

## CHAPTER 4

### DISCUSSION AND CONCLUSION

#### 4.1. Discussion

Because PSBI was already working with PLWH groups and the fact that PLWHs understand each other better than their non-PLWH counterparts, the program targeted only PLWH volunteers. Therefore, this project was limited to working only with a small group of people who had low education and were slightly ill. However the low educational background did not create extra barriers in the learning process and did not seem to play a role in good provision of care. Notwithstanding the criterion on HIV status, the program included one HIV affected volunteer. After close observation, it was found that there was no difference between her attitude toward HIV/AIDS care and her performance compared to the PLWH volunteers. Therefore, there could be more advantages in the future, if the program would include other people next to PLWHs.

The program manager had no decision power on the selection of volunteers but delegated the responsibility on volunteer selection to the four PLWH groups. This was due to the fact that the organization was in the process of handing over the Home Based Care Project to the PLWH groups. In the future, PLWH groups are expected to run the Home Based Care Program by themselves. The selection of their own staff was one of the strategies to empower the PLWH groups.

Problem based learning was found to be very effective and appropriate for volunteers who had some experiences prior to training. However, for those who had no experience, it was quite difficult for them to imagine the needs and problems of clients. If home visits to client's houses along with explanation during visit by professional staff, could be arranged prior to theoretical training, then volunteers would benefit more from a problem based learning method.

A True-false questionnaire on knowledge test does not seem to be the most appropriate tool if used alone. The disadvantage of True-false questions is that it does not give detail of volunteers' knowledge. However, this type of questionnaire was selected because of the low educational level of volunteers. During training, it was found that multiple choice questions are more appropriate for the volunteers with an education background above Pram four.

For the Attitude test, one could argue that including the HIV/AIDS Home Care Provider Attitude Scale is redundant, based on the fact that the volunteers were selected from a pool of existing volunteers, therefore, they already have a positive attitude. This Attitude test has an important section on care providing aspects extending the viewpoint to a more active concept of attitude as a care provider. Therefore, there was a significant difference between the pretest and the posttest. Aspects of volunteers' behavior were taken care of by the client satisfaction questionnaire.

Skill training which was arranged for 8 weeks, which seems to be too short for the volunteers to develop certain skills especially these that require frequent applications and close supervision to build skills.

Client satisfaction was measured only once at the sixth visit. If it can be measured periodically, the results could be used as feedback for improving the training program. This would also benefit the PLWH volunteers. It should be noted that since there was a high mortality rate among the clients, some client's satisfaction was measured through a proxy who was the main caregivers of the client. This could create some bias.

From the volunteers' voices, it seemed that female volunteers were better accepted as care provider than the male counterparts. The majorities of the clients were not familiar with care provided by a male and tended to avoid when male volunteers offered to provide care; this was also the case in male clients. This might be due to the fact that the caregiver role has long been a responsibility of woman in the Thai society. In future training, the program should more focus on female volunteers to overcome this limitation.

Several clients' condition became worse in a short period. During the first month of practice, before measuring client satisfaction, seven clients out of 24 passed away. Although, these clients were not included in the study, their death had a major impact on the PLWH volunteers. During the second and the third month, 13 out of 30 clients passed away. At times, it was necessary for the PLWH volunteers to make

them realize that the care provided by them was not a substitution for saving life. It was needed to reassure that the main purpose was on care and comforting the client during their life threatening condition.

Some volunteers, in the beginning, had difficulty coping with severe symptoms and dying patients. They blamed themselves not being able to save the life of their clients. Counseling (by debriefing) and peer support was necessary to help the volunteers to overcome sorrow, feelings of being lost, resulting in more positive coping with emotions. Effective coping strategies as well as the evaluation of coping ability should be well prepared in this type of program. However, it was not possible to measure the level of coping and to determine whether the psychological, peer support was sufficient for the volunteers to maintain their wellbeing. Therefore, possible dropouts among volunteers could occur over time.

It was surprising to notice that all of the clients have caregivers. Moreover, the PLWAs perceived a very good relationship with caregivers, which is a great improvement compared to the past years, when PSBI staff provided care directly. At that time, most of the clients were left to be ill alone at home. It might be that regular care and visits of volunteers had contributed to reduce feelings of fear among relatives, seeing that it did not require nurses to provide care might have a positive effect among family members.

Two volunteers who did not pass either knowledge, attitude or skill tests and therefore were considered as unqualified as home care provider. Although in a real

world situation, attitude and skills seem to play a more important role in provision of basic care compared to knowledge. Taking into consideration that this work is voluntary work; future training should emphasize attitude and skills. A program that will be too strict may affect the willingness in receiving training as the volunteers might be either afraid to lose face for not passing the evaluation or lose confidence and motivation in providing care.

#### **4.2. Conclusion**

This project aimed to improve care for PLWAs at home by enhancing capacities of PLWH volunteers. In phase I, the project focused on formal, resource-intensive training to build capacities of PLWH volunteers and evaluated knowledge, attitude and skills gained by volunteers as well as satisfaction of the clients received care provided by volunteers.

The evaluation findings suggest that most of the volunteers have basic knowledge on HIV/AIDS care, good attitude towards their role as home care provider, and have the required skills to perform home care activities. Knowledge, attitude and skills were obviously improved when compared before training. The experienced volunteers made better progression than the inexperienced ones. After training, the volunteers had competencies as expected. The coping strategies were spontaneous in place when needs were raised and the volunteers were able to cope well with the situation.

The majority of the clients had high satisfaction on care provided by volunteers as well as high satisfaction on the relationship with volunteers. The lowest score in the satisfaction on the provision of care was on helping to plan the future. This may indicate that clients have a need to talk about preparing for dying. Although the issue of dying was addressed during the terminal care session in the training, this finding could indicate a need for more attention for aspects of palliative care.

The lowest scores on satisfaction within the relationship with volunteers were on (1) volunteers understanding on the needs of the clients, (2) the ability of clients to discuss all problems with volunteers and (3) the limited involvement of families. This could be explained by the fact that data collection was conducted after the sixth visit only, which is a short period to establish an excellent interpersonal relationship. The limited family participation in home care can be explained by the fact that data were collected during practical training of the volunteers which was too early to develop family participation.

Although not all of the volunteers completed the training, the number of volunteers who passed was sufficient to start up the Home Based Care project in the four districts. The program continues with phase II at present with financial support from MOPH until Jun 2003.