CHAPTER 4

DISCUSSION AND CONCLUSION

4.1. Discussion

The project of "Village leaders training program to improve knowledge and attitude toward people with HIV/AIDS" using the participatory learning process: a case study of Ban Nong Khun Yai, Nong Phok District, Roi-Et Province" aimed to provide village leaders the accurate knowledge, and understanding about HIV/AIDS and enable them to transfer their knowledge gained from the training to their family members and other villagers. As a result, it was expected that they will apply these knowledge into practices of HIV prevention, HIV/AIDS patients care, and live normal lives withHIV/AIDS people. The outcomes of the project implementation were outstanding, although there are some points needed to be improved for the best possible results of future works. These outcomes are summarized as follows:

1. Goal achievement:

The project goal was that people in the village take parts in assisting, supporting and caring for people with HIV/AIDS in the community. After the completion of the project, the majority of people realized about community's HIV/AIDS problems. In the village, there aresupporting programs for people infected with HIV/AIDS such as donation and visit to HIV/AIDS patients and their family which happen more often. Importantly, village leaders requested no prostitution in the village which normally on every Sunday there weresome prostitutes coming to the village for commercial sex services. The outstanding success of the project was partially resulted from an external factor which was the visit of public health officers from various health centers during the six months of the training. This worried people of the village and their leaders that the officers would see 'bad' things in the village. As a result, they were more careful in

their daily living and behaviors, for example, not eating raw meat, garbage cleaning, house cleaning and visiting HIV/AIDS patients as well as not visiting those prostitutes who came to the village and so forth. After the completion of the training project, when there are no health officials visiting the village, it is not known how or whether the villagers would change their behaviors. This is an issue to be continually studied by the investigator. However, there is still another evaluation phase i.e. after one year of the project completion when the investigator has to assess people awareness towards HIV/AIDS problems and their continuous support and cares for HIV/AIDS patients.

2. Objectives achievement:

The first objective was that participants of the training project have increased accurate knowledge and better understanding about HIV/AIDS. Assumption of the research was that "discrimination of people against HIV/AIDS and fear of the disease resulted from a lack of accurate knowledge and understanding about HIV/AIDS" , therefore, the investigator employed the training process to educatepeople who participated in the training. The outcomes of the project implementation showed that mean scores of all participants increased (Table 3.7), but there was insignificant differences between the average scores (equal to 0.56). This was because most participants (83.5 percent) already had good knowledge and good understanding before training. The mean pre-test scores were 16.7. After completion of training, mean scores only slightly increased. When considered the average scores of each individual group, there is an increase (Figure 3.1). However, the lowest scores of participants in both before and after training were equivalent. This indicated that some participants have not gained any knowledge after training. This can be clearly distinguished when considered scores of participants by group (Table 3.8 and 3.9). Healthcare volunteer, housewife and elderly groups have the equivalent lowestscores both before and after training. Only village leader group had an increase in the lowest scores after training. This could be related to:

1. The long training period which caused participants to forget contents discussed in the group.

2. Some participants did not believe in experiences of their group members or did not believe other persons. In participatory leaning participants have to learn from one another experience. The public health officers or speakers were only to help encourage continuous group works, not teaching them. Participants had to use their experience in making decision about what they had listened to from their group members.
3. Some participants, when small group activities taken place they did not pay much attention. Some even left the training to their home; and came back when the big group activities started.

However, from finding level of knowledge and understanding before and after training using t-test statistical value, it was found that the level of knowledge and understanding of participants after training decreased but still in a satisfactory level. The mean value of attitude increased after training as shown in Table 3.6.

Healthcare volunteer group whose works involved community healthcare should be the group with best understanding about HIV/AIDS. However, from the training results, it was found that this group had insignificant change in average scores whereas village leader, elderly and housewife groups were the best learning group respectively (Figure 3.1).

From questionnaire, by comparing participants' answers before and after training, there were some questions answered correctly by the participants in pre-test but after training these questions were answered incorrectly. There were some questions that participants provided incorrect answers for both pre and post tests. For example, question "HIV/AIDS can be transmitted from sharing food or using utensils such as glass plates, spoons etc with HIV/AIDS patients?"; participants presented correct answer for this question before training but 3 people (2 elderly and 1 house wife) presented incorrect answer after training. Two village health volunteers, 1 house wife and 1 village leader provided incorrect answer in both pre and post tests (as shown in Table 3.10). For question 7 "HIV/AIDS can be transmitted through mosquito's bite, if the mosquito bit a HIV infected person and then bite non HIV infected person?"; 1 house wife provided correct answer for pre-test but presented incorrect answer in the post test. There were 10 people with incorrect answer for both pre and post tests. Most of them were elderly. This would be because participants were still not sure and believed that

there is a chance of getting infected from insects. This is contrary to academic information which shows that AIDS can not be transmitted through mosquito's bite, if the mosquito bit a HIV/AIDS infected person and then bite non infected person.

From Table 3.21, the majority of participants answered questions correctly for pre-test but presented incorrect answers in post-test. Besides, participants of each group provided incorrect answers in both pre and post tests because of unclear questions. Most participants did not understand the questions.

In terms of HIV/AIDS treatment knowledge (Table 3.23 and Table 3.25), some participants did not understand. Some participants were persuaded by media which advertise that AIDS can be curable.

From Table 3.29, question 20 "HIV-positive persons can live with family and community?" was an important question. It showed that majority of participants agreed that HIV/AIDS patients can live with community. There were only 2 housewives and 1 elderly whose answer for pre-test was correct for but incorrect for post-test. An elderly who provided incorrect answer was the one who stop having meal during the simulated situation.

For other questions on knowledge and understanding, most participants answered them correctly in both pre and post tests. There were some questions that participants provided incorrect answers before training but provided accurate answers after training. This showed that the training employed participatory learning was suitable for the groups of participants. Some questions were not clear for some participants who have limited understand of the common Thai language, particularly the elderly who could not read. Majority of participants used local language which some words have different meaning compared to the common Thai language. Therefore, the investigator employed other techniques for implementing the project such as observation, creating simulated situation, and so forth.

Using questionnaire method for project evaluation may lead to 'untruth' telling especially when there was a short time interval between pre and post test. Participants might memorize the questions to be able to answer it later. This training project was conducted in 4 months period. Therefore, the increased differences of mean scores arelikely to be a result of a better understanding about HIV/AIDS of the participants. However, in the project evaluation, investigator should also adopt qualitative evaluation into the assessment to confirm the evaluation results.

The second objective of the project was to evaluate participants' opinion and attitude towards HIV/ADIS patients. Outcomes of the project showed that participants had better attitude towards HIV/AIDS. This is evident by the increased average scores from 6.69 (S.D=1.96) to 7.08 (S.D=1.92) after the completion of project. When considered mean scores of each individual group, it was found that healthcare volunteer and village leader groups have decreased mean scores, but the scores for "not sure" answers increased. This implied that the training project using participatory learning technique helped participants to develop critical thinking process and having arguments during thinking and decision making processes. When participants have more answers of "not sure", it also meant that participants have more rational arguments to the questions. Participants initiated self learning process and would be able to apply it to solve everyday life problems and community problems. However, when considering scores of the participants for each question, it was found that majority of participants had better attitude towards HIV/AIDS patients. This was shown by a high number of participants whose answers for post test were correct. It was consistent with the testing used statistical t-test value which mean value of scores after training was increased (Table 3.6). However, for question 1 "AIDS is a very frightful disease" there were participants of every group provided incorrect answer for both pre and post test. The participants interpreted the meaning of this question as that AIDS is a very frightful disease because once infected, there is no cure for it and a person who is infected will die soon. But the meaning referred by the investigator was that HIV/AIDS infected persons were frightful. This leads most participants to provide incorrect answer in both pre and post tests.

The project evaluation by the use of simulated situation was conducted by inviting pretended HIV/AIDS patients to join lunch with the participants. It appeared that three elder woman participants stopped eating when they were informed that HIV/AIDS patients joining lunch with them. It implied that changing people's attitudes towards HIV/AIDS is hard task and needed time. However, most participants have positive attitudes towards HIV/AIDS patients. This was observed from the visit of the participants to people with HIV/AIDS and their family, the sharing food, the donation and the encouraging behaviour to get their neighbours to visit HIV/AIDS patients.

Before the training the started, the investigator visited people with HIV/AIDS in the village and to observe and interview them and their family about the reactions of people in the community towards their illness. It was revealed that, normally, HIV/AIDS patients were discriminated against by people in village as there was no one came to visit them or even asked about their illness, except their closed relatives. Some of their relatives did not come to visit them either. HIV/AIDS patients had never been out of their house because they were afraid of people's rejection. During the training, participants led their neighbours to visit those patients. This showed that participatory learning method employed in the training project could confide people's confidence and could help creating critical thinking and enable them to socialize with HIV/AIDS patients. The obvious observation was the changes of people behaviors during the frequent visits of healthcare officials during the implementation of the project.

The village leaders training program to improve knowledge and attitude toward people with HIV/AIDS was a long and continuous process. During training, there were many healthcare officials entered the village, and they often came to observe people behaviours. This action caused people's behaviours to change such as:

1. Usually, people do not pay much attention to cleaning their houses nor the surrounding areas, but when healthcare officers visited the village, people were very keen for cleaning as they did not want to embarrass themselves with dirty house.
2. There were prostitutes from restaurants in Nong Phok District and the nearby districts to the village on every Sunday. When the project started for a period of

time, this was solved by the village leader who asked the procurer to abandon the prostitution in the village.

3. Participants

Participants for this study were on a voluntary basis. As the training was conducted during the harvest reason, there were insufficient numbers of volunteers. The residential officials of the village health center had to request people to participate in the training. However, the participants had to absent from their works, and this affected their earnings for a living. In part of participant, there are some points to be improved:

1. Some participants were shy to speak up because they were afraid of makingmistakes; they preferred to listen to others.
2. Some participants had personal business to do during the training. They often walked back home to finish their tasks during the group dividing process.
3. Participant's learning was different depending on background knowledge and experience of each individual.

Good points were as follows:

1. There were various groups of participants; therefore it created variety of participants' experiences and then created different learning.
2. Participants were leadersof the village and their roles were different. This brought about comprehensive experience transferring to other groups.
3. Participants' number was reasonably appropriate for group activity arrangements and convenient for trainers. This created coverage learning.
4. Village leader group was respected by people in the community; therefore it was good for the knowledge and experience transferring. This was because this group of people often has opportunity in transferring knowledge and experience to members of the community including their family, neighbours and community. Not only the village leader group is accepted and respected by people in community, they are a role model for people in the community as well. Good behavioral role model is one of good teaching techniques.
5. Groups of participants had power in decision making to solve problems of their community. This made the training process of putting ideas into practice much easier and tangible.

4. Training process using participatory learning

Participatory learning process is favored by public health organizations to employ it into training process to improve and develop knowledge of both healthcare officials and the public. It is believed that this learning process can encourage people to actually learn andable to apply knowledge into practices. For the village leader training project to reduce problem of discrimination against HIV/AIDS, the investigator employed this particular technique into the operation of the project. This technique has both strengthsand weak points. Points to be modified are:

1. It consumed long period of time to adjust participants and their thinking process because majority of participants were used to lecturing and teaching by others. These differ from participatory learning which emphasize on mutual experience learning of the participants.
2. This learning technique is not suitable for participants whose background knowledge is poor. However, in that case, trainers could provide information to initiate discussion.
3. Some participants were talkative or able to persuade group members to follow and believe in their reasons which could be incorrect. These people usually are persons with political influence, persons who villagers respect and/or the elderly.
4. When there were conflicts in opinion between, they usually would not negotiate. This prevents group process from carrying on.
5. The technique is time consuming and needs many trainers unlike didactic training which is controllable and not many trainers are needed.

Advantages of the participatory learning technique are as follows:

1. Atmosphere of the training process was entertaining as there were game plays accompanied with the training. Most participants were not bored because they were involved or participated in speaking, listening and group discussion.

2. Learning from each other experiences is a learning process that really happens in everyday life. This enabled participants to gain knowledge and understanding and able to apply to their daily lives.
3. It enabled participants to be confident in their capacity because the ideas or conclusion come from group discussion, not the trainer's idea alone.
4. There was a democratic process which encouraged rationalization in decision making process.
5. It is a dynamic and infinite learning process.
6. The technique can be applied into real-life problem solving.

5. Facilitators

Most facilitators were public health officials from healthcare centers and district public health offices who had lots of experience, knowledge and coordination skills. All had been trained with participatory learning technique. However, there were weak points and strengths of the facilitators. The weak points needed to be improved were as follows:

1. Each individual facilitator had distinct knowledge. Counseling, supporting and assisting participants to develop their learning therefore were different in each individual group.
2. Facilitator had different teaching skills.
3. Some facilitators advised participants didactically using their own knowledge and experience. Participants were listener only.

Strengths of facilitators were as follows:

1. They worked as a team.
2. They have profound knowledge in public health issues and able to provide participants the information they needed.
3. They are local people. They have good communication skills and able to communicate local languages with the participants.

4.2 Conclusion

The technique adopted in the operation of the village leaders training program to improve knowledge and attitude toward people with HIV/AIDS was participatory learning. The project was to train leaders of the village who are respected by the community. These leaders were to be leader in practice, and transfer their knowledge and experience to their family members and the communities. The outcome of the training project revealed that the participants gained better knowledge and understanding about HIV/AIDS. Questionnaire method was employed to evaluate opinion and attitude of participants towards HIV/AIDS patients. Results showed that healthcare volunteer group and village leader group have less positive attitudes towards persons with HIV/AIDS. According to this result, it can be concluded that to alter people attitudes is difficult task. Knowledge alone may notchange attitudes, it has to rely on other factors as well. However, the operation of participatory training, aimed to educate participants, alter their attitudes and encourage their proper behaviors which would help to solve problems. From the operation of the project, studied outcomes are summarized as follows:

1. Of the 40 people recruited, there were 38 people who were able to participate throughout the training as two people absent. Information of these two absent persons was not included in the project evaluation.
2. Accurate understanding about HIV/AIDS of the participants increased very little. Before training, mean scores was equal to 16.70 and after training mean score was 17.26. Mean scores increased by 0.56. Opinion and attitudes of the participants changed both better way and poorer. Healthcare volunteer and village leader groups have decreased positive attitudes whereas housewife and elderly groups were found to have better positive attitudes. However, in project evaluation by simulated situation, it was found that there were 3 women from the elderly group who had negative attitudes towards HIV/AIDS patients as they immediately stopped having meal when acknowledged that there were HIV/AIDS patients participated in the meal even though they had just started. The answers for questionnaire on attitude towards "the living with HIV/AIDS is a high risk of getting infected with HIV/AIDS" and on question 9 "HIV/AIDS people should not be allowed to participate in community activities?" were

incorrect. This indicated that changing people attitudes is somewhat difficult. However, from the evaluation, participants who had negative attitudes towards HIV/AIDS patients were only 7.89%, and all of them were female.

3. The investigator evaluated community practices towards HIV/AIDS patients by employing observation and interview methods. It was found that people have a increased positive behaviors towards persons with HIV/AIDS such as they went to visit those patients and their family, talked with them, shared food and donated utensils for them. Before the training taken place, very few people paid attention to HIV/AIDS patients.

Lessons learnt from the operation of the project:

1. Project management skills were gained as the project was to be conducted by the research himself. Every effort was used to complete the project as planed. Critical thinking technique, time management, budget management and process of decision making were all used.
2. Operation of project helped to broaden work experience, coordination and cooperation with the community, problem learning with the community and team working. All these are essential tools in problem solving process.
3. During the operation of training, the investigator learnt about conflicts which normally can happen every time, in every group of people at every level. Conflicts happen correlatively to critical thinking. Listening to reasons of others and application of analytical thinkingwere also gained from the project implementation. Data analysis and experience of each individual are vital and important for the resolutions to conflicts. Negotiation skills, advices and suggestion of those important persons or respectable persons couldalso help solving the conflicts.
4. The investigator learnt about participatory learning technique and applied it to use with people in the community. After the participation in community activities, the investigator realized that participatory learning was not a new subject. It is a technique that people in the community are familiar with and actually taken it into real-life practices.Community has a learning process similar to a participatory learning based on Western theory which is a learning

by experience sharing and by using group process. It is especially that group process is a way of life of people in rural areas. People in rural areas like to participate in community activities. They have customs and traditions to participate throughout the year. Every month there is a traditional activity or festival to celebrate. Most members of the community will get together when there is a traditional activity. When people in the community group together, they will exchange their experience. This creates learning process in the community. Mostly, it was life learning and devolving of fine customs and traditions. However, even though there are experience learning and group learning, rural community also has a learning that differs from Western theory. Rural community has rules and prohibits that people in the community have to follow. In addition, power of village leader especially the elderly whose power is acknowledged from people in community have an influence on community members' decision making. When members of community have exchanged their experience and there is group learning, these lead to real-life practices. In final stage, village leader or the elderly will be supervisor as well as giving decision in carrying out each activity.

5. There is no ending in learning and most knowledge sources are in community. Learning is various and involved many components. Knowledge and technologies of old generation have been transferred to new generation from time to time.
6. Community still has a number of problems waiting to be solved. To solve the problems, every single governmental sector as well as the public should cooperate with one another. However, at the present, problems are not solved as people usually see problems as a responsibility of either government or people not of both parties. People of community should be allowed to participating in every stage of all problem solving.
7. HIV/AIDS is still a major problem of communities in Nong Phok District because there are still many contributing factors to the wide spread of HIV/AIDS such as drug uses, alcohol consumptions, poverty problem and so forth.