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**HIV/AIDS EDUCATION
FOR
WORK PLACE AND PERSONAL CHANGE**

by

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**THESIS SUBMITTED IN PARTIAL FULFILMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
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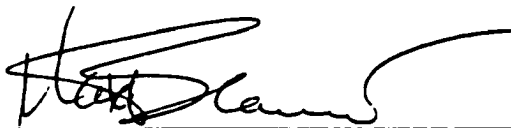
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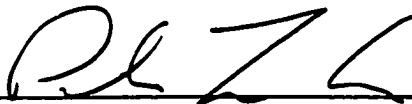
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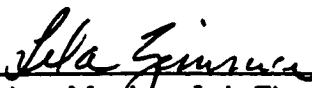
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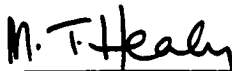
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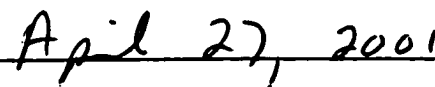


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ABSTRACT

Education for adults, or andragogy, can improve the knowledge and skill base of employees. Adults bring a huge variety in personal backgrounds, family experience, religion, education and expertise to their work place. A disease like HIV/AIDS stigmatizes those it affects, and barriers can arise in health and service delivery consciously or unconsciously. Work place education or "training" can address such issues.

This research investigated the effects of participation in the "Reducing Barriers by Building Partnerships" HIV/AIDS education program through a descriptive, quantitative research process. A survey was distributed through health and social service agencies whose staff or volunteers had taken one to five of the modules during the past five years. The return rate was 45.2% and resulted in feedback from 16.4% of the population of past participants.

The survey respondents were primarily women, ranging in age from 21-61. Most attended voluntarily and most were paid for their attendance time. The highest degree of changes occurred in the area of gain in knowledge. In the attitude and behavior questions, the majority responded that they remained "about the same" and a minority reported positive change. The textual responses indicated that positive change did occur exemplified by "Ran across homophobic people and tried to change their opinions" and "I speak with knowledge and therefore pass on what I learned to stop stigma of stereotyping". Education did result in positive rather than negative transfers in knowledge, attitude and behaviors. The learning environment was strongly praised, indicating an andragogical approach and the successful implementation of a transformative learning experience.

The implications for practice and the recommendations include the necessity of a strong theoretical base in the implementation of adult learning opportunities, the recognition that work place training situations can include transformational learning experiences to not only improve service delivery but to strive for a socially responsible society, the need to encourage attendees of multi-module training to complete their involvement, and the need to disseminate the research information. The "Reducing Barriers by Building Partnerships" HIV/AIDS program exemplified a successful adult training initiative.

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DEDICATION

In an environment of lifelong learning,

and

In the spirit of working towards positive change in our world,

I dedicate this work to my children.

CHAPTER I: INTRODUCTION

Epidemics have far-reaching social consequences. Public knowledge that an invisible microbe is causing illness and death can bring irrational fears and widespread panic... The social sanctions suffered by victims of disease fit well under the broader rubric of social stigmatization... The social construction of HIV/AIDS ... has made it among the most stigmatizing medical conditions in modern history.

(Kalichman, 1995, p.191-192)

The acronyms HIV and AIDS evoke an emotional response. We respond internally to the fear associated with the disease process and with fear in our varied understanding of the transmission process. We respond to the stigma associated with this disease, and we consider the potential sources of infection in each individual. Sometimes we respond externally through our behavior, ranging from changes in our communication style to responses as severe as ridicule, assault and abuse. As a society, we have difficulty in coping with this medical condition.

For an individual with HIV or AIDS, societal response can result in many challenges. Tross and Hirsch's (1985) study (as cited in Kalichman, 1995, p. 111) found that "A positive HIV antibody test result can lead to loss of employment, the threat of eviction, denial of health and life insurance, refusal of professional services, and denial of health and dental care". Although this quote is fifteen years old, these challenges still remain. The challenges exist not only for the individual, but also for his/her family, friends and significant others. Stigma exists, and can have a disturbing and negative impact on many aspects of their lives.

In the central interior region of British Columbia, the number of individuals who have tested positive for the HIV virus continues to grow. As a region, we have a commitment to supporting

individuals in remaining within their community. Individuals with HIV/AIDS need access to a wide variety of services to address the changing aspects of their medical condition. This may involve the services of a number of health and social service agencies, and may involve dealing with many professionals and front-line staff throughout the course of their disease process.

Health and social service agency employees are members of the broader community, and as such they are often a reflection of their community. As adults, they bring to their workplace a great variety in background experiences, education, family upbringing, religious viewpoints, and communication skills. This range results in a broad spectrum of professional behaviors in working with clients who have or are impacted by HIV/AIDS. Positive and unfortunately some negative interactions can occur. These interactions can have an impact on an individual's ability to maintain themselves in our community. The interactions also can impact an individual's ability to live a life of dignity.

In 1993, AIDS Prince George developed a proposal to encourage social change through education. They received funding through the federal AIDS Community Action Program (ACAP) to design, develop, implement and evaluate an educational program designed for employees of health and social service agencies. The program became the fifteen hour, five module series entitled "Reducing Barriers by Building Partnerships". The modules are a) "HIV/AIDS 101", which introduces the disease and its transmission; b) "The impact of HIV/AIDS on those infected and affected", which explores the needs of victims as well as their families and friends in preparing and dealing with the disease and death; c) "Homophobia, heterosexism and HIV/AIDS", which explores the feelings, attitudes and stigmas associated with the gay and lesbian portion of our population; d) "HIV/AIDS and First Nations people", which

provides historical and current information on the rising rates of HIV/AIDS among this population; and e) “HIV/AIDS in a diverse community”, which mentions other populations such as intravenous drug users and encourages us to accept the diversity which exists within our communities. The titles and objectives for each module are listed in Appendix A. The program is unique in a number of ways: it addresses not only the technical or medical aspects of the disease but also the social and emotional impacts, it provides information on marginalized groups in society which have either been associated with HIV/AIDS or are currently at greater risk of transmission of the disease, it encourages participants to examine their attitudes and values towards this disease and towards marginalized groups, and it examines the role that the social determinants of health play in the constellation of factors associated with HIV/AIDS. The program has been offered only within the central interior region of the province of British Columbia and during the last five years. The program has been hosted through health and social service agencies to their staff and volunteers as a work place education initiative.

The education of adults, or andragogy, is an intrinsic component of most work places.

Workshops and inservices assist in not only the ongoing training of adults to achieve the best service possible, but also assist in ensuring that the social climate, philosophy of operation, and policies and procedures are shared by all employees and associated volunteers. Education can also be a process for change. Transformational learning is the process of educating for personal change and for external change in relation to improving the society around us. In this case, the core content of the educational program is HIV/AIDS. However, the program moves far beyond this topic in addressing emotional, social, cultural, and historical factors. This thesis research will examine the impacts of the work place educational program, "Reducing Barriers by Building Partnerships".

CHAPTER II: THE PROBLEM

Statement of the Problem

There are a variety of factors that influence the health of a population. These include income and social status, social support networks, education, employment and working conditions, social environment, physical environment, personal health practices and coping skills, healthy child development, health services, gender and culture. Health should therefore not be viewed exclusively in terms of illness and death but rather as a dynamic state that individuals and communities strive to achieve and maintain. Information on the major social and economic trends and variations in health status and understanding of health issues is important. This information provides a better understanding of health issues so the changing needs of services can be anticipated and new strategies developed to improve health.

(Northern Interior Regional Health Board, 2000, p. 6)

"Information on..... and understanding of health issues is important" (NIRHB, 2000, p. 6). These key words set the stage for this thesis research, "HIV/AIDS Education for Work Place and Personal Change". Service providers need current, applicable, non-judgmental knowledge and understanding of health issues in order to provide the best service possible to their clientele. Individuals with HIV or AIDS, families and friends of individuals with HIV or AIDS, and members of marginalized groups in society deserve the best service possible in order to address their health needs. As mentioned above, the social determinants of health encompass a variety of factors. This section of the thesis will examine a number of the social determinants characteristic of the central area of British Columbia, establish that HIV and AIDS continue to arise, explore the historical process which led to the establishment of the workshop series "Reducing Barriers by Building Partnerships", describe the problem which led to the development of this study, and begin defining the research and its variables.

The Health Services Plan 2000-2003 for the Northern Interior Regional Health Board (NIRHB) identifies this region as accounting for 3% of the province's population (p. 6 - 7). Thirty-one percent of this population is under the age of 19, and 63% falls between the ages of 20 and 64 years. The portion of the elderly of 65+ years (7%) is lower than the provincial average of 13%. In terms of education, the report stated that "In 1996, 4% of the NIHR population had a trade level education, 28% had a non-university level education, and 16% had a university level education" (2000, p. 7). The last statistic for university level education is far less than the provincial average of 25%. The Northern Interior portion of British Columbia is a resource based area, with a population that is traditionally working class. The economy relies heavily on the forestry sector, with mining, manufacturing and tourism being significant employment areas (2000, p. 5). The aboriginal population totals 9% of the regions' population, and "Aboriginal persons have a considerably stronger representation in the Northern Interior Health Region than throughout British Columbia (British Columbia Aboriginal population, 4%)" (NIRHB, 2000, p. 7).

The British Columbia Center for Disease Control publishes statistics on HIV and AIDS. The past participants of the "Reducing Barriers by Building Partnerships" modules have come primarily from the Northern Interior Health Region's communities of Prince George, Vanderhoof and Burn's Lake. The workshop series was also offered once in the Cariboo Health Region's community of Williams Lake and associated rural areas. As well, Prince George is recognized as a regional referral center for health issues for the entire northern portion of the province. Therefore, the tables below contain information from both the Northern Interior and the Cariboo Health Regions plus information from British Columbia as a whole. Table 1 identifies the number of persons who newly tested positive by health region from 1994 to 1999. However the

totals may be misleading. “An HIV positive test report is designated to the appropriate HEALTH REGION according to the location of the physician/clinic site where the person was tested” (MacDougall, Rekart, Knowles, Spencer & Elliot, 1999, p. 37). Therefore, if an individual is concerned about stigma, lack of privacy, lack of services, or any other real or perceived barrier, they may travel to another region of the province to be tested. Their test and their result will then be tallied within the region where the test occurred. Regardless, the following table indicates that positive tests for HIV continue to occur within the two local health regions.

In Table I, the “Rate” rows are the rate per 100,000 population. The “Tests” rows are the number of HIV tests performed at the provincial laboratory including positive and negative results. The Total column is cumulative from 1989 - 1999, although amounts for 1989 - 1993 are not shown.

Table 1

Persons Testing Newly Positive for HIV by Health Region and Year

Health Region	HIV	1994	1995	1996	1997	1998	1999	TOTAL
Northern Interior	persons	8	5	2	4	2	4	52
	rate	6.47	3.95	1.55	3.03	1.50	3.00	
	tests	3426	3989	4034	4099	3981	3700	33,027
Cariboo	persons	2	2	3	2	1		18
	rate	2.90	2.82	4.09	2.64	1.3		
	tests	1,088	1627	1738	1979	1861		12,729
British Columbia	persons	840	690	714	561	482	427	7283
	rate	22.82	18.23	18.39	14.17	12.02	10.55	
	tests	104,118	130,338	138,250	140,278	137,701	135,284	1,085,630

(MacDougall, Rekart, Knowles, Spencer & Elliot, 2000, p. 37)

Table 2 shows the AIDS case reports by year of diagnosis. In this table, the report is “designated to the appropriate HEALTH REGION according to the patient’s place of residence at the time of his/her diagnosis of AIDS (ie. first disease indicative of AIDS)” (MacDougall et al, 2000, p. 11). This information is, then, more specific to the region the individual lives in. However, it does not account for information should an individual chose to move upon diagnosis or at any point in the disease process. Individuals may chose to return to their home community or to a community with strong familial or friendship supports, or move for any other reason. The information below therefore does not provide us with data on the number of individuals with AIDS who are living within a region at any given time. Table 2 is structured in approximately the same format as Table 1, using the terminology of cases instead of persons, and eliminating the tests row.

Table 2

AIDS Case Reports by HEALTH REGION and YEAR OF DIAGNOSIS

Health Region	HIV	1994	1995	1996	1997	1998	1999	TOTAL
Northern Interior	cases		1	2	5	3	2	19
	rate		0.79	1.55	3.78	2.25	1.50	
Cariboo	cases			1			1	7
	rate			1.36			1.31	
British Columbia	cases	292	252	154	138	133	103	2880
	rate	7.93	6.66	3.97	3.49	3.32	2.55	

(MacDougall et al, 2000, p. 11)

AIDS/HIV is a medical condition which carries with it associated stigma unprecedented in this century (Kalichman, 1995, p. 192). For those living with or impacted by HIV/AIDS, this stigma can add challenges to the already existing difficulties in living with the physical disease process.

All of us in society have the right to live and die with dignity. For those with HIV/AIDS, this has not always been easy.

The Prince George AIDS Society embarked on a series of community and consumer consultations in 1993 in order to determine the future direction of the organization, and the service needs of consumers. In 1995, they applied for AIDS Community Action Program (ACAP) federal funding to further assist with the development and evaluation of a project entitled “Reducing Barriers by Building Partnerships”. In their application, they stated that “We have identified the many barriers to service for people living with HIV/AIDS as the need to be addressed at this time” (AIDS PG, 1995, p. 3). This statement was clarified further on page 7, in saying “We will address the barriers to equitable service for people living with HIV/AIDS such as stigma, ignorance and fear by workers in the human services”, and on page 8 with “Local people living with HIV/AIDS (PLWHIV/AIDS) are articulating their desire and need to remain in their home community and to be able to access the support and services they need to ensure a good quality of life”.

The project initially aimed to assist in developing stronger communication channels between service providers, and to strengthen the social community within the service agencies through the education process. The goals were further refined in the statements “to provide knowledge and foster insight in health care and social service agencies in order to ensure sensitive, adequate, accessible service and care for those living with HIV/AIDS in Prince George” (Walmsley & Keith, 1998, p. 4). The second goal was “to strengthen social environments in social and health service agencies for persons living with HIV and AIDS” (Walmsley & Keith, 1998, p. 4). This thesis research investigated the impacts of participation in this educational program, and

explored the participants' perception of personal and work behavior change. Research to investigate the results of an educational intervention helps in understanding the benefits and drawbacks of the educational process.

The "HIV/AIDS Education for Work Place and Personal Change" research investigated the effects of participation by health and social service agency employees in the AIDS Prince George's "Reducing Barriers by Building Partnerships" educational program. As such, I looked for specific information based on specific questions. As this was a descriptive study it sought to answer research questions rather than to test an hypothesis.

This inquiry targeted past participants of the workshop series in the investigation of three research questions, "Has participation in the 'Reducing Barriers by Building Partnerships' program resulted in changes in your knowledge, attitudes, beliefs and/or actions on a personal level and in your workplace?" The second question was "Has your participation resulted in a positive, negative or neutral transfer or change?" This second question will be further clarified in the literature review section of this proposal. The final summarizing question was as follows "What is the overall impact of participation in the 'Reducing Barriers by Building Partnerships' program?"

Significance of the Problem

The "Reducing Barriers by Building Partnerships" educational program series pilot project ran from 1996-1998. The evaluation plan was designed in advance of the implementation of the sessions. AIDS Prince George gathered quantitative data in a pre-test and post-test format as well

as qualitative data to evaluate the program. The pre-test and post-test questions asked participants about changes in knowledge and attitudes regarding the technical content and the population groups discussed in each module. Each module was analyzed statistically using the software program "Statistical Package for the Social Sciences" (SPSS), with Module One information at a nominal level and performing two-way chi-square tests, and Modules Two through Five analyzed using the Mann Whitney U test for ranked or ordinal data for non-paired results (Walmsley & Keith, 1998, p. 13). The qualitative evaluation component included questions such as "The most important thing I learned today was...", "As a result of this workshop I will..." and "What would you change about this module..." (Walmsley & Keith, 1998, p. xvi-xvii). The evaluation was compiled in 1998 and included the summary statements as follows: "It appears that in general, the learning objectives for each module were met. It was evident that the program participants were extremely positive about the modules and there were very few negative or critical comments" (Walmsley & Keith, 1998, p. 5). The report suggested further evaluation of the "Reducing Barriers by Building Partnerships" program using a qualitative research design.

The "HIV/AIDS Education for Work place and Personal Change" thesis research addressed the suggestion for follow-up inquiry into the program. It was determined that a quantitative and descriptive research design would provide further information from a greater number of past participants than a qualitative research design. The initial evaluation had provided surface input on whether the participants enjoyed the program and learned from the program. From this initial information, several areas for further investigation arose. Did the workshop series make a difference in the personal lives and work lives of the program participants in the months and years following the workshops? Did the educational program results in changes in attitudes

and/or changes in behavior? How did this gain in knowledge translate into changes in the work place? What aspects of the learning environment contributed to the participants' enjoyment of the program? Further evaluation and inquiry would provide deeper insight into the effects of this educational program.

Nationally, the AIDS/HIV health community has recognized the need for more evaluation and research in its programs. AIDS Prince George staff members are currently participating in both provincial and national committees to assist in developing frameworks for research and evaluation. This study is timely in that it contributes to the knowledge base at a time when the importance of such inquiry is recognized among the HIV/AIDS health community. The information in this research will be disseminated not only locally but also provincially and nationally through a variety of academic means.

Definition of terms

The "HIV/AIDS Education for Work Place and Personal Change" thesis research involved the use of a survey (see Appendix B) to gather input from past participants of a workshop series. This section will define the basic concepts and terms in relation to the process of the inquiry and the content of the survey instrument.

This inquiry examined the process of change through education. The term education refers to "the act or process of acquiring knowledge" and "the knowledge or training acquired by this process" (Collins, 1995, p. 409). Change is defined as "to make or become different; alter" and

“the act or fact of changing or being changed” (Collins, 1995, p. 221). As the participants of this program were adults, the framework of this educational opportunity falls within the field of adult education, or andragogy.

The goals of the “Reducing Barriers by Building Partnerships” program were to strengthen social environments, and to provide knowledge and foster insight within health and social service agencies. The challenge was to operationalize these goals into identifiable and measurable variables. To do so, this research focused on some work place and personal experiences which respondents could self-measure. The concept of change can be defined as any movement, whether positive or negative, as reported by the programs’ past participants. The survey opened with a section on demographics, in order to gather generic information. The survey’s three central sections consist of sections entitled knowledge, attitudes, and behaviors or actions. Broadly speaking, these are the three variable areas. The dictionary defines knowledge as “the facts or experiences known by a person or a group of people” (Collins, 1995, p. 724). The word attitude is defined as “the way a person views something or tends to behave towards it, often in an evaluative way” (Collins, 1995, p. 78). The term behave is listed as “to act or function in a specified or usual way” (Collins, 1995, p. 114) while behavior is defined in psychological terms as “the response of an organism to a stimulus” (Collins, 1995, p. 114). These variable areas were further considered in terms of knowledge, understanding, confidence level, empathy, discussion of clients and client groups, advocacy, service provision, and work place changes. Additional categories of usefulness, helpfulness, and situational reflection provided data relating to the impact of participation in the workshop series. This study requested that respondents measure their own changes in the above areas, through a process of self-reflection. Respondents were asked to decide themselves what the impact of their own participation was. This research did not

set standards or use external measurement processes. The methodology section will further clarify the research procedures.

Summary

Living with dignity, access to services and the ability to remain in one's own community are issues which face individuals infected with and impacted by HIV/AIDS in the central interior of British Columbia (AIDS PG, 1995, p. 3, 7, 8). The non-profit organization AIDS Prince George developed and implemented an education program directed towards health and social service agency employees and volunteers in order to provide knowledge and foster insight into HIV/AIDS. The program has been in existence for five years. The "HIV/AIDS Education for Work Place and Personal Change" research investigated the impacts of participation in the "Reducing Barriers by Building Partnerships" education program. The research explored the knowledge, attitudinal and behavioral changes in relation to personal and work place change. The inquiry requested information based on the perceptions and self-reflection of the workshop series' past participants. The provision of such education and the implementation of this research are vital components in the process of education for social change

CHAPTER III: LITERATURE REVIEW

The process of personal and professional change through education is the primary concept explored in this thesis. However, the topic area is multi-disciplinary in nature due to a number of factors. The provision of opportunities for learning places the primary focus in andragogy, or adult education. The provision of services to individuals with or associated with HIV/AIDS places the setting in both health care and social services. The examination of stigmas and attitudes or beliefs touches upon sociology, the process of attitudinal and behavioral change falls within psychology, and the implementation of work place training is most often encountered in business literature. In order to examine the basis or need for both the provision of the educational program and for the research itself, this section will first explore education in health care settings, beginning with HIV/AIDS education.

HIV/AIDS education

Professional, non-judgmental and timely service provision will affect not only the client's health and social situation, but will also assist in reducing real or perceived barriers to the access of service. However, service providers are also individual adults with a variety of historical influences including education, religion, family upbringing, culture, and other factors which impact their actions consciously or unconsciously. Staff who work with HIV/AIDS clients and families can themselves have complex emotional reactions.

Nurses, for example, may experience conflicts between their personal mores about sexuality, homosexuality, and drug use, which are based on religious beliefs and upbringing, and their professional responsibilities. Phobias about becoming infected with HIV, combined with fear of death and dying, cause considerable stress on the job, adding a dimension that must be addressed by educators.... An organization focused educational program approach can go beyond changing individual professional attitudes and utilize peer influence to create positive group norms. (Dworkin, 1992, p. 673)

Literature in HIV/AIDS education speaks to the need for the ongoing education of service providers. In AIDS Education for Health Care Professionals in an Organizational or Systems Context, Joan Dworkin (1992) explained that:

...health care for persons with acquired immunodeficiency syndrome (AIDS), and members of their families, mainly is delivered within health and human services organizations..... Addressing organizational, community and health care delivery system issues as part of an education program provides a forum for defining problems and a basis for uniting professionals and developing solutions. (p. 668)

Dworkin points out that administrators and front line staff are actually gatekeepers in terms of service provision, and that one of the goals of education is to “change or improve attitudes and behavior toward affected persons” (Dworkin, 1992, p. 670). There is a need to “prepare health professionals to care for persons affected by HIV” (Dworkin, 1992, p. 670). She also reminds us that HIV/AIDS affects not only the identified patient but also the entire family.

Dworkin further explored this topic in relation to the larger community in which health and social service agency personnel work and live.

Many of the organizations in which they work are microcosms of their communities, reflecting the diversity of attitudes, beliefs, fears, and misinformation found in the general population. Some professionals share the views of their community; others do not and attempt to change those around them; others must work in a hostile environment (p. 674).

Dworkin concluded by encouraging the sharing of knowledge, and the development of a multi-disciplinary approach in the provision of services to individuals infected with and affected by HIV/AIDS. This article was by far the most comprehensive and the most relevant to this research as it speaks to the need for education of health care professionals on preparation for caregiving. As well, the article addresses societal and personal attitudes and emotions as does the “Reducing Barriers by Building Partnerships” program.

The right to refuse to provide services to clients is an issue that one does not expect will arise in health or medical services. However, the nature of HIV/AIDS and its associated stigmas have resulted in documented situations of this attitude and behavior. Randall, Bryce, Bertler, Pope and Lawrenchuk (1993) investigated “knowledge and attitudes related to human immunodeficiency virus (HIV) ... among 807 state and 2797 local public health personnel in Michigan” (p. 127). One of their findings was that “32.4 percent believed that they should have the right to refuse treatment, and 9.4 percent reported that they would not be willing to provide routine public health services to an HIV-infected client”(Randall et al, 1993, p. 127). They concluded that “... public health personnel are in need of HIV education that focuses on... the development of appropriate attitudes toward persons infected with HIV” (Randall et al, 1993, p. 127). The results of this study are quite shocking, and greatly reinforce the need for health and social service personnel oriented education programs such as the “Reducing Barriers by Building Partnerships” program.

The above resource items described HIV/AIDS education directed towards the same target population as this research, which was service providers in health care with the purpose of education for social or work place change. The field of HIV/AIDS education often focuses on the

area of prevention. Education for prevention teaches individuals about the disease itself, the means of transmission, strategies for reducing this transmission and the associated behavior changes which are needed. For this review of the literature, I perused thirteen resource items including journal articles, a conference proceeding, and a 300 entry bibliography. The vast majority of these (twelve out of fourteen resources) explored education for prevention among various members of the public. However, many of the resources addressing education for prevention did discuss attitudinal change, behavioral change and research characteristics that are relevant to this thesis research. The literature overwhelmingly speaks to the positive results of education in affecting knowledge levels about the topic of AIDS/HIV, as shown in Dworkin (1992), Randall et al (1993) and Strauss et al (1992).

Strauss, Corless, Luckey, van der Horst & Dennis, 1992 explored the impacts of education on future community and professional leaders in an HIV/AIDS prevention education program for students at the University of North Carolina. The authors stated "AIDS was dealt with in this course not only as a disease, but also as a case study of how societies deal with contagion, stigma, disability, death, social stratification, and access to scarce resources" (Strauss et al, 1992, p. 569). The research used pre-test and post-test methods to examine attitudinal and cognitive changes over the period of the course. They state "the literature on the impact of AIDS education suggests that knowledge and attitude changes do occur over the course of educational programs" (Strauss et al, 1992, p. 570). Again, the right to refuse to provide care arose.

Attitudes toward the rights of health workers to refuse to care for persons infected with HIV changed over the course period. There was a significant reduction in the percentage of those who indicated that physicians (-13.7%) and nurses (-13.5%) had such a right. Attitude changes were found, demonstrating by the course end increased understanding and tolerance for persons who are HIV positive" (p. 571).

Does the process of education always result in positive changes? One of the literature resources used an electrifying title to draw attention to its content. In AIDS Education may Breed Intolerance Yam (1991) quoted organizational behavior researchers at the Georgia Institute of Technology who state that “a little education may be worse than no education at all” (Yam, 1991, p. 30). The author suggests that programs which are less than 45 minutes in length can result in workers being less tolerant of individuals with or impacted by HIV/AIDS. He goes on to state that “In contrast, longer programs, those lasting more than two hours, improved the attitudes of employees” (Yam, 1991, p. 30). This article did not specify the occupations of the employees, nor the research setting, methodology or reference information. However, this was also a very short article of six paragraphs only. The distinction in the length of presentations needed does provide some positive reinforcement for the “Reducing Barriers by Building Partnerships” program, as it consists of five modules which are each three hours in length.

The next two literature resources focus on education for prevention (Kirby, Short, Collins, Rugg, Kolbe, Howard, Miller, Sonenstein and Zabin, 1994) and (WHO, 1990). These articles refer to changes in various public groups regarding transmission, whereas this research deals with staff members and volunteers who work with individuals infected by or affected by the disease. However, the articles do contain several relevant points. In School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness, authors Kirby, Short, Collins, Rugg, Kolbe, Howard, Miller, Sonenstein and Zabin (1994) reviewed 23 studies of school-based programs in order to investigate the distinguishing characteristics of the programs they deemed effective in reducing sexually risky behavior. The researchers identified six characteristics, the majority of which deal with specifics on sex education which are not applicable here as this research focuses on changes in knowledge, attitudes and behaviors in the work place and in personal life.

However, the second characteristic is relevant, and is as follows: “In general, the effective programs were based upon theoretical approaches that have been demonstrated to be effective in influencing other health-risk behaviors: for example, social cognitive theory, social influence theory, social inoculation theory and cognitive behavioral theory” (Kirby et al, 1994, p. 353).

The marked need for education of health care professionals regarding HIV/AIDS, and the ongoing need for appropriate evaluation of HIV/AIDS programs are the most important issues for this research. The proceedings document from the World Health Organization 1990

Consultation on the Monitoring and Evaluation of AIDS Education/Health Promotion Programs

contains the following item:

Attitudes toward people with AIDS reflect mixed sentiments. While most people have expressed feelings of compassion, many would not work with a person with AIDS. There is some evidence to suggest that accurate knowledge is associated with less stigmatizing attitudes and fewer unnecessary personal anxieties. (p. 5)

This again speaks to the not only the stigmatization that occurs with HIV/AIDS, but also to the outcomes of an educational process in terms of attitudes and emotions. The report encourages

A continued investment in national educational programmes for the general public....in order to maintain high levels of awareness about HIV/AIDS....correct widely prevalent misinformation and myths, and counteract discrimination and stigmatization.... And improve the quality and depth of people's knowledge... (p. 6)

The World Health Organization's 1990 consultation included thirteen representatives from eleven countries, whose purpose was to “examine the practical relationship between monitoring and evaluation studies and decisions concerning the development and implementation of health education and health promotion programs for AIDS prevention” (WHO, 1990, p. 1). The consultation team discussed the conclusions and lessons learned from existing programs, examined and listed the technical challenges inherent in the evaluation and monitoring processes,

considered a number of means of addressing organizational barriers to monitoring and evaluation, and developed 10 recommendations for national and regional WHO programs. The report also stated that:

The evidence of behavioral change in the general population is weak. Educational programmes for the general public can be made more effective if messages and materials are pretested on representative members of the target audience..... and supported by the provision of adequate and accessible services... (p. 5)

This report reinforces the need for research examining the effects of an HIV/AIDS educational program, in order to further develop the knowledge base on attitudinal and behavioral change.

This also speaks to the need for educational opportunities which are well planned and implemented. This inquiry will investigate the learning environment of the "Reducing Barriers by Building Partnerships" workshop series, in order to learn about the successful and the unsuccessful factors in the implementation of the program.

Although this report is speaking to national and regional AIDS/HIV programs, the above quotes again reinforce the goals of our local workshop series by reinforcing the role of education in changing attitudes and in increasing accessibility to services for individuals with and impacted by HIV/AIDS. The report continues in stating that:

Monitoring and evaluation can help those concerned to track progress, assess effectiveness, measure impact, calculate cost efficiency and improve the planning of programmes. They also disseminate information about the experience gained. (p. 6)

The report therefore provides support for the need for research such as this thesis: research that examines the effects of education. The first research question "Has participation in the 'Reducing Barriers by Building Partnerships' program resulted in changes in knowledge, attitudes, behaviors and/or actions on a personal level and in the work place" speaks directly to the

problem areas identified in working with individuals infected or affected by this disease and with associated and other marginalized groups in society.

Adult education and transformational learning.

The field of adult education recognizes that adults are different from children in their learning needs, situations and processes. This section of the thesis will introduce the concept of adult education, define and describe this field of education, introduce the category of transformational learning, and explore several frameworks for positive and productive adult learning environments.

Throughout history, the word education has been viewed more in terms of children than in terms of adults. The theory of education was known as pedagogy. "The label 'andragogy'... is based on the Greek word aner... meaning 'man not boy' or adult (Knowles, 1980, p. 42) was developed in Europe. Researcher Malcolm Knowles first introduced this term into North America in 1968. The comparisons between pedagogy and andragogy are shown in Table 3 on the following page.

Table 3

A Comparison of Assumptions and Designs of Pedagogy and Andragogy

	Pedagogy	Andragogy
ASSUMPTIONS		
Self-concept	Dependency	Increasing self-directedness
Experience	Of little worth	Learners are a rich resource for learning
Readiness	Biological development, social pressure	Developmental tasks of social roles
Time perspective	Postponed application	Immediacy of application
Orientation to learning	Subject-centred	Problem-centred
DESIGN ELEMENT		
Climate	Authority-oriented Formal Competitive	Mutuality Respectful Collaborative Informal
Planning	By teacher	Mechanism for mutual planning
Diagnosis of need	By teacher	Mutual self-diagnosis
Formulation of objectives	By teacher	Mutual self-negotiation
Design	Logic of the subject matter	Sequenced in terms of readiness Problem units
Activities	Transmittal techniques	Experiential techniques (inquiry)
Evaluation	By teacher	Mutual re-diagnosis of needs Mutual measurement of program

(Reprinted with permission from Knowles, M. (1984). The Adult Learner: A Neglected Species (3rd ed.), Houston: Gulf, p. 116, and as cited in Spencer, 1998, p. 17)

The field of adult education itself is still a relatively new and undefined field within education.

In what is considered the starting point of many modern developments in adult education, the 1919 Report to the British Ministry of Reconstruction by its Committee on Adult Education defined adult education as... all the deliberated efforts by which men and women attempt to satisfy their thirst for knowledge, to equip themselves for their responsibilities as citizens and members of society or to find opportunities for self-expression. (Selman & Dampier, 1991, p. 3)

Currently, the definition of adult education most frequently cited is that which was contained in the Recommendations on the Development of Adult Education prepared for UNESCO and approved formally in 1976. Adult education is:

...the entire body of organized educational processes, whatever the content, level or method, whether formal or otherwise, whether they prolong or replace initial education in schools, colleges and universities as well as in apprenticeship, whereby persons regarded as adult by the society to which they belong develop their abilities, enrich their knowledge, improve their technical or professional qualifications or turn them in a new direction and bring about changes in their attitudes or behavior in the twofold perspective of full personal development and participation in balanced and independent social, economic and cultural development....
(cited in Selman & Dampier, 1991, p. 3-4)

The diversity suggested above remains one of the challenges in attaining a clear and concise definition. "The field of adult education and training remains broad, fractured and amorphous, differently understood, labeled and defined in different countries and by different interests" (Tight, 1996, p. 3). The first research question will provide direct and relevant feedback regarding the effectiveness of this adult learning opportunity to the various stakeholders of this process, including the health and social service agencies, the past participants, the host agency AIDS Prince George, and the academic community.

Earlier in this thesis a question was posed: "Does the process of education always result in positive changes?" The reference Developing and Training Human Resources in Organizations by Wexley and Latham (1991) addresses this question. In Chapter Four, the authors discuss the retention and transfer of learning, and provide interesting information applicable to this study.

Transfer refers to the extent to which what was learned during training is used on the job. Three transfer possibilities exist:

Positive transfer: Learning in the training situation results in better performance on the job.

Negative transfer: Learning in the training situation results in poorer performances on the job.

Zero transfer: Learning in the training situation has no effect on job performance. (Wexley & Latham, 1991, p. 96)

This description of possibilities relates to this study's second research question, "Are these changes of a positive, negative or neutral nature?" The "Reducing Barriers by Building

Partnerships” program was designed as a work place training initiative, with an end goal that was to improve environments and access to service for individuals with or impacted by HIV/AIDS. It would be helpful to know if participation in the educational program has resulted in a positive, negative or neutral transfer situation.

The third research question, "What is the overall impact of participation in the 'Reducing Barriers by Building Partnerships' program?" leads to an examination of the learning environment in relation to the goals of this educational program. These goals involve the strengthening of social environments by providing knowledge and fostering insight. The specific educational term for this is transformational learning.

Adult education is primarily interested in people, the changing of people to become better citizens, better workers, better contributors to society.... Education for transformation, however, is intentionally towards a vision of society that is socially responsible, for those work situations that promote humanization and freedom for creativity. (Scott, 1998, p. 186)

Scott (1998) explained that within adult education, there are two primary kinds of transformation, social and personal and a third type known as change in knowledge. Specifically,

The aim of the change is to catalyze a fundamental shift in people's beliefs and values and must include a social vision about the future based on a value system that includes the struggle for freedom, democracy or equity, and authenticity. (Scott, 1998, p. 178)

In order to assess if a change is transformative, Scott provides four criteria:

1. there must be structural change,
2. the aim or intention must be grounded in a future vision that includes freedom, democracy and authenticity,
3. there must be a shift in what counts as knowledge, and
4. the change must be based on conflict theory (Scott, 1998, p. 179)

One of the primary theorists in transformative learning is Mezirow. Cranton (1998) explores Mezirow's ideas in the article Transformative Learning: Individual Growth and Development Through Critical Reflection. Mezirow's theories are summarized as follows:

Transformative learning theory draws on research and ideas from philosophy, psychology, sociology and education.... Meaning schemes are our expectations of what will happen, based on what has happened. Meaning perspectives are the broader views we hold about the world around us. We have meaning schemes and perspectives about knowledge, culture and ourselves, ...Often our perspectives have gone unquestioned. We do not know where they came from and have never examined their validity. When we are led to question our assumptions, critical reflection, the central process in transformative learning takes place. (Cranton, 1998, p. 198)

Transformative learning is a process which encourages social change. Social change has also been suggested in the "Reducing Barriers by Building Partnerships" goals through the process of strengthening the work environment.

Although the field of adult education is fractured and differently understood, there exists a considerable body of research which speaks to positive and productive learning environments for and with adult participants. In Adult education: Helping adults begin the process of learning, Campbell (1999) explores the role of nurses as educators in their work places. She defines adult education as "a cognitive process influenced by a variety of elements such as prior learner knowledge, learner attitudes, and beliefs toward the source, content, topic, and mode of presentation, and state of the learner". Campbell further states "As a noun, learning refers to the phenomenon of internal mental change characterized by a flash of insight or rearrangement of neural paths. It can be seen externally in the form of permanent behavioral change" (p. 31). Campbell translates her theory into twelve instructional methods adapted from Galbraith's (1990) book Adult Learning Methods: A Guide for Effective Instruction. The methods are

learning contracts, lecture, discussion, mentorships, computer assisted, distance learning, case study, demonstration, simulation, forum, panel and symposium.

Galbraith uses the terminology "adult learning transactional process" (1991, p. 1) to describe the learning situations discussed here. He states that the following six principles should be present:

1. An appropriate philosophical orientation must guide the educational encounter.
2. The diversity of adult learners must be recognized and understood.
3. A conducive psychosocial climate for learning must be created.
4. Challenging teaching and learning interactions must occur.
5. Critical reflection and praxis must be fostered.
6. Independence must be encouraged. (Galbraith, 1991, p. 16)

Galbraith further defines the most common elements as being "collaboration, support, respect, freedom, equality, critical reflection, critical analysis, challenge and praxis" (1991, p. 3). He is insightful in recognizing that theory and reality do not always match, in stating that

When the vast array of settings in which adult learning occurs and the reasons for the learning, whether it be for personal, social, professional, recreational, or political, are considered, it is rather naive to think that all elements of the transactional process that will be incorporated. However, it does not eliminate our responsibility in the teaching and learning encounter to put forth the effort. (Galbraith, 1991, p. 3)

Galbraith continues by suggesting "seven adult learning methods that seem most appropriate for the transactional process: discussion, simulation, learning contracts, inquiry teams, case method, critical incident and mentoring" (1991, p. 103). Galbraith's theoretical framework is therefore applied through specific learning method suggestions, which provide a good basis for planners and presenters of adult learning situations.

Work place educational opportunities such as the "Reducing Barriers by Building Partnerships" program can be described as health and social service education or inservicing, according to the

fields of employment of the participants. The program can also be described as training, which is the generic term for employee learning opportunities. Tight (1996) defines training as “preparing someone for performing a task or role, typically, but not necessarily, in a work setting” (p. 18).

As such, literature on training is usually located in the field of business. Such inconsistencies are common within the field of education, and are just one example of not only the complexity of the field but the incongruities within the terminology. Regardless of the positioning of the field, this educational opportunity was designed as a work place education program.

Tight provides an historical framework to the specific field of training and development in the following information:

It is quite common to recognize four waves of change in training and development practice since the Second World War. The first wave focussed on job skills training; the second, from the 1970's onwards, on management and supervisory training; and the third, in the 1980's on organizational development and performance technology. We are now, supposedly, dealing with the fourth wave, the focus of which is on information, knowledge, and wisdom. (1996, p.20)

Training can be further defined as "the systematic acquisition of skills, rules, concepts or attitudes that result in improved performance in the work situation" (Goldstein and Gessner, 1998, p. 43 as cited in Tight, 1996, p. 19). This information is particularly relevant to this research as it mentions concepts, attitudes and performance and mirrors our discussion of knowledge, attitudes and behaviors. Tight provides a further quotation in saying "As a result of training we are able to respond adequately and appropriately to some expected and typical situation" (Deardon, 1984, p. 59 as cited in Tight, 1996, p. 19-20). This reflects the underlying reason for offering educational programs in the work place, the development and reinforcement of the abilities of the employees to deal with the challenging situations arising from HIV/AIDS and in working with the marginalized groups identified in the modules.

In the late 1980's, the concept of the "learning organization" arose as an international concept. "The learning organization concept may provide the catalyst which is needed to push forward, in an holistic way, the many strands, ideas and values with which organizations must now concern themselves" (Jones and Hendry, 1992, pp. 58-59 as cited in Tight, 1996, p. 45). It is interesting that the aspect of ideas and values is mentioned here as a function of an organization. The concept of the learning organization specifies that learning is more than just individual or group learning, but rather that systematic learning is needed as well. This reflects back to Dworkin's suggestions that learning must be addressed at the organizational level. Tight suggests that "it represents an interaction between the organization's component parts, and the outside environment, to the benefit of the organization as a whole" (1996, p. 40).

A learning organization is one that has a climate that accelerates individual and group learning. Learning organizations teach their employees critical thinking process for understanding what it does and why it does it. These individuals help the organization itself learn from mistakes as well as successes. As a result, they recognize changes in their environment and adapt effectively. Learning organizations can be seen as a group of empowered employees who generate new knowledge, products and services; network in an innovative community inside and outside the organization; and work towards a higher purpose of service and enlightenment to the larger world.

(Marquardt and Reynolds, 1994, p. 22 as cited in Tight, 1996, p. 43)

Tight does mention that the concept of a learning organization has been criticized, with suggestions that it may be "diaphanous and unrealizable" (p. 44), there are "substantial variations in practice and experience" (p. 44), and there is a lack of research establishing links between the concept and the success of the organization. However, the concept is now a part of the international community of business and adult education. There are elements of this concept which are laudable, and which can have a positive impact on not only the work place but the provision of services as follows:

Benefits for customers include... making available products and services that meet their evolving requirements....the rate of innovation, not just in products and services, but in process adaptability and responsiveness... Benefits for employees include.... the ability to enhance both internal and external employability.... the opportunity for better job security.... a sense of self-respect...the availability of the right people with the right skills in the right place at the right time.
(Mayo and Lank, 1994, pp. 9-13 as cited in Tight, 1996, p. 44)

The thesis survey provided respondents with an opportunity for input on the organization and presentation of the workshop. The final research question, "What is the impact of participation in the 'Reducing Barriers by Building Partnerships' educational program" will provide insights into both the learning environment and the applicability and usefulness of the content and presentation of this workshop series.

Attitudinal and behavioral change

The concepts of attitudinal and behavioral change are also a key component of this thesis inquiry. This portion of the Literature Review will provide brief information on these extensive and complex fields. The goals of the "Reducing Barriers by Building Partnerships" workshops include the strengthening of social environments within health and social service agencies, and the fostering of knowledge and insight within such agency employees. The ACAP funding application identified the need to address barriers to service such as stigmas and attitudes of health employees. This literature review assists in understanding what attitudes are, how they are formed, how they are interrelated with behavior, and how they are related to adult learning.

Attitude is defined as “an evaluative disposition toward some object... an evaluation of something or someone along a continuum of like - to - dislike or favorable - to - unfavorable.” (Zimbardo & Leippe, 1991, p. 31). The authors point out that attitudes are learned, and are influenced by society and its behaviors and rules. Similarly, “An attitude is a relatively stable opinion containing a cognitive element (your perceptions and beliefs about the topic) and an emotional element (your feelings about a topic, which may range from negative and hostile to positive and loving)” (Wade & Tavis, 1998, p. 667). The basis for attitudes is varied, including “thinking, conformity, habit, rationalization, economic self-interest, and many subtle and environmental influences” (Wade & Tavis, 1998, p. 668).

One of the initial North American researchers in the measurement of attitudes was Thurstone (1928). “His work, based on the methods and theories of the psychophysicists, provided the foundation for the modern techniques of attitude measurement” (Eiser, 1994, p. 3). Eiser (1994) summarizes Thurstone's work as follows:

The principal question which Thurstone himself addressed was that of how favorable or unfavorable an individual or group could be said to be towards a given issue. He was not especially concerned with a person's reason for holding a given position, but simply locating that position on an ‘attitude continuum’ ranging from extreme unfavorability (anti) to extreme favorability (pro). The assumption of continuity here is very important. It leads us to thinking in terms of degrees of favorability rather than looking for dividing points between different ‘sides’.

(Eiser, 1994, p. 4)

Eiser continues by saying “Not all attitude measurement restricts itself to Thurstone's single continuum of opposition/support” (1994, p. 4). However, this research is designed to be descriptive in examining the level of change in variables such as attitude, and will not investigate the reasons for or factors affecting these changes in an individual.

The impact of feelings or the emotional element, as identified in Wade and Tavris above, is a primary factor in learning. The motivational theories of Wlodkowski (1985) in terms of the interaction of learning and feelings are summarized here:

Affect or the emotional feelings, concerns, and passions of the adult are a major motivational factor while learning is taking place. Most psychologists accept the idea that thinking and feeling interact or influence one another as well as to lead to changes in behavior. It is important to note the degree or intensity of feeling may be most influential on immediate behavior. Harmony between thinking and positive feelings sustain motivation, involvement, and interest in the subject.
(Campbell, 1999, p. 34)

Learning is impacted by feelings, feelings are a component of attitude. Attitudes affect behaviors and behaviors affect attitude. The interrelationship of these facets of human beings is extremely complex, and provides insight into the variety and the uniqueness of the adult learning situation.

As human beings, many of our behaviors are not consciously considered acts. We react based on our internal beliefs, attitudes, histories and experiences. As mentioned earlier, the term “behave” is defined as “to act or function in a specified or usual way” (Collins, 1995, p. 114). In terms of stigmatizing situations, we may behave in manners which are not morally appropriate but which are at the same time socially appropriate. The “Reducing Barriers by Building Partnerships” program recognizes that social behavior changes according to society’s mores, and provides a learning experience with the purpose of changing the experiences of individuals with and associated with HIV or AIDS in terms of health and social service agency interactions.

“Ultimately, the goal of an influence agent is to change the target’s behavior” (Zimbardo & Leippe, 1991, p. 30). The workshop series also attempts to sensitize service providers to more morally appropriate behavior. Zimbardo and Leippe provide an interesting distinction through asking “has an influence attempt totally failed if the target’s behavior does not change? Not by a

long shot. The influence effort may have succeeded in changing the target's beliefs or attitudes" (p. 31). The "Reducing Barriers by Building Partnerships" program was designed to educate employees in the hopes that their behaviors and/or their attitudes may be influenced by increased knowledge and understanding of the issues and challenges faced by individuals with and associated with HIV or AIDS.

The relationship between attitudes and behaviors is not always clear cut. Wade and Tavis (1998) point out that

Although it is commonly believed that the way to change behavior is first to change attitudes, it also works the other way around: Changing behavior can lead to a change in attitude because the new behavior alters our knowledge or experience. (p. 668)

This thesis inquiry requested that the workshops' past participants reflect on changes in attitudes and changes in behaviors within separate sections in the survey, inviting both numerical and textual responses. This research does not attempt to impose a direction upon the change, or even necessarily to link the attitudinal and behavioral changes. It is valid to acknowledge that change does occur in both directions. This would especially be applicable in work place settings, as the impacts of an individuals' attitude and/or behavior can be reflected back to that individual based on interactions with clients and co-workers.

Psychologist Albert Bandura has been a primary researcher and developer of Social Learning Theory.

Social Learning Theory stresses the interrelationship between people, their behavior, and their environment in a process called reciprocal determinism. While the environment may determine or cause certain behaviors, a person may act in ways to change the environment. The theory states that behavior depends on a person's self-confidence and outcome expectations. (Campbell, 1999, p. 34)

More specifically, “...This approach focuses on how people learn behavior patterns both from being directly reinforced and from observing the consequences that follow the actions of other people” (Zimbardo & Leippe, 1991, p. 44). In social learning theory, “...the person, the behavior, and the environment all interact to change one another” (Zimbardo & Leippe, 1991, p. 44). The Building Partnerships program hoped that by training a number of individuals from a workplace, changes would occur both initially following the training and on an ongoing basis through personal and workplace readjustments in attitudes and behaviors. This research questioned past participants about changes in self-confidence, which Campbell states is a factor in the potential for change in behavior. This research inquired into the effects of participation on service provision, and asked about changes in the work place due to staff participation in the workshops. As discussed in the AIDS Education portion of this Literature Review, Dworkin (1992) refers to the need to address the organization and organizational issues in the education process. The name of the workshop series itself, “Reducing Barriers by Building Partnerships” reflects this approach, as the name can refer to building and strengthening systems both internally within an organization and externally between organizations.

Contribution of this Research

The literature review, particularly in the area of education for HIV/AIDS, highlighted a number of gaps. These gaps are the lack of research on education for social change rather than education for prevention, the lack of research with Canadian content, the lack of research addressing interdisciplinary populations in health care service providers and the lack of research oriented

towards social service agency staff. This thesis research, “HIV/AIDS Education for Work Place and Personal Change”, will be a start in addressing some of these areas.

Most HIV/AIDS education in the literature is oriented towards prevention of the transmission of the disease. This literature review did discuss two articles that addressed education for change in health and social service staff (Dworkin, 1992) and (Randall et al, 1993), and one which was oriented towards post-secondary students (Strauss et al, 1992). The reference lists in the three resources, as well as the text Understanding AIDS: A Guide for Mental Health Professionals do give further sources on education for work place change. However, most of these research studies were targeted to one field of health care only, for example to nurses or to physicians. This inquiry is the only one involving a multi-disciplinary population, that of staff and volunteers in a number of health and social service agencies in the community.

The literature reviewed also highlighted a lack of reference material with Canadian content. All of the items reviewed here were American. This study adds a Canadian component to the literature, one that is uniquely northern in its perspective, and representing Prince George and several surrounding communities specifically.

This thesis inquiry will contribute to the body of knowledge involved in the fields of adult education, and the associated fields of psychology, sociology, business and health care because it is investigating the relationship between education and attitudinal and behavioral change in the work place and in personal life. The information will provide insight into the effects of an educational process.

Summary

Living with HIV/AIDS requires the accessing of health and social service systems to address physical, financial, social, emotional and other personal needs. The literature indicates that personnel in health and social service agencies are a reflection of their communities. As HIV/AIDS is one of the most stigmatizing disease processes of this century, individuals impacted by this disease will understandably encounter a broad range of attitudes and behaviors within health and social service agency staff.

Research in HIV/AIDS education has primarily focused on education for prevention. A number of sources discuss education for transformative learning, the process of developing a more socially responsible society through individual learning. Changes in attitude and behavior can be a component of this learning process.

This chapter explored the literature in relation to this study's three research questions: the need for HIV/AIDS education for health and social service agency personnel will be addressed in the first question, "Has participation in the 'Reducing Barriers by Building Partnerships' program resulted in changes in knowledge, attitudes and behaviors or actions on a personal level and in the workplace?" The theory of attitudinal and behavioral change also applies to this research question. The field of adult education or andragogy provided information on the educational setting, resulting in the second question "Has participation resulted in positive, negative or neutral transfer or change?". The sub-field of transformative learning, and theory on the learning environment are reflected in the third and summarizing research question, "What is the impact of participation in the 'Reducing Barriers by Building Partnerships' program?"

CHAPTER IV: METHODOLOGY

Methodology

The research project "HIV/AIDS Education for Work Place and Personal Change" explored the effects of participation in an educational program through a quantitative and descriptive research process within a postpositivist framework. Specifically, a quantitative approach is "a research method that emphasizes numerical precision; a detached, aloof stance of the researcher's part; ...and, often, a hypothetico-deductive approach" (Palys, 1997, p. 423). The goal in descriptive research is "to accurately portray the characteristics of a particular individual, situation, group, sample or population" (Palys, 1997, p. 77). A postpositivist framework is:

A theoretical tradition that reflects classic positivism but differs in two ways. First, it is less rigidly realist, acknowledging that we may not be able to know things with certainty; knowledge may end up being probabilistic rather than certain. Second, postpositivists show considerably less hostility toward metaphysical concepts like attitudes and beliefs, and now believe that verbal reports can include valid and reliable data. (Palys, 1997, p. 423)

The decisions made in the planning of this research methodology are reflected in the above definitions. In positioning this research within the postpositivist approach, a balance is maintained between the use of an aloof approach involving a survey and the compilation of numerical information, and the acknowledgement that my interest in this research was stimulated by my own past participation in these modules. However, this participation predates the development of this research project. I am therefore familiar with the module content and presentation style, but chose to use a questionnaire to maintain an appropriate distance from the areas examined, and to gain information from the past participants to research this project.

The survey (Appendix B) and a covering letter (Appendix C) were distributed to past participants of the "Reducing Barriers by Building Partnerships" workshops inviting them to provide scale and textual feedback on the educational program. The survey, therefore, invites respondents to describe their own insights into their own change process rather than observing them through an external, positivist research process. The scale and textual information provide reliable and valid input relating to the three research questions.

Target Population

AIDS Prince George received funding for the project that became the "Reducing Barriers by Building Partnerships" workshop series in 1994. Staff members conducted focus groups, literature reviews and associated research in the process of developing the content for the workshops. AIDS Prince George staff and volunteers began presenting the workshops in 1996 to staff and volunteers of health and social service agencies. By the year 2000, 27 agencies from four communities in the central interior of British Columbia had participated in the workshops. The agencies provide a variety of services including counseling, parenting skills, public health services, transition services, long-term care, acute care, palliative care, living expense funding, home support, addictions services, needle-exchange and many other services. The clients of these agencies represent the full spectrum of the population including babies, children, teenagers, young parents, adults, and seniors. A brief review of that attendance lists indicated approximately 457 different individuals had participated in between one and five of the modules. The gender breakdown of these participants was 368 women (84.5%), 67 men (15.4%) with 25

names being indecipherable or gender unknown. The first few workshops offered did not record participant names, so it was not possible to determine an exact number of individual participants. This did not, however, affect this research as the particular agencies initially involved invited all staff members who participated in a workshop to complete a survey. This research targeted the entire population of past participants of the workshop series with the exception of present and past staff of AIDS Prince George as well as student participants of a local training agency.

Instrumentation

This research was conducted through the use of a quantitative survey (Appendix B). The research proposal and a draft of the survey were reviewed by the Ethics Committee at the University of Northern British Columbia during the summer of 2000. The survey was designed to be completed anonymously and confidentially. Informed consent was implied through the process of including a covering letter, through the anonymity, and through the voluntary nature of the response process. The survey was organized in five sections which were as follows: demographic information, knowledge, attitudes, behaviors and/or actions, and concluding comments. The questions numbered twenty, although many questions had more than one part. The survey resulted in 45 variables and a further 14 opportunities for textual input. Questions included closed questions such as age and gender, tables with Likert type selections, yes/no questions, comments, and open ended questions. The survey was preceded by an attached covering letter which explained not only the background of the research, but gave agency

specific information on due dates and drop off points for the completed questionnaires (see Appendix C).

Pilot Project

The survey was pilot tested in advance of its finalization. A draft of the survey, along with a covering letter, a feedback sheet, and a second copy of the survey was distributed to six past participants of the “Reducing Barriers by Building Partnerships” workshops. All six individuals were from differing agencies, and had participated in a range of module amounts. Some of the individuals had participated recently, others in years past. The pilot project respondents were asked to fill out the survey, to time themselves in doing so, and then to provide input via the feedback sheet as well as to make any suggested changes to wording, content or format on the second copy of the survey.

Four of the six pilot project participants provided feedback. The completion time varied from 10-40 minutes. The respondents felt the wording and the content were fine, but suggested that the length of time since their participation affected their ability to fill out the survey. There were several comments requesting clarification of wording, and questioning potential breaches of confidentiality. Based on their feedback, changes were made to the content of the survey. In a number of the questions which invited comments, a statement was added requesting general information and asking respondents not to include confidential client/staff information. The headings were changed to be more specific in identifying the marginalized groups being

discussed in a module, to ensure individuals commented on their feedback regarding groups in society such as the gay and lesbian population and the First Nations population.

I ran a second pilot project in distributing the revised survey to two individuals. Both felt that the changes enhanced the clarity and reduced the intrusiveness of the survey, and felt this final version would provide the needed input based on the research's purpose.

Distribution

AIDS Prince George provided a list of the 27 participating agencies, their primary contact names where available, addresses and phone numbers. As mentioned previously, one agency was eliminated because its participants had been short term students who would no longer be involved with the agency. I contacted each agency by telephone in advance to ask they distribute the survey to their employees and volunteers who had participated in the education. Ten agencies requested a list of their past participants, and AIDS Prince George faxed these out as requested. Approximately 75% of the agency contacts were very helpful in reviewing the participant lists, in providing me with an estimate of the numbers of surveys to provide to them, and in distributing the surveys to their employees and volunteers. Some of the agency contacts were not reachable despite numerous phone calls. In those situations, we communicated via answering machines. In three cases, communication was via electronic mail. Following these initial contacts, an appropriate amount of surveys were hand delivered to the specific contact person at each organization. I mailed the surveys to the contact person in agencies located in towns other

than Prince George. Most of the agencies then distributed the surveys to the specific individuals on the participant lists. The agency contacts were predominantly female (21 out of 26 or 80.8%).

The “Reducing Barriers by Building Partnerships” workshops have been offered since 1996. In any workplace, there is a change of employees and volunteers over time. All of the workplaces had names, on the lists of participants, of individuals who were no longer working or volunteering with them. This resulted in a reduction in the number of potential respondents. The amount of attrition varied from one hundred per cent in two of the agencies, to only a few of the names in other agencies. In order to address this attrition, the research was publicized in the Northern Interior Regional Health Board’s employee newsletter, in the Prince George Citizen newspaper, in the University of Northern British Columbia’s graduate newsletter, and through Bruce Strachan’s talk show on the Prince George radio station CJCI. Two individuals came forward as a result of this public relations process. Following the collection of the surveys, a thank you card with preliminary information on response rates was sent to all of the participating agency contact persons.

Summary

The “AIDS/HIV Education for Work Place and Personal Change” research investigated the effects of participation in the educational program “Reducing Barriers by Building Partnerships” through a quantitative, descriptive research process within a postpositivist framework. The target population was all of the past participants of this workshop series with the exception of myself,

the students from a local training agency, and present and past staff of AIDS Prince George. The research was approved through the University of Northern British Columbia's Ethics Committee. The study was conducted using a quantitative survey which was initially piloted to six individuals, with four of these providing input. The survey was distributed through 26 agencies whose staff and volunteers had participated in the educational program. The agency contacts were key in the distribution and collection of the surveys.

CHAPTER V: RESULTS

Data collection

The thesis research “HIV/AIDS Education for Work Place and Personal Change” asked respondents to analyze the impact of their own participation in the “Reducing Barriers by Building Partnerships” HIV/AIDS education program. The survey was distributed through 26 health and social service agencies in the central interior of British Columbia. Each agency received surveys with covering letters containing due dates and collection locations specific to their agency. I hand collected the completed surveys as well as the remaining blank copies from each local agency shortly after their due date, and left a note with each requesting the mailing of any further surveys directly to my home. The out of town surveys were mailed directly to my home, and I communicated via telephone or electronic mail with the contact persons. Table 4 (on the next page) provides statistics on the distribution and collection process. Of the 325 surveys initially handed out, 166 surveys were actually distributed to potential respondents. A total of 161 blank surveys were either returned directly to me, destroyed at the agency (destroyed copies are indicated with a D in Table 4) or in the case of agency #9 the fate of the surveys is unknown. A Public Relations campaign through various local media was conducted to reach individuals who may have changed employment or volunteer situations since participating in the workshops. The media campaign resulted in two individuals coming forward, and are shown as line 28 (PR for Public Relations) in Table 4 on the next page.

Table 4

Survey Distribution Statistics

Agency	Participants	Total surveys distributed	Returned undelivered	Net surveys distributed	Surveys turned in/completed
1	14+	15	12	3	2
2	11	9	4	5	4
3	11	10	2	8	2
4 (Elim)*	8	3	(3D)	0	0
5	7	5	0	5	2
6	24	20	16	4	1
7	16	20	13	7	3
8	59	45	5	40	8
9 (Elim)***	28	25	(25?)	?	0
10	22	20	17	3	0
11	20	15	12	3	3
12	14	26	(16D)	10	6
13	20	15	9	6	3
14	8	8	2	6	5
15	72	15	0	15	11
16	20	20	(5D)	15	6
17	4	4	3	1	1
18	6	5	0	5	1
19	3	3	(2D)	1	1
20 (Elim)*	3	3	(3D)	0	0
21 (Elim)**	13	0	0	0	0
22	6	6	(3D)	3	2
23	14	15	6	9	4
24	3	3	0	3	3
25	8	6	1	5	3
26	9	4	0	4	1
27	34	5	(2D)	3	1
28 (PR)	N/A	2	N/A	2	2
Totals	457	327	161	166	75

In calculating distribution and response rates, several agencies were eliminated. Two agencies reported 100% attrition in the staff which had participated in the AIDS Education workshops (see Table 4, agencies numbered 4* and 20*). One agency had been previously eliminated as it was a student training center (Table 4, agency number 21**). I eliminated one further agency, (Table 4, number 9***), as I was not able to determine if their surveys were ever distributed. I did not receive a single completed survey from this agency, and was not able to reach the contact

person despite numerous attempts. With the exception of this one agency, all of the other 25 agencies were helpful in distributing and returning the surveys, or in providing information on non-distributed surveys.

Of the 166 distributed surveys, a total of 75 were completed or partially completed and returned to me. This resulted in a 45.2% return rate (surveys divided by distributed surveys). The amount of surveys in relation to the total population of past participants is 75 out of 457 or 16.4%. The surveys were given a code number as they were turned in, with a separate list recording the code number and the agency from which the completed survey derived.

The returned surveys were screened before data entry. The participants had been asked to fill in the sections of the questions relating only to the modules they had attended. Not all respondents followed these directions, however, the inappropriate data was screened out and not entered in to the software program. Also, not all of the respondents answered all of the questions. Although the survey returns numbered 75, the total for each question may not total 75. Some of the tables indicate the number of missing responses, while others indicate only the data that is relevant to the question. This is especially applicable in the textual responses (Appendices D through Q). The appendices list the total number of responses at the bottom of each list of comments.

The data was entered into the computer using the Excel software program. The textual comments were entered directly into the software Work and as shown on the surveys, including any grammatical or spelling errors but excluding any words or phrases that may have identified a specific work place such as a Health Unit, or a specific learning institution such as the name of a university. Many of these responses are quoted in the Results and Conclusions portions of this

thesis, and all responses are listed in the appropriate appendix. The order of entry of the textual comments was changed in each of these appendices, to ensure that any one individual's responses could not be tracked throughout the appendices. The content of each appendix was categorized and included in tables throughout this chapter. Comments that did not provide meaningful information (for example, "probably" in Appendix F) are not included in the category counts. As the majority of the textual responses were positive in nature, I have included a count of the negative responses within the textual tables mentioned above. The textual response categories are summarized at the end of this chapter.

The Office of Social Research at the University of Northern British Columbia assisted with the entry of the numerical variables. The research assistant analyzed numerical variables using Excel for frequencies and percentages, and developed tables in the Word software program based on my suggestions. The research assistant entered the numerical data on a single-entry basis, and I randomly checked these entries to ensure accuracy.

This chapter presents the results obtained from the 75 completed and partially completed surveys that were returned. The information is organized according to the major sections in the survey: demographics, changes in knowledge, changes in attitude, changes in behavior, and the concluding comments section. The numerical information will be presented in the form of tables and within the text throughout Chapter Five. Appendices D through Q contain the textual comments, and relevant comments and categorical tables are included in this chapter. The results will be summarized briefly.

Demographic Data

The first section of the survey provided information on the modules the respondents attended, their last year of attendance, gender, age, and attendance arrangements. The respondents were health and social service staff and volunteers from 22 agencies (Table 4).

The “Reducing Barriers by Building Partnerships” educational program has five different modules (Appendix A). Question A asked the participants to indicate which modules they attended. The majority of respondents (67 out of 75 or 89.3 %) had attended Module 1: HIV/AIDS 101 (Table 5). Participants were not required to attend the modules in order, however they were encouraged to begin with Module One and progress through to Module Five.

Table 5

Modules Attended

Module Attended	Surveys (N)	Yes
Module 1 (Mod-1) HIV/AIDS 101	75	67 (89.3%)
Module 2 (Mod-2) Impact of HIV/AIDS on Those Infected & Affected	75	56 (74.7%)
Module 3 (Mod-3) Homophobia, Heterosexism, and HIV/AIDS	75	51 (68.0%)
Module 4 (Mod-4) HIV/AIDS & First Nations People	75	50 (66.7%)
Module 5 (Mod-5) HIV/AIDS in a Diverse Community	75	44 (58.7%)

A definite trend is indicated as the attendance decreases throughout the series. The percentages in Table 5 above are calculated as attendees over respondents as all responded to this question.

Question B asked participants to indicate the year they last attended a module. A significant portion (17 out of 75 or 22.7%) could not remember the year that they had last attended. The

remainder of the respondents were spread out over the years 1996-2000, although there were fewer respondents from the early years of 1996 and 1997 (see Table 6).

Table 6

Year Last Attended

Year	Frequency	Percent
1996	1	1.3
1997	11	14.7
1998	18	24.0
1999	15	20.0
2000	13	17.3
dk	17	22.7
Total	75	100.0

Question C asked participants to indicate their gender. Health and social service agencies traditionally are staffed primarily by women. The survey respondents were primarily female (64 out of 74 or 86.5%). Ten of the respondents (or 13.5%) indicated that they were male.

The next question in the demographic data section asked participants to write in their age. In total, 68 of the 75 respondents filled in this question. The ages have been summarized in 5 year categories in Table 7. The mean of the ages was 42.78, the mode of the age ranges was 46-50 with 17 responses. Twenty-seven (39.7%) of the respondents were between 21 and 40, while 41 (60.3%) of the respondents were between 41 and 61 years of age indicating that the distribution of the ages was skewed to the older age range. However, there were respondents across the broad range of 21 to 61 years of age.

Table 7

Age of Survey Respondents

Age	Frequency
21 - 25	5
26 - 30	6
31 - 35	8
36 - 40	8
41 - 45	8
46 - 50	17
51 - 55	9
56 - 60	6
61 - 65	1
Total	68
Missing	7
Mean	42.78

The final question in this section of the survey asked participants about their attendance situation. Almost two-thirds (46 out of 66 or 69.7%) of this question's respondents indicated that their attendance was voluntary with 20 individuals (30.3%) stating that their attendance was mandatory.

The second portion of the question E asked if participants were remunerated, with the options of "paid", "non-paid", or "other with an explanation" requested. Most of the respondents (46 out of 66 or 69.7%) were paid for their attendance time, with 18 individuals (27.3%) indicating that they were not paid for their attendance time. Two individuals chose the "other" category, and provided explanations such as "Hospice training" or "both paid and unpaid" (Appendix D).

To summarize, the demographic information provides us with insight into the respondents. The majority of respondents (89%) attended Module One, with a decreasing amount attending each of the further modules. Some respondents (23%) had difficulty remembering their last year of

attendance. Respondents were primarily female (86.5%), with mean age of 42.78. Most respondents (69.7%) attended the sessions on a voluntary basis, and most were paid for their attendance (69.7%).

Data on Knowledge Change

The next section of the survey asked respondents to explore the amount of learning that occurred by providing a rating of (1) none, (2) very little, (3) little, (4) medium, and (5) lots. Question F asked respondents to rate the amount of knowledge learned in each of the modules they had taken (Table 8). The total number of respondents for each module is listed in the “N” column. Two columns have been combined into the “Med+Lots” column, showing a range between 68% and 81.3% of respondents indicating they had learned either a medium amount or lots during these workshops.

Table 8

Knowledge Learned

Module	None	Very Little	Little	Medium	Lots	(Med+Lots)	N
Mod-1) AIDS/HIV 101	0 (0.0%)	7 (11.3%)	12 (19.4%)	21 (33.9%)	22 (35.5%)	69.40%	62
Mod-2) Impacts of AIDS/HIV	1 (1.9%)	5 (9.3%)	7 (13.0%)	21 (38.9%)	20 (37.0%)	75.90%	54
Mod-3) Homophobia/Heterosex	2 (4.0%)	5 (10.0%)	9 (18.0%)	20 (40.0%)	14 (28.0%)	68.00%	50
Mod-4) First Nations	1 (2.1%)	3 (6.3%)	5 (10.4%)	19 (39.6%)	20 (41.7%)	81.30%	48
Mod-5) Diverse Community	1 (2.4%)	3 (7.3%)	5 (12.2%)	14 (34.1%)	18 (43.9%)	78.00%	41

The second knowledge area question asked respondents to rate the changes in the amount of understanding toward the situation of client groups in the modules. Table 9 indicates that respondents reported changes across the full range of possibilities. The percentage of individuals

reporting “medium” or “lots” of change ranges from a high of 73.8% for Module 5 to a low of 60.8% for Module 3.

Table 9

Change in Understanding of Client Situation

Module	None	Very Little	Little	Medium	Lots	(Med+Lot)	N
Mod-1) Individuals with HIV/AIDS	1 (1.6%)	6 (9.8%)	10 (16.4%)	27 (44.3%)	17 (27.9%)	72.20%	61
Mod-2) Families/friends of	2 (3.7%)	5 (9.3%)	10 (18.5%)	28 (51.9%)	9 (16.7%)	68.80%	54
Mod-3) Gay and lesbian people	3 (5.9%)	4 (7.8%)	14 (25.5%)	19 (37.3%)	12 (23.5%)	60.80%	51
Mod-4) First Nations people	2 (2.1%)	4 (8.2%)	9 (18.4%)	22 (44.9%)	12 (24.5%)	69.40%	49
Mod-5) Other marginalized/diverse people	1 (2.4%)	3 (7.1%)	7 (16.7%)	23 (54.8%)	8 (19.0%)	73.80%	42

Data on Attitudinal Change

The attitudinal change section of the survey asked respondents to report any changes in attitudes or beliefs that may have occurred as a result of their participation in the “Reducing Barriers by Building Partnerships” workshops. This section introduces a new rating scale. The scale relates to the potential for positive, negative or neutral transfer due to an educational experience, as described in the Literature Review. Each of the remaining scale questions is based on a five point system, with the ratings of (1) lots more negative, (2) more negative (3) about the same, (4) more positive and (5) lots more positive. The wording for each of the scales changes according to the question’s content, but the categories remain the same.

The first question in this section asked respondents if there have been changes in their attitudes toward the situation of any of the client groups (Table 10). The majority of respondents in each module reported that their views remained the same (53.2% to 60.5%). However, the totals of the “more positive” and the “lots more positive” columns indicated a range of 34.9% (for Module 5) to 45.1% (for Module 1) did indicate positive changes in their attitudes towards the situation of client groups. The largest change was found for “individuals with HIV/AIDS”, while the smallest change was for the “other marginalized/diverse people” category.

Table 10

Changes in Attitude Regarding Situation of (Client) Groups

Module	Lots more negative	More negative	About the same	More positive	Lots more positive	(More + lots more)	N
Mod-1) Individuals with HIV/AIDS	0 (0.0%)	1 (1.6%)	33 (53.2%)	18 (29.0%)	10 (16.1%)	45.10%	62
Mod-2) Families/friends of.....	1 (1.8%)	1 (1.8%)	32 (57.1%)	14 (25.0%)	8 (14.3%)	39.30%	56
Mod-3) Gay and lesbian people	1 (1.9%)	1 (1.9%)	30 (56.6%)	13 (24.5%)	8 (15.1%)	39.60%	53
Mod-4) First Nations people	1 (1.9%)	1 (1.9%)	29 (55.8%)	13 (25.5%)	8 (15.4%)	40.90%	52
Mod-5) Other marginalized/diverse people	1 (2.3%)	1 (2.3%)	26 (60.5%)	8 (18.6%)	7 (16.3%)	34.90%	43

The following questions I and J asked for a “yes or no” response, followed by a request for textual input if the initial response had been “yes”. The first question was “Have there been times at work when something has happened which made you think about what you learned or talked about during the Building Partnerships workshops?” The responses were fairly evenly split, with 34 (50.7%) indicating “yes” and 33 (49.3%) reporting “no”.

The respondents provided written examples of situations at work in which they had thought of the workshop information (Appendix E). The textual responses to this question are categorized in Table 11 below, with the first column indicating the frequency of each category's response and the second column indicating the nominal ordering of the response category. The comments included 17 responses on knowledge learned such as "wearing gloves all the time", "requests for finances not previously understood", "switching from mugs to disposable cups to cut back on colds and flu germs", as well as 7 comments on attitudes of self and other staff such as "Not specific story but it makes me stop and think about my values so I can provide a more non-judgmental service". Respondents also provided 6 comments on impacts on their organization such as "we need more workshops and education", and "being able to pass on the knowledge gained ... to staff if questions arise".

Table 11

Thoughts at Work: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	17	1
Attitudes (including changes)	7	2
Behaviors (including changes)	0	
Knowledge learned & passed on	1	4
Organizational impacts	6	3
Resources (including networking)	1	4
Time since participation	1	4
Advocacy	1	4
Negative comments (Miscellaneous)	1	4
No changes (Prior knowledge etc)	0	

The next question asked the same content but in the context of situations outside the work place. 33 (or 50.8%) indicated "yes" and 32 (or 49.2%) indicated "no" to this question.

A total of 31 respondents provided textual information (Appendix F). The written comments again included a high number of examples of information learned (11 responses), such as "...ink

bottles used in tattoos should be changed between clients, needle change is not enough”, and “a general discussion about contraceptives with friends” (Table 12). Attitudinal change responses numbered 7, and included comments such as “Generally, I have become a more inclusive/open-minded individual”. This time the responses included advocacy (7), with examples of the ways in which survey participants had responded to issues of racism or discrimination. These are exemplified in the comment “uniformed or rude comments, racial, sexist jokes etc – I leave or speak up stating I don’t agree or appreciate or want to hear that”. These comments also address one of the original goals of this educational program, that of social change through education.

Table 12

Thoughts Outside of Work: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	11	1
Attitudes (including changes)	7	2
Behaviors (including changes)	0	
Knowledge learned & passed on	0	
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	1	3
Advocacy	7	2
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	1	3

The final question in the section on attitudinal change asks respondents if there have been changes in their confidence levels in working with individuals in the client groups (Table 13).

The majority indicated their confidence levels remained the same, as the results range from 53.5% to 61.4%. However, the totals of the “more confidence” plus the “lots more confidence” columns range from 36.9% to 45.9% with the highest change for the “individuals with HIV/AIDS” and the lowest change for “families and friends of HIV/AIDS”.

Table 13

Changes in Confidence Level

Module	Lots less confidence	Less confidence	About the same	More confidence	Lots more confidence	(More + lots more)	N
Mod-1) Individuals with HIV/AIDS	0 (0.0%)	0 (0.0%)	33 (54.1%)	22 (36.1%)	6 (9.8%)	45.90%	61
Mod-2) Families/friends of.....	1 (1.8%)	0 (0.0%)	35 (61.4%)	16 (28.1%)	5 (8.8%)	36.90%	57
Mod-3) Gay and lesbian people	1 (1.9%)	0 (0.0%)	28 (53.8%)	17 (32.7%)	6 (11.5%)	44.20%	52
Mod-4) First Nations people	1 (1.9%)	0 (0.0%)	28 (53.8%)	17 (32.7%)	6 (11.5%)	44.20%	52
Mod-5) Other marginalized/diverse people	1 (2.3%)	0 (0.0%)	23 (53.5%)	14 (32.6%)	5 (11.6%)	44.20%	43

Data on Behavioral Change

The behavioral change section of the survey asks participants about any possible changes in their behavior or actions both inside and outside of their work place. This section contained one scale question, and six “yes or no” questions all of which invited further textual comments.

Question L asked respondents to rate the amount of change in the empathy they demonstrate when working with any of the client groups. Table 14 summarizes the responses according to the modules. Once again, the majority of the respondents (between 53.8% and 60.4%) responded that their level of empathy demonstrated at work has remained the same following participation in the modules. However, the combination of the “more” and the “lots more” columns reported a range of 35.8% to 44.1% indicating a positive change in the levels of empathy they demonstrate in the work place.

Table 14

Changes in Empathy Demonstrated at Work

Module	Lots less empathy	Less empathy	About the same	More empathy	Lots more empathy	(More + lots more)	N
Mod-1) Individuals with HIV/AIDS	1 (1.7%)	0 (0.0%)	32 (54.2%)	21 (35.6%)	5 (8.5%)	44.10%	59
Mod-2) Families/friends of.....	2 (3.5%)	0 (0.0%)	33 (57.9%)	16 (28.1%)	6 (10.5%)	38.60%	57
Mod-3) Gay and lesbian people	2 (3.8%)	0 (0.0%)	32 (60.4%)	13 (24.5%)	6 (11.3%)	35.80%	53
Mod-4) First Nations people	2 (3.8%)	0 (0.0%)	28 (53.8%)	17 (32.7%)	5 (9.6%)	42.30%	52
Mod-5) Other marginalized/diverse people	2 (4.9%)	0 (0.0%)	23 (56.1%)	11 (26.8%)	5 (12.2%)	39.00%	41

Questions M, N and O contained three options for answering: yes, no, and not applicable. These questions asked if respondents had noticed changes in the way they carried out their work. The purpose of the “not applicable” answer was to screen out individuals who may not have been in a position to appropriately answer a question. For example, participants may not be dealing with any of the client groups in their work places or they may no longer be working or volunteering in a health or social service agency. The calculations for the percentages for these questions screen out the not applicable answers.

The question “Have you noticed any changes in the way you discuss any of the (client) groups with co-workers” resulted in a total of 15 out of 41 respondents (29.4%) indicating they had changed the way they discussed any of the client groups with co-workers, and 16 “not applicable” responses. The majority (70.6%) reported that “no” change had occurred.

The 17 textual responses to this question are in Appendix G. Respondents commented on knowledge learned (4 responses), attitudes (2 responses) and advocacy (3 responses) (Table 15).

This question resulted in the first responses in the area of “knowledge learned and passed on”, exemplified in “By being better informed I am able to discuss the situation and ask more informative questions”, and “I think we all have a better understanding and therefore can now speak with knowledge and not from assumptions”. However, most of the comments (6 of 17) clarified their existing and previous frameworks, in “have always supported clients regardless of health issues”, and “I have always been careful about confidentiality and shared information”

Table 15

Changes at Work Regarding Discussion of (Client) Groups: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	4	2
Attitudes (including changes)	2	4
Behaviors (including changes)	0	
Knowledge learned & passed on	3	3
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	0	
Advocacy	3	3
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	6	1

When asked if they have changed the way in which they provide services to the client groups, 19 out of 51 individuals (37.3%) indicated that they had changed, with a further 16 indicating that this question was not applicable to them. However, 32 (62.7%) indicated that they had not changed. In reflecting upon changes at work regarding the provision of service, 6 individuals gave specific examples of behaviors or actions including “I am more aware of my body language – how I ask questions etc – more sensitive to their experiences”. Of the six responses, four individuals used the terminology “more empathetic” to describe their behaviors. Again, individuals made comments (2) reflecting their past and present philosophy, such as “I consider myself to be empathetic and work diligently in my care delivery”. This question engendered the

new response category of “Resources – including networking” which speaks to the increased knowledge regarding resources in the community and includes networking. Three individuals commented on this, including one who addressed accessibility in the comment “More aware of making services more accessible”. Eighteen individuals provided textual responses to this question (Appendix H and Table 16).

Table 16

Changes in Service Provision at Work: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	4	2
Attitudes (including changes)	4	2
Behaviors (including changes)	6	1
Knowledge learned & passed on	3	3
Organizational impacts	0	
Resources (including networking)	3	3
Time since participation	0	
Advocacy	0	
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	2	4

Respondents were asked if they had noticed any changes in the amount of advocacy they do for and with a client or group. Seventeen out of 47 (36.2%) indicated that they had noticed changes, 18 indicated "not applicable, and 30 (63.8%) stated that they had not noticed changes. Seven individuals again commented that advocacy had always been an important facet of their jobs. The remainder of the respondents clarified their experiences increasing usage of resources (2) such as “more calls to community agencies”, “connecting people to other support systems”, and changes in behaviors (2) such as “able to explain need better and necessity of item required” (Appendix I and Table 17).

Table 17

Changes in Advocacy at Work: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	0	
Attitudes (including changes)	1	3
Behaviors (including changes)	2	2
Knowledge learned & passed on	1	3
Organizational impacts	0	
Resources (including networking)	2	2
Time since participation	0	
Advocacy	0	
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	7	1

Question N asked if participants had noticed any changes in their work place as a result of staff member participation in the workshops. The number of “yes” responses remained about the same as the above questions, as 24 out of 62 individuals or 38.7% indicated that they had noticed changes. Thirty-eight of the respondents (71.3%) indicated that they had not notices any changes in their work place. Appendix J lists the comments from the 28 textual responses to this question. The greatest number of responses fell in the category of “Knowledge learned”, with 12 responses including “using universal precautions”, and “A better more accurate knowledge base”. Attitudes were identified by 7 respondents with statements such as “Everyone seems more open minded”, and “Greater understanding and knowledge, less prejudice”. Eight respondents discussed behavioral changes including “A bit less of off-color joking”. This question engendered two negative responses regarding the content of some of the modules, such as “Many co-workers resented the tone of the First Nations component....ears were shut and important information was not internalized”, and “most staff members not pleased with the training content”.

Table 18

Changes in Work Place due to Staff Participation: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	12	1
Attitudes (including changes)	7	3
Behaviors (including changes)	8	2
Knowledge learned & passed on	0	
Organizational impacts	2	4
Resources (including networking)	0	
Time since participation	0	
Advocacy	0	
Negative comments (Miscellaneous)	2	4
No changes (Prior knowledge etc)	0	

Question O addressed social change in asking participants if they had noticed any changes in their personal lives, outside of the workplace, in terms of the way they discussed any of the marginalized groups. Twenty-four of the 65 respondents (36.9%) reported that they had noticed changes in this area, with 41 (63.1%) indicating no changes. The 20 comments (Appendix K) included a high of 11 responses regarding advocacy, such as “Over the last few years I find myself trying to educate people I come in contact with, because I find most people very stuck on old beliefs”. Two individuals commented on the learning and passing on of knowledge, in “Share HIV information with family/friends” and “Let people in my life know what I learned” .

Table 19

Changes Outside of Work Regarding Discussion of (Client) Groups: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	2	3
Attitudes (including changes)	1	4
Behaviors (including changes)	3	2
Knowledge learned & passed on	2	3
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	0	
Advocacy	11	1
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	0	

The final area of information requested in this section asked for changes in the amount of advocacy (outside of work) that participants are doing for marginalized groups. Only 9 out of 56 respondents (13.8%) indicated there was a change in their advocacy, with the majority of respondents (56 or 86.2%) indicating that there was no change. The 10 textual responses (Appendix L) include the comment “Knowing the history ie. Aboriginals, you can begin to understand why they may be there, as well as how the systemic marginalization is embedded into our society, and everyone deserves equality” which is indicative of knowledge learned and understanding gained. The single item in the “knowledge gained and passed on” contains a recommendation, “People judge out of ignorance, I just pass on what I learned, My suggestion to all is to take modules”. Of the five individuals who indicated they continued their practices according to prior experiences, two of these related back to their work. An example of this is the statement “Like I said before I have advocated for clients for a long time. That is part of my job”.

Table 20

Changes Outside of Work Place in Personal Advocacy: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	1	2
Attitudes (including changes)	0	
Behaviors (including changes)	0	
Knowledge learned & passed on	1	2
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	0	
Advocacy	1	2
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	5	1

Data from the Concluding Comments Questions

The concluding comments section of the survey was designed to allow general feedback on the workshops, and to allow respondents to summarize the impacts of their participation. This section also provides information on the presentation and organization of the workshops.

The first two questions asked individuals for comments on what they liked most and what they liked least about the workshops. These questions resulted in more comments than any other questions as 58 individuals provided information on what they most liked (Appendix M) and 33 individuals commented on least liked aspects (Appendix N). Table 21 and the remaining tables includes an expansion of categories due to the content of the comments.

Eighteen respondents reported that they most liked the workshop content. Comments included general statements such as “Basic easy to understand info”, as well as statements mentioning specific content areas such as “The First Nations workshop was a real ‘eye’ opener” and “How issues of racism and homophobia are brought forward”. The second highest category was the 13 responses regarding the workshop facilitators, including “The humanness and realness of the facilitators and the knowledge they shared”. Workshop participants listed the participatory environment in 11 responses, including the statements “Information was given in fun with demonstrations and interactive exercises” as well as “A lot of good discussion was generated. I liked the high interactive environment immensely”. They also commented on the learning environment (8), with five individuals using the word “open”. This question also engendered 6 statements relating to the transformative learning process, with examples such as “I enjoyed the knowledge from experts and the chance to examine my feelings”, and “The way it was presented

allowed me to see where I needed work because my values and beliefs play a part in how I analyse and then work with my clients” (see Table 21).

Table 21

Most Liked Aspects of Workshops: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	1	7
Attitudes (including changes)	1	7
Behaviors (including changes)	0	
Knowledge learned & passed on	0	
Organizational impacts	4	6
Resources (including networking)	4	6
Time since participation	0	
Advocacy	0	
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	0	
Participation/Discussions	11	3
Facilitators	13	2
Environment: Openness, sharing	8	4
Transformative learning	6	5
Positive comments- no specific area	0	
More attendance opportunities	0	
Content	18	1

In terms of the areas that participants liked least, 8 comments identified specific content areas.

Examples of content areas that were not liked include “The fact that the workshop commenced with an exercise that indicated/accused all participants as homophobic and racist”, “the approach and tone of the First Nations content”, “A large part appeared to be political indoctrination”, and “A slightly condescending attitude towards certain groups (eg. Church) – there should be no labeling of other beliefs”. Three comments expressed concern that the participant was not able to take more or all of the workshops, resulting in the new and positive category of “More attendance opportunities”. Four individuals provided information that they did not have a least liked area with comments such as “I appreciated it all”. There were no responses in the categories of facilitators, environment, and participation. Three individuals commented on the

length of the workshops, including “Having 5 parts may mean people are unable to commit for the entire series and so miss out on information” (see Appendix N and Table 22).

Table 22

Least Liked Aspects of Workshops: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	0	
Attitudes (including changes)	5	2
Behaviors (including changes)	0	
Knowledge learned & passed on	1	6
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	2	5
Advocacy	0	
Negative comments (Miscellaneous)	0	
No changes (Prior knowledge etc)	0	
Participation/Discussions	0	
Facilitators	0	
Environment: Openness, sharing	0	
Transformative learning	0	
Positive comments- no specific area	4	3
More attendance opportunities	3	4
Content	8	1
Length	3	4

Question R asked participants if they thought that the workshops were useful to them in their work place. This question resulted in the highest positive response of any of the yes/no questions, with 51 out of 63 (79.7%) responding “yes” to this question and 13 individuals (20.3%) responded “no”. This question also engendered a high rate of comments with 48 individuals providing written information (Appendix O). The strongest result came in the category of “knowledge learned”, with 31 responses. Again, there were general statements such as “At the time they increased my knowledge” as well as specifics such as “Better understanding of how HIV/AIDS affects people”. The next highest category was that of impacts upon the organization or the work place, with 8 people providing responses exemplified by “Ensured we all had a similar base of info” and “Made us realize that we need separate policies regarding

HIV. Also brought forward how much work needs to be done on the ‘isms’ in our place”. The one negative comment crossed a number of categories such as content, facilitators and environment with the statement “Partially – good and relevant info was negated in parts due to ‘accusatory’ tone”.

Table 23

Usefulness of Workshops in Work Place: Textual responses

Category	Frequency	Order
Knowledge learned (including changes)	31	1
Attitudes (including changes)	3	3
Behaviors (including changes)	3	3
Knowledge learned & passed on	2	4
Organizational impacts	8	2
Resources (including networking)	1	5
Time since participation	1	5
Advocacy	0	
Negative comments (Miscellaneous)	1	5
No changes (Prior knowledge etc)	1	5
Participation/Discussions	0	
Facilitators	1	5
Environment: Openness, sharing	1	5
Transformative learning	0	
Positive comments- no specific area	0	
More attendance opportunities	0	

Participants were next asked if the workshops were useful for situations outside of work. Again, the result was higher than many of the previous yes/no questions, as 39 out of 61 respondents (or 63.9%) indicated “yes” and 22 individuals (36.1%) responded “no”. The highest response category was “knowledge learned and passed on” with 9 responses in total (Appendix P). Five of those individuals mentioned that the impact of their participation was expanded to include their families, as exemplified in “So I had educated information that I could pass on to family, friends and others”. Advocacy was again a result of participation, as four responses provided examples such as “Provide me with more info for people who don’t know or understand (eg. Its NOT only gay people who get HIV)”. Three individuals hinted at their previous knowledge base, such as “a

good review and update in some areas and learned new information in other areas”, and “It did not expand my knowledge nor change how I viewed the issue”. This question resulted in two negative responses, including the “I have discussed the teachings of AIDS PG with friends and family members and the slant that is portrayed by AIDS instructors and the filthy graphic comments made by them”.

Table 24

Usefulness of Workshops in Personal Life: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	5	2
Attitudes (including changes)	0	
Behaviors (including changes)	0	
Knowledge learned & passed on	9	1
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	0	
Advocacy	4	3
Negative comments (Miscellaneous)	2	5
No changes (Prior knowledge etc)	3	4
Participation/Discussions	0	
Facilitators	0	
Environment: Openness, sharing	0	
Transformative learning	0	
Positive comments- no specific area	0	
More attendance opportunities	0	

The final question allowed for any further input from respondents. Appendix Q contains the list of comments from 37 individuals, however some of these comments originate in portions of the survey that did not request comments and have been typed in here. For example, the comment beginning with (G*) was written in beside the scale Question G. The category of “positive comments” had 9 responses, with examples including “...these workshops should be mandatory for all medical workers, helping profession, general public...”, and “excellent information given in an open way”. The 10 comments on the passage of time included “it has been so long it would be nice to be refreshed to some degree on these”, and “the workshop was over three years ago –

very difficult to remember specifics”. Six individuals commented on their past life experiences or educational experiences, with “I am not trying to be negative, I spent 10 years in LA, lost many friends to AIDS – so my awareness and education were more advanced than most of my co-workers”, and “these workshops are valuable – they didn’t significantly impact my knowledge and skill base only because I have previously done... training”. The one negative response was “It was a disgusting experience for me and many others who left the modules or never returned. Problem is they left with more negatives then when they started”.

Table 25

Other Comments Regarding the Workshops: Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	3	4
Attitudes (including changes)	3	4
Behaviors (including changes)	1	5
Knowledge learned & passed on	0	
Organizational impacts	0	
Resources (including networking)	0	
Time since participation	10	1
Advocacy	0	
Negative comments (Miscellaneous)	1	5
No changes (Prior knowledge etc)	6	3
Participation/Discussions	0	
Facilitators	1	5
Environment: Openness, sharing	1	5
Transformative learning	0	
Positive comments- no specific area	9	2
More attendance opportunities	3	4

The textual comments throughout the survey provided us with insight into the impacts of participation in the “Reducing Barriers by Building Partnerships” HIV/AIDS education program.

The categories of the textual comments are summarized and totaled in Table 26 as follows

Table 26

Category Totals for All Textual Responses

Category	Frequency	Order
Knowledge learned (including changes)	91	1
Attitudes (including changes)	41	2
Behaviors (including changes)	23	6
Knowledge learned & passed on	23	6
Organizational impacts	20	7
Resources (including networking)	11	10
Time since participation	15	8
Advocacy	27	4
Negative comments (Miscellaneous)	7	12
No changes (Prior knowledge etc)	31	3
Participation/Discussions	11	10
Facilitators	15	8
Environment: Openness, sharing	10	11
Transformative learning	6	13
Positive comments- no specific area	13	9
More attendance opportunities	3	14
Content	18 + 8	5
Length	3	14

The categories can be grouped to provide us with a summarization of the comments according to change and content areas, as shown in Table 27.

Table 27

Grouping of textual comments: Summary

Content Grouping	Total frequency	Includes variables (frequency)
Knowledge	97	Knowledge learned (91)
		Transformative learning (6)
Behaviors	84	Behaviors (23)
		Knowledge learned/passed on (23)
		Advocacy (27)
		Resources (11)
Learning environment	65	Participation/discussions (11)
		Facilitators (15)
		Environment (10)
		Length (3)
		Content (18 + 8)
Attitudes	41	Attitudes (41)
Organizational impact	20	Organizational impact (20)
Attendance	18	Time since participation (15)
		More attendance opportunities (3)
Positive comments	13	Positive comments (13)
Negative comments	7	Negative comments (7)
No change	31	No change (31)
Total	376	

Representativeness and validity

The purpose of descriptive research is to adequately represent or describe a population. As this research process involved the completion of a survey in a voluntary nature, the issues of bias and representativeness need to be addressed to explore if there has been an impact on the results.

Secondly, this section will explore the validity of the research, in determining if the content asked what it meant to ask.

Volunteer bias

The issue of volunteer bias arises when surveys are distributed through the mail or by being dropped off to a potential participant or organization. In this case, the surveys were distributed through a key individual within the health and social service agencies. However, their means of distributing the surveys onwards to potential participants did vary. Some distributed the surveys directly to specific individuals, others mentioned the surveys at staff meetings and encouraged individuals to pick up a survey from a central location, and others communicated the information via posters or other non-personal means. The completion of the surveys was designed to be voluntary and confidential. The surveys were not numbered or tracked or matched to individual's names. This process was followed to ensure that there was no misuse of the survey information within the agency, and to ensure that respondents felt safe and anonymous in order to encourage the most open and honest responses possible. However, as Palys (1997) indicates,

Volunteers are often different from non-volunteers in ways that may affect the results of your research. A variety of studies, for example, have shown that people who participate in social science research tend to be more highly educated, politically more liberal, less authoritarian, more in need of social approval, more intelligent, and most interested in the issue being addressed than those who don't. (p. 147)

Palys suggests using return graphs to track the frequency of returns, and compare the first wave against a second wave of returns. However, logistically this was not possible for a number of reasons. Firstly, the surveys were distributed through 26 different agencies. Secondly, the surveys were collected in a central location in each agency after a staggered response period that averaged 2-3 weeks. It was simply not logistically appropriate to try and encourage a second wave and a second round of responses for this varied group of organizations. It is possible that volunteer bias exists within these results, however the area of representativeness does provide reassurance as follows.

Representativeness

Representativeness is "a term used to describe how well a sample represents the population from which it's drawn. A sample is considered representative when the distribution of characteristics in the sample mirrors the distribution of those characteristics in the population" (Palys, 1997, p. 425). This research invited participation from staff and volunteers in 26 health and social service agencies in four communities. Beyond the names of the agencies, there is little information on the characteristics of the population of past participants. However, the data does provide us with some examples and insights in four areas.

Of the 26 agencies, surveys were completed by staff or volunteers in 22 of the agencies (see Table 4). Therefore, the vast majority of the agencies (84.6%) were represented in the data collection. The survey respondents were primarily female (86.5%), while the count of the past participants had shown that females constituted 84.6%, and the percentage of agency contacts which were females numbered 80.8%. Therefore, the responses were definitely representative according to gender and host agency. On an observational basis, the gender results mirror the

make-up of staffing in most health and social service agencies, as they are predominantly staffed by females. The respondents ages reflected almost the complete range of possibilities, as the ages ranged from 21-61. The mean of the respondents was 42.78, which is close to the midpoint of the range of the ages. However, the majority of respondents or 41 out of 68 individuals, are over the age of 40. Again, by observation it can be noticed that our work force is aging.

The textual comments throughout the survey also provide us with information on the population. Examples of positive comments on the workshops such as "Enjoyed the workshops and feel they were/are worthwhile for our community" as well as negative comments such as "It was a disgusting experience for me and many others who left the modules and never returned" indicate that the survey did reach a cross-section of the population, both those who were interested in the modules and the research, and those who were certainly not interested in the content of the modules.

Finally, the surveys which were partially or fully completed did number 75 returns. An aggregate of 75 responses helps in reducing individual propensities in self-reporting, and trends can be identified across the returns. The above points and the amount of returns provide the rationale that the results are representative of the population surveyed.

Validity

Palys defines validity in "the most general sense, to whether research measures what the researcher thinks is being measured". As the instrument was designed specifically for this research project, relating to this educational program's content, it is not an instrument that has

been used or tested elsewhere. However, both the pilot project and the textual results indicate validity exists in this research.

The instrument was piloted through four individuals, all of whom were past participants of the workshop series. As reported in the Methodology section, all tested the survey, reviewed the content and the structure, and gave suggestions for change. The survey was then re-distributed to two of pilot participants, who reported that the changes improved the survey and that the survey would provide the information sought through the research questions.

The content of the textual results provide an interesting insight that also shows validity does exist. Table 26 provides a summary of the categorization of the textual responses. These categories were inductively derived once the comments had been entered into the Appendices. These comments derive from two types of open-ended questions; broad questions such as "What did you like most (or least) about the workshops?" and more specific questions such as "Have you noticed any changes in the way.... you discuss any of the (client) groups with co-workers?" The comments derived from the open-ended questions mirrored either the questions themselves or the Literature Review content areas. Categories such as knowledge learned, attitudes, behaviors, organizational impacts, networking, time since participation, and advocacy reflected the question areas. Categories such as participation/discussions, facilitators, environment, transformative learning reflected the Literature areas. Because these inductively developed categories do not contain any other content areas, the validity of the survey is shown in the responses to these open-ended questions. The survey measures what is was supposed to measure.

Summary

The results of the “AIDS/HIV Education for Work Place and Personal Change” research survey provided information on the demographics of the respondents, their self-reported changes in knowledge, attitudes and behaviors, and their insights into the presentation of and the usefulness of the “Reducing Barriers by Building Partnerships” workshops. Although each question requested information on a specific variable, the textual responses contained information relating to a number of the variables. Therefore, the textual responses for each question were categorized and counted, and the frequencies of the categories were reported in table form. The category totals were summarized at the end of this chapter. The survey may have some volunteer bias, although the returns are representative in terms of gender, derive from most of the host agencies, mirror the age of the general work force, and number 75 in total. Based on the pilot information and the analysis of the textual responses, content validity appears to be high.

CHAPTER VI: CONCLUSION

The “HIV/AIDS Education for Work Place and Personal Change” thesis research has been based upon three research questions:

Has participation in the “Reducing Barriers by Building Partnerships” program resulted in changes in knowledge, attitudes, behaviors and/or actions on a personal level and in the work place?

Has participation resulted in a positive, negative or neutral transfer or change?

What is the impact of participation in the “Reducing Barriers by Building Partnerships” educational program?

Chapter Six will discuss the conclusions drawn from, and the implications of this research. The delimitations and the limitations of this research will be examined, suggestions for further research will be proposed, and recommendations arising from this research will be presented. The chapter will conclude with a summary of this research.

Conclusions

In this portion of the chapter, conclusions will be drawn from the research in relation to each of the three research questions. This information is derived from the results relating to each content area, regardless of the source of the information in the survey. For example, the discussion of changes in knowledge will draw numerical information from survey Questions F and G, but will draw textual information from any of the appendices which contain information on knowledge learned.

Did participation result in changes?

The first research question was “Has participation in the ‘Reducing Barriers by Building Partnerships’ program resulted in changes in knowledge, attitudes, behaviors and/or actions on a personal level and in the work place?” The results have shown that the answer to this multi-faceted question is “yes” in all areas, although the changes in knowledge were numerically much stronger than the changes in attitude or the changes in behavior. The areas of knowledge, attitude and behavior will be addressed separately in the following sections.

Changes in Knowledge

Survey questions F and G requested information on changes in knowledge and changes in the understanding of client situations. These numerical variables are supplemented by 97 textual comments, not including the 23 responses in the “knowledge learned and passed on” category. Knowledge was the only item that was mentioned in all of the textual response appendices.

Knowledge and Understanding

The results of Question F indicated that most of the respondents experienced an increase in their knowledge base, with between 68% and 81.3% reporting medium to lots of learning from the modules taken. This was essentially an introductory question, as the initial evaluation (Walmsley & Keith, 1998) provided detailed information on the learning that occurred in each module.

The survey’s second question in the knowledge section began laying the groundwork for social change. The question asked if respondents experienced a change in their understanding of the client groups discussed in the modules. The literature has shown that changes in knowledge

about and understanding of an item or an idea can positively influence attitudes and behaviors toward the item or idea being considered. The number of participants who reported medium to lots of change in their understanding of client situations ranged from 60.8% to 73.8% of respondents. This again is a positive result. Between these two results, it is evident that the primary impact of these workshops has been in the area of knowledge gained.

The survey respondents indicated that they had increased their knowledge in technical or medical areas such as details on the progression of the disease, in personal health care practices such as universal precautions, in historical contexts such as First Nations history, in their understanding of the social and emotional needs of clients and their families, in their awareness of community resources, and in many, many other associated areas. This knowledge base forms a framework for an understanding of an issue in the broad perspective, and has moved the participants beyond the narrow framework of dealing only with the disease. This constitutes an holistic approach to health and social service delivery, encompassing a model that is socially rather than medically driven. The social model of service delivery is critical in addressing the needs of the whole person, rather than only addressing the needs of a component of an individual's issues.

The Literature Review identified knowledge as being a factor in an individual's attitudes. Wade and Tavis (1998) described an attitude as having a cognitive and an emotional component. As one survey respondent stated: "Knowledge and understanding equal less discrimination and fear". The development of a solid knowledge base is then an important factor needed in encouraging change in attitudes and behaviors. This is reinforced by the comment "Greater understanding and knowledge. Less prejudice". It would be very difficult to encourage a shift in

attitudes and a shift in work place behaviors without first addressing the knowledge needs of the staff and volunteers.

The importance of learning opportunities in the work place can not be overstated. Simply the act of providing or encouraging such opportunities sends a message to the staff and volunteers that their professional development is encouraged; there is confidence in their ability to learn; their personal learning needs are important; and, that there is a recognition that as the world changes, so do the skill and knowledge areas needed to cope with these changes. The offering of educational opportunities by employers expresses a belief that the employees themselves are very important in the delivery of service. Tight spoke to the recent fourth wave in training and development, focusing on "information, knowledge and wisdom" (1996, p. 19). The recent concept of the learning organization has at its core the development of individual, group, and systemic knowledge and skills to address the needs of today's work place. The development of knowledge is a critical component in the functioning of today's health and social service organization. As one respondent indicated, "We need more education and workshops".

Previous knowledge.

Table 26 provided the total figure of 31 comments relating to "No change (Prior knowledge etc)". Respondents wanted to reassure us that their lack of change was not due to the content or presentation of the workshops, but due to the fact that they were already knowledgeable about these topic areas. Examples include "To clarify – It's not that the modules weren't informative, its just that I already knew a lot of it" and "I don't believe my understanding has changed. I have always had an appreciation of groups listed from a S. W. perspective".

Changes in attitude

The Literature Review section on attitudinal and behavioral change defined attitude as having an evaluative component. Both Thurstone (1928) and Zimbardo and Liepe (1991) discussed the continuum of like – to – dislike or favorable – to – unfavorable which defines the continuum. This research asked respondents if they experienced any changes in their attitudes or beliefs as a result of their participation in the “Reducing Barriers by Building Partnerships” workshops. This section will discuss the two numerical variables, changes in attitude regarding the situation of (client) groups, and changes in confidence levels regarding working with the (client) groups as well as examine the textual feedback regarding attitudinal change.

Attitudes and confidence levels.

The results for Question H, requesting a rating of the changes in attitude and Question K, requesting a rating of the changes in confidence levels, are remarkably similar. The changes in attitude question had a majority of responses (53.2% to 60.5%) in the “about the same” category. The combination of the “more positive” and the “lots more positive” categories ranged from 34.9% to 45.1%. The changes in confidence level responses also had a majority of responses (53.5% to 61.4%) in the “about the same” category, with the two categories of “more confidence” and “lots more confidence” ranging from 36.9% to 45.9% of responses. These results are numerically substantially lower than the results from the knowledge category questions.

Appendices F and G contain 14 comments categorized as attitudes, with 8 of these reporting positive changes. Examples of these include “It helped me be more open and aware of the higher risk activities and diverse people I come in contact with”, “Generally I have become a more

inclusive and open-minded person”, and “A close friend revealed his sexual preference and I think I was more open-minded”. These examples speak to the original workshop goals of fostering insight and strengthening social environments, and show us that the workshops have resulted in changes in attitudes among some of the participants. As presented in the Literature Review, the original definition of change stated that change is any movement, whether positive or negative, as reported by the program’s past participants. These responses indicate that change has occurred. As expressed in the above example regarding sexual preference, the attitudinal change of being more open-minded will have been resulted in a less judgmental, more accepting interaction. Such a change can be very meaningful, and is an expression of a more accepting relationship. Each small change such as this gives hope for the development of a kinder, more understanding community and society.

The textual responses discussing attitude numbered 41 in total. The category of “Attitude” shows comments in 11 out of the 13 questions inviting textual input. Question N-b, inviting input on changes in the work place due to staff participation also resulted in 7 responses on attitudes. Examples of comments included “Everyone seems more open-minded” and “less prejudice”. Again, these are very important pieces of information as one of the original goals of the workshops was to strengthen social environments in health and social service agencies. Attitudes underlie our actions, and if we can continually strive to become more open and accepting, then our clients will have more of a chance to receive equitable and accessible service. As adults, we bring to our work places a variety of background experiences and knowledge based on familial upbringing, religious background, education and life experience. Any positive change in our attitudes will affect the work we do.

Changes in behavior

The area of behavioral change was operationalized in the following five variable areas: changes in levels of empathy demonstrated at work, changes in discussions of (client) groups both at work and outside of work, changes in service provision at work, changes in advocacy regarding (client) groups both at work and outside of work, and changes in the work place due to staff participation in the workshops. Numerically, the data indicates that between 38.6% and 44.1% of participants reported medium to lots of change. Of the 110 comments in Appendices H through M, 79 comments gave examples of positive changes, 21 responses indicated that they had not changed in the areas discussed, two of the responses indicated a change to the negative, and seven of the responses did not provide us with useable information. Barriers to equitable service such as ignorance, fear and stigma were identified earlier in this paper. This workshop series has resulted in positive changes in all areas, as the discussion of these five variable areas will show.

Empathy.

Question L used a scale to request information on changes in empathy demonstrated at work. The responses to this question are similar to the attitudinal scale questions. Between 53.8% and 60.4% of the respondents reported that their behaviors are about the same. The combinations of “more empathy” and “lots more empathy” categories resulted in a range of 35.8% to 44.1% reporting changes. Therefore, the results are positive in that between one-third and one-half of the respondents are translating their participation into actual changes in the work place. The expression of or use of an empathetic approach in dealing with clients is further described in textual comments such as “I feel I gained more of an understanding as to what the client faces, so I would be able to work with the client in a more nonjudgmental way, to deal with what faces them instead of focusing on the horrible disease”, and “Being more empathetic, less critical of

their choices – more supportive – more focused on the need to teach people – knowledge that will help them increase their choices”. Stigmas are one of the primary barriers to service, and the judgmental approach of a case worker can have an impact on service delivery. Education that results in changes in the empathy demonstrated can potentially have a positive impact on the lives of individuals with or impacted by HIV/AIDS.

Communication.

Appendices H and L provide textual input on changes regarding discussion of (client) groups in the work place and in personal life. Five of the comments can be categorized as “Knowledge learned and passed on”. The following comment is interesting because it indicates the connection between knowledge, attitudes and communication:

Being able to make others aware of the issues that impact people’s life and the choices they are able to make with the knowledge they have – Being so aware of people’s needs and share that with others before judgements take place.

This quote as well as the comment “Let people in my life know what I have learned” speak to the broader impact of the workshops, indicating the content did not just remain with the participants.

This is a very positive statement as it indicates that the content has been accepted and internalized, and that the participant feels strongly enough about the information that he/she wants others to be aware of it as well.

In Appendix H, the category of “Knowledge learned and passed on” once again provides interesting insights especially with the statements “Giving information in a fun way. Also using the modules to give clients small pieces of information over time for learning that meets their learning needs” and “More focused on the need to teach people – Knowledge that will help them

increase their choices”. Marginalization of groups in society can result in a decrease in choices in a variety of ways, including lack of choices due to lack of knowledge or education and lack of choices due to inherent program or service barriers. Empowerment is the concept of enabling others to make their own choices, rather than the process of making a choice for someone. This study indicates that the workshop series has significant potential to empower clients within our communities.

Appendix J provides more information on changes in communication. The comments “More awareness of conversation and who might be around”, “One co-worker acknowledged his inappropriate vocabulary around clients” and “A bit less off color joking” speak to the strengthening of social environments through increased care in communication. Our society’s mores are often reflected in the language that we use, the assumptions we make, even in the jokes we communicate. Stigmas are reinforced through our language usage. As one of the original funding applications listed a goal of enabling individuals to remain in their home community, the community in general needs to exhibit an open and accepting environment for all peoples. Language usage is a key to this.

Service provision.

The third behavioral change variable area for discussion is that of change in service provision at work. Appendix H contains 18 responses to this request for information. Some of the responses identify content areas discussed previously, such as increases in knowledge and changes in attitudes, but also changes in approach such as being more empathetic as well as teaching others the module information. The issues of resources and of networking are addressed here for the first time. It is very important for service providers to have knowledge of and encourage use of

the services that exist in a community, keeping in mind that each community has differences in availability and structure of services. This also reduces the need for any one provider to attempt to address all needs, which is generally a difficult or impossible task. Service providers also have differences in their points of entry, and in their client definitions. Knowledge of one's own community can enhance the range of service options for a client, and, as one respondent indicated, "More aware of making services more accessible".

Advocacy.

Numerically, the advocacy change frequencies numbered 36.2% for work place advocacy, and 13.8% for personal advocacy. Twenty-seven of the comments from the survey identified the learning of strategies that could be termed as advocacy, although only one of these was written down as a response to the two questions concerning advocacy. The Collins Concise Dictionary (1995) defines the term "advocate" as "1. to support or recommend publicly, 2. a person who upholds or defends a cause, and 3. a person who intercedes on behalf of another" (p. 17).

Examples of advocacy from other appendices include "How to comment when negative comments made regarding First Nations people, homosexuals were discussed" and "When topic came up in conversation was more assertive about cutting off negative talk", and "Ran across homophobic people and tried to change their opinions" yet these are not identified by the respondents as advocacy. I would conclude that the meaning of the term "to advocate" is not necessarily understood by many of the participants in terms of their personal roles.

The respondents indicate that there is some understanding of their professional role as an advocate for clients in their comments on advocacy at work. Examples include "I have always tried to advocate for ALL of my clients" and "We were strong advocates before the training" and

are included in the "No change" frequencies. The ability to advocate for and with one's clients is an essential function in a health and social service agency, especially in terms of working with individuals who face stigmas due to health, race, sexual orientation, age or any other marginalizing factor. It can be very challenging to be an advocate for a client with personal aspects that one doesn't respect, or like, or agree with. The purpose of this educational program was to develop knowledge and foster insight among employees, as well as to strengthen social environments within agencies to encourage and ensure that the needs of a client are addressed in the most professional manner possible. Advocacy can play a strong role in service provision.

The following comment addresses not only the individual's advocacy but also his/her approach with "The biggest change in fact I almost never let a negative statement re: HIV/AIDS, gays/lesbians/IDU's etc go by without 'gently' commenting on a more generous point of view". The use of the word "gentle" is evocative of positive yet persistent encouragement for social change. Imagine what society would be like if each of us did not allow negative comments to continue about individuals or groups based on race, sexual orientation, health, economic factors or any other discriminatory aspect! In summarizing this area of change, it is very positive to see the increase in understanding and action regarding marginalized groups.

Work place changes.

The final variable area in the broad category of behavioral change is that of changes in the work place due to staff participation in the workshops. Appendix J provides the 28 textual responses to this question. Eight of these responses are categorized as "Behavior".

The statement “Knowledge of issues helps the work team work in consistent manner with our clients” introduces the area of operational procedures. Consistency is important for many reasons: it ensures that clients are treated in the same manner in each interaction; it ensures that service provision does not vary due to outside factors such as time, location or knowledge; and it ensures staffing changes do not result in service changes. In order for this to occur, it is helpful if the staff receive the same or similar training, and that procedures are formally or informally communicated.

The specific category “Organizational impacts” includes two statements. The first expresses positive results in saying “Brought us closer together as a result of shared experience” which addresses the need for teamwork and mutual support in a work environment. The second comment identified an area of concern in saying “Most of staff still do not want to talk about issues of marginalization”, indicating some frustration with co-workers. However, the act of participating in the module may have opened the door for enhanced communication on the issue. The following comment touches on “Knowledge learned”, “Attitude” and “Behavior” in stating “Increased knowledge and confidence among my co-workers. This created a more supportive atmosphere for both clients and myself (when in need of a second opinion or someone to ‘vent’ to)”. These responses speak to Dworkin’s (1992) statement that “An organization – focused educational program can go beyond changing individual professional attitudes and utilize peer influence to create positive group norms” (p. 673). As stated previously, an organization is often a microcosm of society. Therefore, it follows that not only the clients need a respectful service area, but all workers need to be part of a respectful working environment. The employees and volunteers themselves will also reflect their environment, there may be individuals as described in the modules’ client groups who are working within these health and social service agencies.

Positive changes in an environment will especially assist marginalized individuals to feel more comfortable and potentially more effective if their working environment supports them as well.

Summary

The research question “Has participation in the ‘Reducing Barriers by Building Partnerships’ program resulted in changes in knowledge, attitudes, behaviors and/or actions on a personal level and in the work place” has been answered in this portion of the chapter. This research was designed to question the individual participant on their internal knowledge and attitudinal changes, and their external behavioral changes, and not to externally observe or test these changes. The research has given us a large number of examples of these changes: examples internally in knowledge gained, examples internally in attitudes that have shifted, and examples externally in behaviors and actions both in the work place and in their personal lives. The process of social change through education is ultimately displayed through external attitudes and behaviors. Numerically, the change figures were not as strong as the textual examples sometimes indicated. This reflects one of the challenges of adult learning situations: that participants come to the situation with differences in backgrounds, experiences and knowledge. This research did not presume a level playing field within the adult participants, hence the approach in requesting the individual analyze himself regarding his/her perceived change levels rather than imposing an external measure of change. The numerical results also reflect the previous knowledge that the population had come with, knowledge that may have been gained through college or university experiences, through the popular media of television, newspaper and radio, and through previous workshops or seminars in content area the same or similar to this educational program. Such knowledge becomes ingrained, and it is difficult to ascertain the original source of the

knowledge and of the attitudes and resultant behaviors. The research does indicate that change did occur in all of the areas investigated.

Has participation resulted in positive, neutral or negative transfer or change?

The second research question, “Has participation resulted in positive, negative or neutral transfer or change?” draws us back to Wexley and Latham (1991) in the Literature Review. It is easy to presume that any learning situation will result in an increase in, for example, the knowledge base of an individual participant. Wexley and Latham, as well as Yam (1991) state this is not necessarily so. There are a number of reasons why a learning experience could result in a negative transfer. If the content of an education session is controversial, if the presentation or the learning environment is less than optimum, if the participants are not motivated, if the information is not applicable, or if the information provides too little content, then negative transfers may occur. The “Reducing Barriers by Building Partnerships” workshops are based on a medical topic that raises fears in the general population. The workshops challenged individuals to examine their beliefs and value systems. The content included taboo topics such as gay and lesbian lifestyles and issues, and the historical marginalization of First Nations people. The workshops discussed stigmas, morality, disease, sex, addictions, racism, sexism and many associated topics that some individuals are simply not comfortable with. There was a risk that the workshops could have resulted in a negative change, with a resulting decrease in the openness and increase in the stigmas expressed professionally and personally in our communities. A negative transfer or change would be a disastrous result for any educational situation.

The possibility of a zero or neutral transfer or change is also an area that we tend not to consider when reviewing educational opportunities. A zero transfer would indicate that the workshop content was not relevant to people's needs, that the participants did not care about the information presented, and that the educational opportunity did not challenge its participants in any way. The zero transfer could occur if the participation did not result in any difference in the lives of the workshop attendees. This would have an impact on employee training, in that employers are most certainly not willing to support a training opportunity which, in essence, is not meaningful. A neutral or zero transfer or change would also be a disastrous result for an educational situation.

The research results show that all of the variables measuring change have scored in the range of positive change. The knowledge area resulted in the highest positive gains, while the attitudinal and the behavioral change responses showed lower rates of positive transfer and higher rates of neutral or "no change". Negative transfers did exist, with frequencies of 1-2 individuals in total. The results indicate the "Reducing Barriers by Building Partnerships" workshops were definitely a success in terms of the transfer to the work and personal situations of participants, especially in the area of creating change in the knowledge base of respondents.

A number of the questions asked respondents to provide "yes", "no" or "not applicable" answers, and to add comments following any "yes" answers. For example, Question M asked "Have you noticed any changes in the ... way in which you discuss any of the (client) groups with co-workers". These open-ended questions did not specify if the responses should be positive or negative changes, yet of the 376 textual responses only 7 responses described negative situations. A further 31 responses indicated "no changes", leaving a grand total of 340 statements

expressing positive feedback. These figures indicate a very strong case for the positive effects of the "Reducing Barriers by Building Partnerships" educational program.

What is the impact of participation?

The third research question, "What is the impact of participation in the 'Reducing Barriers by Building Partnerships' educational program" will be addressed by examining the participants' analysis of the learning environment, the strengthening of the social determinants of health through the participation in these modules, evaluating the results in relation to the original goals of the workshop series, addressing the existence and impact of Social Learning Theory, and acknowledging the impacts to individuals beyond the past participants. This final research question therefore pushes the boundaries beyond personal and work place change to look at the broader change issues involved in education for social and community change.

Analysis of the learning environment

One of the impacts of participation in the workshops and in this research process has been the analysis of the learning environment by the respondents. The concluding section of the survey asked for input on most liked aspects of the workshops, least liked aspects of the workshops, applicability of the workshops to both work place and personal life situations, and any other areas the respondent wished to comment on. The purpose of these questions had been to provide insight into the factors influencing the success of these workshops. The primarily textual input again provides positive results overall, and provides some very specific input important to adult learning situations.

Was this andragogy?

The respondents provided the information that the learning environment was a key factor in the success of these workshops. The “Reducing Barriers by Building Partnerships” workshops reflect the andragogical approach in that participants stated the workshops were participatory, relaxed, worthwhile, provided opportunities to explore issues, provided a good and current knowledge base, provided factual information, were interactive and intimate, and left participants feeling good (see Appendix M and P). The participants are adults who experienced the opportunity to learn about the content in an atmosphere of mutuality, respect, inquiry, and informality. The word “open” was used by five respondents in this section of the comments. Reflecting back to Knowles’ Comparison of Assumptions and Designs in Table 1, the feedback indicates that the workshops encouraged learners to share their knowledge, provided information with immediate application, were problem and reality centered, allowed for mutual self-negotiation in the time lines of the modules, were respectful, collaborative and informal in their presentation style, and encouraged self-diagnosis. The workshops also used six of the twelve strategies suggested in Campbell (1999): lecture, discussion, case study, demonstration, forum and panel. The variety of presentation methods, the resources of the guest speakers, the participation of the group members, the collaboration between teachers and learners, and the challenge and critical reflection that was encouraged resulted in the wide variety of positive comments from the survey respondents.

The “Reducing Barriers by Building Partnerships” program incorporated many of Galbraith's (1991) characteristics in its five modules by providing lecture material, reading material, discussion, demonstration, guest speakers, collaborative group work, questioning, self-examination, learning objectives, case examples and many other techniques in its presentations.

The aim of the learning opportunity was to encourage individuals to learn, enjoy, reflect, consider and perhaps change through their participation in this program. The content and presentation structure therefore addressed all six of the guiding principles for the transactional learning experience as identified in Galbraith's theories.

Throughout the survey, the respondents commented on the provision of workbooks for each of the modules. Comments such as “Being able to pass on the knowledge gained (using the resource material) to staff if questions arise” from Appendix E, “I used words/examples the instructor had used in our modules – I passed on booklet to person” in Appendix F, and in Appendix M “Resource material. Provided a good knowledge base re: meaning of acronyms, transmission, protection and definitions”. The workbooks were helpful to adult learners because they allowed participants to review the material at a later time if they chose, they provided written information and reduced the need to take notes, they included exercises which could be useful and applied outside of the workshops, and they provided an opportunity for the learning to be further disseminated after the workshops.

The participants identified the andragogical approach that was the underpinnings of this educational program. The participants responded very positively in their analytical comments. It then follows that the andragogical approach was a key factor in the success of these workshops.

Was this a transformational learning opportunity?

In Scott (1998), transformational learning was defined as encompassing three aspects: social, personal and knowledge transformations. Respondents commented that “I enjoyed the chance to examine my feelings”, it was an “open atmosphere exposing of myths and taboos”, “the way it

was presented allowed me to see where I needed work because my values and beliefs play a part in how I analyse and then work with my clients”, and the “content on marginalized people was thought provoking”. As Cranton (1998) stated “When we are led to question our assumptions, critical reflection, the central process in transformative learning takes place” (p. 198).

Question Q asked survey participants to identify their least liked aspects of the workshops.

Interestingly, a number of comments reflected people’s discomfort with this type of discussion as suggested by the following quotes: “The section on homophobia – thought the (perceived) goal of exercise reached a little high. Education does not always bring ACCEPTANCE”, “would have liked more emphasis on people confronting, acknowledging bias, prejudice”, “A large part appeared to be political indoctrination”, and “The fact the workshop commenced with an exercise that indicated/accused all participants as homophobic/racist”. The process of considering one’s own beliefs and attitudes, and the identification of the source of these is not always an easy or a comfortable process. For some individuals, it can not only be very uncomfortable but also not acceptable:

The thought that we were asked if OUR attitudes towards homosexual people had changed. I think most people’s beliefs are entrenched and as long as everyone we affect is treated with respect and consideration – no one can ask anyone to change their beliefs and attitudes. (from Appendix P)

Cranton (1998) discussed Mezirow’s theories of transformational learning. These theories are reflected in the goals of the “Reducing Barriers by Building Partnerships” program, specifically by encouraging individuals to add to their knowledge base, to explore their beliefs and assumptions, and to consider applying these transformations to the behaviors and attitudes they bring to and use in their work settings. Transformative learning stresses the need for learners to be reflective about their learning.

The learning environment in the “Reducing Barriers by Building Partnerships” workshops exemplified the philosophy of adult education and was a strong example of a transformational learning opportunity. Question R asked respondents if the workshops were useful to them in their work and in their personal lives, and in both situations the participants answered overwhelmingly “yes” (79.7% and 63.9%). This indicates that the workshop series has been a valuable experience in the educational lives of its participants. The program meets the four criteria for transformational learning as identified by Scott (1998, p. 179). These workshops therefore exemplify the successful implementation of a transformational learning opportunity due to the positive results and positive feedback on the discussion of attitudes, beliefs and values and their relation to daily work and personal behaviors and actions.

Determinants of health

The Northern Interior Regional Health Board’s Health Services Plan: 2000 – 2003 identified ten of the key determinants of health. This workshop series addressed six of these determinants: social support networks, (employment and) working conditions, social environment, personal health practices and coping skills, health services, and culture. The results of this research have indicated that changes in knowledge have been significant, knowledge that relates to health and social service employees’ and volunteers’ understanding of the broader issues affecting health and health services. The issues of marginalization, stigmas, historical context, and discrimination impact on the social environment, employment and working conditions, and culture. The goals of the program had identified the strengthening of partnerships between service agencies, which speaks to the determinant of social support networks. The technical knowledge will assist in the instruction of personal health practices and coping skills. This research resulted in the

documentation of change due to this educational program. It is evident that the "Reducing Barriers by Building Partnerships" was not just a prevention education program, nor was it solely focused on technical health issues. The mandate and the resulting impact of this educational program have resulted in a strengthening of six health determinant areas, a strong achievement to be recognized and celebrated.

Original goals of the educational program

The original goals of the "Reducing Barriers by Building Partnerships" HIV/AIDS education program were listed as "to provide knowledge and foster insight in health care and social service agencies in order to ensure sensitive, adequate, accessible service and care for those living with HIV/AIDS in Prince George" (Walmsley & Keith, 1998, p. 4) and "to strengthen social environments in social and health service agencies for persons living with HIV and AIDS" (Walmsley & Keith, 1998, p. 4). The results have indicated that there was a strong change in the knowledge level of participants in the workshop series, with 60.8% to 81.3% of respondents reporting medium to lots of change in their knowledge levels. The goal of fostering insight relates to not only the changes in knowledge but also the changes in attitudes. About half of the respondents reported that their attitudes remained the same, with a number of individuals commenting in an overall manner that they came into the workshop with previous standards of compassion and understanding. Additionally, 34.9% to 45.9% of the respondents reported changes in attitudes regarding the situation of the client groups and changes in confidence levels regarding working with the client groups. These results indicate that there was some progress made in terms of fostering insight in the health and social service agency employees. The goal of ensuring sensitive, adequate, accessible care for those living with HIV/AIDS was not directly

addressed within this research, as the research focused on the employees rather than the clients. However, as the research did ask for information on changes in the behaviors of employees, information was collected that relates to the goal even if it does not directly address the goal. This research asked respondents if there was change in the empathy they demonstrated at work, and 38.6% to 44.1% indicated that they were more or lots more empathetic in their work places. This addresses the aspect of sensitive provision of service. The anecdotal or textual responses provide a number of important examples of changes in actions in the work place, changes that would have a positive impact on the clients' access to adequate service and care. Examples of these comments include "Obtained a better understanding of the resources available, at the local level, therefore able to provide the best possible treatment for the client", "more calls to community agencies", and "connecting people to other support systems". This research provides information that the knowledge and abilities of health and social service agency employees and volunteers have improved as a result of the HIV/AIDS education program.

The second goal of strengthening social environments within health and social service agencies is also addressed by the above numerical changes in attitudes and behaviors. The yes/no questions did result in lower percentages of change information, as their percentages ranged from 29.4% to 38.7%. The above discussion on the internalization of new information, the amount or lack of reflection in the completion of the surveys, and the length of time since participation would also be relevant to these results. The textual information does indicate some important examples of changes, and these validate the achievement of the second goal. The questions regarding changes in the discussion of (client) groups at work and the changes in the work place due to staff participation especially speak to this goal. Comments such as "way less politically incorrect comments and/or jokes", "brought us closer as a result of shared experience" and

“more understanding coworkers” indicate that changes have occurred regarding social environments in the work place.

Our work places are microcosms of our community. This research also addressed the strengthening of social environments outside of the work place, as a recognition that the greater community is also a very important facet in meeting the needs expressed in the original funding application by AIDS Prince George.

Social learning theory

The Literature Review addressed the aspect of direction in terms of attitudinal and behavioral change. Wade and Tavis (1998) state that changes can occur in both directions. This research addresses changes in attitude first in the survey, then requests information on changes in behavior. However, this was the order of the survey and not an imposed order regarding the direction of change. Although it may appear that this research addressed changes in knowledge leading to changes in attitude leading to changes in behavior, this is not the only progression addressed. The overall impact of the workshops is far beyond that as identified in this research, as individuals will learn from the changes in the behaviors of their co-workers and from the changes in the environment on an ongoing basis. This speaks to the impacts of advocacy as discussed above. Differences in the way workshop participants communicate will lead to differences in the way their co-workers, clients, friends and families think and perhaps result in changes in their attitudes and behaviors. Examples of these comments include “Over the last few years I find myself trying to educate people I come in contact with, because I find most people very stuck on old beliefs”, and “I speak with knowledge and therefore pass on what I have learned to stop stigma of stereotyping”. These actions will potentially result in a snowball effect

of change. If past participants work towards addressing stigmas and negativity, they will educate others who will also potentially begin to work towards a more equitable and accepting society. These comments and ideas are reflective of Bandura's Social Learning Theory (Campbell, 1999), the recognition that change may come from within or as a result of direct interaction, but may also come from the observation of or interaction with the environment. This also indicates that the change process will be ongoing, and not end simply because the educational participation has ended. This workshop series has been well grounded in theory, and as such, exemplifies the second characteristic identified in Kirby et al, that is " the effective programs were based upon theoretical approaches" (1994, p. 353).

Impacts beyond past participants

The impacts of participation in these workshops also extends to individuals associated with participants, individuals who may be employees or volunteers themselves, individuals who may be clients, and individuals who may be family members or friends of the participants. This information is derived from the 23 textual responses relating to "Knowledge learned and passed on" (see Table 26). Examples of the above situations are provided by respondents in saying "I share the information learned with co-workers who are working with HIV individuals or couples" (Appendix G), "Perhaps increased comfort, confidence client groups/volunteer service people seem to ask educative questions that I answer and can provide direction for more info/services" in Appendix H, and "Share HIV/AIDS information with friends/family". This indicates that the impacts of participation are exponential, affecting a much broader range of individuals than just those who participated in these workshops. As this research defined its population as only those who participated in the workshops, it is therefore not possible to measure or even to speculate on the expanded impacts of the "Reducing Barriers by Building

Partnerships” program. However, the notion of the broader range of impacts is truly exciting to envision.

Implications for practice

The implications for practice portion of this thesis will move the conclusions further into the area of applicability. This section will first address the question "Was change necessary" for the participants of the "Reducing Barriers by Building Partnerships" workshop series, and the implications of this discussion. This section will also consider implications regarding andragogy, transformational learning, and module attendance.

Was change necessary?

The research results have indicated that over 50% of the respondents reported "no change" in their attitudes and beliefs. Of the 376 textual comments, 31 responses addressed the issue of no change due to prior knowledge, attitudes and behaviors. Of these responses, 17 provided information that they had previously provided service in a positive manner with comments such as "Like I said before, I have advocated for clients for a long time. That is part of my job", "I have always been careful about confidentiality and shared information" and "Have always supported clients regardless of health issues". The question which then arises can be stated as "Was change necessary?"

The positioning of this research needed to be very carefully addressed as it was very important the participants did not feel that they had been judged, or provided with an implied message that change was needed. It was critical to the ongoing provision of services in this sector that the implementation of this research project did not result in negative connotations towards service providers. It was also critical that the research not result in negativity towards AIDS Prince George, the host of the ongoing workshop series. The development of the research instrument, and the implementation of the research process were intended to gather information in a non-judgmental and welcoming manner, in order to provide insight and understanding into the research question areas.

The Literature Review provided information that organizations are a microcosm of our communities. The definition of attitude included the information that an attitude is a point on a continuum from very positive to very negative. The “Reducing Barriers by Building Partnerships” workshops address the aspect of continuum in a number of their content areas, including the continuum of personal sexuality and the continuum of attitudes towards the gay and lesbian population. Given the aspects of the microcosm of our community, and the continuum of attitudes, it was reasonable to expect that participants in the workshop would reflect their communities and represent the full spectrum of the continuum. Some individuals will have been enlightened, empathetic, respectful and flexible in their provision of services before the workshops. It then follows that some participants will fall at the other end of the spectrum in a variety of areas. The results of this research confirm that this spectrum does exist. The comment “Just reiterated what I already knew. I’m empathetic and understanding and open – minded” provides an example of an individual with positive attitudes and behaviors, while the comment “About how it is normal to be gay and everyone should embrace their lifestyle:

ABNORMAL. AIDS PG mandate seems to be acceptance of the gay lifestyle, and if you don't, YOU ARE THE ODD ONE OUT" is a strong example of an individual who is on the negative end of the spectrum regarding attitude toward the gay and lesbian population. Therefore, the assumption was not that all participants should experience changes in all areas. The workshops and the research recognized that there was probably room for change in some individuals in some areas as investigated.

The existence of the spectrum also presents the need for modification in viewing the numerical results. Given that some individuals entered the workshop series with previous knowledge, the fact that 60.8% - 81.3% reported "medium to lots" of learning is that much more positive. Given that some individuals entered the workshops with a positive attitudinal and behavioral base, the fact that 34.8% - 45.9% of respondents reported "medium - to -lots" of change in the attitudinal and behavioral variables is again much more positive. Given that with the existence of the full spectrum, it was possible that some individuals are the far negative end of the scale would probably not have been influenced to change through this relatively short workshop series, the results again appear in a more positive light. Therefore, this educational program did initiate change to many of the individuals within the middle portion of the spectrum.

Andragogy

In the Literature Review, Scott's comment "Adult education is primarily interested in people, the changing of people to become better citizens, better workers, better contributors to society" (1998, p. 186) provided a basis for the implementation of this adult education opportunity. In the

Conclusions portion of this thesis, the results indicated that the educational approach was andragogical in nature, and that this was a key factor in the success of the workshops. The implications for practice that arise from these conclusions provide direction for planners and practitioners for and of adult learning situations, and can be very simply stated as follows.

Adult learning opportunities need to be well grounded theoretically. Planners need to be respectful of their audience, develop the material and the presentation style to reflect the needs of the learners, and allow learners to contribute their own rich body of knowledge to the learning experience. The power of the instructor needs to be shared: the facilitation of input from the participants; the sharing of the instructional role with individuals who speak from a different voice such as guest speakers or panel members; and the implementation of instructional strategies in a variety of mediums to address the range of learning styles. Examples of this include visual learners who can benefit from written materials in workbooks, aural learners who can benefit from lecture or taped materials, and kinesthetic or experiential learners who can benefit from hands - on work or exercises. Adult learners come from a wide variety of backgrounds, with varying knowledge, skills, family or religious experiences, work or life experiences. An andragogical approach is critical to the effectiveness and acceptability of an adult learning opportunity.

Transformational learning

The Conclusions section stated that the "Reducing Barriers by Building Partnerships" program was an example of a transformational learning experience. The results and textual information proved the workshop series was successful. What are the implications for practice?

The participants of this educational program were health and social service agency staff and volunteers. This program was a work place training initiative. Participants began by learning the technical details of HIV/AIDS, and moved on to addressing difficult and challenging issues, yet their feedback was positive! This strongly indicates that it is possible to provide work place education with a transformational learning component. It is possible to challenge people, gently and carefully, to consider their attitudes and beliefs and the impacts these have in their work places. It is possible to encourage social change through a work place education program, and it is possible to present "a social vision about the future based on a value system that includes the struggle for freedom, democracy or equity, and authenticity" (Scott, 1998, p. 178). Practitioners need to learn from these results and conclusions, and should not fear the inclusion of transformational learning opportunities within their training situations.

Module attendance

The "Reducing Barriers by Building Partnerships" workshop participants were health and social service agency employees and volunteers. Respondents were then, by definition, presently or previously employed or volunteering in these agencies. The respondents' participation in the modules ranged from 67 out of 75 (89%) in Module One, to 44 out of 75 (58.7%) in Module Five. This question helped in defining the attendance population in each module, and a definite trend is indicated. The decline in the attendance numbers as participants moved through the modules reflects the original encouragement to begin attendance at Module One and work through them in order whenever possible. However, these figures also indicate that there is a large body of individuals who were not able to complete their attendance of all five modules. This dilutes the effectiveness of the workshop series, and leaves the sense of an unfinished

opportunity among a considerable body of individuals. Practitioners need to consider means to address this within the ongoing planning and promotion of the modules. Encouragement needs to be given to health and service agencies to track the attendance of their employees, to provide a variety of opportunities for access to the modules in recognition of the variety of work schedules which exist today, and to lengthen the contact with an educational agency in order to accommodate the needs of the employees. Use of technology such as electronic mail to publicize workshops, and spreadsheeting software to track participation will potentially lessen the work load of this function.

It was noteworthy that many individuals (17 out of 75, or 23%) could not recall their last year of attendance in a module. This is further reflected in the written comments about the difficulty of remembering content and details when a workshop occurred two or three or more years previously. The bulk of the attendees in 1998 and 1999 may reflect the busiest years in terms of the hosting of the workshops by AIDS Prince George, but also may reflect the unwillingness or inability of potential respondents to recall workshops held a number of years previously. The survey was distributed in the fall of 2000, and the lower number of respondents from 2000 may reflect the timing of the distribution (part way through the year) as well as the reduced staffing at AIDS Prince George during that year.

Respondents provided textual information on the challenges of remembering content and its impact due to the length of time since participation. These comments are dispersed throughout the results, including comments in Appendix E, "I'm sure there have been times at work when something has happened, but the workshop was 3 years ago", Appendix H, "Hard to remember", the comment "Can't remember" once in Appendix M and twice in Appendix N, the comment "I

can't remember much of what we did, its been a long time" in Appendix P, and nine comments in Appendix Q as summarized in the results section. The challenge of presenting a workshop series is to make the information interesting, relevant, current, memorable and integrated into practice. As adults, these participants came to the workshops with varying learning needs, interest areas, and previous knowledge. One individual commented "It's been many years since I've taken the workshops, but the information learning has stuck with me, unlike many other workshops". Evidently, for this individual, the information's relevance made it particularly memorable. Because of the diversity inherent in adult learners, there are no easy solutions to the dilemma of the passage of time. There will also not be a single solution in the length of time that individuals will remember a workshop, as this too will vary from person to person. The demographic information in Question B and the textual responses from the participants clearly indicate that the passage of time was a difficulty for approximately 5 - 10 out of the 75 survey respondents. Practitioners need to be aware of the differing situations of participants, and solicit their input to ensure that the content is current, relevant and memorable. Participants may be able to provide suggestions for follow - up mechanisms, and ongoing consultations with sponsoring agencies may provide insights into the effectiveness of the learning experience.

The final section of the demographics requested information on the attendance situation of respondents. It is very positive that over two-thirds of the participants (46 out of 66 or 69.7%) reported that they voluntarily attended the workshops. It can be surmised that this means they attended because they chose to, that they were interested in increasing their knowledge in the content areas, and that they were willing to commit time and energy to their learning process. It is interesting that although only one-third of the attendees were present on a mandatory basis, almost two-thirds of attendees were remunerated. Generally speaking, when an employer

requires a staff member to attend a workshop, union contracts require that the employee's time be considered work time and the individual's wages must be paid. Therefore, the twenty mandatory attendees would probably have been paid for their time, and over half (26 out of 46 or 56.5%) of the voluntary attendees must also have been paid their wages. This indicates a willingness by the remaining voluntary attendees to attend workshops without receiving remuneration, possibly as a means of professional and/or personal development. These figures also indicate employer support for educational experiences in the workplace. Because this research has identified very positive effects of participation in this workshop series, it would be important for this research information to be disseminated to the health and social service agencies. Practitioners also need to encourage organizations to recognize the value of ongoing training opportunities, and be prepared to defend and advocate for the continuation or expansion according to identified training needs.

Delimitations and Limitations

The delimitations of a research plan are those areas that are under the control of the researcher, while the limitations are areas not under the researcher's control. In this research project, there were a number of both. This section will briefly explore these.

Delimitations

The delimitations of the research “HIV/AIDS Education for Work Place and Personal Change” can be categorized into three areas; the operational definitions, the research instrument, and the generalizability. It was a challenge to operationally define the change process in a manner related both to personal change and to work place change in sensitive yet realistic language, as discussed in the Definition of Terms portion of this thesis paper. I consulted with present and past AIDS Prince George staff in assisting in the process of refining the survey questions, and in operationalizing the definition of change. This was accomplished through several consultation meetings. As also mentioned previously, these operational variables needed to be positioned in a way that invited personal reflection on change without alienating the participants through implying that they needed to change. The range of information received provides the feedback that the operationalization of the variables was successful.

The second delimitation of this research relates to the design of the survey instrument. As this was original research relating to a unique educational program, there was no existing survey instrument. I created this instrument based on the research questions, and on feedback during the consultation process. While the survey did provide a large amount of information, the process of implementing and evaluating the instrument resulted in the identification of several areas for change or improvement.

The survey was distributed through the health and social service agencies that had participated in the “Reducing Barriers by Building Partnerships” workshops. The contact person in each agency was responsible for distributing the surveys to their agencies’ past participants. The success of

this distribution process varied (see Table 4 for numerical information). In retrospect, I would recommend a change in the covering letter (see Appendix C). The covering letter should have had a section for the past participants' name to be written in, with accompanying instructions that the respondent tear off the covering letter before turning the survey in to ensure the anonymity of responses. This would have encouraged the contact persons to directly distribute the survey to all remaining past participants within the agency. Also, the covering letter of the survey asked respondents to "please fill in the survey question areas that relate to the modules that you have taken". Some respondents missed this piece of information, and filled in portions of the tables for modules which they had not taken. These data pieces were eliminated prior to the recording or entry of the data in the software programs so there was no actual impact on the results.

The content of the survey instrument could have been improved. The demographics section did not include a question on previous formal education levels. This was a drawback, as such a question could have provided valuable information on not only the amount of prior education but also the professional or non-professional status of respondents. Three of the respondents referred back to their university or their professional training. A second question could have inquired about previous training in HIV and AIDS diseases and associated processes. Three of the comments refer to such previous educational experiences, as mentioned in Appendix Q "Have been to other HIV/AIDS workshops". A third question for inclusion could have been "Why did you take these workshops?" This question could have provided information on areas such as personal motivation for attendance, the individual's learning needs, and the success of public relations strategies. A fourth question could have asked if participants had previously had education in AIDS/HIV, in First Nations history, in gay and lesbian issues, and in regards to other marginalized groups such as intravenous users. A further change would involve the use of

numbers instead of letters in defining each question on the survey. The capitalized letters proved to be confusing because of the use of letters to define each appendice. The survey change scales asked respondents to rate their level of change. This resulted in trend information. Another way of structuring this might have been to use two scales for each variable, the first asking the respondent to assess their level prior to the module and the second for their level following the module. This would have provided more specific information on not only the levels of change, but also the positioning of each individual on the spectrum both prior and following their educational experience. However, this would have lengthened the survey. The survey would also have been more difficult for the respondents to fill out in relation to each of the modules, but may have provided a much better picture overall of our respondents.

The third delimitation of this research relates to generalizability. The investigation of the AIDS Prince George's educational program, "Reducing Barriers by Building Partnerships program" was carried out within a constructivist framework, using quantitative research methods. Constructivist thought recognizes that "individuals perceive or construe the same event in different ways" (Cranton, 1998, p. 194-5). This reflects the views in adult education that individuals vary in their backgrounds, experiences and knowledge. Therefore, their perspective on an educational experience will also vary. This thesis research used a quantitative methodology to reach past participants of a specific educational program, in order to both hear their unique perspectives as well as look for patterns in responses and in impact statements. The "HIV/AIDS Education for Work Place and Personal Change" research was also very specifically contextual relating only to the delivery of these program modules in the specific location of this region of the province of British Columbia. Therefore, only portions of this research are generalizable to other work place education programs. The numerical results and the specific comments belong to this offering of this program. The implications for practice are generalizable to other adult

education opportunities. The recommendations are both specific and generalizable according to their identified audiences.

Limitations

The limitations of this thesis research also fell into several categories: the response procedures, the definition of change, and the meaningfulness of the change. In terms of response procedures, the survey was of a voluntary nature, and was distributed in work place settings. The attrition of staff and volunteers has been addressed in the Distribution section.

The second limitation was that the survey asked for people's perceptions of their own change, rather than observing the change itself. Participants were asked to engage in self-reflection, and to provide honest responses based on their own self-knowledge and insight. Not all individuals are comfortable with self-reflection. The returned surveys certainly showed a great variety in the depth of the responses. Some individuals chose to write lengthy, thoughtful comments while others chose to only complete the closed questions. While this limitation may have influenced the response rate and results, the process of participation did add to the benefits of the original participation in the program, thereby continuing the original goal of strengthening social environments.

The meaningfulness of the change, as expressed by respondents in the survey process, needed to be analyzed and applied carefully. For the respondents who indicated that change has occurred, it must be noted that we can only apply this information in the context of the staff and volunteers of the health and social service agencies. In other words, we cannot extrapolate this to mean that

the individuals with and impacted by HIV/AIDS will therefore also have experienced changes in their experiences with agency staff and volunteers. It must be emphasized that this research does not speak to the experiences, past or present, of individuals with/or impacted by HIV/AIDS. It was beyond the scope of this research to address the impacts on the clients themselves. This research speaks only to the self reported experiences and self-perceptions of the staff and volunteers who provide services to individuals with or impacted by HIV/AIDS.

The survey's concluding section asked respondents to indicate if the workshops were useful to them in the work place and in their personal lives. These results were quite strong as 79.7% said the workshops were useful for work, and 63.9% indicated the workshops were useful outside of work . This is a stronger response than a similar but related earlier question set, and presents a bit of a contradiction. The results of previous questions asked if participants thought of the workshops while at work (50.7% said yes) and outside of work (50.8% said yes). While the two questions sets differ slightly, they are related. One can surmise that since the process of learning in adults builds upon previous knowledge and experience, the addition of new knowledge or changes in attitudes can sometimes occur subconsciously. Adults may internalize information without consciously recognizing this process. Therefore, the respondents may have been able to acknowledge that the workshops contained relevant and useful information but not necessarily be able to specifically identify the application to either work or personal situations. A potential second factor lies within the process of completing a survey. Some respondents may have carefully considered each question and taken the time to think through and record their thoughts. Others may have quickly written their responses and not had or taken the time to reflect on each question. The third factor has been discussed previously: the length of time since participation in the workshops has affected the conscious memory of the workshop content and impact. Some

respondents indicated that it was difficult to recall specific information after the passage of time since participation. Regardless of the speculations regarding the difference in the results of the two questions, the respondents have strongly indicated that the workshops were useful to them in both their work and their personal lives.

Suggestions for Further Research

The thesis research “AIDS/HIV Education for Work Place and Personal Change” has examined the impacts of participation by health and social service agency staff and volunteers in a work place educational program. This research has shown that the participation has resulted in significant changes in knowledge, and some changes in attitude and actions. The research leaves a number of areas for further exploration and possible research questions:

- a) Do people with/impacted by HIV/AIDS report changes in health or social service agencies?
- b) Have individuals with/impacted by HIV/AIDS benefited from changes in staff/volunteers?
- c) What are the attitudes of health and social service agency staff towards the client groups before the workshops, immediately following the workshops, and at six month and one year intervals following the workshops?
- d) How can retention of knowledge be improved?
- e) How can changes in attitudes and actions be reinforced and encouraged?
- f) What are the barriers to creating attitudinal and behavioral change?

In adult learning situations, each individual brings a unique history of educational experiences, family environment, religious participation, personality and many other factors. It would be interesting to explore, via a qualitative approach, the following questions:

- g) What are the components in the workshops, and what are the personal factors which resulted in positive changes in a select few individuals in knowledge, attitudes and behaviors?
- h) What are the components in the workshops, and what are the personal factors which resulted in negative changes in a select few individuals in knowledge, attitudes and behaviors?

Recommendations

The "HIV/AIDS Education for Work Place and Personal Change" research has resulted in insights into the changes in knowledge, attitudes and behaviors among past participants of the "Reducing Barriers by Building Partnerships" workshop series. The conclusions and implications for practice have solidified the findings and translated them into a path for the future. The following recommendations provide specific direction to three categories: the field of adult education and training, the area of health and social service agency organizations and specifically those whose primary function is addressing HIV/AIDS, and the specific organization AIDS Prince George.

Adult education and training

- 1) It is recommended that organizations planning and implementing adult education or training opportunities ground their approach theoretically in the principles of andragogy. The diversity of

the adult learner demands that their uniqueness be considered philosophically, strategically, and practically.

2) It is recommended that organizations planning and implementing adult education or training include the opportunity for transformational learning theory where appropriate.

3) It is recommended that any implementation of a multiple-module educational program give careful consideration to the encouragement of participants to complete the full series. Given the unique needs and schedules existing in today's work place, this may involve creative management of workshop scheduling and ongoing repetition of the offerings of various components. It is recommended that usage of current technology be improved to address these scheduling and public relations needs.

Health and social service agencies, specifically HIV/AIDS organizations

4) It is recommended that the "Reducing Barriers by Building Partnerships" educational program be considered for implementation in communities throughout British Columbia and Canada. As the module content and the presentation style are both critical components in the effective realization of the goals of the program, it is recommended that they be emulated in any new offering of this workshop series.

AIDS Prince George

5) It is recommended that AIDS Prince George further develop the component of, and understanding of advocacy within the "Reducing Barriers by Building Partnerships" program. Given the implications of Social Learning theory, and the ongoing possibilities for change, this will strengthen the overall impact of this educational program.

6) It is recommended that AIDS Prince George implement a process to follow up on the number of past participants who did not complete the module series, in order to ensure that the maximum impact of the educational program is achieved.

7) It is recommended that AIDS Prince George develop strategies to inform the community of the results of this research, to consult with the community on the implications of this research, and consult with the community on the future development of the "Reducing Barriers by Building Partnerships" educational program.

Summary

This thesis research was a wonderful opportunity to investigate an existing educational program. The program is strongly grounded in theory, strongly supported by its developers and host, strongly supported by the body of past participants, and now strongly documented through this research. The "Reducing Barriers by Building Partnerships" program exemplifies a successful work place educational initiative.

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APPENDICES

- Appendix A Reducing Barriers by Building Partnerships Modules and Descriptions**
- Appendix B Survey**
- Appendix C Survey Covering Letter**
- Appendix D Question E-b: Attendance Explanation**
- Appendix E Question I-b: Thoughts at Work Regarding Learning**
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- Appendix M Question P: Most Liked Aspects of Workshops**
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- Appendix O Question R-b: Usefulness of Workshops in Work Place**
- Appendix P Question S-b: Usefulness of Workshops in Personal Life**
- Appendix Q Question T: Other Comments Regarding the Workshops**

Appendix A

REDUCING BARRIERS BY BUILDING PARTNERSHIPS

MODULES AND DESCRIPTIONS

The following lists the titles and subsequent learning objectives for each of the "Reducing Barriers by Building Partnerships" modules.

A) **HIV/AIDS 101**: Upon completion you will:

1. Understand the significance of the acronyms HIV and AIDS.
2. Know how HIV is transmitted and understand the components of the Transmission Equation.
3. Know the components of the HIV Continuum and how the infection progresses from HIV to AIDS.
4. Be able to state how to protect yourself from HIV infection

B) **The Impact of HIV/AIDS on Those Infected and Affected**: Upon completion you will be able to:

1. Identify and respond to common emotional reactions of individuals infected and affected by HIV/AIDS along the HIV continuum.
2. Recognize the physiological manifestations of the virus along the HIV continuum and be able to respond to the effects of these health problems on accessibility of service.
3. Respond to the needs of those infected and affected by HIV/AIDS who are experiencing grief, loss, and the necessary preparations for anticipated death by exploring your own feelings and thoughts around these issues.

Appendix A continued

C) **Homophobia, Heterosexism and HIV/AIDS**: Upon completion, you will have:

1. Explored the basis for your own sexuality and your values about sexuality.
2. Explored your personal feelings and attitudes about sexual orientations different from your own.
3. Examined how the stigma of homophobia creates barriers which affect interactions with people living with HIV/AIDS and their significant others.

D) **HIV/AIDS and First Nations People**: In this workshop you will;

1. Examine the effects of colonization on First Nation health.
2. Begin to understand the multiple losses experienced by First Nations people and how these losses relate to increased risk of HIV infection.
3. Examine how culture could shape the delivery of service to First Nations people living with HIV/AIDS.

E) **HIV/AIDS in a Diverse Community**: Upon completion you will:

1. Understand the concepts of diversity and marginalization.
2. Examine your assumptions about others, what you base these assumptions on, and how they affect your interactions with others.
3. Practice techniques that challenge habitual assumptions.

(AIDS Prince George, 1999)

Appendix B

Reducing Barriers by Building Partnerships

AIDS/HIV EDUCATION WORKSHOPS

Participant Survey

DEMOGRAPHIC INFORMATION

A) Please check off the Building Partnerships modules which you attended:

Module	Attended?	Yes	No
Module 1 (Mod-1) HIV/AIDS 101			
Module 2 (Mod-2) Impact of HIV/AIDS on Those Infected & Affected			
Module 3 (Mod-3) Homophobia, Heterosexism, and HIV/AIDS			
Module 4 (Mod-4) HIV/AIDS & First Nations People			
Module 5 (Mod-5) HIV/AIDS in a Diverse Community			

B) Please check the year that you LAST attended a Building Partnerships module:

Year	(check one)
2000	
1999	
1998	
1997	
1996	
Don't know	

C) Please place a check mark beside your gender: Female _____
Male _____

D) Please write in your current age: _____ yrs.

E) Please place check marks beside your attendance options (in both a and b questions).

a) Mandatory attendance _____ OR Voluntary attendance _____

b) Paid attendance time _____ OR Non-paid attendance time _____ OR other (explain) _____

Appendix B continued

KNOWLEDGE: This section explores the amount of learning that occurred.

F) Please place a check mark in the square that rates the amount of knowledge you learned in each of the Building Partnerships modules.

Module	None	Very Little	Little	Medium	Lots
Mod-1) AIDS/HIV 101					
Mod-2) Impacts of AIDS/HIV					
Mod-3) Homophobia/Heterosex					
Mod-4) First Nations					
Mod-5) Diverse Community					

G) As a result of taking the module, do you feel there have been changes in the amount you UNDERSTAND about the situation of any of the client groups (listed below)? Please check the amount of change.

Module	None	Very Little	Little	Medium	Lots
Mod-1) Individuals with HIV/AIDS					
Mod-2) Families/friends of					
Mod-3) Gay and lesbian people					
Mod-4) First Nations people					
Mod-5) Other marginalized/diverse people					

ATTITUDES: This section asks you about any changes in attitudes or beliefs that may have occurred.

H) As a result of taking the module, do you feel there have been changes in your ATTITUDES towards the situation of any of the client groups (listed below)? Please check the amount of change.

Module	Lots more negative	More negative	About the same	More positive	Lots more positive
Mod-1) Individuals with HIV/AIDS					
Mod-2) Families/friends of.....					
Mod-3) Gay and lesbian people					
Mod-4) First Nations people					
Mod-5) Other marginalized/diverse people					

I) Have there been times at work when something has happened which made you think about what you learned or talked about during the Building Partnerships workshops?

a) Yes _____ No _____

b) If Yes, then please write down what happened/what you thought about (write in a general way: please do not include confidential client/staff information).

Appendix B continued

J) Have there been times outside of work when something has happened that made you think about what you learned or discussed during the Building Partnerships workshops?

a) Yes _____ No _____

b) If Yes, then please write down what happened/what you thought about.

K) Have there been changes in your own CONFIDENCE level in working with individuals (in the client groups) as a result of your participation in the Building Partnerships workshops? Please check the amount of change.

Module	Lots less confidence	Less confidence	About the same	More confidence	Lots more confidence
Mod-1) Individuals with HIV/AIDS					
Mod-2) Families/friends of.....					
Mod-3) Gay and lesbian people					
Mod-4) First Nations people					
Mod-5) Other marginalized/diverse people					

BEHAVIORS &/OR ACTIONS: This section asks about any possible changes in your behavior or actions both within and outside of your work place.

L) Do you feel there have been changes in the amount of EMPATHY that you demonstrate when you are working with any of the client groups (listed below)? Please check the amount.

Module	Lots less empathy	Less empathy	About the same	More empathy	Lots more empathy
Mod-1) Individuals with HIV/AIDS					
Mod-2) Families/friends of.....					
Mod-3) Gay and lesbian people					
Mod-4) First Nations people					
Mod-5) Other marginalized/diverse people					

M) Have you noticed any changes in the way you carry out your work in any of the following areas...?

a) The way in which you discuss any of the (client) groups with co-workers

1) Yes _____ No _____ N/A _____

2) Please comment (please write in a general way: do not include confidential client/staff information)

Appendix B continued

b) The way in which you provide services to the clients/groups?

1) Yes _____ No _____ N/A _____

2) **Please comment** (please write in a general way: do not include confidential client/staff information)**c) The amount of advocacy you do for/with any of the clients/groups:**

1) Yes _____ No _____ N/A _____

2) **Please comment** (please write in a general way: do not include confidential client/staff information)**N) Have you noticed any changes in your work place as a result of staff member participation in the Building Partnerships workshops?**

a) Yes _____ No _____

b) **Please comment** (please write in a general way: do not include confidential client/staff information)**O) Have you noticed any changes in your personal lives (outside of work) in any of the following areas...?****a) The way in which you discuss any of the marginalized (client) groups ?**

1) Yes _____ No _____

2) **Please comment:****b) The amount of advocacy you do for/with any of the marginalized (client) groups?**

1) Yes _____ No _____

2) **Please comment:**

Appendix B continued

CONCLUDING COMMENTS: This section asks you some general questions about the Building Partnerships workshops.

P) What did you like the MOST about the Building Partnerships workshops you attended?

Q) What did you like the LEAST about the Building Partnerships workshops you attended?

R) Were the Building Partnerships workshops useful to you in your workplace?

a) Yes _____ No _____

b) Please comment (please write in a general way: do not include confidential staff/client information)

S) Were the Building Partnerships workshops helpful to you for situations outside of your work place?

a) Yes _____ No _____

b) Please comment:

T) Are there any other comments that you would like to make about the Building Partnerships workshops?

~~~~~**THANK YOU** for taking the time to fill in this survey~~~~~

PLEASE place your completed survey in the envelope/box described in this survey's covering letter.

Thanks

## Appendix C

### Reducing Barriers by Building Partnerships HIV/AIDS Education Workshops

#### Survey Covering Letter

#### Dear Survey Participants:

This covering letter will give you a brief overview of the research "HIV/AIDS education for work place change". I hope you will take a few minutes to read this information, and then fill out the attached survey.

My name is Christine James. This survey is my thesis research for my Masters in Education degree at UNBC. I wanted to do a project that would be helpful to the community, and I am very interested in training that is related to our work places.

The purpose of this research is to find out if your knowledge, attitudes, beliefs or actions changed after you took part in any of the "Reducing Barriers by Building Partnerships" workshops offered by AIDS Prince George. **Everyone who took any of the modules is asked to please fill out this survey.** It is being distributed to all of the health or social service agencies that encouraged their staff to take these workshops. Your participation is CONFIDENTIAL, ANONYMOUS, and VOLUNTARY. The only people that will see your survey are myself and my committee at the University. The surveys will not be looked at by staff at your agency or at AIDS PG.

Please do not discuss your survey with anyone else, as it might influence their answers.

This survey will take you 10-20 minutes to fill out. Please fill in the survey question areas that relate to the **modules that you have taken.** Whether you have taken one or all five of the workshops, your comments are still needed. The questions ask you to think about the course, and to give us your thoughts on how the workshops affected you. This survey will help to understand what (if any) changes have occurred within people, within your workplaces, and within our community as a result of the Building Partnerships workshops. Have they made a difference? If so, what? If they haven't, then we also learn from your answers.

Please fill in this survey by: \_\_\_\_\_

Please put your completed survey in the brown envelope (marked AIDS/HIV Education Survey) that is \_\_\_\_\_

I will analyze the results, and send out a summary copy of the research information to your agency/work place.

You will also be welcome to view a copy of my thesis in the library at UNBC next year (hopefully !!), or contact the AIDS Prince George office as I will also give them a copy of the completed thesis.

For further information, please feel free to contact me (Christine James) at:  
(Home phone) 250-962-8645  
(e-mail) CLJames@telus.net

If you have any questions about this research, please contact the Chair of UNBC Education, Dr. Paul Madak at 960-5555. If you have any concerns or complaints about the research, please contact the Office of Research and Graduate Studies at UNBC, phone: 250-960-5555.

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY !!!!

## Appendix D

### Question E-b: Attendance Explanation

Hospice training  
(paid) by agency  
Recommended (attendance)  
paid and unpaid  
Both-attended on days worked/days off

Total: 5 responses

## Appendix E

### Question I-b: Thoughts at Work Regarding Learning

Staff feel prepared re precautions (general conversation)

Wearing gloves all the time

We face situations on daily basis in which we have to use our knowledge of social issues & the skills to provide the support and understanding that people need to get through difficult situations. It is difficult to point out at a one situation in particular.

Sexual health, resources & testing, symptoms - identifying

How to comment when negative comment made regarding First Nation people, homosexuals were discussed

That we do not have specific policies in place in regards HIV/AIDS. It seems many in our workplace do not want to discuss issues impacting on HIV ie. Racism, homophobia, etc

A negative response/amusement with tact taken - everyone is homophobic & racist

Attitudes of some human/social service workers/professionals towards marginalized groups-lack of understanding about systemic discrimination

Switching from mugs to disposable cups to cut back on cold & flu germs that could put clients who are infected HIV &/or AIDS at risk

Not specific story but it makes me stop to think about my values so I can provide a more non-judgemental service

Just questions re: how HIV is contacted

Being able to pass on the knowledge gained (using the resource material) to staff if questions arise

Client questions

When clients divulge the fact to me that they have to be diagnosed with AIDS/HIV or Hep. I thought- I'm glad I had the training as am better informed to their situation.

Requests for bed covers for night sweats. Transportation for Vancouver counselling sessions

Uninformed comments from other staff .Joint mtg with participants & AIDS Society. When participants request assistance with items not usually requested (frequency)

Requests for finances for needs previously not adequately understood

Medical professionals using word "contamination" Do not touch or go near person. Very uneducated as to the transmittal of HIV/AIDS. Also numerous professionals don't understand the difference between HIV & AIDS - How can people be uneducated in this day & age?

I'm sure there has been times @ work something has happened, but the workshop was 3 yrs ago. I think we all think about things we learn from the workshops we attend. We need more education & workshops I paid more attention in general to handling blood. More aware of the risks

Have not had direct patient contact (hands on)

In working w/a client who had just been diagnosed I used what I had learned about what the impact/grief/stigma was for that person & examples given in helping deal w/feelings & social judgements

Attitudes of myself and others

Knew someone with HIV - more understanding

Work together to achieve a common goal

How great to see so many community members in attendance

I am more aware of making judgements about how some contracted AID/HIV

Better understanding of IV drug users & the issues that arise w/their rigs when shooting - also don't hold back from giving out needles when doing needle exchange program

I work in a Health Unit as a Public Health RN I test for HIV. It helped me be more open & aware of the higher risk activities & diverse people I come in contact with

I felt more comfortable & confident when interacting with high-risk youth, in particular one individual who suspected that she may be HIV positive

On a regular basis -with clients

## Appendix E Continued

Very important to disinfect the dishes, wear gloves when changing bandages, do

A needle-stick injury to self (Lancet) could have been from one of five people – thought about the consequences of worst scenario – reaction from other staff if I had contracted HIV

Total: 33 responses

## Appendix F

### Question J-b: Thoughts outside of Work Regarding Learning

Can't remember

Speaking of STD's & HIV-someone made a comment of it just being a "gay" disease-I was shocked

Discussing information w/friends who are also front line professionals & finding out that many have misinformation. I have loaned my modules out on many occasions

When topic came up in conversation was more assertive about cutting off negative talk

In Amnesty International work with Gay Pride parades other Gay related events in the region

When discussing the Gay & Lesbian lifestyles & how AIDS PG AGGRESSIVELY "promotes the gay lifestyle" by teaching that sexual behavior & lifestyles are not different than anyone else's. And should be accepted. This is pushed big time

Listening to people use homophobic & racist language. How some people in larger community still see HIV as a "gay disease or punishment for immoral behavior"

Ran across homophobic people & tried to change their opinions

Same as above

Same as I

A general discussion about contraceptives with friends

Probably

Discussion with own children

Not worrying about physical contact w/"street"people. Having a daughter w/a condition had more impact on my understanding & empathy

Same as I b

While working in food distribution (voluntary) services the issue has arisen. Questions about risk

Uninformed or rude comments, racial, sexist jokes etc-I leave or speak up stating I don't agree or appreciate or want to hear that

Discussions with people about perceptions relating to people with HIV/AIDS

When some "friends" heard where I volunteered, they asked my husband "Aren't you worried she'll bring AIDS home?"

These "friends" are fairly educated, hold fairly high positions in the community, & I was appalled at their reaction at first, then I proceeded to education them with the right type of info on HIV/AIDS

The people who live in neighbourhoods near Queensway (particularly children) where prostitution and drugs are prevalent

In both scenarios, the 1 thing I learned was how sexuality is more of a spectrum than black & white straight/bi/gay/lesbian.

This helped my general understanding of many who are in between these points. Otherwise I didn't feel I learnt a lot.

Based on my attitudes before the course

Info that ink bottles used in tatoos should be changed between clients, needle change is not enough. Info that HIV test may not show positive until up to 6 months past exposure.

In speaking about HIV/AIDS w/someone who was judging with no awareness of facts. I used words/examples the instructor had used in our modules (I passed on booklet to person)

Attitudes of my self and others

Don't pass judgements

as above

Generally...I have become a more inclusive/open-minded person.

A close friend revealed his sexual preference, & I think I was more open minded

An overall greater understanding of those people marginalized by society

Increased empathy & understanding of an individual's plight with HIV. I did not know this person directly, however, I was familiar w/his spouse

Friend with Hep C – precautions he is taking to protect his (family...) in his care – re: cleanliness practise – use of bleach, sharing of razor, toothbrush: Discussion/education with this individual

Total: 31 responses

## Appendix G

### Question M-a-2: Changes at Work Regarding Discussion of (Client) Groups

Yes in general concern, re HIV transmissions

If HIV is present I bring it forward as a piece of the work

We have a fairly aware workplace w/lots of discussion. We're sensitive regarding marginalization. As well we are a feminist organization. We carry out discussion w/the same amount of empathy & awareness as before the BP workshops  
Increased confidence in approaching subject of HIV/AIDS and what may be perceived as supportive vs not supportive interventions

By being better informed I am able to discuss the situation & ask more informative questions

I share the information learned with co-workers who are working with HIV individuals or couples

Have explained 'truth' vs. myth that come out in conversations

Hasn't changed as a result of this workshop

I have always been careful about confidentiality and shared information

I have always tried to advocate on behalf of ALL of my clients – wherever indicated

I think we all have a better understanding & therefore can now speak with knowledge & not from assumptions

I orient new & existing staff-it helped

Expressed more confidence in my ability to work with, and if possible, relate to the client

Have always supported clients regardless of health issues

I am very open minded about clients etc

Being able to make others aware of the issues that impact people's life and the choices they are able to make with the knowledge they have- Being so aware of people's needs & share that with others before judgements take place.

Total: 17 responses

## Appendix H

### Question M-b-2: Changes at Work Regarding Provision of Services

Just that my information on AIDS is more correct

Perhaps increased comfort, confidence client groups/volunteer service people seem to ask educative questions that I answer & can provide direction for more info/ services

More caring

A clearer understanding has helped me be more empathetic

I feel I gained more of an understanding as to what the client faces, so I would be able to work with the client in a more nonjudgemental way, to deal with what faces them, instead of focusing on the horrible disease.

Use more empathy with client and family

I consider myself to be empathetic and work diligently in my care delivery

Same as above. I have more confidence in what I am speaking about

NEEDLE EXCHANGE CLIENTS: I do not feel I have to give needles on a 1-1 basis. If someone only brought in 2 needles & wanted 10 needles- that's OK

I am more aware of my own body language- how I ask questions etc- more sensitive to their experiences

Obtained a better understanding of the resources available, at the local level, therefore able to provide the best possible treatment for the client

Hard to remember. We have used universal precautions since day 1 - however staff may have relaxed in attitude re: stigma attached to individuals ???

Being more empathetic, less critical of their choices- More supportive- More focused on the need to teach people- Knowledge that will help them increase their choices.

Giving information in a fun way. Also using the modules to give clients small pieces of information over time for learning that meets their learning needs

Have a greater knowledge base

More empathetic

More aware of making services more accessible

HIV/AIDS has never been an issue. We treat them the same as any other client. We have always had open discussions on the topic

Total: 18 responses



## Appendix I

### Question M-c-2: Changes at Work Regarding Advocacy

Easier to talk with people about HIV and AIDS as I feel I know more

I always advocate for clients

This has not changed for me I grew up with 1st Nations people & I did a research paper on HIV/AIDS in university so my knowledge & acknowledgement level was probably OK before the course

More calls to community agencies

We try to do relative to family need

Not my job

Connecting people to other supportive systems

A strong belief in advocacy has always been an active part of my work w/families

In general conversation

Especially with staff

I do this anyway, their HIV status is not a factor in this

We were strong advocates before the training. We have always been conscious of helping to give voice to persons who are marginalized in our society. Our clients are a marginalized group

Not r/t this workshop

Perhaps more response to questions of service providers and low (no) health risk in providing food (volunteer work)

But not in the sense of legal advocacy or as an associate at a meeting

Able to explain need better & necessity of item required

I, at one point requested a specialized caseload for persons living with HIV/AIDS

I am part of an AIDS support/Ed group & have also been involved in developing many community events about HIV/AIDS

Total: 17 responses

## Appendix J

### Question N-b: Changes in Work Place due to Staff Participation

More knowledge & comfortable

More understanding coworkers

I think that initially staff in general are more aware from what they learn. People remind each other to use gloves more than we used to

I admired those who admitted & confronted their issues over homophobia. It took courage in today's political climate.

Those from my workplace who went probably weren't the ones who had the most homophobia issues.

I'm not sure who attended. I suggest nursing staff would benefit from these work shops

Using universal precautions

more

Knowledge of issues helps the work team work in consistent manner with our clients

More awareness and 'sharing'?

See previous page (Needle Exchange program at .....)

Increased knowledge & confidence among my co-workers. This created a more supportive atmosphere for both clients & myself (when in need of a second opinion or someone to "vent" to)

Everyone seems more open minded

More awareness- Less fear- More empathetic

A better more accurate knowledge base

Brought us closer as a result of shared experience

Greater understanding & knowledge. Less prejudice

More empathy

Most of staff still do not want to talk about issues of marginalization

Most staff members were not pleased with the training contents

Regarding accessibility!

More knowledge base

Greater comfort level with clients, knowledge, topic

But I do think some people may be more comfortable as they are no longer misinformed as to the dangers etc of working with those who may be affected

More awareness of conversation & who might be around

Initially.. One co-worker acknowledged his inappropriate vocabulary around clients. For a brief time there appeared to be some awareness

A bit less of off-colour joking

Many coworkers resented tone of 1st Nations component- felt (agency...) & workers were being attacked- therefore ears were shut & important info not internalized

Total: 28 responses

## Appendix K

### Question O-a-2: Changes in Personal Life Regarding Discussion of (Client) Groups

Stop people from judging others when they don't have the "whole picture" - Be more empathetic  
 More understanding & empathy  
 Way less politically incorrect comments &/or jokes  
 More understanding  
 Has crossed over to my volunteering Amnesty International work  
 Have always been respectful  
 I find I advocate for people more (in informal settings)  
 I'm less tolerant of homophobia & with persons who "blame" HIV/AIDS on the homosexual community. I didn't tolerate it before, but now I'm more likely to give voice to my feelings  
 s/a  
 Advocate  
 Not just this workshop but a combination of learning  
 Yes, as mentioned above in volunteer work that provides food to people  
 Share HIV information with friends/family  
 Easier to help stop 'myths' etc....  
 When people make assumptions, or judgements, I address the underlying issues that people may be uneducated too  
 Over the last few years I find myself trying to educate people I come in contact with, because I find most people very stuck on old beliefs  
 Let people in my life know about what I learned  
 I speak with knowledge & therefore pass on what I have learned to stop stigma of stereotyping.  
 Less prejudice  
 Absolutely- the biggest change in fact I almost never let a negative statement re: HIV/AIDS, gays/lesbians/IDU's etc go by without "gently" commenting on a more generous point of view

Total: 20 responses

## Appendix L

### Question O-b-2: Changes in Personal Life Regarding Advocacy

Wish we could do more, however resources dictate

Do not really advocate but have personal friendships with members of some of mentioned people

I still do the same in regards my work

see M) c

same as above

General comment: Received in depth training in social work program at university that addressed marginalized groups, radical structural social work, oppression etc thought the workshops re-affirmed my beliefs and attitudes- from before Knowing the history, ie. Aboriginals, you can begin to understand why they may be there ,as well as how the systematic marginalization is embedded into our society, and everyone deserves equality

Like I said before I have advocated for clients for a long time. That is part of my job

As above. People judge out of ignorance. I just pass on what I learned. My suggestion to all is to take modules

Well yes in my work. I have had to address HIV/AIDS issues at many levels- the street to the Board Room.

Total: 10 responses

## Appendix M

### Question P: Most Liked Aspects of Workshops

I learned that I was homophobic & didn't believe I was  
 Shared info in a relaxed atmosphere that encouraged participation  
 I enjoyed the knowledge from experts & the chance to examine my feelings. Tolerance is not necessarily a good thing  
 Open atmosphere exposing of myths taboos  
 Nothing  
 How issues of racism & homophobia are brought forward  
 Meeting people in the community  
 Education. Good facilitators  
 Putting condoms on woodies  
 Values - Beliefs- systems- Self-disclosures- how it brought people together  
 Information was given in fun with demonstrations & interactive exercises  
 A lot of good discussion was generated. I liked the high interactive environment immensely  
 Openness  
 Group discussions  
 Can't remember  
 Basic easy to understand info  
 Openness of the facilitators  
 The health related information, the impact of HIV/AIDS on people in contact with someone infected  
 General format  
 Resource material. Provided a good knowledge base re: meaning of acronyms, transmission, protection & definitions  
 Raising issues to awareness. Increased understanding of what is supportive, what to ask, how to ask, when to listen  
 Education & Direct dialogue around topics many individuals don't discuss  
 Participatory  
 The information I received  
 Facilitator knew the subject  
 It was a rehash of previous info & knowledge  
 HIV/AIDS fact  
 content  
 Very informative-gave good perspective of how discrimination, the disease etc affects people we work with  
 It was presented in a clear way that made it much more understandable  
 The way it was presented allowed me to see where I needed work because my values & beliefs play a part in how I  
 analyse & then work with my clients  
 Learning with coworkers  
 The kind of interaction with other staff (positive) coming away from the workshops feeling good & having learned.  
 Opportunities to explore issues.  
 It was open, personal & not guarded. It was pretty nitty gritty. That was good.  
 Discussions with colleagues. Factual information about the illness  
 The discussion with my colleagues  
 Good discussions & participation. Worthwhile program for public education, nursing staff etc. I think social workers  
 are generally aware- or I would hope so  
 Presenters were very knowledgeable and able to field questions well  
 The facilitators were so knowledgeable & would answer any/all questions  
 The amount of information that was presented & how it was presented. The 1st Nations workshop as a real "eye" opener  
 The humanness & realness of facilitators and the knowledge they shared  
 Did similar workshop previously and good to get a refresher  
 The intimacy and sharing  
 Interactive  
 All of the individuals from this community coming together to increase knowledge  
 Difficult to recall- individuals who were positive, sharing their stories

## Appendix M

### Continued

Community support

Listening to First Nations person with HIV speaking

The female native HIV+ individual who talked very openly about her life with drugs & HIV

P. Geo. Staff excellent! We had 80+ people attend & almost all stayed the full 2 days. Great for our community

It was a fun, informative workshop- lots of participant involvement

Very informative

Content on marginalized people was thought provoking

The facilitators were excellent. They maintained a warm and pleasant attitude despite the weary topics

Participatory

Very informative, getting along with others

Straight up casual yet informative and interesting

Good Instructors – humour, were at ease with the group – good participation from group

Total: 58 responses

## Appendix N

### Question Q: Least Liked Aspects of Workshops

N/a

N/a

The thought that we were asked if OUR attitudes towards homosexual people had changed. I think most peoples' beliefs are well entrenched & as long as everyone we affect is treated with respect & consideration- no one can ask anyone to change their attitudes or beliefs

I would have liked to participate in all five modules

Nothing

A slight condescending attitude towards certain groups (eg. Church) - There should be no labeling of other beliefs

Can't remember

Having to articulate the groups' work to others The p

First Nations workshop

That I didn't have the opportunity to take all the workshops- I was away on LOA

Length. 6 - 2 hour sessions

Nothing

The section on homophobia thought the (perceived) goal of exercise reached a little high. Education does not always bring

ACCEPTANCE. Felt that class mates who expressed tolerance but not acceptance were being told they were phobic

The fact that the workshop commenced with an exercise that indicated/ accused all participants as homophobic/racist

Although recognize difficulty of doing so with professional/community colleagues- would have liked more emphasis on

People confronting/acknowledging bias/ prejudice

The section that had us look at identifying with an ethnic group. For 3rd generation and beyond Canadians this can sometimes be impossible to do

I appreciated it all

Not enough time to discuss the issues that came up

I would like AIDS PG to come to my workplace for workshops

A large part appeared to be attempted political indoctrination

Don't remember

Nothing comes to mind

Having 5 parts may mean people are unable to commit for the entire series & so miss out on info

N/A all excellent

I can not think of anything. Maybe there could be more about how to effectively counsel our clients

2 very snowy days! Hurrah for the PG AIDS society for coming

Nothing

Not really applicable in work setting or with client population

Nothing. I was VERY satisfied.

Somewhat repetitive

N/A

Would have liked more instruction with dealing with AIDS clients in community setting ie. LTC more education in the medications

The First Nations woman went off on a tangent about the injustice of residential schools. Yes, but I didn't do it to you

Total: 33 responses

## Appendix O

### Question R-b: Usefulness of Workshops in Work Place

Important information for professional development due to client group we work with  
 More understanding from more knowledge  
 All of the above comments  
 Accurate & current information. Simple booklets for reading  
 Not at this time  
 Not in concrete ways as much as perception  
 The principles of understanding a marginalized group are broad  
 In education we re issues around AIDS  
 Made us realize that we need separate policies regarding HIV. Also brought forward how much work needs to be done on the "isms" in our place  
 Interesting to listen to different ideas  
 We see a wide variety of people here & encouraging use of condoms  
 Not particularly. It did not expand my knowledge nor change how I viewed the issue  
 Reinforced extant understanding & knowledge- updated statistical info  
 They were useful & enjoyable however I didn't find that they had a lot of new information  
 Added to knowledge base  
 A good review/update in some areas & learned new info in other areas  
 At the time they increased my knowledge  
 More current info- easily accessed  
 Good for staff to get knowledge, ask questions in a safe environment  
 Many people did not seem to know the basics of universal precautions...how HIV is contacted etc  
 I am the financial controller & do not have an active role with the client base  
 Increased knowledge & awareness  
 Good series. Raised awareness. Saw variety of views etc. in my workplace  
 For co-workers  
 Ensured we all had a similar base of info  
 Being better informed gives me a much better understanding & seems to make the client a little more comfortable when they realize I know something of what they are dealing with.  
 Very informative  
 Great review of info already aware. Reinforced should not be fearful of ?people? with -  
 Partially- good and relevant info was negated in parts due to "accusatory " tone  
 Knowledge. Comfort- increased with understanding  
 As stated previously, it made me more aware of some of the issues these people face on a daily basis  
 More education/knowledge = more understanding  
 I can't remember much of what we did, its been a long time. I remember using info from workshop afterwards, in my Workplace & feeling good about it.  
 Have clients with HIV. We do not have as many as we should  
 I appreciated receiving current medical information about HIV/AIDS  
 Could have been  
 Not particularly- though interesting  
 They answered a few of my concerns  
 As I deal w/ HIV/AIDS people & with people who live lifestyles that put them into contact with this, the understanding gained from modules helps me deal with issues arising  
 Bring a refocusing on the issues when dealing with my clients and for my own safety  
 First Nations info was very helpful  
 Reinforced many of the positive things that we do at the Health Unit. Reinforced networking for HIV in our community  
 As I have already said  
 Provided me with more information to teach/share with my volunteers  
 They could be if we as a hospice group were to encounter HIV/AIDS clientele



## Appendix O Continued

Better understanding of how HIV/AIDS affects people

As stated in previous answers

Greater understanding of issues-broader knowledge base helps to know what to look for & pay attention to with clients

Total: 48 responses

## Appendix P

### Question S-B: Usefulness of Workshops in Personal Life

Provide me with more info for people who don't know or understand (eg. It's NOT only gay people who get HIV)  
 Discussing w/friends & family as many have misinformation or unnecessary fears from lack of accurate information  
 Am more discerning as to what info I pass on  
 As above  
 See above re Amnesty International work, understanding of gay/lesbian acquaintances  
 I have discussed the teachings of AIDS PG with friends & family members & the slant that is portrayed by AIDS  
 instructors & the filthy graphic comment made by them  
 I had been doing education in moments already  
 Again, educating people who know little  
 Same as above  
 See R  
 It helped me to better articulate my feelings & beliefs when I've come across intolerant/ignorant people  
 Pass the info on to others  
 Unsure  
 I can speak more specifically my knowledge is not hearsay  
 Not really. I had informal information on AIDS so I had a base of knowledge to start with  
 Increased knowledge and awareness  
 Volunteer work  
 Same  
 Good info on HIV/AIDS to share with children  
 Same as above  
 So I had educated information that I could pass on to family, friends and others  
 Things we learned at the workshops were useful in many settings and gave you things to think about  
 Understanding of people in general. Also a great place to send growing children for sex ed. If it comes better from a  
 3rd party !  
 I did not require consciousness raising or a change in my values and beliefs  
 I only was able to attend the introductory presentation, but it gave a good overview  
 Personal understanding & explanations. Passed on to my children and grandchildren  
 Can always use the awareness it brings  
 Just for the general knowledge  
 But not to the same degree as in my former workplace. This is due to my exposure to high-risk clients  
 For educating others  
 Just reiterated what I already knew. I'm empathetic and understanding and open-minded.

Total: 31 responses

## Appendix Q

### Question T: Other Comments Regarding the Workshops

Are they still being offered?

These workshops are valuable-they didn't significantly impact my knowledge/skill base only because I have previously done HIV/AIDS training, First Nations, & Sexuality/diversity/unlearning racism work etc

(F\*):To clarify- It's not that the modules weren't informative, its just that I already knew a lot of it. This does not mean that it wouldn't be more effective for the majority of people with a lesser knowledge base.

Excellent information given in an open way

Very good

Enjoyed the workshops & feel they were/are worthwhile for our community. It's too bad we can't educate others/general public in our community as well

Without participating in all modules I don't think I should comment

Useful information

The workshops were very good

I liked them

I believe the workshops should be offered on ongoing basis for people who didn't have the opportunity to take them before- & for people just getting in the field

A very worthwhile course. Recommend it highly

I appreciate the chance to take part

No

About how it is normal to be gay and everyone should embrace their lifestyle: ABNORMAL ( table G\*) AIDS PG mandate seems to be acceptance of the gay lifestyle, & if you don't, YOU ARE THE ODD ONE OUT. Should try teaching AIDS education-where-how-what. It was a disgusting experience for me & many others who left the modules or never returned. Problem is they left with more negatives then when they started.

I was already aware of this issues & information. I had been involved in an AIDS service organization before so there was little change for me

Excellent ! Knowledge, understanding = Less discrimination & fear

No

I think that these type of workshops should be mandatory for all workers-medical, helping profession, general public, because there are many uneducated people & they FEAR HIV/AIDS & they act accordingly (M-a\*) Confidentiality is utmost for clients that have HIV/AIDS, so it was/is imperative to monitor what I would discuss with coworkers (not so much), the helping professional (especially) due to the reaction if they connected client with agency

It has been so long it would be nice to be refreshed to some degree on these

(B-year\*) Please note: although I have been told that I attended the workshop, I have little recollection, therefore am unable to fill in the survey with any degree of accuracy or insight

This workshop was over 3 years ago. Very difficult to remember specifics

(G\*) I don't believe my understanding has changed. I have always had an appreciation of groups listed from S.W. perspective

I took this course in April 1997, fortunately I found my old notes to jog my memory otherwise I think the time lag before evaluating it has been too long to ensure people can remember what they learned. I also was able to attend only one session

I would just like to say the people who facilitated our training were great & I think follow up modules if possible would be of great benefit to all agencies.

Sorry but its been too long and my memory isn't as sharp

Cannot remember workshop/very little

Yes- so much time has passed since- lots of influences since then

Difficult to recall workshop. Lots of education/experiences since '98, various influences

Can't remember content. Have done lots of reading re:HIV/AIDS as well. Have been to other HIV/AIDS workshops, can't remember if knowledge is from this workshop or others attended over the last 2 years.

(K) don't work with this client group

Great workshop! Well done! Thank you!

\*(A)I can't recall but maybe (MOD-5) was incorporated into the first 4 sessions.

### Appendix Q Continued

I was impressed by the amount of information that was covered-& would be interested in attending the modules I missed

It's been many years since I've taken the workshops but the info. Learning has stuck with me (unlike many other workshops).

It was well done

(F\*) I have a lot of previous knowledge due to involvement in workshops in BCCW & Aurora Treatment Centre for Women

Total: 37 responses