

CHAPTER 2

PROJECT DESCRIPTION

2.1 Rationale

The Ministry of Public Health to screen and detect for the cancer at early stage originally established the cervical cancer-screening program. In Roi-Et Province, the corresponding screening program was planned and organized by the Provincial Public Health Office to implement at provincial, district and sub-district levels. In addition to provision of screening service at the provincial and district hospitals, the training course in the Pap smear method was also organized for health staff at Sub-district level.

Despite of wide screening service available at all areas and levels, it was found that there was significantly low number of women receiving screening in Roi-Et province. For example, the service rate in 1999 was 7.5% for the overall province and only 5.1 % in Chaturaphukpiman district. The screening found 0.34% and 0.64 % of cervical cancer cases respectively (Public Health Office, Roi-Et Province, 1999)

For Linfa Sub-district, the program targeted 15% coverage of fertile women who attended family planning programs at the health centers with repeat screening at least every 5 years. The Health Center is providing free screening service for cervical cancer on every Wednesday by well-trained staff, however, similar to district and provincial situation the screening rate was still lower than the target. It was only 6.6 % coverage. Among those screened population, there was no cervical cancer case found. However, there were as

high as 35.9 % of other diagnosed cases such as Vaginitis, Leucorrhoea, and other related diseases. There was one death associated with cervical cancer reported, accounting for 24.28 mortality rates per 100,000 population (Death Report, 1998). The death caused by cervical cancer could result in both direct and indirect loss to the family financially and mentally, which can not be estimated. This could eventually affect social and economics of the country in long term.

According to the service information registration of the Linfa Health Center, the majority of women participating in screening were the group of mothers with recent baby-delivery and women who attended family planning programs. The second majority group was women who have suspicious symptoms such as abnormal vaginal discharge with unpleasant odor, vaginal itchiness and infection or inflammation at the cervix. It may be said that most women did not intend to come for cervical screening directly.

From the author's experience and from informal interviews with responsible staff at the Linfa Health Center, the major factors contributing to the lower service rate were a lack of knowledge, misbelieve, shyness, a lack of information and previous bad experience with other health services. These problems indicated the need to educate the populations with the correct information and knowledge about cervical cancer. One potential resolution is providing health education using participatory learning process technique.

In the past, health staff provided health related information and knowledge through conventional approaches such as personal advice, group teaching/ tutorials and

distribution of information leaflets to people who come for family planning services once per week. These methods provide only one-way communication from the staff to patients with the lack of interaction between the provider and the receiver. The conventional health education therefore only aims to increase the knowledge level of the villagers while the practical skills for further implementation of the knowledge are not developed.

The new approach of health education for the group of fertile women at the Linfa Health Center should emphasize on two-way communication by adopting the participatory learning process. This may be achieved by participation of the women in learning activities such as sharing knowledge, experiences and opinions about cervical cancer in a group discussion session. Learning from others within the group will help them to understand the concept easily and become aware of the correct healthcare behaviors, especially those associated with cervical cancer. Knowledge about cervical cancer will include knowledge in risk factors, the degree of severity and the importance and advantages of screening at a very early stage. The participatory learning method appropriate for this learning process is a continuous and endless learning cycle, known as a learning spiral. The process begins with analysis of personal experience and regular practice for any existing problems, then analyzes for the sources and roots of the problems. The casual factors are then analyzed for their relation and connection, which will help to understand the whole picture of all related causes. The participatory learning emphasizes on creation of new knowledge and interactive learning atmosphere that helps the participants to absorb accurately. This learning process will also help to increase the level of the participants' self esteems and confidence in their capability. This approach is,

therefore, widely employed in several programs of health promotion and personal development and in the development program for quality of life (Pensirinapa 1995, referred in Bussabong Jaathanond, 1997:2).

Previous policy reviews and study reports indicated that there was a weakness in cervical cancer screening service for the group of fertile female villagers at Linfa Sub-district that led to the lower service rate than the target. The author, as one of the health officer at Linfa Sub-district and the person responsible for health promotion in this area, proposed and organized the training program using participatory learning process for the group of female village leaders and village health volunteers. This group of women was selected for this training and for further distribution of knowledge in cervical cancer in the area post-training, as they normally play a major role in developmental activities of the villages and receive great respects from other women in the villages. The use of participatory learning approach in this training program was selected as the most appropriate method for learning of cervical cancer knowledge and eventually to promote and encourage other targeted fertile women to participate in screening.

2.2 Study Objectives

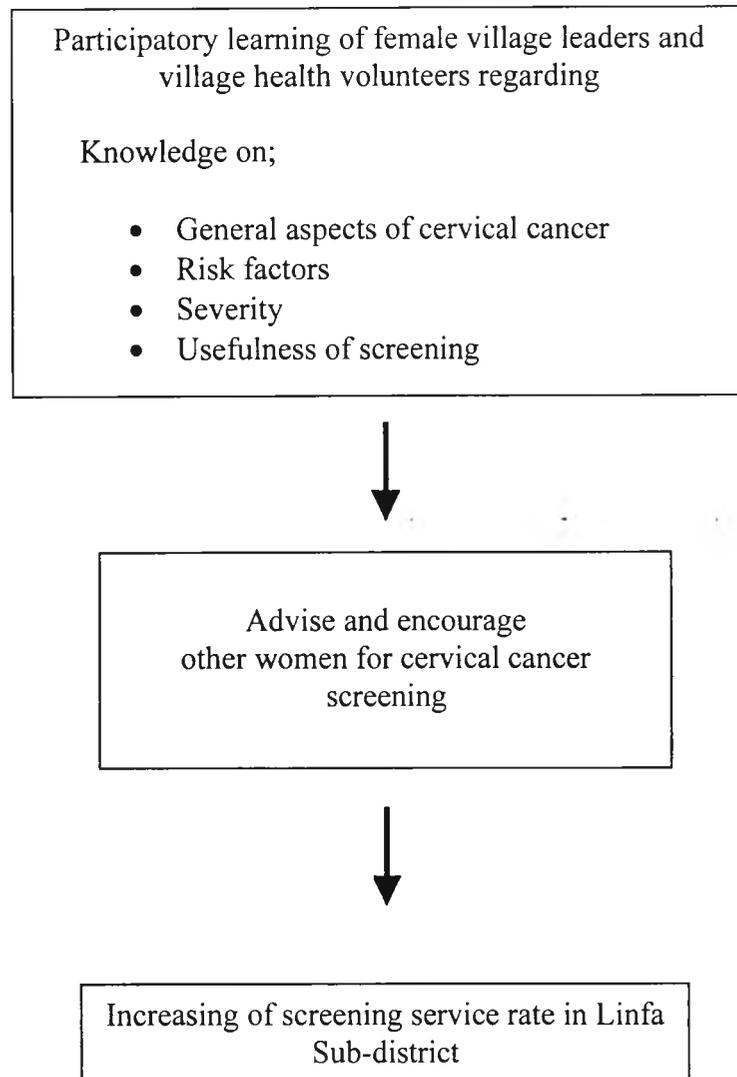
2.2.1 General objectives

- To increase knowledge regarding cervical cancer for the married women by participatory learning in Linfa Sub-district, Chaturaphukpiman District, Roi-Et Province.

2.2.2 Specific objectives

1. To increase knowledge for the married women on;
 - Knowledge about cervical cancer.
 - Risk factors in developing cervical cancer
 - Severity of cervical cancer
 - Importance and advantages of cervical cancer screening
2. To compare cervical cancer knowledge before and after training

Figure 2.1 Conceptual framework of the project



2.3 Approaches and Procedures

2.3.1 Staff preparation

- Request for cooperation from the facilitator team who had been trained by participatory learning approach in the resolution means for public health problems course. There were a total of 8 facilitator who have well technical experience in running participatory learning program. Of this team, there were four facilitators from the health office of Chaturaphukphiman District, one facilitator from the Chaturaphukphiman District Hospital and three well-trained staff from the Linfa Health Center.
- Conduct facilitator meeting for one day to set up and develop training.

2.3.2 Preparation of participants and community

- Recruit 30 participants (see selection procedure outlined in section 2.3.4).
- Conduct introductory meeting for the participants for one day.
- Organize the pre-training test of the prospective participants using questionnaires one week prior to the training session.
- Request for co-operation from the leader of every village and inform the prospective participants of the training schedule.
- Liaise with the person responsible for food and drinks catering.

2.3.3 Preparation of training materials and instruments

Materials and equipment necessary for the training were prepared. Those needed for the activities included notebooks, papers, pens, pencils and games' equipments. Instruments necessary for data collection were copies of questionnaires, training schedules, blank forms for participants' registration, tape recorders and video cameras.

2.3.3.1 Instruments

Questionnaires for Quantitative data (pre and post test)

The questionnaires used in the project were modified and adjusted from the questionnaires of Nuchanad Chukiart to suit this particular study site. (Reliability = 0.71) They were reviewed for accuracy of language use and content validity by a team of qualified senior professors prior to a try out with a pilot group of 30 women whose main characteristics were similar to the target participants. The questionnaires were then edited and reviewed prior to printing of the final copy.

The questionnaires contained two main sections as follows:

a) General information and demographical data section

There were 15 questions for this section of general information and demographic data. Which required the participants to provide information on their age, occupation, income, age at the time of marriage, age of first pregnancy, number of children, reasons for screening/not screening, perception of cervical cancer information and experience with screening service.

b) Knowledge assessment section which contained four subsections as following:

1. Knowledge in cervical cancer: The questions were in the form of multiple choices, which covered materials on characteristics of cervical cancer, causal factors, symptoms, methods of treatment, screening and appropriate behaviors for diagnosed patients.
2. Knowledge in risk factors in developing cervical cancer.
3. Knowledge in the degree of severity
4. Knowledge in importance of screening

Scoring method and interpretation

Interpretation of the first section questionnaires was straightforward and did not require scoring of the data. The second section of the questionnaires required scoring to obtain quantitative results. The scoring approach is outlined as following:

The first set in the second main section, covering general knowledge in cervical cancer, contained 9 questions. Each question represented 1 score, so total of 9 scores. The scoring method for this subsection of general knowledge in cervical is:

Score < 5	=	need improvement
Score 6-7	=	Moderate level of knowledge
Score 8-9	=	Good level of knowledge

Scoring method for the remaining three subsections, which covered knowledge in risk factors, severity and advantages of screening employed the Likert's rating scale. The questionnaires contained the range of multiple answers for the participants to choose from

including strongly agree, agree, unsure, disagree and strongly disagree. For the questions requiring positive response the score is given in descending order, that is

Strongly agree	=	5 scores
Agree	=	4 scores
Unsure	=	3 scores
Disagree	=	2 scores
Strongly disagree	=	1 scores

The questions with negative statements were scored in ascending order as follows:

Strongly agree	=	1 scores
Agree	=	2 scores
Unsure	=	3 scores
Disagree	=	4 scores
Strongly disagree	=	5 scores

There were total of 26 questions with total of 130 scores for three combined subsections.

The interpretation of summative scores for each subsections were assigned as following:

- **Knowledge in risk factors contained 10 questions, each of maximum 5 scores with total of 50 scores.**

Score < 30 = correct understanding of the knowledge needs improvement

Score 30-40 = correct understanding of the knowledge is at moderate level

Score > 40 = correct understanding of the knowledge is at good level

- **Knowledge in severity contained 9 questions, each of maximum 5 scores with total of 45 scores.**

Score < 27 = correct understanding of the knowledge needs improvement

Score 27-36 = correct understanding of the knowledge is at moderate level

Score > 36 = correct understanding of the knowledge is at good level

- **Knowledge in advantages of screening in early stage contained 7 questions, each of maximum 5 scores with total of 35 scores**

Score < 21 = correct understanding of the knowledge needs improvement

Score 21-28 = correct understanding of the knowledge is at moderate level

Score > 28 = correct understanding of the knowledge is at good level

2.3.4 Recruitment of participants

The recruitment process of the participants for this training program is summarized as follows:

1. **Participants:** The participants consisted of 30 female leaders and village health volunteers from 9 villages within the area of Linfa Sub-district, Chaturaphukphiman District, Roi-Et Province.
2. **Selection method:** The participants were selected by purposive selection.
3. **Selection criteria:**
 - Ability to read and write
 - Willing to participate in the program
 - Reside in the area through out the period of the study
 - Married or used to be married (married, divorced, widow and separated)
4. **Selection procedure:** 30 participants were previously planned and classified into 3 groups and were selected according to the criteria for each group as following

- Group 1 containing both women who had screening experience and those who did not have screening experience was selected from the group of female leaders with a total number of 12 people.
 - 6 women were each selected from 6 separate villages with the number of household less than 120.
 - The other 6 women were selected from 3 separate villages (2 each) that contain more than 120 households.
- Group 2 contained female village health volunteers who had come for screening at the Linfa Health Center in 1999. One woman was selected from each village with total of 9 people.
- Group 3 was a group of female village health volunteers who never had screening experience. One woman was selected from each village with total of 9 people.

2.3.5 Training venue

The training site was selected to be at the Linfa Health Center, Chatura-phukphiman District, Roi-Et Province as it is situated at the center of the Sub-district and the transportation was convenient for the participants.

2.3.6 Training session

Four main learning activities and several entertaining activities were included in the training session plan to maximize the participants' perception of the knowledge provision and involvement in each learning activity while being stimulated with the supplementary

activities in between. Table 2.1 summarizes the training session plan, which includes essential learning activities, their procedure and means of data collection for each activity.

Table 2.1 Training session plan

Procedure and activity	Data Collection
<p><u>Activity 1: Sharing experience</u> The participants were divided into 3 groups. Each group was required to select a group leader and a secretary then the group members were allowed to discuss and share experience within each group.</p> <p>Group 1 contained 9 members who were village health volunteers with screening experience. They were required to discuss under the topic of “ why coming for cervical cancer screening”.</p> <p>Group 2 contained 9 members who were village health volunteers with no screening experience. The discussed topic was “ Why not coming for cervical cancer screening”.</p> <p>Group 3 contained 12 members who were the village leaders and required discussing under the topic of “ How to encourage women to come for cervical cancer screening”.</p> <p>At the end of the session each group was required to summarize the discussion content and present to the entire meeting.</p>	<p>There were two facilitators available for each group in this session. One facilitator was to assist and encourage the group members to share their experience at their best and the other facilitators was to observe the meeting and collect qualitative data by taking notes and recording tapes.</p>
<p><u>Activity 2: Problem identification</u> The participants were divided into 3 groups, A, B and C. Each group contained evenly 10 members, mixed between village health volunteers with and without screening experience and members of village leaders. Each group was allowed to brainstorm the problems and reasons for coming and not coming for cervical cancer screening.</p> <p>At the end of the activity each group was required to summarize the discussion content and present to the entire meeting.</p>	<p>After the presentation the facilitators were to conclude the problem factors and to provide supplementary knowledge to the entire meeting. The participants were also allowed to ask questions during this meeting session.</p>

Procedure and activity	Data Collection
<p><u>Activity 3: Problem analysis and priority setting</u></p> <p>Members of group A, B and C above analyzed the problems with not coming for screening service, listed problems according to their significance and present to the meeting.</p>	
<p><u>Activity 4: Problem solving and planning</u></p> <p>Members of group A, B and C brainstormed for means of resolution, set plan to promote cervical cancer screening and presented their work.</p> <p>The contest with first, second and third prizes was organized for the promotion plan of the three groups judged by the vote of the participants. Finally all three plans were combined together by the participants to be the new project plan for the Sub-district level to implement in the future.</p>	
<p><u>Supplementary activities</u> (see Appendix 4)</p> <p>Other supplementary activities were also adopted between sessions of main activities stated above in order for the participants to be able to connect learning materials and stimulate the participatory learning process as well as for entertaining purposes.</p>	

2.3.7 Evaluation activities

The summary of the evaluation activities for the training program is outlined in Table 2.2.

More detail of evaluation procedure of the project is discussed in Chapter 3.

Table 2.2 Evaluation activities

Procedure and activity	Data collection
<p>1. Primary data were collected for first outcome evaluation at one month post-training from:</p> <ul style="list-style-type: none"> • Organize a meeting and a group discussion session to follow up with the implementation of the training materials according to the plan. • Post-training test 	<ul style="list-style-type: none"> • Collect qualitative data from group discussion session. • Collect quantitative data by the questionnaires in post-training test.
<p>2. Secondary data were collected for second outcome evaluation at six months after the training from:</p> <ul style="list-style-type: none"> • Implementation of the training materials by the participants. • Screening service registration of the Linfa Health Center and the Chaturaphukphiman District Hospital. 	<ul style="list-style-type: none"> • Collect qualitative data by talking to women who received screening service after the training. • Collect quantitative data from the screening service registry of the Linfa Health Center and the Chaturaphukphiman District Hospital.

Figure 2.2 Summary of project procedure

(1st Month)

Step 1: Pre-training preparation

- Recruitment of 30 participants
- Collect demographical data
- Pre-test of knowledge level



Collection of quantitative data

(2nd Month)



Step 2: Two-day training session using participatory learning approach was organized for a group of female village leaders and village health volunteers.

- Sharing experience in cervical cancer and screening
- Problem identification
- Problem analysis and priority setting
- Problem solving and planning
- Commitment



Collection of qualitative data

(3rd Month)



Step 3: First outcome evaluation

- Post-test of knowledge level
- Group discussion to follow up the implementation step



Collection of quantitative and qualitative data

(3rd-8th Month)



Step 4: Second outcome evaluation

- Implementation according to the plan and follow up for evaluation



Collection of quantitative data from service registry

(8th Month)



Step 5: Project conclusion & report at 8 months post-training

2.3.8 Conclusion of project outcomes

The final meeting was held at eight month to conclude the outcome of the training project. The summary of the project concluded is shown in Figure 2.2.

2.4 Activity plan with time table

The project activities and procedure were planned as in Table 2.3.

Table 2.3 Activity plan of the project

Activities/ Month	Aug-00	Sep-00	Oct-00	Nov-00 to Apr-01	May-01	Jun-01	Jul-01
Step 1 Preparation <ul style="list-style-type: none"> • Selection of study subjects • Interview general data • Pre-test 							
Step 2 two-day training session		18-19					
Step 3 First follow up (One month post-training) <ul style="list-style-type: none"> • Post-test • Follow-up meeting 			19				
Step 4 Second follow-up and collection of screening service record (Six month post-training)							
Step 5 Conclusion of project outcome							

2.5 Result

Preliminary data was collected from literature review of previous study reports and policy documents in screening programs for cervical cancer including review of other relevant materials. Quantitative data were collected from the pre-test and post-test using the questionnaires conducted by the staff members of the health center at Linfa Sub-district. Qualitative data were obtained from group discussion session and by observation. The participants' involvement in the training activities were observed by the responsible facilitators who were previously trained in the course of resolutions for public health problems, organized by the Health Office of Chaturaphukphiman District and the District Hospital. The facilitators also have technical and professional experience in running participatory learning programs.

Quantitative data were analyzed by statistical methods. The values of percentage, mean and standard deviation were obtained for each set of data and pre-training and post-training data were compared using the Paired t-test. Qualitative data were analyzed according to their content by combining all factual information, atmosphere and any incidence occurring during the group discussion session and other activities and from observation of the participants during the training process

The training program adopting participatory learning approach for increasing cervical cancer in married women. The study result of this project are reported in 5 sections which are; 1) General information and demographical data of the participants; 2). Summary of two- day training activities; 3) Level of cervical cancer knowledge of the participants

before and after the training; 4) First outcome evaluation at one month after the training; and 5) Project assessment six-month after the training.

2.6.1 General information and demographical data

2.6.1.1 Demographical data

The participants were village female leaders and village health volunteers. 63.3 % of the participants were between 26 and 35 years old (average age 33.6). The majority (80%) of the participants' education was at primary school level. The occupation of the participants was rice farmer 100%, with family monthly income less than 2800 Baht (56.6 %), 96.6% were married and living with their spouse. 70 % of the women married at the age of less than 20 (average married age 19.8 years old). 48.2 % had first baby at the age of less than 20 years old. The majorities (90 %) of the women have not more than 2 children. General demographic data are summarized in Table 2.4

Table 2.4 Demographical data of the participants

General Information		Number (n=30)	%
Gender	Female	30	100
Age	Less than 25 years old	1	3.3
	26-35 years old	19	63.3
	36-40 years old	9	30
	41-45 years old	1	3.3
	average	33.6	
Education level	Primary school	24	80
	Secondary school	4	13.3
	Tertiary education	2	6.6
Occupation	Agriculture (Rice Farmer)	30	100

General Information		Number (n=30)	%
Family monthly income	Not more than 2,800 Baht	17	56.6
	2,801 - 5,000 Baht	9	30
	More than 5,000 Baht	4	13.3
Marital Status	Married	29	96.6
	Divorced	1	3.3
Age at the time of first marriage	Younger than 15 years old	1	3.3
	15-20 years old	20	66.6
	21-25 years old	8	26.6
	26-30 years old	1	3.3
	Average	19.8	
Age at the time of first pregnancy	Younger than 15 years old	1	3.3
	15-20 years old	14	48.2
	21-25 years old	14	48.2
	26-30 years old	1	3.3
	Average	20.7	
Number of children	1-2 children	27	90
	3 children	2	6.6
	No children	1	3.3

2.5.1.2 Participants' cervical cancer screening experience

70 % of the participants used to receive screening service for cervical cancer and the last time of 53.3% of this group was less than one year. The reason for participation in screening (36.6%) was having suspicious or abnormal symptoms such as odorous vaginal discharge, abdominal pain and vaginal itchiness. 80.9% of the screening results were normal and 57.1 % were able to receive the test result within one month after the screening. Within the group of women who never had cervical cancer screening, the main reason for not coming for screening was "not having any abnormal symptoms" (66.6%). The majority of the participants (83.3%) have previously perceived information on

cervical cancer with the Health Center as the major source of information (92%). The detail of participants' experience in cervical cancer screening is shown in Table 2.5

Table 2.5 Participants' experiences with cervical cancer screening

Variables	Number	%
Screening experience	N=30	
• Have screening experience	21	70
• Never have screening experience	9	30
Last time of screening	N=21	
• 1-2 year	16	76.1
• 3-5 years	4	19
• More than 5 years	1	4.7
Reason for screening	N=21	
• Having abnormal symptoms	11	52.3
• Accompany with friends	4	19
• Recommend by staff during another service session	3	14.2
• Other	3	14.2
Screening results		
• Normal (negative)	17	80.9
• Positive	3	14.2
• Don't know the result	1	4.7
Time length before receiving screening results		
• Within 1 month	12	57.1
• More than 1 month	9	42.8
Reason for not participating in screening	N=9	
• Not having abnormal symptoms	6	66.6
• Afraid of positive results	1	11.1
• Afraid of pain during screening	1	11.1
• Shyness	1	11.1
Perception on cervical cancer information	N= 30	
• Yes	25	83.3
• No	5	16.6
Source of cervical cancer information	N=25	
• Sub-district Health Center	23	92
• District Hospital	2	8

2.5.2 Summary of two- day training activities

i) Group discussion - sharing experience

The participants were divided into 3 groups and the members of each group were allowed to share their experience in cervical cancer screening. Qualitative information was collected in order to support the quantitative data obtained from the interview and from the questionnaires. Following are the outcome of this activity for each group.

Group 1 contained the group of village health volunteers who did not have previous screening experience. The discussion topic was “ *Why not receiving cervical cancer screening?*” and the main reasons expressed by the group members were:

1. Shyness: they did not want to expose themselves (during the screening) to the local health staff whom they know and well acquainted with.
2. Afraid of positive test results or incurable diseases that will worry them.
3. Not have money and afraid that they could not afford the screening expenses.
4. Not have any abnormal symptoms so believed that they are fine.
5. Believe that this disease is not serious, as there is no severe symptom like other diseases.
6. Not understand the importance of screening as not perceived of serious campaign/ continuous promotion about this cancer from the health staff unlike other diseases.
7. Afraid of positive results that will embarrass them.
8. Shy to expose to every health staff and doctors.
9. The women from previous generation were all right without the cervical cancer screening.

10. Experience bad verbal treatment from the service staff.

11. Did not have time to go for screening.

Group 2 contained the group of village health volunteers who have screening experience.

The discussion topic for this group was “ *Why have participated in cervical screening*”.

The main reasons expressed by the group members were:

1. Afraid of developing cervical cancer.
2. Having abnormal sign and symptoms such as abdominal pain, abnormal vaginal discharge, itchiness, and abnormal menstrual period.
3. Test to ensure that they are okay
4. Accompany with friends
5. Not having menstrual period after the injection of contraception liquid and afraid of cervical cancer.
6. Believe that they are in the risk group as they used to have uterus operation.
7. Believe that they are in the risk group as they do a hard work.

Group 3 was the group of female village leaders who discussed under the topic of “*How to encourage other women to participate in cervical cancer screening*”. The group’s opinions are summarized following:

1. The screening service should be free of charge.
2. The female leader should encourage other women individually to come for screening.
3. Should provide screening service for every married woman young and old.

4. Provide knowledge about the danger of this type of cancer.
5. Organize a special screening program in the health center with the assistance from another mobile screening unit. This will overcome the shyness problem happened with the screening from the Linfa health staff.
6. Survey the need for screening and provide knowledge at the same time.
7. Providing the relevant knowledge by the health officer will help increase the interest level among the female villagers to receive screening.
8. Allocate the responsible areas within each village and survey the list of the target group who have and have not done screening.
9. In addition to free screening service, a special gift free should be provided for a woman who participates in screening.
10. Encourage women to visit the health center together as a group of several women as this will overcome the shyness problem.

ii) Problem identification

The reasons and problems of the female villagers for not participating in cervical cancer screening were concluded and summarized in the review meeting as follows:

1. Not understand the importance of screening and not know the danger of the cervical cancer.
2. Most women are shy to expose themselves for screening.
3. Misbelieve that young women do not develop cervical cancer and old women do not need screening
4. Not knowing that the screening service is free of charge

5. Afraid of pain during screening
6. Waste their time to come for screening

iii) Problem analysis and priority setting

The meeting bodies analyze and conclude the problems with setting priority of those problems for actions. The outcome of the activities are summarized as follows:

- **Problems of women who receive service**
 - Lack of knowledge and information on cervical cancer
 - Shyness
 - Misbelievers
 - Afraid
- **Health staff problems**
 - Insufficient provision of knowledge and information
 - Bad verbal expression

iv) Problem solving and planning

In this activity the participants helped in brainstorming and planning the means of resolution to solve the problems addressed previously. The main purpose is how to encourage fertile women in the villages to receive screening service. The outcomes of this activity are:

1. Provide knowledge about cervical cancer and advantages of screening by the mean of group and individual talking during any social occasion within the community and by the mean of local broadcast news.

2. Advise to come for screening on every Wednesday at the health center or at the district hospital.
3. Survey and organize the list of the intended women for the staff to make and an appointment for screening.
4. Appoint for the next meeting.

v) Post-training commitment

This activity involved allocation of detail responsibility according to the plan agreed by the participants and responsible staff. It is the responsibility of the participants to implement the resolution plan after the training, that is, by providing cervical cancer knowledge to other female villagers and by promoting cervical cancer screening.

vi) Other activities

Other supplementary activities were included in the training session in order for the participants to improve various skills and to be able to connect the learning materials received through the day. The activities also helped to stimulate the participants to involve in and enjoy all activities according to the training schedule.

2.5.3 Level of the participants' knowledge in cervical cancer at pre- and post-test

Table 2.6-2.9 showed quantitative comparisons between pre and post-test knowledge levels of the participants about cervical cancer, risk factors, severity, and importance of screening.

Table 2.6 General knowledge in cervical cancer

Knowledge level (n=30)	Pre-test (%)	Post-test (%)
Good	3.3	13.3
Moderate	50	53.3
Need improvement	46.6	33.3
Mean	5.4	6.2
Standard Deviation	1.3	1.1

Table 2.7 Knowledge in risk factors of cervical cancer

Knowledge level (n=30)	Pre-test (%)	Post-test (%)
Good	3.3	30.0
Moderate	83.3	70.0
Need improvement	13.0	0.0
Mean	34.6	38.1
Standard Deviation	4.4	3.5

Table 2.8 Knowledge in severity of cervical cancer

Knowledge level (n=30)	Pre-test (%)	Post-test (%)
Good	13.3	33.3
Moderate	63.3	63.3
Need improvement	23.3	3.3
Mean	30.8	34.1
Standard Deviation	4.9	4.4

Table 2.9 Knowledge about importance of cervical cancer screening

Knowledge level (n=30)	Pre-test (%)	Post-test (%)
Good	16.6	33.3
Moderate	66.6	63.3
Need improvement	16.6	3.3
Mean	24.2	27.1
Standard Deviation	4.7	3.2

2.5.4 First outcome evaluation (one month after the training)

The review meeting was conducted at the Linfa health center for the staff and all participants to discuss and conclude the outcome of their work during the one-month period after the training. The summary of their work activities is following:

- Survey of 682 fertile married women and organizes the list for the relevant health officers.
- Advise and recommend other women in the village at their convenient opportunity and approaches such as announcement in the local broadcast news and advising in person or in a group.

2.5.5 Project assessment (six months after the training)

The meeting was conducted at six month after the training to discuss and conclude the outcome of the training project. It was found that there were total of 114 women received screening service during six-month post-training period. Of this group, 100 women were the local residents and 14 women were from outside areas (Mahasarakam Province).

This later group lived in the nearby area to Linfa Sub-district and perceived of the news from the participants and so participating in the screening program.

From the registry record, 100 local women could be classified into two service groups, which are 64 women receiving screening service at the Linfa health center and 36 women receiving screening service at the Chaturaphukpiman district hospital. By considering solely the local number, the project outcome is said to be satisfactory and successful, as it constitutes 98.8% of the targeted plan, which was 101 women of Linfa Sub-district (15% of women who participated in the family planning program).

The final meeting was organized to conclude the overall project outcome and to present it to all related personnel, health staff and participants contributing to this project.

2.6 Problems, Conflicts and means of resolution

2.6.1 Problem with pre-training and post training data collection

- There were several sections in the questionnaires and each contained several items for the participants to complete. The majority of the participants with primary education level had difficulty in understanding and answering the questions. The staff assisted by reading out and explained each individual question to the participants and this led to time consuming for data collection step.

2.6.2 Problems during the training session

- During group discussions and presentation activities some participants spent too much time talking about irrelevant materials. The facilitators solved this problem by allocating limited time for each person to speak. On the other hand, the facilitators had to encourage some quiet participants to express their opinions more in a group discussion session.
- Inadequate equipments when the participants were divided into 3 groups and each group required a separate tape recorder and materials necessary for collection of quantitative data during group discussion activities. The supplementary equipments were obtained by borrowing from other nearby organization.

2.6.3 Problems after the training

- The time period after the training was the harvest season when most villagers were busy in farms. This led to some degree of inconvenience for the participants to advise other women about cervical cancer and screening as planned.