to 50% of hospital beds are already occupied by AIDS patients. The **HIV associated TB** will put an extra burden on hospital services in the future. The demand for care and treatment will soon place extra pressure **on health services**(WHO,1999, p. 8). TB is the main complication of the hospitalized AIDS and AIDS-Related Complex(ARC) patients in Thailand with average proportion of around 40%, the highest proportion of above 60% is found in Bangkok (Payanadana, Kladphuang, Talkitkul, & Tornee, 1995, p. 39). TB and HIV are the most important cause of death in the economically active population (25-44-year old age group) (Rigsby & Friedland, 1997, p. 245). TB imposes on the economy current and future costs due to premature death and ill health. The greatest burden of this morbidity and mortality are causing a serious **impact on socioeconomic development** (WHO, n.d. p.17). This trend also will lead to a serious impact on **TB control**.

Every year one million people die from TB in South East Asia and things are getting worse due to poor control programmes, HIV, population growth and poverty (WHO, 1999, p. 3). The major limitation of current efforts to TB control **is ineffective**

education (Johnson & Helitzer, 1995, p. 129-139). People living with HIV are at risk of developing TB. Therefor, They should be given health education an encouraged to seek early diagnosis and treatment of cough and other symptoms suggestive of TB (Godfrey, 1998, p. 4).

TB is like any other infection disease. It can happen to anyone. And most importantly it can be completely cured but only if the disease is diagnosed in time and treat properly (WHO, 2001, p4). Early diagnosis and effective treatment of TB among HIV-infected patients are critical for curing TB, minimizing the negative effects of TB on the course of HIV, and interrupting the transmission of *M.tuberculosis* to other persons in the community (MMWR, 1998, p. 1). The treatment of tuberculosis is essential to prolong the lives of PHA. In Thailand, 60 per cent of AIDS patients have had pulmonary tuberculosis. It is estimated that correct tuberculosis treatment may give HIV-positive people who develop tuberculosis up to two additional years of life. Tuberculosis can cured through a six-month short course therapy (Economic and Social Commission for Asia and the Pacific, 1998, p. 20).

The above mention can not be trued if without using participatory learning approach to educate PHA who is particular TB vulnerability. The participatory learning approach will be the entry point of self-care, care seeking, getting the patients into the treatment system and adherence in TB/HIV.

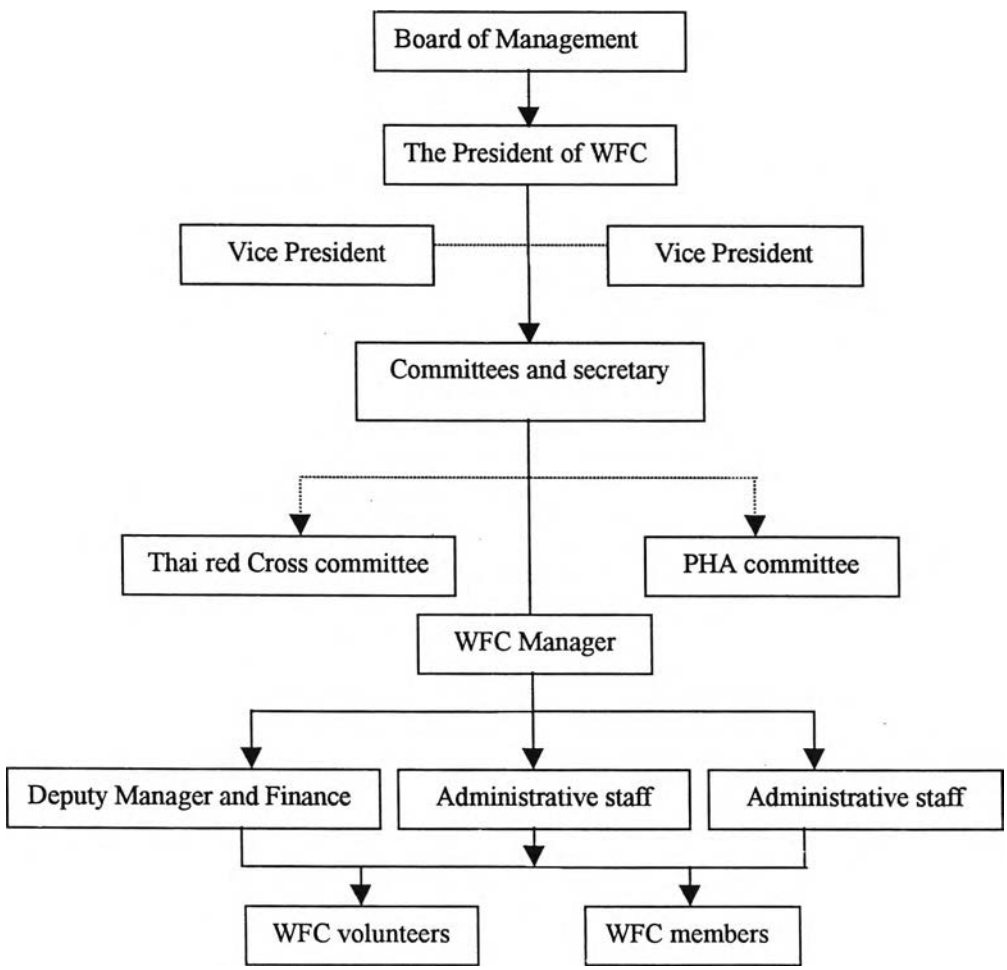
3.3 Background of target group: Wednesday Friends' Club (WFC)

Wednesday Friends' Club (WFC) is the HIV self-help group which under the structure of the program on AIDS of the Thai Red Cross who is the consultant and provide technical support to WFC.(See figure 3.1) WFC was founded, by several HIV/AIDS patients from Chulalongkorn Hospital in 1990, to being the first support group of its kind, at 1871 Rama 4 Road, Pathumwan, Bangkok which is the same area of the Thai Red Cross Programme on AIDS. WFC can be contacted by phone number 02-255 7893-4,fax number 02-255 7894 or email: WFC@redcross.or.th and http:redcross.or.th/wfc. 70% of those that came to the WFC are HIV infected patients and 30% are non-infected (general people). The aim of the WFC is to help infected patients develop a better quality of life. Members (Annual activities report of WFC 1999-2000, Thai Red Cross ,Programme on AIDS)

WFC has 798 members who are PHA (CDC, 2000, p27). WFC's service activities are focus on HIV phone, group counseling, face to face counseling, public speaking and support group. The support group is conducted via Cooperated with Social Welfare Department of Chulalongkorn Hospital arrange the small group meeting (10-12 persons) once a month on every 2nd Wednesday of the month time during 1.00to 3.00 pm. and an educational seminar has 50 to 80 audiences attended on every 4th Wednesday of the month time during 1.00 to 3.00 pm.. The purposes of support group are emphasized on mental and emotional support that goes hand in hand with medical treatments and established a system to the support the on going treatments for patients including provided the knowledge for improving the quality of members lives.

On every 3rd Wednesday of the month, WFC will arrange WFC's member meeting to provide the recreation, counseling, exchange the experience, moral support, health education and information regarding health.

Figure 3.1 WFC Organization Structure; April 1999



Source: Annual activities report of WFC 1999-2000, Thai Red Cross, Programme on AIDS

Currently WFC has four full-time staff, one is manager, the others are assistant manager and 2 general staff (see figure 3.1), working Monday to Friday from 09.00-

19.00 Hours. WFC has 9 regular volunteers, who are a group of people who willing to contribute their time to work for social in order to assist others, working every week. There are also additional volunteers who come whenever they have time. WFC volunteers will receive only 150 Baht per day for their transportation costs (Annual activities report of WFC 1999-2000, Thai Red Cross Programme on AIDS).

Data from the survey which was conducted by Social Welfare Department Chulalongkorn Hospital show that 78% of PHA are interested in the WFC, 58% interested in activities and gave advice to others, 52% interested in education and information course, 52% interested in occupation returning scheme for replacement (Social Welfare Department Chulalongkorn Hospital, 1998 in Samitaketrin, S, 1999, p.60).

From the research studied of Samitaketrin (1999) on "Mental Health of persons with HIV/AIDS who participate in a self-help group", which was conducted at Bamrasnaradune hospital in 150 PHA who came to receive the hospital service by using the face to face interviewed construct questionnaires on May 1998-August 1998, was found that 40% of them will join with HIV Self -help group once a month.37.5% of attendants come for group counseling and talking about health problems and how to care. The most benefit of joining with HIV Self -help group is receive the useful information on health, group counseling and the opportunity to discuss and exchange ideas, experiences and offer to each other (Samitaketrin, 1999, p.p. 62-63)

As above data and mentions, these evidence show that WFC is a self-help group which feasible for the study intervention due to the following reasons:

1. The focal point reaching to PHA directly both the number of target group and status of HIV infection. For a variety of reasons, formal medical and social agencies have often had difficulty reaching people at risk for HIV infection (Centers for Disease Control Prevention, 1995, p. 42).
2. Readiness of agreement from Director of Thai Red Cross Programme on AIDS. (as per discussion on January 31, 2001 at anonymous clinic, Thai Red Cross Society)
3. Readiness of organization which consider from the long live of agency, well management structure and their activities to conduct the study intervention and monitor..
4. Readiness of involved staff has attempted to improve health education work for their members and target group.

3.4 PROBLEM STATEMENT

The goals of educating PHA about TB infection and disease are to promote TB prevention and care. To achieve these goals accurate information must be provided to PHA to make them aware of their risk status. The real challenge lies in matching the right education approach with the right people. Of course, PHA are the right people that should get this opportunity.

From the study "Health promotion Situation in Thailand and other countries" in 1995 by Suwan, Silapasuwan, and Kiewtgaka found that the limitation of strategy in health education in Thailand is lack of appropriate model development and health information to target group mostly are passive. Therefore, those message can not effect the target group change behavior. The implementation will use various method, 88.5% in the distribution of paper, brochure, 85.0% in lecture and 78.4% in seminar and training(1995, p.p. 61,73).

As review the annual activities report of WFC 1999-2000 found that WFC have regularly arranged a talk on the health knowledge related HIV/AIDS by changing the issue from time to time. The knowledge about TB was hold only one time on August 16,1998 at 10.00-12.00 but it was supplement of anti-retrovirus which was a major issue. The speaker is personnel from anonymous clinic, the Thai Red Cross Society. There were 220 audiences ,male110 and famale100(Annual activities report of WFC 1999-2000, Thai Red Cross, Programme on AIDS) Since the time is limited and large number of attendance, very few members have a chance to ask the questions, no time for exchange the ideas or experience include the facility has to be used as the time limited. After giving the knowledge, WFC has not any plans for monitoring or evaluation the result of activities. This might be due to the activities design for giving the chance for PHAs to receive the related health information only information only. (source: Group interviewing among involved staff of WFC on February 9,2001)

A variety of studies have failed to show a consistent link between knowledge and preventive behaviors. Mostly of education or knowledge alone is insufficient for changing behavior particularly addictive and / or pleasurable behavior (Stine, 1996, p.360). Health knowledge of some kind is probably necessary before a conscious personal health action can occur, but the desired health action will probably not occur unless a person recieves a cue strong enough to trigger the motivation to act on that knowledge(Green & Kreuter, 1991, p. 155). Everett Former U.S. Surgeon General state that anyway, the education is the "basic-weapon" and actually it's our "only weapon". We have to education everyone about the disease so that each person can take responsibility for seeing that it is spread no further(Stine,1996, p. 357). PHA must be convinced of their risk of infection and transmission but not with scare tactics. Behavior modification as a result of a scare is short lived (Stine, 1996, p.p. 361-362). The challenge is how the knowledge will relate with the practice in these groups. The participatory learning will be the alternative for that solution due to its process will enabling people to active in participation and raise their self-esteem consequences to make decision in changing behavior.

3.5 PURPOSE OF THE STUDY

3.5.1 Purpose for PHA

The goals of using Participatory Learning approach to educate PHA, who are vulnerable risk for TB infection or active disease, are to promote and encourage

symptomatic persons as well as contacts for practicing self-care in TB prevention and seeking care(such as examination or treatment services). Misunderstanding and lack of TB knowledge and practice create barriers both to seeking care and continuing care. Deficiencies in any of these critical areas can result in a variety of poor outcomes, including delayed diagnosis, the risk of disease transmission to the contacts of an infectious persons, the progression of disease, and the development of drug resistance (Center for Disease Control and Prevention,1995, p. 6).

3.5.2 Purpose for the NGO organizer

From this study, the NGO organizer will learn the appropriateness of using the participatory learning process with PHA. Lessons learned can be used for designing a group

3.5.3 Goal

The study goal is to enable PHA who are the WFC's member to increase control over, and to improve their health from TB in order to maintain their healthy ill status, live normally and productivity.

3.5.4 General objective

To develop an appropriate model of participation learning model to improving knowledge, attitude and practice in TB prevention and care among HIV seif-help group in Bangkok.

3.5.5 Specific objectives and measurement indicators

1. Within the twelve month of the study, 2 workshop f participatory learning education on TB prevention and care will be conducted for 80 case of PHA members of WFC self-help group in Bangkok.

   Measurement indicators: Number of workshops, number of target participants, number of staff involved, level of working team participation and appropriation, working performance on time, appropriate of place, supplies and equipment used.

2. To identify the association of participatory learning process component and group functioning as an strategy in education among PHA members of WFC self-help group in Bangkok

   Measurement indicators: Participation component :group size (divide into small group for group work), level of members' participation, two-way communication and flow. Group functioning: sharing idea and experience, problem analysis and solving , appropriate use of various activities, decision making, self care planing.

3. The target group will increase the knowledge, and attitude in TB prevention and care, after participate in the workshop

Measurement indicators: Level of knowledge, attitude and decision making from pre-post tests questionnaires as the following issues:

- Part I. Facts about TB which comprise of what TB is , Modes of transmission, the reason of TB isolation, the differences between TB infection and disease, who is vulnerable to TB and why, severity of the disease, signs and symptoms, treatment, benefits of improving behavior.
- Part II. How PHA should perform themselves in order to stay healthy ill with or without TB.
- Part III. How PHA are planning about their health care.

4. After workshop participation, the participation will be able to perform the following health practices:
   - Transmission prevention practices.

   Measurement indicators: Level of knowledge and practices from pre- post test score, demonstration skill in group and observation behavior during participate such as covering the mouth with the hand when coughing and using sputum pots with lids.

5. To identify the effect of participatory learning approach and TB physical examination compliance after the 3rd and 6th month of participation.

Measurement indicators: The rate of TB physical examination compliance at TB division.

3.6 Operation Definitions

The following term are defined for the purpose of the study.

- **Participatory learning** : is process to empowerment and raising the self-esteem by encourage the participants to share their ideas, experiences and knowledge with each other, which resulting them can identify their risks and make decision in TB prevention and care practices under the atmosphere of trust and openness between the facilitator and participants.

- **Knowledge** : refers to the understanding of facts about TB which comprise of what TB is , modes of transmission, the reason of TB isolation, the differences between TB infection and disease, who is vulnerable to TB and why, severity of the disease, signs and symptoms, treatment, benefits of improving behavior.

- **Attitude** : Attitude the feeling and belief what the participants want to be done related to TB prevention and self care behavior.

- **Practice** : refer to productive –operations in order to TB prevention and care, giving correct answer related those issues and seeking care compliance.

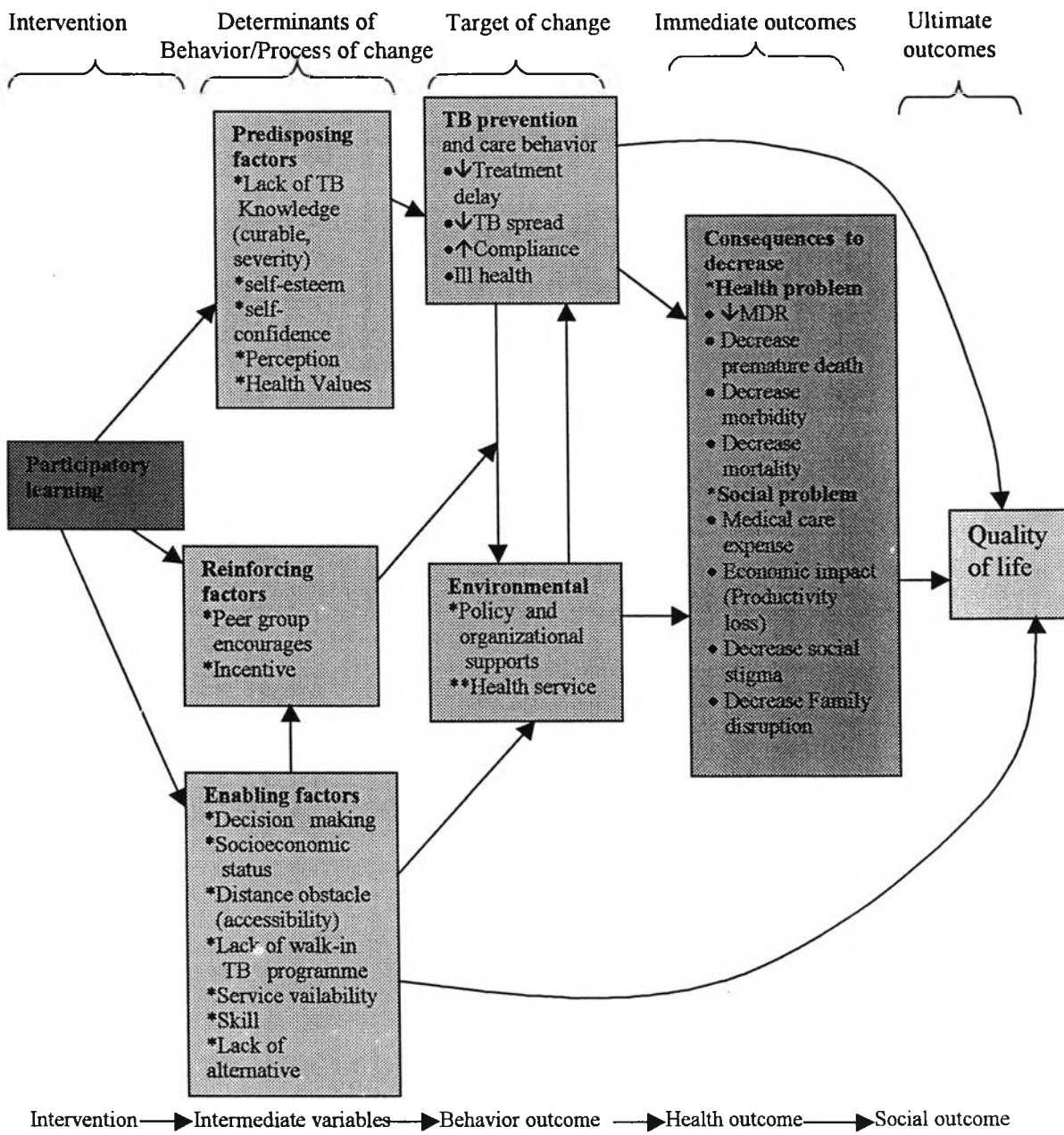
3.7 Research Methodology

3.7.1 Conceptual model of the study

As problems statement mention mostly of education or knowledge alone is insufficient for changing behavior because health and health risk are caused by the multiple factors. Therefore health education design to influence behavior must be multidimensional. The PRECEDE-PROCEED model (Green & Kreuter,1984, p. 373) is a planning model designed to explain health-related behavior and living condition that influence them. It uses a problem-solving approach to help group change behavior.

The participatory learning approach is compatible with PRECEDE-PROCEED model because the participation can empower to act on their own behalf. The analysis and solution for problems have to carefully identify by using this model.

Figure 3.2 Conceptual framework



Source: Adapted from Green & Ottoson, 1994, p. 375

3.7.2 Study population

The setting of the study is located in Bangkok.80 Thai people living with HIV/AIDS both male and female who are the members of WFC will be purposive selection to participate in this program within these inclusion criteria:

1. Target PHA must be the member of WFC and to be examined and diagnosed to confirm the state of HIV infection which is less than 1 year.
2. Target PHA must not have AIDS-Related Complex (ARC) that would be constraint for learning, sharing in class and may not able to complete the program requirement.
3. Target PHA currently must not on the TB treatment.
4. Target PHA must be able to communicate since the communication is the heart of participatory learning approach. They must be able to speaking, listening, and writing.
5. Target PHA are the Bangkok resident, working and permanently residing in Bangkok. This program requires consistency activities and long term follow up.
6. Voluntary and willing to join the project entirely without interference of any other activities. These target PHA are volunteer to join this program as the ethical concern and informed the objective of the program and expected role of participants.

3.7.3 Study design

This study is cross-sectional descriptive study with one group pre-post test that aims to compare knowledge, attitude and practice in TB prevention and care before and after participate in health education program. Using a participatory learning approach to design the project by using a precede-proceed model to analyze relative factors, a consultative process with PHA were initiated early in January 2001 and preparatory studies will be carry out to examine the knowledge, attitude and practice of TB prevention and care among members of Wednesday Friend Club (WFC) which is HIV self-help group in Bangkok. The purposive sampling, an average of 80 cases of PHA who are the member of WFC will be recruited according to the criteria setting.

The 12-month from May 2001 to April 2002, project will be implemented in close collaboration with the government agency (TB division) and WFC (source. As discussion with Director of TB division and Manager of WFC) with financial support from international donor agency. WFC will assist in coordinate and recruit PHA to join with this project since the beginning of the study. TB division is very meaningful unit in this study because TB division play an important role in contribution the support in kind which can not assess by providing physical examination and treatment for participants who seeking care. There would be 2 evaluation studies; comparison between the first evaluation before and the second evaluation after the intervention. The second evaluation would be done 3 times; after the intervention promptly, 3 and 6 months later.

3.7.4 Data collection and data management

The collection of baseline data will be implemented before intervention which will be input for program planning by coordinate with WFC. Since this study involves with HIV/AIDS status, therefore, the data collection has taken into account confidentiality including inform consent and confidentiality of data have to apply. The working committee comprises of TB assign staff, WFC training manager, and organizer NGO staff. Working team means researcher, assistant, TB division staff and WFC staff. The external consultant who from the academic and Director of TB division will provide the program consultation.

Table 3.1 Plan for data collection

Phase	Data collection method	Respondents /Source
Need assessment/ baseline survey	*Review of secondary data *General group interview *Face to face interview construct questionnaires *Focus group discussion *General interview to policy maker	*WFC, related research study from various libraries. *WFC staff *Target PHA (WFC member) * Target PHA (WFC member) *WFC staff, Director of TB division
Program planning	*General group meeting	*Working committee
Implementation	*Pre-post test questionnaire *Participatory observation *Focus Group discussion	*Participants *working committee *Participants
Monitoring and evaluation	*Questionnaires *Group meeting *Group meeting *Review of secondary data	*Participants *Working committee *External expert and working committee *TB division statistic (compliance rate)

Some details of data collection techniques (instrument)

- **Review of secondary data**

To collect some relevant information from WFC and related research study will be searched in assessment phase. In the phase of monitoring and evaluation will be collected data by the working committee who are the staff of TB division and familiar with this data and system. The data recording form will be develop with agreement of working team to reflect the indicators.

- **General group interview/ general interview**

For getting more deep information, the general group interview and general interview with involved people will be conducted, both from provider who is also policy maker (Director of TB division) and clients(WFC staff), in the phase of need assessment (situation analysis) and feasibility of the study design.

- **Questionnaires**

In this study 2 kinds of questionnaires will be used.

Face-to-face interview construct questionnaires will be used during the need assessment process (baseline data) which will be performed at the WFC office to investigate the knowledge, attitude and practice of PHA about TB prevention and care. There are two parts of the questionnaire, part 1 is knowledge, attitude and practice about TB prevention and care include the health education design, and another part is demographic data and additional information about the characteristic of Target PHA. Questionnaires are designed to make the target fell free and relax to answering the questions, hence, the part II which is confidentiality will be use after interviewer and

target PHA are familiar. Researcher develop questionnaires and were check the validity by the expertise. Interviewer are trained WFC volunteer who have some experiences in kind of this task and familiar with the target PHA. Most questions are close-ended with orders choices but also include a few open-ended questions, which sequence of information. This technique will consume more time. The time spent on each target PHA will be unlimited but not over 60 minutes. However, this technique will be appropriate with PHA who mostly are low literacy. (See appendix I : Interview Questionnaire)

Self-administering questionnaires will be used to evaluate participants ' feeling and group activities at the end of workshop. The participants will fell free to response the question by themselves. The competence of reading and writing are part of qualify participants.

- **Focus group discussion (FGD)**

The focus group discussion will be used in the phase of need assessment and implementation. The first phase is aiming to get more in-depth information on resources support requirement and self care planning. (See Appendix 2 question guide for focus group discussion) The facilitator will be NGO staff who work and familiar working with PHA. The target PHA will consist of 8-10 persons, who are member of WFC. The result of FGD will use in designed intervention. During implement the participatory approach in training, focus group will be useful technique to raise concern and empower target PHA to active in participation and benefit in process evaluation.

- **Participatory Observation**

The participatory approach will be used various techniques such as group discussion, role play, group work. The groups have to change their roles from time to time. Thus, the participatory observation will be appropriated with those kind of things and researcher will get more information from both groups and individuals since researcher is a part of activities process and familiar with participants. The observation will test the reliability of the responses to the questionnaire. It is an important method for data collection in the qualitative approach. Facilitators and staff will develop the checklist in the measuring level of participation and self care practice. This technique will be use in the assessment and implementation phase.

3.7.5 Data analysis

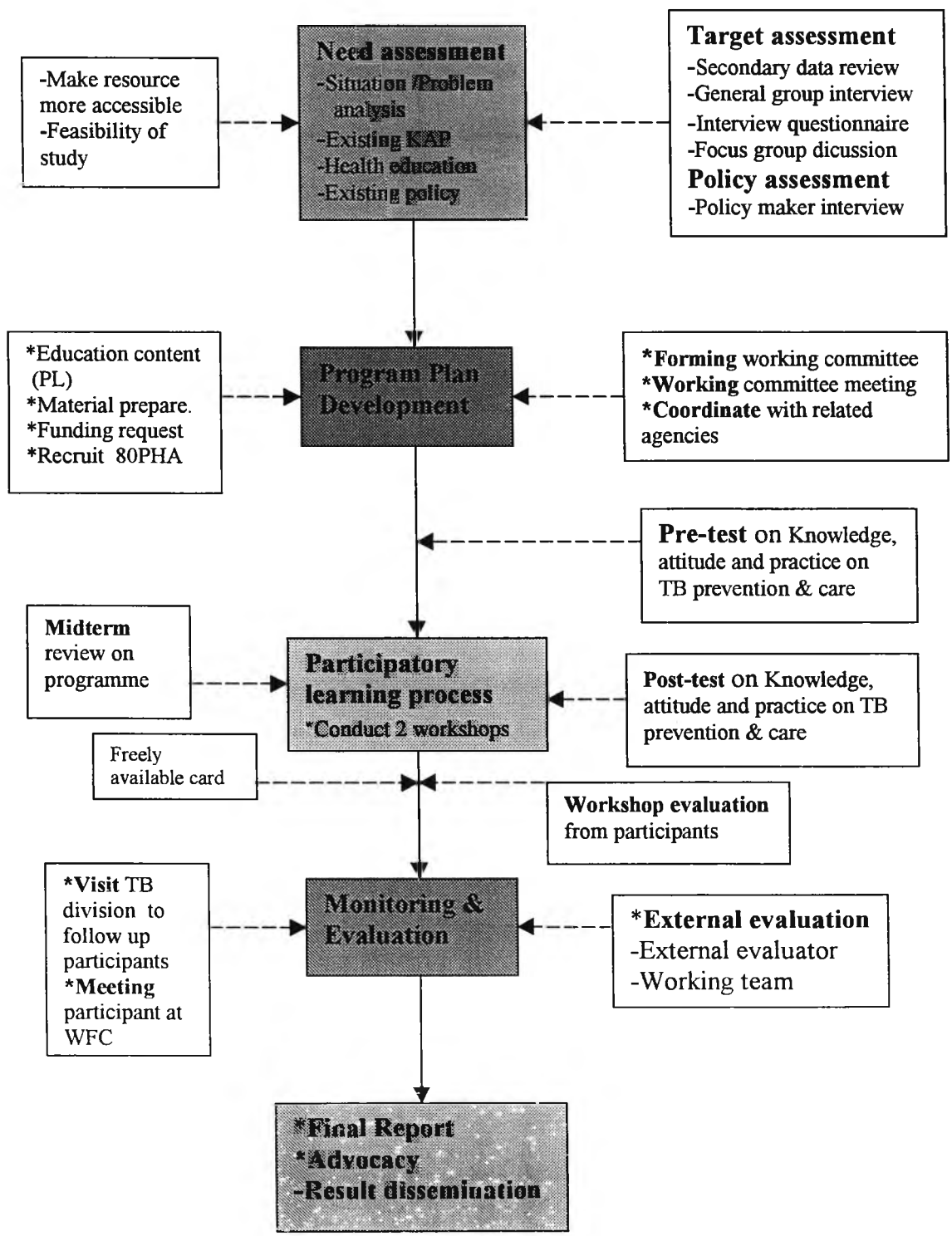
This study combines both quantitative and qualitative method. Quantitative analysis such as interview questionnaire will be analyzed by using Statistical Package for Social Science (SPSS) computer software package. The quantitative data will be collect from FGD which will be analyzed to reveal the related information.

3.8 Intervention design

The participatory methods are designed through group discussion and use various activities which lead into expressing to sharing idea and experience. The planning for participatory learning in target group are divided into four process as

following need assessment, program plan development, implementation and evaluation. (See figure3.3 Framework of the study)

Figure 3.3 Framework of the study



3.8.1 Needs Assessment

This process aims to identify and analysis TB situation and problems which relate with PHA , needs of PHA and feasibility of policy commitment include resources. Some collection of base-line data was based on a participatory approach. The activities in this process are comprise of secondary data review, general PHA group interview, interview questionnaire, focus group discussion and Policy maker interview.

3.8.2 Program Plan Development

The working committee must come to meeting for working agreement in role and responsibility of each other such as who will do what with whom when why and how. Program plan development will be consulted the working committee idea and researcher will draft and propose it in working committee meeting for agreement. Each agency will be assigned to response the appropriate kind of job as following:

1. General co-ordination and administrative with related agency or person such as external resource persons, prepare the material with health educator, develop pre-post test questionnaires and guide questionnaire, prepare venue for workshop, data collection and analysis will response by researcher and assistant.
2. Recruit PHA members will be performed by WFC both announcement and recruitment with assistance of researcher include to make appointment member to join the workshop.

3. TB division staff will be support some materials education and have to plan to join the workshop and be a very important part of implementation also monitoring and evaluation process.

3.8.3 Implementation

The working team will divide the role and responsibility as the education planning. The process rely on the concept that people will solve their own problems best in a participatory group process , however, the group collectively will have enough information and experience to begin to address its own problems(WHO &UNDP-World Bank Water and Sanitation Program.1997, p. 4). When people know that they are responsible for finding a solution they start to demand information. Such demand opens the way for information exchange and dialogue. Technical information is best provided in response to needs identified by the community, following its own process of problem of problem identification and analysis. External intervention with technical information and support too early interrupts the process and has a negative effect (WHO &UNDP-World Bank Water and Sanitation Program.1997, p. 5). The only exception that should be made to this is when the group clearly asks for specific technical information in order to move forward or if its information is incorrect. Be guided by the requirements of the group when facilitating activities (Wood, Sawyer, & Hebert , 1998, p.p. 17-19). These activities will be responsed by health educator and researcher include working team. The activities will work best in small group. Therefore, large groups will be divided into smaller groups of 5-8 persons for some for the activities, since they provide greater stimulus and opportunity for participation

(Wood, Sawyer, & Hebert, 1998, p. 10). This process will used various techniques such as group discussion, group work, role play, presentation. Before activities start, pre-test questionnaires will be provide to participants to complete them.

Since this project collaborate with TB division, TB staff will provide impressive TB service with free cost and other support such transportation fee (which raise fun from donor), and provision of information about access include guide the direction to get TB division with the map. All participants will get the free card for TB examination and have to present this card to TB staff whenever make decision to compliance within 3 months. These cards are reserved for the participants who attend this workshop only.

Before the training is finished post-test questionnaires will be reached to participants' hands again to show what they get more after training. The recommendation for training activities and design also will be evaluated.

3.8.4 Education content

Concepts in participatory learning is learning process which uses problems to motivate learners to find answers to solve the problems. The researcher ask questions based on the problems which will be captured the attention of the groups. The education goals are the participants can clarify and define the scope of problems, analyze the causes of problems, know why drug must be taken regularly and why all of the drugs given must be taken until treatment is completed , can avoid spreading the disease, set the goal of problem solving, identify the way of practice. These the

activities design to raise health awareness because health awareness comes about when people can describe how disease are transmitted in their environment and through their own behaviors. Once people understand how transmission occurs, they can identify the different ways to block the transmission routes. They can also weigh the advantages and disadvantages of blocking those routes in their households and communities(Wood, Sawyer, & Hebert, 1998, p. 15).

These will be done under the principle of decision- making by target PHA as the statement that the people closet to a problem understand their own situation are those best able to find the solution. Their involvement will result in a higher level of effectiveness and sustainability than could be expected from externally imposed solution(WHO &UNDP-World Bank Water and Sanitation Program,1997, p. 5).

As above mention the education content are designed into 7 steps as table 3.2

Table 3.2 Seven step of education content for TB prevention and care

Step	Activity	Tool
1. Problem identification	1. PHAs stories 2. Health problems of PHAs	1. Flip chart
2. Problem analysis (identify health factors and priorities)	1. Mapping Health problem 2. Good and poor health behaviors 3. What TB is, sign,symptom(disease-oriented) 4. How severity and TB disease spread (Risk of factor –orientated)	1. Health problem Mapping 2. Transmission route 3. Flip chart
3. Planning for solution	1. Blocking the spread and severity of TB (how it can be cured, how you can avoid spreading the disease, how to decrease the risk of transmission, why drug must be taken regularly) 2. Selecting the barriers 3. How to look after your body (Investigating PHAs practices)	1. Blocking the routes 2. Barriers chart
4. Selection for solution	1. Choosing health improvements 2. Choosing improved health behavior 3. Taking time for questions	1. Health options 2. Question box 3. Flip chart
5.Planning for new facilities and behavior change	1. Planning for change 2. Planning who does what 3. Taking time for questions	1. Planning posters 2. Planning posters 3. Problem box
6. Planning for monitoring and evaluation	1. Preparing to check our progress	1. Monitoring (checking) chart
7. Participatory evaluation	1. Checking our progress	1. Various tool options

Source: Adapted from Wood & Simpson, 1998, p. 8

3.8.5 General education activities

Before start the workshop training, the relax atmosphere is very importance, hence the ice-breaking by games should be introduce to group and will be use from time to time during workshop. The researcher have to inform and ask idea about what the purpose of this workshop, how can it be success, how can everyone working together (set ground rules for group discussion and group work by participants.) Keep the participant go along with team all the times by giving clear instruction, what will happen now and next, participants have to know the step of training and summarize whatever the group found.

The privacy place for workshop is considerable one important factor for participants who do not disclose their HIV status. Other logistic preparation such as food and drink, ready material, ready referral hospital for medicine in case of sickness, educational media and demonstration supplies

3.9 Calendar of Activities

Activities	2001									2002				Responsibility Person
	1-2	5	6	7	8	9	10	11	12	1	2	3	4	
Baseline assessment process	X													Researcher
1. Coordinate with Manager of WFC, and Director of TRC on AIDS programme	X													(from January-March)
➲ Situation analysis & project feasibility.	X													
➲ Review related documents														
➲ Expert & policy maker consultation**	X													** 15Nov2000
	X													& 4Jan2001
2. Programme preparation for baseline assessment	X													Researcher and WFC volunteer
➲ formation of working com. &training of interviewer	X													
➲ preparation of material	X													
➲ Coordinate & request permission with WFC and TRC Director	X													
➲ Develop tools	X													
➲ Pre-test the tool(questionnaire)	X													
➲ Interview questionnaire	X													
➲ FGD	X													
➲ Data analysis	X													
Financial support request 3.Develop proposal	X													Researcher
4.Request funding		X												Researcher and working com.
PL preparation														Researcher
5. Coordinate with related agencies	----------												▶	and working
6. Forming a research team & meeting			X											team
7. PHA Recruitment			X	X										Researcher
8. Workshop preparation		X	X	X										and working com.
Workshop implementation			X	X										Researcher,
9. Conduct PL workshop			X	X										health educator
➲ Pre-test questionnaire			X	X										and working
➲ PL process &activities			X	X										com.
➲ Post-test questionnaire			X	X										
➲Workshop evaluation														
10. Monitoring & evaluation														Researcher
➲ Visit TB division to follow up participants				X	X	X	X	X	X	X				and working com.
➲ Meeting participants at WFC						X	X							
11. Data collection &analysis			----------									▶		Researcher
12. Report writing (financial&activities)			x	x	X	x	x	x	X	x	x	x	X	Researcher
13. Monitoring & evaluation programme							X					X		Researcher & Working com.
14. Advocacy														
➲ Book printing (Publish)												X		Researcher,
➲ Meeting to Disseminate results													X	Working committee

3.10 Monitoring and evaluation of the study

The monitoring and evaluation will be performed under the information and data which were collected in various time by working committee, PHA participants and external evaluators. The monitoring and evaluation will include the project (workshop) monitoring and evaluation and program monitoring and evaluation.

The project monitoring will be used the observation form and progress project form which be developed for recording the progression of activities and task. For the project evaluation will used the observation forms for measuring the education process. The pre-post test questionnaires and review compliance statistic at TB division for measuring the outputs. Review compliance statistic will be follow up will be done in the 3^{rd} and 6^{th} months of training. This process needs close coordinate and collaborate with TB staff.

The program monitoring and evaluation will be decided by working committee and external evaluators. This process needs to develop the program /process progress record as indicator developed. Monitoring will be done every 4 months and evaluation will be done 2 times during midterm by working committee and final evaluation by external evaluators.

3.11 Ethical consideration

This study will be approved by the Ethical Committee of The Thai Red Cross Society before beginning. Every PHA will be informed about the details of the project and will be asked to sign the written informed consent before being enrolled in the study.

3.12 Program Budget

Total budget of this program is Baht. The phase of baseline data assessment was contributed by researcher This program will cooperate with TB division which will contribute (subsidize) the amount of 560,000 B by providing the physical examination and treatment Therefore, the program requests the money from international donor only Baht as the below description.

Table 3.3 Estimated expenditure for program activities

Budget category	Unit cost (Baht)	Multiplying factor	Total cost (Baht)	% of Total
Baseline assessment*General assessment, Meeting with agencies, interview questionnaire, FGD, Data analysis*	*400,000 * / Total*	*40,000 */ Total*	***40,000****	3.05
1. Personnel			**214,000**	16.33
• Researcher	12,000/ M	12 M x 12,000 B	144,000	
• Assistant staff (Part-time)	4,000/M	12 M x 4, 000 B	48,000	
• Fringe benefit (insurance)	1,000/M	12 M x 1,000 B	10,000	
• Consultant	2,000/time	6 time X 2,000 B	12,000	
1. Communication &Rent			**48,000**	3.66
• Telephone, E-mail, Postal	2,000/ M	12 M x 2,000 B	24,000	
• Rent space office & computer	2,000/M	12 M x 2,000 B	24,000	
2. **Travel**	1,500/M	12 M x 1,500 B	**18,000**	1.37
3. **Supplies &Equipment**				0.46
• Disks, Photocopying ,A4 paper	500/M	12 M x 500B	**6,000**	
4. Workshop activity			**294,620**	22.48
Supplies &Equipment preparation			25,820	
• Marker Pen (5 color/package)	70/package	70 B x 16G	1,120	
• Sticky tape 1 roll/ group	30/roll	30 B x 16 G	480	
• Flip chart 20sheet/ group	5/sheet	20roll x5 Bx 16 G	1,600	
• Note book 1 book/ person	10/book	80Px 10 B	800	
• A4 Paper 5 ream/ month	500/M	12 M x 500 B	6,000	
• Card 5" x 8", 210 gram	110/pack	16 Pack x 110 B	1,760	
• Film 1 roll/ workshop	120/ roll	2 roll x 120 B	240	
• Tape recorder 60'/tape	35/ tape	32 tapes x 35 B	1,120	
• Software education(toolkit)	80/package	80 P x 80 B	6,400	
• Disks	150/box	2 boxes x 150B	300	
• Photocopying & film developing	500 / M	12 M x 500 B	6,000	
Workshop day			268.800	
• Lunch & tea break 3 D x 2 Times	160/D	80 P X 160 B x 6 D	76,800	
• Rent meeting room 3D x 2 Times	2,000/D	2,000 B x 6D	12,000	
• Transportation for PHA& Perdium 3Dx 2 Times	200/P	80 Px 200 Bx 6 D	96,000	
• Professional trainer 3D x 2Times	2000/D	2000 B x 6 D	12,000	
Monitoring &Evaluation				
• Transportation for PHA to TB division .	400/ P	80 P x 400 B	32,000	
• Transportation for PHA follow up meeting. 2times	250/ P	250 B x 80 P X 2 T.	40,000	
5. **Physical examination and treatment****	5,000/ P **	80 P X4, 000 B**	**400,000****	34.76
6. Monitoring &Evaluation (Program evaluation)			**13,000**	0.99
• Mid-term review	3,000/total	3,000 B	3,000	
• Final evaluation by external 2 P	10,000/total	10,000 B	10,000	
7. Dissemination of results			**117,000**	8.93
• Data analysis &Report	7,000/ total	7,000 B/total	7,000	
• Document for dissemination	120/book	1,000book x100 B	100,000	
• Meeting to disseminate results	250/P	40 P x 250 B	10,000	
Grand Total			**1,150,620**	**100**

Remark 1. D stand for Day or Days, B stand for Baht, P stand for Person or Persons

2. *Contribution from researcher, **Contribution from TB division

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