CHAPTER IV

RESULTS

This project aimed to study the outcomes of PRA process and the factors increasing the potential of health care of HIV/AIDS patients of Village Number 4 (Ban Nong Wah) and 7 (Ban Khao Lom). To evaluated the outcome of PRA process, the assessment of attitude of family headman, wives or family leaders, who were the household representatives toward the HIV/AIDS both pre and post the PRA process were conducted. Moreover, the focus group discussion of stakeholders had been conducted during February – November 2004. Then, all data were analyzed and synthesized totally in 6 parts as follows:

Part 1: Attitude towards the HIV/AIDS pre PRA Process

1.1 General Data of Household Representatives Demographic data of household representative consisted of age, sex, status, occupation, education and religion

1.2 Attitude of household representatives toward HIV/AIDS.

Part 2: Group Discussion of Stakeholders pre PRA Process

2.1 Results of focus group discussion of stakeholders

Part 3: Results of PRA Process

3.1 Analytical results of PRA for AIDS realization from 2 villages based on the fundamental activities in terms of risk places, risk behaviors / risk groups, AIDS situation and the evaluation of the community's problem solution potential.

Part 4: Attitude towards the HIV/AIDS post PRA

4.1 General Data of Household Representatives Demographic data of household representative consisted of age, sex, status, occupation, education and religion

4.2 Attitude of household representatives toward HIV/AIDS

Part 5: Focus Group Discussion of Stakeholders post PRA Process

5.1 Results of focus group discussion of stakeholders from 2 villages

Part 6: Comparison of Attitude toward HIV/AIDS post PRA Process

6.1 Attitude of community representatives

6.2 Attitude of stakeholders

Part 1: Attitude Measurement toward the HIV/AIDS pre PRA Process

1.1 General Data of Household Representatives

Demographic data of household representative consisted of age, sex, status, occupation, education and religion (Table 4.1)

Village Number 4, Ban Ning Wah, Thung Yoew Sub-district: 140 samples

Sex: The samples consisted of the equal amount of male and female participants, that is, 47.1 % to 52.9%. The samples were 20 –35 years old (37.9%) whereas 25.0% were 36-45 years old. The majority of sample (83.6%) was married. They were agriculturist (48.6%) and employee (48.6%), respectively. The samples obtained the primary education (76.4%) and were Islamic (75.0 %)

Village Number 7, Ban Khao Lom, Thung Yoew Sub-district: 84 samples

Sex: The samples were female (61.9%) aging 20-35 years old (40.5%) and 36-45 years old (23.2%). The majority of sample (83.3%) was married. They were agriculturist (75.0%) and employee (16.7%), respectively. The samples obtained the primary education (67.9%) and were Buddhist (60.7%)

Table 4.1: Basic demographic information of representatives from households in Moo 4 and Moo 7 (pre-PRA process)

Characteristic	Moo4 (n=140)		Moo7 (n=84)	
	Number	percent	number	percent
Age (years)				
20-35	53	37.9	34	40.5
36-45	35	25.0	20	23.2
46- 55	32	22.9	13	15.5
56-75	15	10.7	15	17.9
75 +	5	3.6	2	2.4
Sex				
Male	66	47.1	32	38.1
Female	74	52.9	52	61.9
Marital status				
Single	14	10.0	10	11.9
Married	117	83.6	70	83.3
Widow	8	5.7	2	2.4
Divorced	1	o.7	2	2.4
Occupation				
Employee	56	40.0	14	16.7
Agriculture	68	48.5	63	75.0
Student	5	3.6	4	4.2
Other	11	7.1	3	3.6
Education				
Primary school	108	77.1	57	67.9
secondary school	24	17.1	19	22.5
Other	8	5.8	8	9.6
Religion				
Buddhist	35	25.0	51	60.7
Muslim	105	75.0	33	39.3

1.2 Attitude of household representatives toward the HIV/AIDS

The samples considered each item. In case of the negative questions (Item 1, 2, 3, 4 and 9), if the samples had the positive attitude, they should answer "Slightly Agree." On the other hand, in case of positive questions (Item 5, 6, 7, 8, 10, 11 and 12), they should answer "Strongly Agree" instead.

Village Number 4 (Ban Nong Wah)

According to the samples in terms of the belief about AIDS, the majority had the *negative attitude*, that is, they agreed that HIV/AIDS was derived from the behavioral causes (83.3%). Some samples had the *medium level of agreement (uncertain / reluctant)* disagreeing that HIV/AIDS should not live with their family (65%); HIV/AIDS should not contact people in communities (63.9%); and AIDS was the punishment from Gods (58.6%). (Table 4.2)

Table 4.2: Attitudes of representatives from Moo 4 about HIV/AIDS

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) %	Medium %	Low (negative) %
#1.should not live with their family	15.0	20.0	65.0
#2. should not contact people in communities	12.5	23.6	63.9
#3. punishment from the gods	22.1	19.3	58.6
#4. behavioral causes	83.3	8.6	8.1

Note # = number

According to the samples, in terms of the attitudes about living and sharing with HIV/AIDS, the majority had the *negative attitude,* that is, they agreed and allowed their children to do activities with children of HIV/AIDS (36.4%); if they know who was infected in the community, they should tell everyone (36.4%). On the other hand, some samples had the *medium level of agreement*, namely, they talked with HIV /AIDS at their home (18.8%); and they invited HIV/AIDS for lunch or dinner (44.9%) (Table4.3)

Table 4.3: Attitudes about living and sharing with HIV/ AIDS (Moo 4)

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) %	Medium %	Low (negative) %
#6.should invite HIV/AIDS for lunch or dinner	44.9	34.3	20.8
#7. talk with HIV/AIDS at your home	55.3	25.9	18.8
#8. allow your children to do activities with HIV /AIDS	36.4	30.7	32.9
#9. if you know who is infected in the community, you have to tell everyone	36.4	29.3	36.4

Note # = number

The majority of samples had the *positive attitude* about the support and assistance provided for HIV/AIDS, that is, they agreed that a support system should be established in the village (74.3%); HIV/AIDS should have a chance to support themselves (73.8%); they should give opportunities to work for healthy HIV/AIDS (70.0%); and the villagers should have activities to support the HIV/AIDS and their families (70.0%) (Table 4.4)

Table 4.4: Attitudes about support systems for HIV/AIDS (Moo 4)

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) %	Medium %	Low (negative) %
#5.a support system should be established in the village	74.3	19.3	6.4
#10. Give opportunities to work for healthy HIV/AIDS	70.0	23.6	6.4
#11. HIV/AIDS should have a chance to support themselves	73.8	17.9	9.3
#12.Villagers should have activities to support the HIV/AIDS and their families	7.0	22.1	7.9

Note # = number

Village Number 7 (Ban Khao Lom)

According to the samples in terms of the belief about AIDS, the majority had the *positive attitude*, that is, they disagreed that AIDS was derived from the punishment of Gods (82.1%). Some samples had the *medium level of agreement (uncertain / reluctant)* agreeing that HIV/AIDS should not contact with people in communities (50.0%) whereas some samples had the *negative attitude* agreeing that AIDS was derived from the behavioral causes (14.5%) (Table 4.5)

Table 4.5: Attitudes about beliefs of HIV/AIDS in Moo 7

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) %	Medium %	Low (negative) %
#1.should not live with their family	32.2	35.7	32.1
#2. should not contact with people in communities	21.4	28.6	50.0
#3.punishment of the gods	3.6	14.3	82.1
#4. behavioral causes (poor behavior that leading HIV/AID)	73.6	11.9	14.5

Note# = number

According to the samples, in terms of the attitudes about living and Sharing with HIV/AIDS, the majority had the *medium level of attitude (uncertain / reluctant),* that is, they talked with HIV/AIDS at their home (50.1%). Some samples had the *negative attitude* that they invited HIV/AIDS for lunch or dinner (34.5%); some samples disagreed that if they know who was infected in the community, they should tell everyone (33.0%) whereas some agreed that they allowed their children to do activities with HIV/AIDS (27.0%) (Table 4.6)

Table 4.6: Attitude about living and sharing with HIV/AIDS in Moo 7

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive)	Medium	Low (negative)
	%	%	%
#6.invite HIV/AIDS for lunch or dinner	34.5	38.1	27.4
#7. talk with HIV/AIDS at your home	50.1	32.1	17.8
#8. allow your children to do activities with HIV/AIDS	27.0	44.1	29.0
#9. if you know who is infected in the community, you have to tell everyone	27.4	39.3	33.3

Note # = number

The majority of samples had the medium level of attitude (uncertain / reluctant) about the support and assistance provided for HIV/ AIDS , that is, they agreed that they should give opportunities to work for healthy HIV/AIDS (69.6%); HIV/AIDS should have a chance to support themselves (66.6%); a support system should be established in the village (64.9%); and the villagers should have activities to support the HIV/AIDS and their families (56.8%) (Table 4.7)

Table 4.7: Attitudes about support systems for HIV/AIDS in Moo 7

Attitudes about HIV/AIDS patients	Level of agreement		
	High (positive) %	Medium %	Low (negative) %
#5.support systems should be established in the village	64.9	22.0	13.1
#10. Give opportunities to work for healthy HIV/AIDS.	69.6	26.2	4.2
#11. HIV/AIDS should have a chance to support themselves	66.6	23.7	9.7
#12.Villagers should have activities to support HIV/AIDS and their families	56.8	29.8	13.4

Note # = number

From the table, the means of attitude about HIV/AIDS about the AIDS belief between Village Number 4 and 7 pre the PRA process were 2.1 and 2.13, respectively implying that the samples had the medium level of attitude (uncertain / reluctant). The T- test was 13.4 showing no statistical significance whereas the P. value =0.89 (Table4.8)

Table 4.8: Comparison of the attitudes about HIV/AIDS between Moo 4 and Moo 7, pre the PRA process

Village	Means of attitude	T-test	P value
Moo4	2.14	0.13	0.89
Moo7	2.13		

P> 0.05

From the table, the means of attitude about living and sharing with HIV / AIDS between Village Number 4 and 7 pre test the PRA process were 2.16 and 2.10, respectively implying that the samples had the medium level of attitude (uncertain / reluctant). The T- test was 0.81 showing no statistical significance whereas the P. value = 0.41 (Table 4.9)

Table 4.9: Comparison of the attitudes about HIV/AIDS and sharing with HIV/AIDS between Moo 4 and Moo 7, pre the PRA process

Village	Means of attitude	T-test	P value
Moo4	2.16	0.81	0.41
Moo7	2.10		

P> 0.05

From the table, the means of attitude about support systems for HIV/AIDS between Village Number 4 and 7 pre the PRA process were 2.64 and 2.53, respectively implying that the samples of two villages had the positive attitude. The T -test was 1.67 showing no statistical significance whereas the P. value = 0.09 (Table 4.10)

Table 4.10: Comparison of the attitudes about support systems for HIV/AIDS between Moo 4 and Moo 7, pre the PRA process

Village	Means of attitude	T-test	P value
Moo4	2.67	1.67	0.09
Moo7	2.53		

P> 0.05

Part 2: Group Discussion of Stakeholders pre-test PRA Process

2.1 Results of group discussion of stakeholders in the community from 2 villages in terms of the attitude about HID/AIDS .

The method used for the qualitative evaluation was the focus group conducted before the PRA process aiming to evaluate the attitude of the stakeholders about HID/AIDS.

The target groups were selected by distributing the questionnaires asked for the selection of the stakeholders from 9 household representatives, that is, 7 men and 2 women consisting of:

Village Headman (male =1)

Community Leader (male =2)

Youth (male =1)

Public Health Volunteer (female =1)

Housewife (female =1)

Local Senior People (male =1)

Family Headman (male =1)

Religious Leader (male =1)

Village Number 4 (Ban Nong Wah), Thung Yoew Sub-district

Results from the group discussions of stakeholders in terms of the attitude about HIV/AIDS were different as follows:

1. Participants opinions were:

According to the group discussions of stakeholders in terms of the attitude about HIV/AIDS, the majority of participants were worried about the infection but they did not disgust HIV/AIDS ; however, they did not know how they could be infected by AIDS. On the other hand, they would disgust HIV/AIDS if the husband / wife had the bad sexual behavior; however, they felt pity to them if the wife or husband was infected by HIV/AIDS without any fault. The minority of participants were not afraid of AIDS because they did not have any contact with HIV/AIDS. Notably, the participants having good knowledge about AIDS would not disgust them as the following sayings:

Man: *"I am afraid that the society does not understand about AIDS, its infection and spread. Actually, I am afraid to be infected."*

Woman: *"Don't worry about the infection; but we should feel pity to them because they have committed wrong things enough."*

According to the observation, the stakeholders still felt worried although they knew that AIDS can be infected by 3 ways. Living with HIV/AIDS, they were sometimes afraid of the infection because of the media saying that all HIV/AIDS had to die as there was no medicine to cure them. In addition, the media usually presented that HIV/AIDS were bad, sexually promiscuous and disgustful. On the other hand, as the Village health volunteers (VHS) had knowledge about AIDS, they did not disgust them. For the focus groups, there were 2 participating in the group discussion consisting of a VHS and a housewife. However, the representative of the youth saw that AIDS was a disgustful infection.

Man: *"I do not want to communicate with AIDS patients because I afraid of in faction; it's socially disgustful."*

In conclusion, as the stakeholders still lacked of knowledge and understanding about HIV/AIDS, they were afraid of AIDS. Additionally, the media also presented AIDS as the horrible disease. Since some infected persons were sexually promiscuous, people disgusted them more agreeing that AIDS was derived from behavioral causes.

2. Opinion of community people

From the group discussions in terms of the attitude of the community, as most villagers were Thai-Muslim, the society did not accept HIV/AIDS and were afraid of the infection as they did not have the correct knowledge of AIDS. The undertakers

(called Suppaburut), who were responsible for cleaning, washing the orifice and wrapping the dead body before the funeral, were worried that they might be infected by AIDS. The media also presented that HIV/AIDS was like a sin; thus people did not want to contact with the relatives of HIV/AIDS. In addition, some HIV/AIDS patients still had the risk behaviors of more infection as appeared in the following sayings:

Woman: *"Can you touch the dead body. Are you infected when you clean or wash the dead body?"*

Man: *"I am afraid of infection derived from cleaning the dead body or the orifice. However, I cannot refuse the task; it's like the socially-disgustful disease but I have to do the task even I am worried."*

Man: *"Nobody would like to contact AIDS patients as they disgust the disease; it's like the socially-disgustful disease."*

Man: *"All societies disgusted AIDS. Even, people died of other diseases, all though that they were dead because of AIDS."*

Man: *"I never see AIDS, so I would like to try it. Suppose that I am infected and dead. My girlfriend moved to the place and my friend likes her; thus the infection is increased."*

Additionally, in terms of traditional merits, the community members disgusted HIV/AIDS and did not want to have any contact with them. For instance, the community members did not want HIV/AIDS or HIV/AIDS to participate in the fests. When the AIDS patients were dead, the villagers did not join the meal at the funeral but they just gave money to the host and left. *(For the funeral tradition, the host would provide the meal to the participants, who gave money for funeral assistance.*

Notably, two persons did not disgust HIIV/AIDS. On the other hand, they suggested the patients to visit a doctor. They would like to give the encouragement to HIV/AIDS because they knew that the society disgusted the patients. They were also worried because there was no support for the patients and their family as the following sayings:

Man: *"If the parents are infected by AIDS, the future of their children was insecure because there is no support for them."*

Woman: *"The infected persons need willpower; the society disgusts them because people do not know about the AIDS infection."*

From the observation, the community still lacked of knowledge and understanding about AIDS although they were acknowledged by a lot of media. They only knew if people were infected by AIDS or not but they did not know about the AIDS factors.

In conclusion, the community, based on the group discussion, still disgusted HIV/AIDS and did not have any knowledge related to the spread and prevention of AIDS.

3. Living and Sharing with HIV/AIDS patients of Family Members

From the focus group discussion, if their relatives were infected by AIDS, the Family members could accept and live together. However, in case of the strangers (villagers in the community, who were not their relatives), not all people could accept them. They could help HIV/AIDS or had some contacts with the patients but they were still reluctant as the following sayings:

Woman: *"If my relative is infected by AIDS, I do not disgust him/her."*

Man: *"I can accept the AIDS patients but not completely; they are not like the normal people." (people who are not infected by AIDS)*

Man: *"I can live with them but I am sometimes uncertain."*

Man: *"I can live with them because the patients have no place to stay."*

Man: *"I do not disgust the patients but I am not confident."*

4. Problems on the Health of HIV/AIDS

According to the group discussion, the patients had some physical problems due to the opportunistic infection prophylaxis such as diarrhea, having no appetite or rash appearing on their body. However, the HIV/AIDS did not visit a doctor to receive a treatment because their relatives were afraid that the community members would know about the infection. In addition, the HIV/AIDS refused that they were not infected by AIDS fearing that the community would disgust them. The care providers did not have any knowledge about the proper practices of HIV/AIDS as the following sayings:

Woman: *"They suffer from diarrhea and cannot take a meal."*

Woman: *"When they are sick, I do not know what to do or if I can touch the patient."*

Man: *"The patient spreads the disease to other persons. In fact, the family cannot accept he/her completely and will help the patient only if necessary."*

5. Economic Problems

The HIV/AIDS were weak and could not work anymore. Moreover, they did not have any willpower and job as they could not work completely. As the community disgusted them, they had problems with their occupations; for instance, if the patients sold food, nobody bought their food. As a result, they did not gain any income and their family was affected financially as the following sayings:

Man: *"AIDS patients suffer from fever or diarrhea; they are weak and cannot do a job."*

Woman: *"They are too weak to cut rubber. Thus, they have neither money nor income."*

Man: *"Nobody bought anything from AIDS persons; their Things are dirty and might make me be infected by AIDS."*

Man: *"HIV/AIDS patients and spreaders will be increased if we do not make a limitation. Thus, the economy of family and nation is affected."*

6. Assistance for HIV/AIDS

6.1 Emotional support

According to the group discussion, the participants felt pity and would like to visit or give things or willpower to the patients as the following sayings:

Woman: *"I would like to take care of the patients, visit them or buy something for them."*

Woman: *"I would like to ask if they have money."*

Woman: *"The patients cannot work; then the community gives them the willpower."*

6.2 Economics support (financial support)

According to the group discussion, there was a fund for HIV/AIDS. In case that the husband was dead, the government occupational fund should give a support as the following sayings:

Woman: *"The OTOP product is derived from the* Sub-district Administrative Organization *SAO / the government unit in our village."*

Man: *"Only a fund will be good."*

6.3 Social support

Social assistance was very important. The community should Not disgust the patients and should solve this problem together. In case that the patients did not dare to reveal themselves, there should be the prevention and control of AIDS including the provision of anti-virus medicine. The community cooperated and tried to solve AIDS problem as the following sayings:

Man: *"The community should take care of HIV/AIDS spreaders. The number of spread should be controlled and improved by the responsible unit."*

Woman: *"The problem is not disappeared; however, there should be the prevention and control of AIDS infection."*

Village Number 7(Ban Khao Lom), Thung Yoew Sub-district

Results from the focus group discussions in terms of the attitudes about HIV / AIDS were different as follows:

1. Participants opinion were:

According to the group discussions in terms of the attitude about patient living with AIDS, the majority of participants were worried that they might be infected by HIV/AIDS but they did not know how they could be infected. However, they did not disgust HIV/AIDS s, especially the housewives, who were infected by HIV/ AIDS without any fault. Notably, most female participants did not disgust HIV/AIDS where the male participants were reluctant and worried about the infection as the following sayings:

Woman: *"I am sorry that my children / relatives are infected by AIDS but I do not dish\gust them."*

Woman: *"I am afraid of opportunistic infection prophylaxis and I " will be careful."*

Man: *"I am afraid to be infected but I did not disgust the patients. However, I would like to know about the infection. If I know that, I would understand it better."*

However, some participants still disgusted the infected persons because they were afraid of the infection agreeing that there should be no meeting or living with HIV/AIDS as the following sayings:

Man: *"I think it's very disgustful. Thus, we should not live together in the same house. However, we can visit the patients but we should not take care of them closely."*

Man: *"I do not disgust them but I will not take a meal together with them."*

In conclusion, the community still lacked of correct knowledge and understanding about the HIV/ AIDS. Although they knew that AIDS can be infected by 3 ways, they did not have the information about the infection.

2. Opinion of Community people

From the group discussions in terms of the attitude of the community, the community was worried about the infection as they did not know about the spread of AIDS in their community. Notably, they were afraid of the infection and the contact with HIV/AIDS. In general, as there were a lot of infected persons, there was the loss of citizen as expressed in the following sayings:

Man: *"If there are a lot of people dying of AIDS, the community will be very worried because all households are infected by AIDS."*

Woman: *"The community knows that the villagers of Ban Khao Lom are infected by AIDS. Although they are alive; the disease cannot be cured completely by taking anti-virus medicine. We all are worried about the loss of villagers. Suppose that there among 10 persons; two of them were infected by AIDS and died; however, we do not know if these people speeded AIDS to whom."*

Man: *"AIDS problem affects the community in many aspects. The community members usually ask me how many villagers in Moo. 7 are infected by AIDS."*

Woman: *"AIDS is one of the social problems, which cannot be solved completely. There is no way to stop the infection in our village. A lot of villagers are infected by AIDS. Maybe Moo 7 and*

Palian will be the deserted village and city. Some said that AIDS is distaste destroy everything."

Notably, the participants disgusting HIV/AIDS patients lacked of knowledge related to the infection. As a result, they were not confident to live with AIDS patients due to the lack of correct understanding about AIDS. In addition, they were acknowledged by the media that persons being infected by AIDS would die as it could not cured by any medicine,

Moreover, the community saw that AIDS was the community's problem, If there were a lot of HIV/AIDS , the image of village would be damaged implying that the community members was worried about their community. Accordingly, the community leaders should be responsible for the community in terms of AIDS problem.

Woman: *"When the community knows that a lot of villagers of Ban Khao Lom are infected by AIDS, they are frightened because these patients must die. So, the community is worried and concerned if their people will be infected by AIDS. Moreover, the community is worried about the loss of people."*

Man: *"AIDS problem affects the community a lot. Most people usually ask why the lot of villagers in Moo 7 is infected by AIDS. Moreover, people are afraid of being infected by AIDS if they visit AIDS patients."*

In conclusion, the community still lacked of knowledge and understanding about AIDS in terms of HIV/AIDS and mutual is living although they were informed by many media.

Notably, as the village health volunteers (VHS) had knowledge about AIDS, they did not disgust them. Thus, there should be the activity held to provide knowledge to the villagers whereas the VHS should be the activity leaders.

3. Living and Sharing with HIV/AIDS of Family Members

From the group discussion, a half of participants though that they could live with HIV/AIDS. In case that the patients had opportunistic infection prophylaxis, they would tell the patients to understand about the separation of utensils as the following sayings:

Woman: *"Sometimes, they are infected by hepatitis. If the patients are infected by the infectious complication such as tuberculosis, we must separate them."*

Man: *"It's not terrible; we can live in the same house."*

However, some participants were afraid of AIDS and they should take care of HIV/AIDS by providing them food separately or did not live together as the following sayings:

Man: *"If there is a patient in house, we have to take care of him/her. We do not live separately but we will provide the patient food separately."*

Woman: *"I'm afraid to be infected by AIDS. We should live separately from the patients and should not contact them."*

In conclusion, the family members still lacked of knowledge and understanding about living with HIV/AIDS. Although they lived with HIV/AIDS, they were worried about the infection. Thus, they were not confident to live with the patients in the family.

4. Problems on the Health of HIV/AIDS

According to the group discussion of stakeholders in terms of the attitudes about AIDS persons, if the patients did not show any symptoms of AIDS, there was no problem. However, some patients had physical problems but they did not visit a doctor to receive a treatment because their relatives were afraid that the community members would know about the infection. In addition, the HIV/AIDS refused that they were not infected by AIDS fearing that the community would disgust them as the following sayings:

Man: *"From the observation of dead AIDS patients, their skin is dry and their body is weak. They also do not want to talk with other people."*

Woman: *"They know that they are infected by AIDS but they do not accept such truth because their relatives could not accept the truth and them."*

Man: *"He / She want to spread the disease to other people."*

In conclusion, the HIV/AIDS did not accept about the infection. On the other hand, they tried to conceal the infection because they were afraid that they community

would disgust them. Some patients did not take care of themselves; thus they were infected by the opportunistic infection prophylaxis.

5. Economic Problems

According to the group discussion of stakeholders, most HIV/AIDS were poor and had to pay a lot of money for their sickness. If the family leaders were infected by AIDS, they could not work due to the weak body. So, the family lacked of income and the relatives had to take care of the patients. Thus, the relatives had to pay a lot of money as well. Notably, being infected by opportunistic infection prophylaxis was the main cause of the loss of income as the following sayings:

Woman: *"I have to pay for the treatment. Although, I can use 30-Baht Health Card but I have to pay for the expenses of travel, labor and care provider. Moreover, I have to stop working, so my income is lost."*

Man: *"The patients cannot work and their family has to take care of them."*

Woman: *"The doctor tells that AIDS persons are usually infected by the complications such as tuberculosis, cancer and brain fungi."*

It could be concluded that the economic problems were derived from the health of HIV/AIDS s. Therefore, they should reveal themselves for the better treatment in order to prevent themselves from the opportunistic infection prophylaxis. Such method could solve problems based on the potential of each family.

6. Assistance for HIV/AIDS

Notably, the stakeholders did not disgust HIV/AIDS and would like to help them in terms of emotional, economic and social aspects.

6.1 Emotional support

According to the group discussion, giving willpower and importance to HIV/AIDS was important such as allowing HID/AIDS to be a lecturer for the working units. The public health unit should visit them 1-2 times per month as the following sayings:

Man: *"We should give them willpower."*

Woman: *"The public health unit should visit them 1-2 times per month or let them do activity with other people."*

6.2 Economics (financial support)

According to the group discussion, HIV/AIDS should receive occupational assistance and support money from both government and private sectors as the following sayings:

Man: *"Situation of organization should donate money for the patients."*

Woman: *"There are some economic assistance from the Ministry of Public Health in terms of income, clothes and food."*

6.3 Social support

According to the group discussion, the HIV/AIDS should receive the opportunity. The lecturer should provide knowledge for them in order to establish the social value as the following sayings:

Woman: *"There should be relaxed activities or visits (once a month) for AIDS persons, so they can see the social importance. They also should be invited to be a researcher or encourage them to raise chicken."*

In conclusion, the stakeholders, as the leaders of the community, should participate in the assistance in terms of emotion, economy and society so that the AIDS patients could live in the society peacefully.

Part 3: Results of PRA Process

3.1 Analytical results of PRA for AIDS realization from 2 villages based on the fundamental Activities in terms of risk places, risk behaviors / risk groups, AIDS situation and the evaluation of the community's problem solution Potential.

Results of PRA process

As mentioned pre test that PRA process was derived from the community participation for problem solution aiming to be established as the further policy of the local administrative organization, the stakeholders should think, analyze, solve problems and encourage for the participation of government sector and community members.

Methods of PRA process

The stakeholders, who were the community representatives, consisting of the religious leader, community leader, scholar, care provider, family headman, housewife,

youth and people affected by AIDS were divided into 2 groups (10 representatives per each village). The representatives would think and analyze the community problems and solution. The process was conducted in 2 villages, that is Village Number 4 (Ban Nong Wah) and 7 (Ban Khao Lom). Each village was then divided into 2 groups (10 persons per a group) and participated in 3 activities based on the guidelines of AIDS Study Program, Chiang Mai University as follows:

1. Risk sources (places) in the community
2. Risk groups and risk behaviors of people in the community
3. The situation analysis about HIV/AIDS and the potential community organization in the community.

Each village conducted the above activities for one day / group for 6 times. The participants in each group consist of:

Village Number 4 (Ban Nong Wah)

Group 1 consisted of:

Village Headman (male = 1)

Community Leader (male=1)

Youth (male=1)

Village Health Volunteer (female=1, femal =1)

Local Senior People (male=1)

Family Headman (male=1)

Religious Leader (male =1)

AIDS patients' (male=1)

Housewife (female =1)

Group 2 consisted of:

Religious Leader (male=2)

Local Senior People (male=1)

Community Leader (male=1)

Family Headman (male=1)

AIDS patients' male= 1)

Religious Leader (male=1)

Housewife (female =1)

Youth (female =1)

Village Health Volunteer (male=1)

Village Number 7 (Ban Khao Lom)

Group 1 consisted of:

Religious Leader (male=2)

Local Senior People (male=1)

Peer of AIDS patient (female=1)

Community Leader (male=1)

Family Headman (male=1)

Village Health Volunteer (female=1)

Youth (male=1)

Housewife (female =1)

Family Headman (male=1)

Group 2 consisted of:

Housewife (female=1)

Peer of AIDS patient (female=1)

Community Leader (male=2)

Village Health Volunteer (female=2)

Family Headman (male=1)

Local Senior People (female=1)

Youth (female=1)

Housewife (female=1)

The activity of PRA in the Village Number 4 (Ban Nong Wah) and 7(Ban Khao Lom) were:

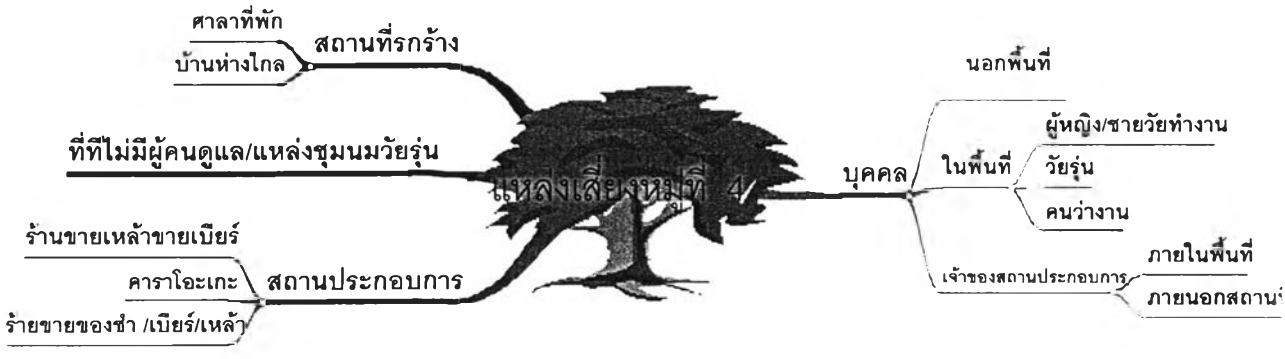
1. Identifying Risk Sources in the Community

The researcher used PRA process for the 2 groups of stakeholder encouraging all participants to participate and express their opinion independently. The results of 2 groups (information was not different for the same village) could be concluded as follows:

Village Number 4 (Ban Nong Wah)

According to the PRA process in terms of the risk sources, most villagers usually went to the *teenager assembly place*, that is, the alcohol shop where they drank alcohol or took a drug. Some of them would go to the city (Thung Yoew Municipality) later because there were entertainment places such as karaoke shop and bungalows leading to the unsafe sexual intercourse. *In addition, (shelter, remote houses) risk sources for strangers* included *teashop/ coffee shop, alcohol/beer-shop and karaoke* which there were waitresses there. The owner of the teashop was the widow (her husband died of AIDS) who was risky for AIDS infection. The local villagers having the information about the infection just went there to drink tea or alcohol. However, the

shop was still the risk source because it was the assembly place for teenagers and adults before they went to the entertainment places in Thung Yoew Municipality. The significant places and risk sources were exhibited in Figure 4.1



(1) = *teenager assembly place*

(2) = alcohol/beer-shop and karaoke

(3) = shelter/remote houses

Figure 4.1: Risk Sources (place) of Village Number 4

Village Number 7(Ban Khao Lom)

According to the PRA process in terms of the risk sources, most villagers usually went to the *grocery, where alcohol and beer was sold,* Favorites Shop (Mia's Shop),after drinking alcohol, some of them would go to the city (Thung Yoew Municipality) later because there were entertainment places such as *karaoke shop* and bungalows leading to the unsafe sexual intercourse. In addition, other risk source included the *teashop* where teenagers or adults would visit before visiting the city like in Village Number 4. The significant places and risk sources were exhibited in Figure4.2.

(1) = Grocery Selling Alcohol / Beer

(2) = Favorites Shop (Mia's Shop)

(3) = teashop/ coffee shop

Figure 4.2: Risk Sources(place) of Village Number 7

2. Risk Behaviors and Risk Groups in the Community

The stakeholders participating in the PRA process analyzed the risk behaviors and risk groups in Village Number 4 (Ban Nong Wah) and 7 (Ban Khao Lom) and set the priority to them from 1 to 10. The participants expressed their opinions independently so that they could find the conclusion. After that the 2 groups helped analyze and set the priority based on the participants' opinions.

Village Number 4 (Ban Nong Wah)

In terms of risk behaviors and risk groups leading to AIDS infection, the indirect behaviors could also lead to the infection. For instance, as people were drunk, went to the karaoke or food shop and had sexual intercourse with someone, they could be also infected by AIDS. According to the analysis, most villagers usually drank alcohol and beer, went to the food shop and tearoom, respectively as the details in Table 4.11

Risk groups of HIV infection consisted of both the actor and the victim such as the housewife infected AIDS from their husband. According to the analysis, *men, teenagers and housewives* were infected by AIDS as the details in Table 4.12

Village Number 7 (Ban Khao Lom)

In terms of risk behaviors and risk groups of the stakeholders leading to AIDS infection, the indirect behaviors could also lead to the infection. For instance, as people were drunk, went to the karaoke or food shop and had sexual intercourse with someone, they could be also infected by AIDS. According to the analysis, most villagers usually went to the food shop, drank alcohol and beer, and went to the tearoom, respectively as the details in Table 4.11. It could be noted that the villagers in the 2 villages did not have the different risk behaviors except the priority of behaviors.

Risk groups of HIV infection consisted of both the actor and the victim such as the housewife infected AIDS from their husband. According to the analysis, *teenagers, men (drinking alcohol / beer) and housewives* were infected by AIDS as the details in Table 4.12

Table 4.11: Risk behaviors of the villagers identified by stakeholders

Risk Behaviors	**Moo4**	**Moo7**
Drinking alcohol	1	2
Go to a restaurant (indirect sex workers)	2	1
Go to Tea/coffee shop (indirect sex workers)	3	3

Table 4.12: High risk groups in Moo 4 and Moo 7 ordered by stakeholders

High Risk Group	Moo4	Moo7
1. men who go to the risk areas	1	2
2. teenagers	2	1
3. housewives	3	3

3. Situational Analysis and Potential Community Organizations for HIV/AIDS Problem Solving in the Community

According to the situational analysis and evaluation of community's problem solution potential of Village Number 4 (Ban Nong Wah), the village consisted of Thai-Muslim persons (80%). Ban Nong Wah had the highest number of AIDS patients compared with other villages in Thung Yoew Sub-district, Palian District. The community participated in the AIDS problem solution incorporated by Sub-district Administrative Organization, Public Health Volunteer and stakeholders in the community. For Village Number 7 (Ban Khao Lom), the village consisted of Thai-Muslim persons (40%). Ban Khao Lom was the second village having the highest number of AIDS patients compared with other villages in Thung Yoew Sub-district, Palian District. At present, the community encountered the problems as the teenagers in the community were involved with AIDS and drugs. However, the community had strong and various leaders so that they could establish the fund.

Two groups of stakeholder from Village Number 4 and 7 helped analyze the situation of AIDS so that they could see the situation and development systematically. The analysis was beneficial for the further realization of the community. Then, the stakeholders analyzed the potential organization, which could solve AIDS problems in

two villages. The stakeholders had been set the priority from 1 to 10 based on the importance in order to select the strong community organization of Group 1 and 2 from Village Number 4 and 7. After that, the participants analyzed the community organizations working for AIDS solution as the following details:

3.1 Results of AIDS Situational Analysis

3.1.1 Village Number 4 (Ban Nong Wah)

The results found that many infected persons were infected by intravenous drug uses and visiting the entertainment places then having sex with waitress/indirect sex workers. Thus, their wives were infected including their babies. Most HIV/AIDS died; some were alive but sick and could not take care of their wife and children. Some HIV/AIDS including their wives did not show any symptoms of AIDS. However, they did not receive any treatment because of the social stigmatization. In the future, as these HIV/AIDS could not conceal their infection, they would receive anti-virus medicines. In addition, the HIV/AIDS showing no symptoms would reveal themselves more due to the access of medicine. There should be fewer HIV/AIDS because they had knowledge and understanding about AIDS from many media. In terms of social aspect, wives lost their husbands and there were a lot of orphans, who were disgusted by their friends at school.

3.1.2 Village Number 7 (Ban Khao Lom)

The results found that many infected persons were infected by men visiting the entertainment place then having sex with waitress/indirect sex workers. Thus, their wives were infected including their babies. Thus, their wives were consequently infected by AIDS. Most AIDS parents died; therefore, there more orphans

left in the community. However, in this village HIV patients received the treatment However, some HIV patients, whose husbands pass, away, were re-married without saying to their new husbands that they were infected by AIDS. Thus, the number of infected person was increased. In the future. AIDS patients showing no symptoms would reveal themselves more due to access of medicine and community acceptance. The PRA participants indicated that teenagers were the risk group for HIV/AIDS as they like to visit the teashop and bar/karaoke in the city.

3.2 Potential Community Organizations for HIV/AIDS Problem Solving in the Community

3.2.1 Potential Community Organizations

For Village Number 4, the Potential Community Organizations consisted of 1) village health volunteers, 2) village headman and 3) spokesman of community broadcast, respectively. For Village Number 7, the Potential Community Organizations consisted of 1) village health volunteers, 2) village headman,3) public health officers and 4)sport president, respectively.

From these 2 villages, the village health volunteer played a significant role for AIDS prevention and solution. It was also the hope of the community, which should participate in the AIDS solution because this organization worked closely with the community, knew problems and had knowledge about AIDS. The public health officers should act as trainers providing knowledge whereas the community leaders should encourage for activities so that the solution could be achieved by the community based on the participation action research. (Table 4.13)

3.2.2 Plans / Activities of the Village

According to the PRA process of stakeholders from two villages, for Village Number 4, the activities the community would like to have were knowledge about AIDS (10 from 13 activities) including sport and condom activity. For Village Number 7, the activities the community would like to have were knowledge about AIDS (4 from 9 activities) including sport and equipments.

Having the plans / projects would lead to establishment of the 3-year and 5-year strategic policy of Sub-district Administrative Organization of Thung Yoew aiming to reduce the rate of infection enhancing the treatment of AIDS persons. (Table 4.14 and Table 4.15)

Table 4.13: Organizations and working groups in HIV/AIDS problem solving in communities

Organizations and working groups	**Moo 4**	**Moo 7**
1. Village Health Volunteer	1	1
2 Health Provider	2	3
3. Village Headman	3	2
4. Spokesman	4	-
5. Rerigious leader	5	5
6. Director of sport center in village	6	4

Tables 4.14: Projects and plans for AIDS policy, Moo 4

Activity (ies)	Subject group(s)	Responsible group(s)
1. Teenage sports	teenagers	Director of sport center in village
2. Folk sports	men (husband groups)	Village leaders
3. Monthly Education program about HIV/AIDS	villagers	Village leaders
4. 4.Education programs about HIV/AIDS in mosques /temples	religious leaders	Imams
5. Educational programs in village	villagers	spokesman
6. Educational programs for religious leaders	Imams	Imams
7. Educational program for an undertaker	villagers	Imams
8. Counseling program about HIV/AIDS	HIV/AIDS patients	HIV/AIDS networks
9. Monthly exhibition about HIV/AIDS	villagers	health volunteers
10. Monthly exhibition about HIV/AIDS in child care centers	Baby sitters / teachers	Village leaders' wives
11. Meeting program with employer	Shop/ companies	Village leaders
12. condom supports in village	Men/teenagers/sex workers	Village Health Volunteers
13. health volunteer networks of HIV/AIDS program	health volunteers/ housewives/ villagers	Village Health Volunteers

Tables 4.15: Projects and plans for AIDS policy, Moo 7

Projects/Activity(ies)	Subject group(s)	Responsible group(s)
1. Educational program about AIDS for hair dressers in barber shops	employers	Imam
2. Prepare the essential material for cleaning dead persons	undertakers	Imam
3. Distribution of condoms for villagers	High risk group	Health center and local government
4. Sports club	Teenagers and young adults	Director of sport center in village
5. Family camping	Teenagers and young adults	Representative from Teenage and young adult
6. Educational program about HIV/AIDS for the leaders of village	Villagers	leaders of village
7. Educational program about HIV/AIDS for Muslim at Mosque	Muslim /villagers	Imam
8. Educational program about HIV/AIDS prevention (using gloves)	Imam	Imam

Comparison of PRA Process between 2 Villages

As two villages were neighboring and the villagers could visit each another conveniently, the PRA process was performed in these two villages. The researcher selected Village Number 4 (Ban Nong Wah) where the stakeholders had the permanent job in the morning and spare time in the afternoon. Village Number 7 was far away from Village Number 4. The villagers there had a job of sticking rubber; thus, they did not have spare time. The PRA process, then, had to be performed in the rainy season. The similarity and difference of these two villages could be concluded as follows:

Risk Sources in Community

The risk sources/places of two villages were tearooms and alcohol shops. However, in Village Number 4, there were two karaoke shops.

Risk Groups and Risk Behaviors

The risk groups of the two villages were not different. Risk Groups were the teenagers and the married men visiting the risk places, housewives might be infected of HIV/AIDS from husbands. In terms of risk behaviors, the villagers like to visit the tearooms in the villages and city, going to food shops or karaoke shops. Thus, the risk behaviors of the two villages were not different. Most teenagers would assemble at the house in Village 4 (Ban Nong Wah) or drank alcohol at the alcohol shop (grocery) in Village Number 7(Ban Khao Lom) before they visited the entertainment places in the city leading to the unsafe sexual intercourse.

AIDS Situation and Community's Potential

In terms of AIDS situation in the past, present and future, the AIDS villagers of two villages were dead and the problems affected the society similarly. However, the addicted teenagers of Village Number 4 were dead whereas the teenagers in Village Number 7 were risky to the drug.

Community's potential: There was a good cooperation between community leaders and members in Village Number 4. There were also monthly meeting regarded as the public relations of the working units in the community. On the other hand, there was the community's fund established in Village Number 7. The community leaders and public health volunteers were creative; however, there were no meetings held in the village.

Plans / Activities in the Village: The stakeholders from two villages (20 representatives per village) consisting of community leaders, religious leaders, Sub-district Administrative Organization, local community senior people , VHS, family headmen, housewives, peer of AIDS patient, youths and HIV/AIDS conducted situation analysis towards HID/AIDS situation in the community in terms of risk sources, risk groups, risk behaviors and AIDS community organizations leading to the establishment of plans / activities in the village. The two villages were similar in terms of sport, knowledge from media, assistance and cooperation.

Part 4: Attitude toward the HIV/AIDS post PRA Process

4.1 General Data of Household Representatives

Demographic data of household representative consisted of age, sex, status, occupation, education and religion (Table4. 16)

Village Number 4, Ban Ning Wah, Thung Yoew Sub-district: 214 samples

Sex: The samples consisted of the male (72.43%) female (25.57%) participants aging 26.45 years old (35.51%) and 20-35 years old (26.17%). The majority of sample (85.05%) were married. They were agriculturist (77.106%) and employee (16.82%), respectively. The samples obtained the primary education (77.57%) and were Islamic (75.23%)

Village Number 7, Ban Khao Lom, Thung Yoew Sub-district: 99 samples

Sex: The samples consisted of the female participants (72.7%) aging 20-35 years old (45.5%) and 36-45 years old (35.4%). The majority of sample (76.8%) was married. They were agriculturist (70.5%) and employee (25.3%), respectively. The samples obtained the primary education (69.7%) and were Buddhist (73.7%)

Table 4.16: Demographics of representatives from households in Moo 4 and Moo 7 (post-PRA process)

Characteristic	Moo 4 (n=214)		Moo 7 (n=99)	
	number	percent	number	Percent
Age (years)				
20-35	56	26.2	45	45.4
36-45	76	35.5	35	35.4
46- 55	41	19.2	16	16.2
56-75	37	17.3	3	3.0
75 +	4	1.9		
Sex				
Male	155	72.4	27	27.3
Female	59	27.6	72	72.7
Marital status				
Single	16	7.5	11	11.1
married	182	85.0	76	763
Widow	16	7.5	8	8.1
divorce	0	0.0	1	1.0
Occupation				
employee	36	16.8	25	25.3
agriculture	165	77.1	70	70.7
student	5	2.3	3	3.0
Other	8	3.7	1	1.0
Education				
Primary school	165	77.6	69	69.7
Secondary school	43	20.1	24	24.3
others	5	2.3	5	5.1
Religion				
Buddhist	51	24.8	74	74.7
Muslim	159	75.2	25	25.3

4.2 Attitude of household representatives toward the HIV/AIDS.

The samples considered each item. In case of the negative questions (Item 1, 2, 3, 4 and 9), if the samples had the positive attitude, they should answer "Slightly Agree." On the other hand, in case of positive questions (Item 5, 6, 7, 8, 10, 11 and 12), they should answer "Strongly Agree" instead.

Village Number 4 (Ban Nong Wah)

According to the samples in terms of the belief about AIDS, the majority had the *positive attitude*, that is, they disagreed that AIDS was the punishment from Gods (95.3%); HIV/AIDS should not live with their family (94.9%); AIDS was derived from the behavioral causes (83.6%); and HIV/ AIDS should not contact people in communities (80.4%). (Table 4.17)

Table 4.17: Percentage of the attitude of representative from household about believed of HIV/AIDS in moo4 (post PRA process)

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) %	**Medium (%)**	**Low(negative) (%)**
#1.should not live with their family	0.9	4.2	94.9
#2. should not contact with people in communities	0.9	18.2	80.4
#3. punishment from the gods	1.4	3.3	95.3
#4. their risks behavioral	10.3	6.1	83.6

Note # = number

According to the samples, in terms of the attitudes about living and sharing with HIV/AIDS, the majority had the *positive attitude,* that is, they disagreed that if they know who was infected in the community, they should tell everyone (67.3%). On the

other hand, some samples had the *medium level of agreement (uncertain / reluctant) to* invite HIV patients for lunch or dinner (78.0%); to allow their children to do activities with children of HIV patients (67.3%); and to talked with HIV patients at their home (54.2%). (Table 4.18)

Table 4.18: Percentage of the attitude of representative from household about living and sharing with HIV/AIDS in moo4 (post PRA process)

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive) (%)	**Medium (%)**	**Low (negative) (%)**
#6. invited the HIV/AIDS for lunch and dinner	16.8	78.0	5.1
#7. talking with HIV/AIDS at your home	39.7	54.2	4.7
#8. allow your children to do activities with HIV /AIDS	27.6	67.3	4.7
#9. if you know who was the infected in the community, you have to tell everyone	8.9	23.2	67.3

Note # = number

The samples had the medium level of attitude (uncertain / reluctant) about the support and assistance provided for AIDS patients, that is, they agreed that HIV/AIDS should have a chance to support themselves (50.5%). The majority had the negative attitude, that is, they should give opportunities to work for healthy HIV/AIDS (48.1%); the villagers should have activities to support the HIV/AIDS and their families (45.3%); and a support system should be established in the village (33.6%) (Table 4.19)

Table 4.19: Percentage of the attitude of representative from household about supporting system for HIV/AIDS in moo4 (post PRA process)

Attitudes about HIV/AIDS patients	Level of agreement		
	High (positive)	Medium	Low (negative)
	%	%	%
#5.supporting system should be established in the village	33.6	65.9	0.5
#10. Give a opportunities to has a work in the healthy HIV/AIDS	48.1	49.1	2.8
#11. HIV/AIDS should have a chance for support themselves	50.5	48.1	1.4
#12.Villagers should have activities to support the HIV/AIDS and their families	45.3	52.8	1.9

Note # = number

Village Number 7 (Ban Khao Lom)

According to the samples in terms of the belief about AIDS, the majority had the *positive attitude*, that is, they disagreed that AIDS was derived from the punishment of Gods (78.8%). Some samples had the *medium level of agreement (uncertain / reluctant)* disagreeing that AIDS patients should not live with their family (40.4%); AIDS patients should not contact with people in communities (35.4%); and AIDS was derived from the behavioral causes (11.1%) (Table 4.20)

Table 4.20: Percentage of the attitude representative from household about believed of HIV/AIDS in moo7 (post PRA process)

Attitudes about HIV/AIDS	**Level of agreement**		
	High (positive)	**Medium**	**Low (negative)**
	%	**%**	**%**
#1. should not live with their family	17.2	42.4	4.4
#2. should not contact with people in communities	12.1	52.5	35.4
#3. design by gods	9.1	12.1	78.8
#4. their risks behavioral	75.8	13.1	11.1

Note # = number

The majority of samples had the positive attitude about the support and assistance provided for AIDS patients, that is, they agreed that HIV/AIDS should have a chance to support themselves (87.9%); they should give opportunities to work for healthy HIV/AIDS (86.9%); a support system should be established in the village (69.7%). However, some samples had the medium level of attitude (uncertain / reluctant), that is, and the villagers should have activities to support the HIV/AIDS and their families (50.14%) (Table 4.21)

Table 4.21: Percentage of the attitude of representative from household about supporting system for HIV/AIDS in moo7 (post PRA process)

Attitudes about HIV/AIDS	Level of agreement		
	High (positive) %	Medium %	Low (negative) %
#5. supporting system should be established in the village	69.7	23.2	7.1
#10. Give a opportunities to has a work in the healthy HIV/AIDS	86.9	9.1	4.0
#11. HIV/AIDS should have a chance for support themselves	87.9	11.1	1.0
#12. Vilaager should have activities to support the HIV/AIDS and their families	50.5	34.3	15.2

Note # = number

From the table, the means of attitude about HIV/AIDS about the AIDS belief between Village Number 4 and 7 post the PRA process were 2.85 and 2.13, respectively implying that the samples of Village Number 4 had the positive attitude whereas the samples in Village Number 7 had the medium level of attitude (uncertain / reluctant). The T - test = 20.13 showing the statistical significant difference whereas the P. value <0.05. (Table 4.22)

Table 4.22: Comparison of the attitude of representative from household believed in HIV/AIDS between Moo4 and moo7 (post PRA process)

Village	Means of attitude	T-test	P value
Moo4	2.85	20.13	0.001*
Moo7	2.13		

* P< 0.05

From the table, the means of attitude about living and sharing with HIV / AIDS between Village Number 4 and 7 post the PRA process were 2.32 and 2.03, respectively. The T- test =5.28 showing the statistical significant difference between two villages whereas the P. value < 0.05 (Table 4.23)

Table 4.23: Comparison of the attitude of representative from household about living and sharing with HIV/AIDS between moo4 and moo7 (post PRA process)

Village	Means of attitude	T-test	P value
Moo4	2.32	5.28	0.001*
Moo7	2.03		

* P< 0.05

From the table, the means of attitude about support systems for HIV/AIDS between Village Number 4 and 7 post the PRA process were 2.43 and 2.67, respectively implying that the samples of two villages had the positive attitude. The T-test = 5.24 showing the statistical significant difference P. value < 0.05 (Table 4.24)

Table 4.24: Comparison of the attitude of representative from household about supporting system for HIV/AIDS between moo4 and moo7 (post PRA process)

Village	Means of attitude	T-test	P value
Moo4	2.43	5.24	0.001*
Moo7	2.67		

* P< 0.05

Part 5: Group Discussion of Stakeholders post P RA Process

5.1 Results of group discussion of stakeholders in the community from 2 villages in terms of the attitude about AIDS.

The method used for the qualitative evaluation was the focus group conducted after the PRA process aiming to evaluate the attitude of the stakeholders (the same stakeholders selected before the PRA process) about HIVAIDS . The samples consisted of 7 household representatives as follows:

Village Headman (male = 1)

Community Leader (male=1)

Youth (male=1)

Village Health Volunteer (female=1)

Local Senior People (male=1)

Family Headman (male=1)

Village Number 4 (Ban Nong Wah), Thung Yoew Sub-district

Results from the focus group discussions of stakeholders in terms of the attitude towards HIV/ AIDS patients were:

1. Participants' opinions:

The findings shown that the majority of participants had the better attitude and they did not disgust the HIV/AIDS anymore. Notably, all stakeholders confirmed that they did not disgust AIDS and would like to make them have a better life as the following sayings:

Woman: "All persons had positive attitude; they don't disgust the patients anymore."

Man: *"It's better. Before, I did not dare to come near him. However, now I dare to touch him when playing football together."*

Woman: *"We participate in this; but the forces from Khun Nian change us."*

From the observation, the stakeholders felt pity to HIV/AIDS , which could be sensed from their eyes and wordings. They did not disgust the HIV/ AIDS anymore and treated to the patients at home quite well.

In conclusion, the attitudes of stakeholders participating in the focus group discussion were more positive as they gained knowledge and understanding about AIDS in terms of infection and living with HIV/ AIDS. Now, the HIV/AIDS revealing themselves to the society were the good examples and could provide feeling and knowledge for other villagers.

2. Opinion of community people

The finding shown that people did not discriminate HIV/AIDS, especially, children with HIV/AIDS. The children with HIV/AIDS could study or have meals with other students in school. The villagers could join the activities with HIV/AIDS without any discrimination. In addition, villagers changed their behaviors; nobody went to the food shops or karaoke shops. Thus, the shops had to be closed as the following sayings:

Woman: *"The attitude of society is more positive. The patients disclosed themselves and visit the health facilities for their treatment."*

Woman: *"The AIDS patients can go to everywhere. They can help themselves and live in the community peacefully."*

Man: *"we can talk to children with HIV/AIDS .nobody discriminate them."*

Man: *"After the doctor (researcher) conducted the meetings (PRA) and Ajarn Nikhom discussed through a community radio broadcast, he (HIV/AIDS t) can join the activities such as playing football."*

Man: *"After the meetings (PRA), nobody goes to the food shops or karaoke shops; they go home directly. Now, the shops are closed."*

Notably, the HIV/AIDS revealing themselves were the alive media, who could express and transfer the feeling of living in the community.

In conclusion, the community did not disgust the HIV/AIDS. They also accepted HIV/AIDS; thus all villagers could live happily in the community. As a result, as HIV/AIDS could take care of their family, they did not cause social and economic problems to the society. Moreover, they could live in the society happily.

3. Living and Sharing with HIV/AIDS patients of Family Members

From the focus group discussion, the family members lived together happily. They had meals together. Moreover, they could give advice about the proper practices to the HIV/AIDS so that the community members did not discriminate them (in fact, people in the community did not discriminate the HIV/AIDS). For instance, when having meals together, they separated water, spoons and dishes because they were afraid that the workers would disgust them. The family members could live together with HIV/AIDS as the following sayings:

Woman: *"I don't dare to have a meal with him; I don't dare to come near him. When having a meal, the grandfathers tell me to protect myself. When going to some places. I bring my own spoon and don't drink water with him to protect myself."*

Woman: *"He looks happy and friendly."*

Woman: *"He's lively, smiling, greeting me and asks me for a drive."*

Man: *"Before the doctor (researcher) came here, we don't know how to deal with the patients. We don't know how to suggest any advice. However, when the doctor came in the vill*age, we have more willpower and dare to go to more places"

It could be noted that all participants agreed that doing the activities together could make the life of the HIV/AIDS better because they were accepted by the family members and could live with other community members. In conclusion, the family members did not disgust the HIV/AIDS and could live together.

4. Problems on the Health of HIV/AIDS patients.

According to the group discussion, the patients were healthy. The HIV/AIDS revealing themselves to the community received the treatment more in order to prevent themselves from the opportunistic infection prophylaxis. Their house was also clean as the following sayings:

Man: *"I have to thank Doctor Nian (researcher) and Tik (VHS) for all suggestions given to the community so that I can give advice to AIDS persons and make them healthier,"*

Woman: *"The doctor told me not to raise a rabbit or a cat, so our house will be clean."*

5. Economic Problems

The HIVAIDS were healthy. They could work and earn money to support their family. In addition, they were not the social burden anymore as the following sayings:

Woman: *"After I reveal them, I visit a doctor more frequently. After taking anti-virus medicines, I gain more weight and can work as usual. My wife and children also work; thus we gain more money."*

According to the observation, the HIV/AIDS did not have economic problems as they were healthy and could work as usual.

In conclusion, the HIV/AIDS did not have any economic problems but they could not work efficiently.

6. Assistance for HIV/AIDS

6.1 Emotional support

According to the group discussion, the participants would like to hold activities and recreation as the following sayings:

Woman: *"We should hold activities or recreation together."*

Man: *"The activity should be held if there is a budget. Then, we should invite the HIV/AIDS to join the activity. We can accept them but not completely."*

6.2 Economics (financial support)

According to the group discussion, there was a fund for HIV/AIDS . The budget was monthly derived from the Sub-district Administrative Organization, Religious Fund and other funds. The old would receive the money monthly. In addition, there should be works provided for the patients as the following sayings:

Woman: *"The working units and organizations should provide financial support. They are not healthy; thus they weak and exhaust. However, they cannot work because they sick."*

Man *"There should be money provided for the patients; like for the old."*

Man: *"The situation analysis of organization should establish the regulations (put in the development plan for HIV/AIDS."*

6.3 Social support

Social assistance was very important. The community should not disgust the patients and should solve this problem together. In addition, there should be meetings held in the community and also the assistance during the recovery as the following sayings:

Woman: *"Nobody discriminate HIV/AIDS. The villagers feel pity to them and can live together with them in the community."*

Man: *"The HIV/AIDS should be helped during the recovery."*

Man: *"I feel pity to them. I help them; the village also."*

Village Number 7(Ban Khao Lom), Thung Yoew Sub-district

Results from the group discussions in terms of the attitudes about AIDS-infected persons / AIDS were different as follows:

1. Participants' Opinions

The findings shown that the majority of participants had the better attitude and they did not disgust the HIV/AIDS anymore. Notably, all stakeholders confirmed that they did not disgust HIV/AIDS and would like to make them have a better life. In addition, they met more HIV/AIDS; thus they could decide which behaviors / actions could lead to HIV/AIDS as the following statements:

Man: *"I don't disgust HIV/AIDS and can communicate with them."*

Man: *"It's ok now. Before, I was afraid of them. Now I don't disgust but feel pity to them. We can live together with them in this village."*

Woman: *"At first, when I start working as a public health volunteer, I was afraid of infection although the doctor provided knowledge about AIDS for me. For example, if a patient used a spoon, I would not use that spoon anymore. Now, I am not afraid of infection. However, I am careful and protect myself such as when the patients are bleeding."*

Man: *"I can do it now after the PRA process."*

However, only a participant was still uncertain and reluctant about the AIDS infection. He did not disgust HIV/AIDS and visited the patients. However, he did not take a meal with the patients because he was afraid of the AIDS infection including other diseases.

Man: *"I go to the funeral and take a meal. However, I don't take a meal in the kitchen of HIV/AIDS."*

Man: *"When the HIV/AIDS have a meal at my home, I will throw away the dishes used. I cannot change such habit."*

Woman (Wife): *"He is very nervous. For example, if a fish is stinking, he will vomit (as he is nervous about everything)."*

It could be concluded that the participants did not disgust HIV/AIDS and communicated with them as usual after the PRA process. In addition, more HIV/AIDS dared to reveal themselves and they could live peacefully. The community accepted them and knew well about HIV/AIDS. However, it was difficult to change their thought completely as they were acknowledged by the media that HIV/AIDS had to be dying because of no medicines. Thus, it would take time to change such attitude.

2. Opinions of Community People

From the group discussions in terms of the attitude of the community, the community did not disgust the HIV/AIDS because they gained the understanding about HIV/AIDS, living and proper practices. As the participants had knowledge about AIDS, they though that AIDS was ordinary because their relatives were infected by AIDS, died and their dead body was taken for bathing (Muslim funeral style). Therefore, the villagers understood more about AIDS disease as expressed in the following statements:

Man: *"The community members don't disgust AIDS persons and they communicate with them as usual."*

Woman: *"It's all right. There is no disgust now."*

Some community members were uncertain but they did not disgust HIV/AIDS patients. However, as they were acknowledged by the media that HIV/AIDS patients had to be dying because of no medicines, they were reluctant. In addition, the media usually presented that HIV/AIDS were sexually promiscuous; thus Thai society could not accept them as expressed by the following sayings:

Man: *"I feel uncertain but I don't disgust them."*

Woman: *"I don't feel unafraid completely; sometimes, I fear."*

In conclusion, the community did not disgust HIV/AIDS. However, the media should erase the existing image of AIDS from the community members' memory. In addition, HIV/AIDS, who revealed themselves could be the good example and could transfer the feeling about living together with HIV/AIDS well.

3. Living and Sharing with HIV/AIDS of Family Members

From the group discussion in PRA process, the participants could live with HIV/AIDS patients though that they could live with HIV/AIDS patients. However, the family members had to take care of HIV/AIDS patients and separate the utensils so that the relatives did not disgust them as the following sayings:

Man: *"I think that the family members don't disgust AIDS patients."*

Man: *"HIV/AIDS can live with us."*

Man: *"I usually visit HIV/AIDS."*

Woman: *"I don't disgust HIV/AIDS because I don't know what to do, if I am infected."*

Man: *"They separate the utensils because they don't want their friends to be infected by AIDS."*

However, some participants were still afraid the HIV/AIDS , one of them has had HIV/AIDS in home.

In conclusion, the family members had less discrimination to HIV/ AIDS when compared with the pre PRA process. It shown that more HIV/AIDS disclosed themselves; the community members could gradually accept them. However, some family members were still have negative attitude HIV/ AIDS due to the media had presented the negative image of AIDS. Therefore, it would take time to adjust the attitude. In addition, knowledge should be continuously provided for families having HIV/ AIDS in the house.

4. Problems on the Health of HIV/AIDS .

According to the group discussion of stakeholders in terms of the attitudes about AIDS persons, the AIDS persons were weak. However, the HIV/AIDS revealing themselves were healthier and could help themselves as the following sayings:

Woman: *"HIV/AIDS, they are weak and easily get infected."*

Man: *"I meet one HIV/AIDS at the mosque."*

It could be concluded that HIV/AIDS revealing themselves were healthier. Thus, they could take care of themselves and could work as usual. In addition, the community accepted them because they were not the burden of family members and society.

5. Economic Problems

According to the group discussion of stakeholders, most HIV/AIDS were poor. If they were not sick, they could help themselves. When the family leaders were dead, the wives could rely on themselves as the following sayings:

Woman: *"The husband is dead; however, his wife having a job to cut rubber in Suan Tor (name of village) could help herself."*

Man: *"The patients cannot work. The relatives and family have to take care of him."*

It could be concluded that the economic problems were derived from the health of HIV/AIDS. If they were still healthy, they could rely on themselves although their family leader was dead. Therefore, HIV/AIDS, who revealed themselves could rely on themselves and could work based on their ability. If the community did not disgust HIV/AIDS, the patients would be taken care in terms of physical, emotional, social and economic aspects. Therefore, HIV/AIDS could have a better life and could live in the society peacefully.

6. Assistance for HIV/AIDS

Notably, the stakeholders did not disgust HIV/AIDS and would like to help them in terms of emotional, economic and social aspects.

6.1 Emotional Support

According to the group discussion, the willpower was the most important thing as as the following sayings:

Man: *"We should give them the willpower."*

Man: *"Just give them the willpower."*

Woman: *"Try to give them the willpower and knowledge."*

6.2 Economy

According to the focus group discussion ,HIV/AIDS should receive occupational assistance and support money from both government sectors such as from Tumbol Council or public health units as the following sayings:

Woman: *"There should be the organization helping AIDS persons, who just have the symptom in terms of exercising; or providing them the medicines and occupation for AIDS persons having the symptoms; and providing them money (salary) for the final-stage HIV/AIDS."*

Man: *"The Tumbol Council (Sub-district Administrative Organization) can do."*

Man: *"The Tumbol Council has established it."*

Man: *"The government should help, that is, to pay Baht 100,000-200,000 per each HIV/AIDS."*

Man: *The community members should establish a fund."*

6.3 Social Support

According to the group discussion, the HIV/AIDS should receive the opportunity. The lecturer should provide knowledge for them in order to establish the social value as the following sayings:

Woman: *"There should be group activities held once a month for the relaxation."*

Man: *"Emotional support should be provided."*

It could be concluded that the stakeholders responsible for AIDS assistance were very important. The physical health should be take care by the public health units whereas the emotional, economic and social support should be performed by the community leaders so that the HIV/AIDS and their family could live in the society peacefully.

Part 6: Comparison of Attitude toward HIV/AIDS pre-post PRA Process

6.1 Attitude of community representatives toward HIV/ AIDS.

The household survey on attitude towards HIV/AIDS was conducted for pre-PRA process (pre –test) aimed to evaluate the attitude of the two villages. Then, the PRA-process was organized in terms of risk sources, risk behaviors, risk groups, AIDS situation and the evaluation of the community's problem solution potential. After three months, the data of attitude about HIV/AIDS were collected once again (post test) in order to compare if their attitude toward HIV/AIDS

Results of Village Number 4 (pre- post PRA)

According to the size of sample, the sample groups were different, that is 140 (Pre- test of PRA) and 214 households (Post- test of PRA). The amount of household survey for Post- test of PRA was increased.

Belief about AIDS

The samples had the disagreeing that AIDS was the punishment from Gods (from 58.6 to 95.3%); HIV/AIDS should not live with their family (from 65 to 94.9%); and AIDS was derived from the behavioral causes (from 8.1 to 83.6%).

Living and Sharing with HIV/AIDS patients

The samples had the *positive attitude* disagreeing that if they know who was infected in the community, they should tell everyone (from 36.4 to 67.3%). The samples agreed that they should invite HIV/AIDS for lunch or dinner (from 25.9 to 78.0%) and allow their children to do activities with children of HIV/AIDS (from 30.7 to 67.3%). and to take with HIV/AIDS at their home (54.2%). Some samples had the negative attitude that they should talk with HIV/AIDS at their home (from 55.3 to 39.7%).

Support and Assistance Provided for HIV/AIDS.

The results indicated that the opinion of the subjects about the Support and Assistance *Provided for AIDS Patient s diseased in all items including* , HIV/AIDS patients should have a chance to support themselves (73.8 to 50.5%); they should give opportunities to work for healthy HIV/AIDS (from 70.0 to 48.1%); the villagers should have activities to support the HIV/AIDS and their families (from 70.0 to 45.3%); and a support system should be established in the village (from 74.3 to 33.6%).

Results of Village Number7 (pre- post PRA)

The size of sample was not different between the pre- and post- PRA process as there were only 15 households added in the process.

Belief about AIDS

The samples disagree that AIDS was the punishment from Gods (from 82.1 to 78.8%). Some samples had the negative attitude that HIV/AIDS should not live with their family (from 32.1 to 40.4%); HIV/AIDS should not contact people in

communities (from 50.0 to 35.4%); and HIV/AIDS was derived from the behavioral causes (from 73.6 to 75.8%). In conclusion, the belief about AIDS disease was increased in the positive way.

Living and Sharing with HIV/AIDS patients

The samples had the negative attitude, which was not different compared between before and after PRA process.

Support and Assistance Provided for HIV/ AIDS

The samples agreed that HIV / AIDS should have a chance to support themselves (from 66.6 to 87.9); they should give opportunities to work for healthy HIV/AIDS patients (from 69.6 to 86.9%); and a support system should be established in the village (from 64.9 to 69.7%). However, some samples had the negative attitude that the villagers should have activities to support the HIV/AIDS and their families (from 56.8 to 50.51%). In conclusion, the samples had positive attitude about Support and Assistance Provided for HIV/AIDS Patients

6.2 Attitude of stakeholders toward HIV/AIDS

The researcher collected data (Focus Group Discussion) to evaluate the attitude of the stakeholders, who were the representatives from Village Number 4 and 7 about HIV/AIDS pre and post the PRA process. At the beginning, there were 9 stakeholders before the process; however, there were only 7 stakeholders left (one stakeholder was dead; one person was busy (Village Number 4) and two persons were busy (Village Number 7). The stakeholders consisted of the village headman, the community leader, the youth, the public health volunteer, the housewife, the scholar and the family

headman. The pre- and post PRA process were separately 3 months performed (August 2004 to November 2004) in order to evaluate the effect of PRA process.

***Results of Village Number4 (pre- post PRA* Process)**

The size of sample group was different between Pre and Post PRA processes, two stakeholders participating in the process were dead and busy. However, the existing stakeholders continued the process for the continuity and proper outcomes. The process was performed for 2.30 hours in Village Number 4, that is, at the Public Health Center of Ban Nong Wah. The guidelines used in the process consisted of understanding and problem solution in terms of six aspects, that is, problem on oneself, community, family members, health of HIV/AIDS patients, economy and emotional, social and economic assistance

1. Participants' Opinion

Pre the PRA process, 90% of sample disgusted the AIDS because they did not have the correct knowledge and understanding about HIVAIDS and post the PRA process, all samples (100%) did not disgust AIDS persons as they gained knowledge and understanding from PRA process including from the activities, media and discussions.

2. Opinions of community people

Pre the PRA process, all samples said that they disgusted HIV/AIDS because the community still lacked of knowledge related to the infection and prevention of AIDS. *Post* the PRA process, all samples (100%) did not disgust HIV/AIDS and could accept HIV/AIDS more as the stakeholders gained knowledge

and understanding from PRA process. In addition, more AIDS dared to reveal themselves as the society accepted them.

3. Living and Sharing with AIDS-infected Persons of Family Members

According to the stakeholders, *pre* the PRA process, they did not disgust HIVAIDS but they were reluctant. Post the PRA process, the stakeholders did not disgust HIV/AIDS and could live with the patients peacefully because they gain the information about AIDS. In addition, more HIV/AIDS dared to reveal themselves and received the treatment so that they were respected as the example of the community.

4. Problems on the Health of HIV/AIDS

According to the samples of stakeholders, *pre* the PRA process, HIV/AIDS were weak and infected by the opportunistic infection prophylaxis. The HIV/AIDS did not dare to reveal themselves because they were afraid that the society would not accept them and disgust them. *Post* the PRA process, the HIV/AIDS were healthier and received more treatment. Thus, as they could work, there was no economic problem and they could consequently live in the society peacefully.

5. Economic Problems

According to the samples of stakeholders, *pre* the PRA process, HIV/AIDS could not gain any income as their body was weak. Their emotion was not good as the community disgusted them. *Post* the PRA process, the HIV/AIDS were healthier but they still could not work completely due to their weak body.

6. Assistance for HIV/AIDS

According to the samples of stakeholders, *pre* and *post* the PRA process, the assistance for HIV/AIDS were not different in terms of support, willpower, recreational meeting, local funds, government funds and village fund.

Results of Village Number 7 (pre- post PRA)

The size of sample group was different as two stakeholders participating in the process were busy. However, the existing stakeholders continued the process for the continuity and proper outcomes. The focus group discussion was held for performed for 2.30 hours at the multi-functional hall in Village Number 7 (Ban Thung Nam Khao). The guidelines used in the process consisted of understanding and problem solution in terms of six aspects, that is, problem on oneself, community, family members, health of HIV/AIDS , economy and emotional, social and economic assistance.\

1. Participants' Opinion

Pre the PRA process, 80% of sample disgusted the HIV/AIDS because they did not have the correct knowledge and understanding about HIV/AIDS . Post the PRA process, all samples (100%) did not disgust HIV/AIDS as they gained knowledge and understanding from PRA process. In addition, HIV/AIDS were accepted in the community and the stakeholders also had a chance to discuss with the patients more frequently.

2. Opinions of Community people

Pre the PRA process, all samples said that the community disgusted HIV/AIDS because the community still lacked of knowledge related to the infection and prevention of AIDS. *Post* the PRA process, most samples did not disgust

HIV/AIDS and could communicate with them as the stakeholders gained knowledge and understanding from PRA process. In addition, more HIV/AIDS dared to reveal themselves as the society accepted them. However, as the stakeholders were acknowledged by the media that all HIV/AIDS had to die because of no medicines, the community was uncertain about the infection.

3. Living and Sharing with HIV/AIDS of Family Members

According to the stakeholders, pre the PRA process, 50% of them did not disgust HIV/AIDS but they were reluctant. Post the PRA process, the stakeholders did not disgust HIV/AIDS and could live with the patients. However, some stakeholders were uncertain about the infection and needed knowledge to erase the horrible image of AIDS.

4. Problems on the Health of HIV/AIDS

According to the samples of stakeholders, pre the PRA process, AIDS persons were weak and infected by the opportunistic infection prophylaxis. The HIV/AIDS did not dare to reveal themselves because they were afraid that the society would not accept them and disgust them. Post the PRA process, the result was similar to Village Number 4, that is, the HIV/AIDS were healthier and received more treatment. Thus, as they could work, there was no economic problem and they could consequently live in the society peacefully.

5. Economic Problems

According to the samples of stakeholders, *pre* the PRA process, HIV/AIDS faced the economic problems due to the poverty. Moreover, they could not gain any income as their body was weak. Post the PRA process, the result was similar to Village

Number 4, that is, the HIV/AIDS did not have any economic problem. In addition, they were healthier and could work as usual.

6. Emotional, Economic, Social Support for HIV/ AIDS

The findings shown that the opinions of stakeholders about the Emotional, *Economic, Social Support for HIV/ AIDS* pre and *post* the PRA process between Village Number 4 (Ban Nong Wah) and Village Number 7 (Ban Khao Lom) was not different in terms of emotional support, participation in self health group, HIV/AIDS, health educator training and financial support (local funds, government funds and village funds).