SAFE SEX INTENTION TOWARDS HIV/AIDS PREVENTION AMONG SECONDARY SCHOOL STUDENTS OF NAKHON PATHOM PROVINCE, THAILAND

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ABSTRACT

A cross sectional study was conducted on March 2006 by interviewing 281 secondary students at Mahidol Wittayanusorn School, Nakhon Pathom, Thailand. The study aimed to identify safe sex intentions and their determinants (and assess the characteristics of socio demographic variables, attitudes, subjective norms and safe sex intention to prevent HIV/AIDS). The instrument used for data collection was a self administered questionnaire.

The study group represented an age range 13-19years and comprised an almost equal number of males and females. The majorities of students were living in dormitories (and were studying in mathayom 4, mathayom 5 and mathayom 6).

The results showed that 70 percent of students had a high level of attitude towards HIV/AIDS prevention. Students had high level of attitude to being abstinence and stay with single known partner to prevention HIV/AIDS, relatively low attitude to use condom and avoid premarital sex. The attitude has statistically significant positive relationship with safe sex intention.

The result also revealed that nearly 70 percent of respondents had good subjective norms and high level of good responds to their parents and teachers norms than friends. 60 percent of students had good intention to prevent HIV/AIDS, only 4 percent had poor intention.

The Study found a statistically significant positive association between safe sex intentions and age, gender and mathayom. It is necessary to provide appropriate sex education in secondary schools and create a good environment in which students are able to discuss sexual and related problems with their teachers and parents. It is also important to encourage them to practice safe sex for HIV/AIDS prevention since they already have good attitude and intention.

KEY WORDS : SAFE SEX INTENTION / HIV/AIDS PREVENTION SECONDARY SCHOOL STUDENT / NAKHOM PATHOM PROVINCE

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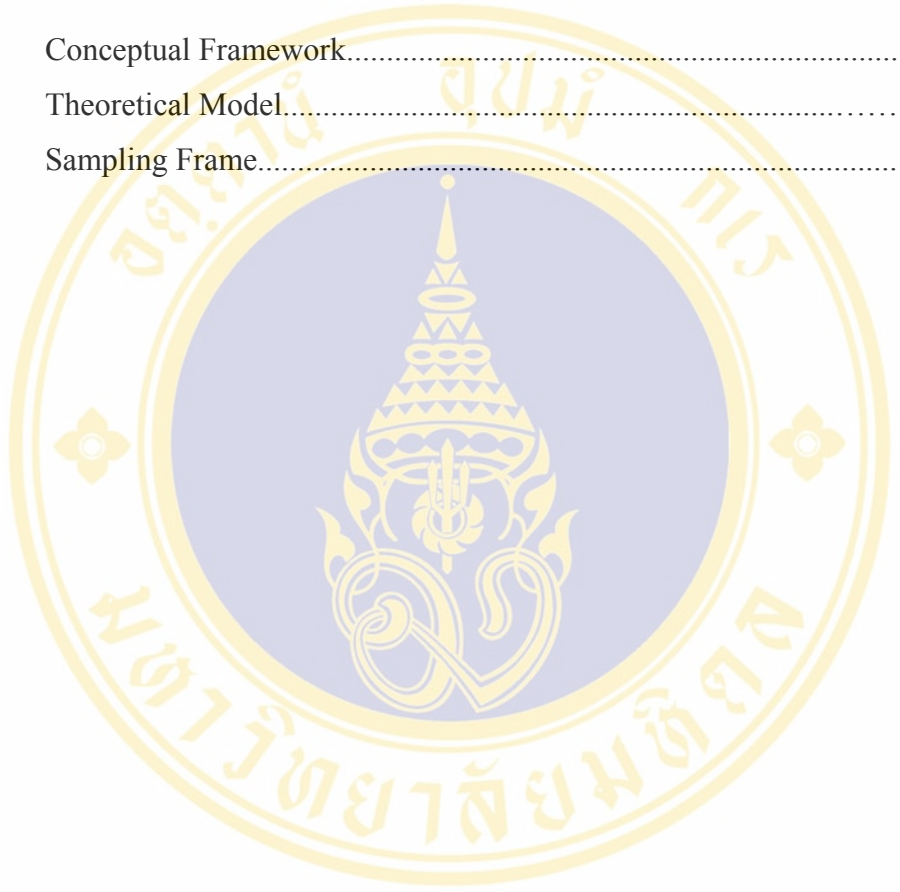

LIST OF ABBREVIATIONS

JICA	: Japanese International Cooperation Agency
TICA	: Thailand International Cooperation Agency
HIV	: Human Immune Deficiency Virus
AIDS	: Acquired Immune Deficiency Syndrome
WHO	: World Health Organization
STD	: Sexual Transmitted Disease
HBM	: Health Belief Model
TRA	: Theory of Reason Action
AIHD	: Asean Institute for Health Development

CHAPTER 1
INTRODUCTION

1.1 Rationale and justification of the study

Adolescent in World

Adolescents is defined by WHO as persons between 10 and 19 years of age, make up about 20% of the world's population, of whom 85% live in developing countries. Yet until now they have been neglected as a distinct group and have generally been subsumed under the heading of child, family or women's health and welfare. This has at least partially been because adolescents were considered to be a relatively healthy age group, one without a heavy "burden of disease", compared, for instance, to newborn infants or elderly adults. However, recognition has been growing in recent years among policy-makers that adolescents have special health-related vulnerabilities. The major causes of morbidity and mortality among young people include suicide, road accidents, drug use (including tobacco use) and sexual and reproductive ill health. Furthermore, adolescence is increasingly seen as a "gateway to health" because behavioral patterns acquired during this period tend to last throughout adult life – approximately 70% of premature deaths among adults are due to behaviors which began during adolescence. Many adolescents around the world are sexually active and because many sexual contacts among them are unprotected, they are potentially at risk of contracting sexually transmitted infections (STIs). Adolescents' use of contraception is generally low and they are less likely to use condoms than adults because of lack of access and, for girls in particular, the inability to insist on their use (1).

Sexually transmitted diseases many be the consequence of unprotected sex with a number of short-term partners, but may also occur among those who have a long-term unfaithful, perhaps older, partner or husband. The risk is often greater for adolescents who are in socially and economically marginalized positions as sexual

activity may take place within a context of coercion or violence or in the course of selling sex for a living. Furthermore, for biological reasons, sexually active girls may be at greater risk of contracting STIs than boys. One of the reasons why young people are particularly vulnerable to STIs is the lack of sex education, including on STI prevention. There is still reluctance in some quarters to acknowledge and properly address adolescent sexual activity despite widespread evidence of how early sex begins and the extent of unwanted pregnancies and STIs in young age groups (1).

Adolescents in Asia

Of the estimated 1.2 billion adolescents in the world today, nearly half live in Asia, and nearly one in four (282 million) live in South Asia(2000). Adolescents aged 10–19 comprise over one-fifth of South Asia's Population. Within the region, Bangladesh and Pakistan have the greatest proportion of adolescents, while India has the greatest absolute number (2).

Adolescents in Thailand

Among Thai population one out of five are adolescents at the age group of 10-19 years old, or about 12.3 million people are adolescents. Adolescents, therefore, are considered to be large and important groups who have special needs. Social changes and conditions such as migration due to education and economic advancements, modernization, social network, and peer group influence encourage boys and girls to involve in premarital unsafe sex. Thai adolescent's both male and females, increasing enter in to the sexual relation without much knowledge of sexuality, reproduction, or contraception and with little emotional preparation. They face enormous risk from sexually transmitted diseases and HIV/AIDS. In 1996, government statistics show that forty seven percent of STD patients were in the group 15-24. Half of the HIV cases among Thai are also in the age group of 15-25(3).

Adolescent and Sexual Behavior

Although, national-level surveys tend to suggest that premarital sex is less common in Asia, more focused in depth studies on adolescent sexual and reproductive health undertaken in some countries of Asia have revealed that it is clearly on the rise. Survey results on sexual behaviors of adolescents in Asia suggest that a noticeable percentage of adolescents are sexually experienced. In Korea, for example, 24 per cent of male and 11 per cent of female secondary school students reported to have had pre-marital sexual intercourse. Among sexually experienced adolescents, a majority of women had their first sexual intercourse with a steady boyfriend with marriage in mind, while a significant proportion of men had the first experience with a commercial sex worker or a casual friend. In the Republic of Korea, Nepal, Thailand, and Vietnam, over half of the adolescent men had sexual intercourse with sex workers. A large number of sexually experienced young men have also reported having multiple sexual partners; close to 70 per cent of male students in the Republic of Korea and about 30 per cent of young men in Thailand had more than two partners. In India, although traditional norms oppose premarital sex, some studies indicate a growing trend towards premarital sexual activities among adolescents. Data from Bangladesh revealed a very high incidence of premarital sex: 61 percent of males as compared with 24 percent of females have had premarital sexual activity among adolescents, and this percentage was much higher in urban than in rural areas. Results from a 1991 study conducted in nine districts of Nepal also found that 20 per cent of young people were engaged in premarital sex. Similarly, a study in Nepal border towns found that less than 65 per cent of unmarried men aged 18 to 24 ever used a condom during sexual intercourse with non-regular sex partners, including commercial sex workers (4).

Malaysia: A study on the reproductive health of adolescents (aged 13-19) revealed that 40 percent of respondents had begun dating from age 13. By the age of 18, 84 percent had started holding hands, 85 percent kissing and necking and 83 percent petting. (4)

In Myanmar, it has been traditionally believed that unmarried people are not sexually active; however, many people acknowledged that unmarried people are engaged in premarital sex. In LaoPDR a study among community members revealed that sex and pregnancy before marriage are common and more or less accepted because of the common belief that pregnancy outside marriage leads to marriage. Similar findings were revealed by the series of country case studies on sexual and reproductive health carried out by the UNESCO Regional Clearing House on Population Education and Communication, Bangkok. However, the motivations for pre-marital sexual intercourse are likely to be different for adolescent men and women. Young men tend to have the sexual debut out of curiosity or for the sake of sexual pleasure, but young women are more likely to have pre-marital sexual intercourse for love, and associate it with marriage or a long term relationship. Because of the differences in the nature of pre-marital sexual intercourse between men and women, the adolescent women often experience negative consequences of pre-marital sexual relations (4).

The low level of contraceptive use among. Sexually active unmarried adolescents have also been reported in numerous surveys. For instance, among Vietnamese college students, only 32 per cent of females and 28 per cent of males used a contraceptive method at first sexual intercourse. In the Lao PDR out of sexually experienced adolescents aged 15 to 25, as many as 79 per cent did not use any contraceptive methods at first sexual intercourse (4).

In Thailand Orachorn (2000) study on sexual behavior among school students among 15-19 years in Phuket Province, found that 47.2% had inappropriate sexual behavior. On the basis of the gender specific, it was reveal that 68% of male adolescents had inappropriate behavior while female students had 38.5 %(5).

Houque (1999) reported in his survey that out of 196 high school students in Salaya sub district in Thailand, 12.8% had sexual intercourse. Out of those who had sexual intercourse, 48% started at the age of sixteen (6).

Adolescents and HIV/AIDS

According to WHO, 333 million new cases of curable STIs occur worldwide each year with the highest rates among 20-24 year-olds, followed by 15-19 year-olds. One in 20 young people is believed to contract a curable STI each year, excluding HIV and other viral infections. In the USA alone, three million teenagers acquire an STI each year.

The HIV/AIDS pandemic is one of the most important and urgent public health challenges facing governments and civil societies around the world. Adolescents are at the centre of the pandemic in terms of transmission, impact, and potential for changing the attitudes and behaviours that underlie this disease (7).

It is estimated that 50% of all new HIV infections are among young people (about 7,000 young people become infected every day), and that 30% of the 40 million people living with HIV/AIDS are in the 15-24 year age group. The vast majority of young people who are HIV positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners (7).

Some young people are particularly vulnerable. In countries where the predominant mode of transmission is by heterosexual sex, girls are often more vulnerable than boys, for both biological and social reasons. Conversely, in countries where the predominant routes of spread are men having sex with men or injecting drug use (IDU). Young people involved with sex work, migrants and refugees, and adolescents living on the street, in war situations or who are marginalised and discriminated against, are all likely to be especially vulnerable. (7).

Other Consequences

Other unwanted consequences of sexual activity include early motherhood, complications of pregnancy and unsafe abortions for adolescent girls, and the psychological and health consequences of sexual violence for both sexes. Teen birth, teen abortion, and sexually transmitted infection rates in the United States are higher

than in most other industrialized countries. In 1999, 48 out of 1,000 U.S. women ages 15-19 gave birth—a rate 11 times greater than in the Netherlands and four times higher than in Germany. The teen abortion rate in the U.S. is more than three times that of France and nearly seven times that of the Netherlands. Many factors influence the differences in teen sexual health between the U.S. and these industrialized nations: affordable family planning services; sustained, realistic media campaigns; public health policy grounded in pragmatism and research; and sexuality information characterized by open, honest dialogue. Philosophically, many European countries accept that adolescents, especially older ones, are going to be sexually active. (8).

Table 1 Teenage Birth Rates and Teenage Abortions

Nation	**Teen Birth Rates** (per 1,000 women ages 15-19)	**Teen Abortion Rates** (per 1,000 women ages 15-19)
United States	48.7	27.5
Netherlands	4.5	4.2
Germany	12.5	3.6
France	10.0	10.2

According to literatures knowledge, attitude, beliefs develops for actions leads to individual behaviors. Human sexual behavior is a planed behavior which depends on strong intention of individuals towards the behavior. HIV/AIDS is a disease directly relating to the human behavior, therefore identifying the intention equally important to predict their behavior and to take measures to develop their intention towards HIV/AIDS prevention (9).

It is clear that adolescents are more vulnerable to HIV infection and other sexually transmitted diseases. During the past, most victims were adolescent who died with AIDS. Providing knowledge, changing their attitude towards safe sex practices will lead to change their behavior towards prevention of HIV infection which may

help to protect millions adolescents from premature deaths. Therefore this study will help to understand adolescent's intention towards the safe sex behavior and associating factors for future planning and further studies.

1.2 Research Question

1.2.1 What is the safe sex intention towards HIV/AIDS prevention among secondary school students in Nakon Pathom province?

1.2.2 What are the factors associate to safe sex intention towards HIV/AIDS prevention among secondary school students in Nakon Pathom province?

1.3 Research Objectives

1.3.1 General Objectives

To study safe sex intention towards HIV/AIDS prevention among secondary school students and determine the factors associate with safe sex intention towards HIV/AIDS prevention.

1.3.2 Specific Objectives

1.3.2.1 To describe the safe sex intention toward HIV/AIDS prevention among secondary school students.

1.3.2.2 To study the association between attitude factor and safe sex intention toward HIV/AIDS prevention

1.3.2.3 To study the association between subjective norms and safe sex intention toward HIV/AIDS prevention.

1.3.2.4 To study the association between external factors and safe sex intention toward HIV/AIDS prevention

1.4 Conceptual Framework

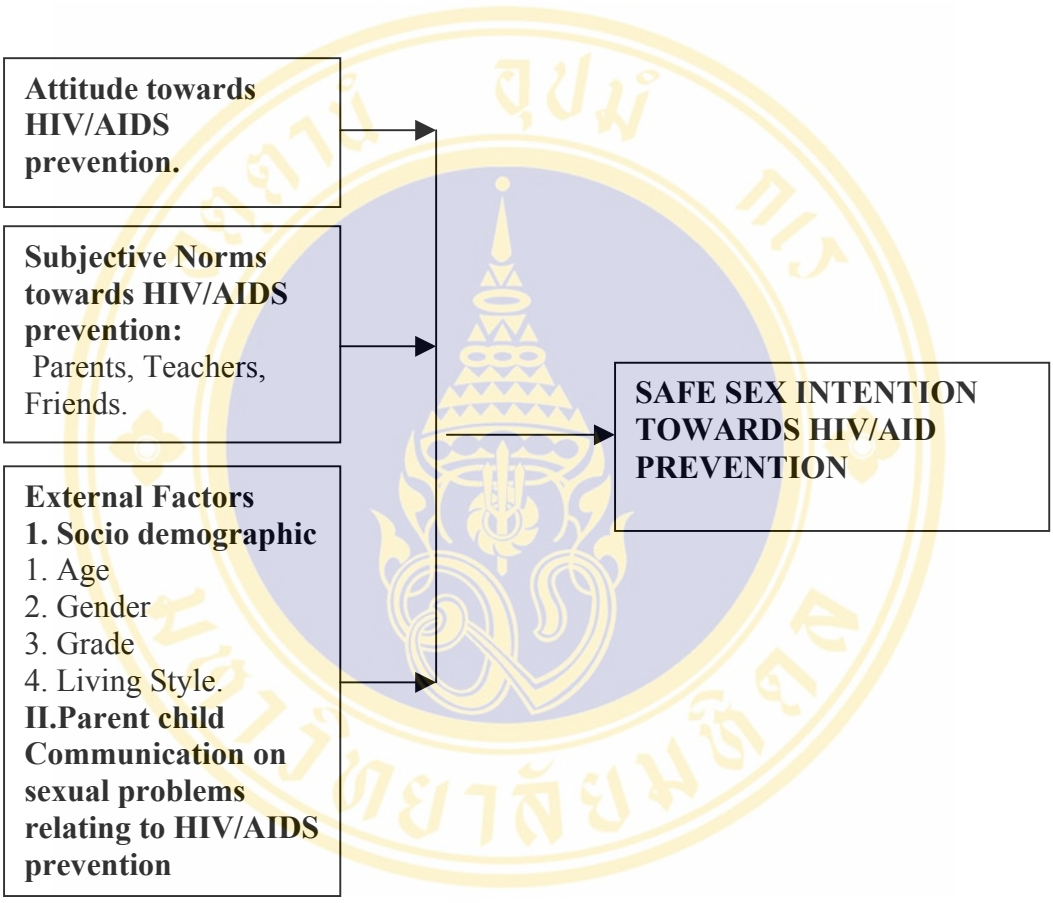

Figure 1 Conceptual Framework

1.5 Operational Definitions

1.5.1 Dependant Variable

Safe Sex Intention: In this study, safe sex intention refers intention of respondents to practice safe sex in order to prevent HIV/AIDS. Including using condoms during sexual intercourse, avoid premarital sex, and stay with single known partner.

1.5.2 Independent Variables

Age: How old the respondents in the study sample, divided in to two groups, Age 13-15yrs and 15-19yrs.

Gender: Refers to male and female.

Living Style: Residence and persons with whom the student is living. It is classified into: with parents at home, without parents at home and a dormitory.

Parent Child Communication on Sexual and Related Problems: In this study parent child communication is defined as communication between child and parent about child's sexual and related problems in order to prevent HIV infection.

Attitude towards HIV/AIDS Prevention: Define as student's beliefs and evaluation towards HIV/AIDS prevention. Respondent's attitude was measured using condoms during sexual intercourse, stay with single and known partner, avoid premarital sex, to prevent HIV/AIDS and attitude in general how to deal with people having HIV/AIDS.

Subjective Norms: Is defined as person's beliefs that specific individuals or group think she/he should or should not perform the behavior in order to prevent HIV/AIDS and his/her motivation to comply with the specific referents. Specific referents in this were parents, teachers and friends of the respondents.

1.6 Limitation of this Study

Because of cultural unacceptability some respondents did not express their real feeling.

Language was another obstacle in this study especially during data collection.

CHAPTER 2
LITERATURE REVIEW

Regarding the objective of this study, the literature review covered the adolescent development, social changes during adolescent, sex interest and sex behavior, young people and HIV/AIDS, previous studies, and theoretical mode of the study.

2.1 Aspects of Adolescent Development

2.1.1 Physical Development

Adolescents experience a growth spurt, which involves rapid growth of bones and muscles. This begins in girls around the ages of 9-12 and in boys around the ages of 11-14.Sexual maturation (puberty) also begins at this time. In response to these physical changes, young adolescents begin to be treated in a new way by those around them. They may no longer be seen as just children, but as sexual beings to be protected or targeted. They face society's expectations for how young men and women "should" behave.(10)

2.1.2 Cognitive Development

A dramatic shift in thinking from concrete to abstract gives adolescents a whole new set of mental tools. They are now able to analyze situations logically in terms of cause and effect. They can appreciate hypothetical situations. This gives them the ability to think about the future, evaluate alternatives, and set personal goals. They can engage in introspection and mature decision-making. (10)

2.1.3 Emotional Development

Adolescents are faced with the large task of establishing a sense of identity. The new cognitive skills of maturing adolescents give them the ability to reflect on who they are and what makes them unique. Identity is made up of two components; those

are self-concept and self-esteem. The Course of emotional development will be unique for each adolescent. Yet some tendencies are seen in specific groups of adolescent. Boys and girls face different challenges in our culture and may have different emotional needs during adolescence. Girls tend to have lower self-esteem than boys some girls may need help learning to express anger and to be more assertive. In contrast, boys may need to learn to be more cooperative and that it's okay to express emotions other than anger. (10)

2.1.4 Social Development

The social development of adolescents takes place in the context of all their relationships, particularly those with their peers and families. Key features of adolescent social development are summarized in Table.(11)

Table 2 Key Features of Adolescent Social Development

Social Group	**Early Adolescence (ages 9-13)**	**Middle Adolescence (ages 14-16)**	**Late Adolescence (ages 17-19)**
Peers	Center of social world shifts from family to friends. Peer group tends to be same-sex. Strong desire to conform to and be accepted by a peer group.	Peer groups gradually give way to one-on-one friendships and romances. Peer group tends to be gender-mixed. Dating begins. Less conformity and more tolerance of individual differences.	Serious intimate relationships begin to develop.
Family	• Increasing conflict between adolescents and their parents. • Family closeness most important protective factor against high-risk behavior.		Family influence in balance with peer influence.

One of the greatest social changes for adolescents is the new importance of their peers. This change allows them to gain independence from their families. By identifying with peers, adolescents start to develop moral judgment and values, and to explore how they differ from their parents. (11)

Young adolescents are very concerned with being accepted by a peer group. This great desire to belong can influence some one to engage in activities that they normally would not consider. (11)

By middle adolescence, the intensity of involvement with a peer group gives way to more intimate friendships and romances. For these teens, peer groups provide a much-needed sense of belonging within the majority culture. (11)

The relationship between adolescents and their parents is changed by the adolescent's social development. However, the shift in the adolescent's social world from family to peers does not lessen the importance of the family in the adolescent's life. Family closeness has been confirmed as the most important protective factor against certain high-risk behaviors such as smoking, alcohol and drug use, and early initiation of sexual intercourse. (11)

The adolescent's new desire for independence leads to increasing conflicts between adolescents and their parents. Minor conflicts and bickering are considered to be normal as teens and their parents adjust to their changing relationship.

The characteristics of an adolescent's community can also have a great impact on his or her social development. Communities include features such as :(11)

- Neighborhood socioeconomic status
- Support networks for families in low socioeconomic status neighborhoods
- Schools
- Religious organizations
- The media
- People who live in the community

2.1.5 Behavioral Development

All of the developmental changes that adolescents experience prepare them to experiment with new behaviors. This experimentation results in risk-taking, which is a normal part of adolescent development. (12)

Engaging in risk-taking behavior helps adolescents to:

- Shape their identities.
- Try out their new decision-making skills.
- Develop realistic assessments of themselves.

- Gain peer acceptance and respect.

Unfortunately, some of the risks that adolescents pursue may pose a real threat to their health and well-being. These include motor vehicle accidents, pregnancy, alcohol and drug abuse, and cigarette smoking. Adolescents need guidance to channel the drive toward risk-taking behavior into less dangerous and more constructive pursuits. (12)

First, adults who work with adolescents must be able to talk with them about the process of decision-making regarding sex, drugs, alcohol and other safety concerns. The goal is to help the adolescent weigh the dangers and benefits of a particular situation, consider his or her own strengths and weaknesses that may affect decision-making, and then make the best decisions possible.(12)

Second, adults must be aware of positive pathways that teens might take to satisfy the need to take risks: becoming involved in a school play, learning to play a musical instrument, taking up a sport. A simple stretch beyond one's former capacities constitutes a risk and can satisfy many adolescents' need for risk taking. (12)

Most adolescents will take risks. Eventually most will learn how to realistically assess risks and then will change their behavior accordingly. For others, risk-taking behavior may signal a problem that is a serious threat to their well being. Signs that an adolescent's risk behaviors are beyond normal experimentation include behaviors that:

- Begin early, age 8 or 9.
- Are on-going rather than occasional.
- Occur in a social context with peers who engage in the same activity.

There are several factors that can help prevent the development of problem behaviors in adolescents, even under adverse circumstances such as poverty:

- Stable, positive relationship with at least one caring adult.
- Religious and spiritual anchors.

- High, realistic academic expectations and adequate support.
- Positive family environment.
- Emotional intelligence and ability to cope with stress.

Unfortunately, these factors are not ones that an individual can create alone. A community must be able to offer the resources to build these elements into its structure. In order for this to happen, the needs of youth must be given priority. (12)

2.2 Social Changes During Adolescent

Social adjustment is one difficulty that found in development of adolescent. Their much be adjustment with the opposite sex in relation that never existed before and to adult out side of the family and school environment. The most difficult are how to adapt with the increase peer group influence, changing in social behavior, new social grouping, new value in relation friendship selection, new value in social acceptance and rejection, and new value in selection of leaders. (13)

According to the increase of peer group influence, they spend much time out side home with the peer-group that certainly has strong influence on their attitude and behaviors. Peer-group is a major recreational outlet of the teenagers. For all these reasons it would be seem important for adolescent that their peer-group contain a certain number of friends who can accept them and to whom they can depend on

Regarding to the new social grouping, the most common social grouping during adolescent are

2.3 Sex Interest and Sex Behavior

To master the important development task of forming a new and mature relationship with members of opposite sex and playing and approved role for one's sex the younger adolescent must acquired more complete and more concept of sex, than they have as a child. Because of growing interest in sex the adolescent seeks

more and more information about it. Few adolescent feel that they can learn all they want to know about sex their parents and they take advantage of whatever source of information are available to them, discussion with their friends, book on sex or experimentation through masturbation, petting, necking, or intercourse. The ends of the adolescent period, most male and female have enough information about sex to satisfy their curiosity. (14)

2.4 Young People and HIV/AIDS

There is way to halt the spread of HIV/AIDS. We must focus on people. More than half of those newly infected with HIV today are between 15 and 24 years old.Yet the needs of the world's 1 billion young people are routinely disregarded when strategies on HIV/AIDS are drafted, policies made and budget allocated. This is tragic as young people are more likely than adult to adopt and maintain the safe behaviors (15).

Young people are the center of the global HIV/AIDS pandemic. They also are the world's greatest hope in the struggle against these fatal diseases. Today's youths have inheriting a lethal legacy that is killing them and their friends, their brothers and sisters. As estimated 11.8 million young people aged 15 to 24 are living with HIV/AIDS. Each day, nearly 6000 young people age between 15 to 24 become infected with HIV. Yet only a fraction of them only knows that they are infected (15).

More than two decade in to the epidemic, the vats majority of young people remaining uninformed about sex sexual transmitted infections (STD). Although majorities of them have heard about AIDS, many do not know how HIV is spread and do not believe they are at risk. Those young people who do know something about HIV/AIDS often do not protect themselves because lack of skills, the support or the means to adopt safe behaviors. (16)

Nonetheless in areas where the spread of HIV/AIDS subsiding or even declining, it is primarily because young men and women are being given a tools and

the incentives to adopt safe behaviors. Young people have demonstrated that they are capable of making responsible choices to protect them self when provide such support, and they motivate and educate them to make safe choices (16).

Educating young people about HIV, and teaching them skills in negotiation, conflict resolution, critical thinking, decision making and communication, improve their self confidence and ability to make informed choice, such as postponing sex until they are mature enough to protect them self from HIV, other STIs and unwanted pregnancies.(17)

2.5 Safe Sex Intention towards HIV/AIDS Prevention

More than two decades after the HIV/AIDS epidemic took root, in many countries continues to record the more and more number of HIV infections and deaths. The United Nations estimates that 34.3 million people in the world have AIDS, more than 50% higher than what the World Health Organization's Global Program projected in 1991, with 24.5 million of them in Sub-Saharan Africa (United Nations 2000). In spite of this alarming statistic, the HIV/AIDS epidemic on the world continent is still spreading rapidly. Although the governments of all countries are searching ways of dealing with the HIV/AIDS epidemic, political leaders in many countries have failed to demonstrate the leadership needed to raise AIDS awareness among their people. Heterosexual relationships became one of the major means in the spread of AIDS amidst the decline in its transmission from blood and blood products (Taylor, 1990; Wahdan, 1995). Individual behavioral change, particularly sexual behavioral change, appears to be the most effective means to prevent further AIDS/HIV spread under the current circumstance in many countries.(30)

Several recent studies have examined the AIDS knowledge level of adolescents and adults. Many researchers have found moderate to high levels of knowledge about AIDS across cultures. However, Roscoe and Kruger (1990) studied junior and senior college students and found that while 90% of the participants

answered two-thirds of the questions correctly, an item concerning the cause of AIDS was the only question answered incorrectly by less than 50% of the participants.(30) A number of studies show high engagement in unsafe sexual behaviors such as a high average number of partners, sex with unknown persons, as well as less than positive views about condom use, and a low rate of behavior change even after learning about AIDS. This suggests that a moderate to high knowledge level of AIDS may not be a predictor of safe sexual behavior practices (see Gray & Saracino, 1989). On the other hand, studies of American and Nigerian adolescents suggest that, as a result of the threat of AIDS, adolescents intend to or have made changes in their sexual behaviors and report lower engagement in unsafe sexual behavior.(30)

Attitudes towards AIDS and/or those persons with AIDS may also help predict behavior change, however the existing literature is inconclusive. Several studies find high levels of empathy, tolerance, acceptance, and positive attitudes towards AIDS or persons with AIDS (Serovich & Greene, 1997; Villarruel et al. 1998). However, other findings show neutral, unfavorable, or unsympathetic attitudes towards AIDS or those persons with AIDS (Carducci et al., 1995; Katz et al., 1995; Konde-Lule et al., 1989). For example, Al-Owaish et al. (1999) report that 80% of Kuwaiti participants felt that persons with AIDS should not be left to live freely in the community. A possible explanation for the variance in findings among studies is demographic characteristics such as nationality, age, sex, religion, ethnicity, and marital status. Knowledge level is another possible predictor of attitude, indicating that increasing knowledge levels of AIDS may produce more positive attitudes towards individuals with AIDS (Carducci et al., 1995).(30)

In addition to knowledge and attitudes about AIDS, previous literature on health behaviors has focused on the role of individuals' perceived susceptibility to AIDS as a motivator of behavioral change. An extensively studied model of health behavior change, posits that individuals must perceive themselves to be at risk of the health threat before they will take actions to reduce risky behaviors or to engage in healthy alternative behaviors.

Research focusing on the effects of beliefs of susceptibility to AIDS indicates that adolescents and adults who report high perceived risk for AIDS practice safer sexual behaviors, whereas those who perceive low risk for contracting AIDS report practicing unsafe sexual behaviors (Gray & Saracino, 1989; Villarruel et al., 1998). However, in a study of health behavior in Kenya, perceived susceptibility to AIDS was not a significant predictor of condom use (Volk & Koopman, 2001). According to the authors of this study, the failure of perceived susceptibility to predict behavior most likely resulted from participants' misconceptions about the origins and transmission of AIDS. For example, some participants reported the belief that anal sex was a safe alternative to vaginal sex (Volk & Koopman, 2001). For these individuals, misconceptions, or lack of accurate knowledge about AIDS, resulted in inaccurate assessments of susceptibility. In this way, it seems that perceived susceptibility must be coupled with accurate knowledge in order to bring about behavioral change.

An additional factor of the Health Belief Model addressed in this study is the role of self-efficacy in predicting individuals' implementation of safer sexual practices. According to the HBM, even when individuals perceive themselves to be susceptible to a health threat, such as AIDS, they will not change their behavior unless they feel confident in their ability to change their risky behaviors (Rosenstock, Strecher & Becker, 1994). In this way, an assessment of individuals' confidence in performing safe sexual practices is a critical element in determining whether or not individuals will actually change their behavior. (30)

In recent years, many researchers have examined psychosocial models of health behavior as these relate to HIV risks and safer sex. Researchers typically have drawn upon common models, such as the Theory of Reasoned Action, Health Belief Model, and used common constructs, such as perceived norms, efficacy beliefs, and attitudes about safer sex.(30)

The Theory of Reasoned Action (TRA) was originally developed by Fishbein and Ajzen as a general model of behavioral prediction. Subsequently, this model has been adopted by researchers to explore determinants of health behavior. According to

the model, behavior is a function of intention to behave in a particular manner. Intention, in turn, is a function of an individual's attitude about the act and the perceived norm regarding the behavior.(30)

The attitudinal component of TRA consists of the individuals perception about consequences of the act, as well as the evaluation of those consequences. For instance, if an individual believes that unprotected sex may result in contracting HIV (perceived consequence of unprotected sex) and that contracting HIV is a dreadful possibility (evaluation of the consequence), then that individual is likely to have an aversive attitude toward improtected sex.(30)

The normative component of TRA consists of the perceived behavioral norm and motivation to comply with the norm. For example, if the individual believes that only promiscuous people use condoms (perceived norm) and wishes to abstain from condom use to avoid seeming promiscuous (motivation to comply), he or she will likely have a positive normative conception of unprotected sex. Theorists have suggested that because intention is composed of both personal (attitudinal) and other (normative) elements, it is the best predictor of the respondent’s decision to practice safer sex.

Information-Motivation-Behavioral Skills Model The Information-Motivation-Behavioral Skills model of AIDS-preventive behavior is based upon the idea that information and motivation combine to influence behavioral skills. All three components are said to contribute to AIDS-preventive behavior. The information component consists of knowledge about HIV transmission and the effects of HIV on the body. This component is quite similar to TRA's perceived consequences of the act. The motivation component of IMB includes attitudes toward AIDS-preventive acts, subjective norms regarding AIDS-preventive acts, and behavioral intentions for AIDS-preventive acts. All of which are similar to TRA constructs (attitudes, norms, and intentions). The behavioral skills component includes efficacy beliefs and negotiation skills, both of which might be subsumed under TT's expectations (e.g., "It would be difficult for me to discuss condom use with a partner").(30)

The Health Belief Model is based upon the premise that perceived severity of consequences, perceived susceptibility to consequences, and perceived benefits of preventive behavior all contribute to health behavior. Severity of consequences and benefits of preventive behavior might be subsumed by TRAs perceived consequences and evaluation of consequences. For instance, if an individual believes that AIDS is a dreadful disease and that using a condom may prevent transmission of HIV, then that individual may be more likely to use a condom than might someone with dissimilar beliefs. In terms of safer sexual behavior, HBM includes perceived susceptibility to HIV infection as an additional factor in risk aversion. (30)

2.6 Related Studies

Age

Adolescent all over the world are sexually active, but the age that they start having intercourse varies between regions and within the country, between urban and rural settings (18) (29). As age increase the likelihood of participation of sexual activities increases. Many authors have documented strong correlation between age and sexual experienced (20) (21).

Gender

Humans are born with biological difference between the sexes, either male or female. Their roles, responsibilities, and feeling are controlled by environments, culture, or society they live. Both men and women our society to endorse stereotype of men that include characteristics such as aggression, independent, competence, dominance, and self-confident, whereas women are described as been more emotional, gentle, warm, sensitive and expressive than men (22). Many authors have documented that there is male female deference in sexual activity. According to Metha S. (23) the male female differential in sexual activity may be explained by the existence of double standards regarding sexual relation in most developing countries.

Living Allowance

Several previous studies found significant association between the money they receive for their expenses and their sexual behavior. Abraham L, Kumar KA (21) found that young people with high personal income have elevated likelihood been sexual experiences. The finding of Wageepiwat S.(24) attitude and experiences sex and AIDS in mathayom 6 secondary students in Bangkok revealed that those who received large amount of money from their parents tends to have more sexual experiences than those who received less amount.

Place of Living

Galambos NL, Tilton Walter LC (25) found that 15-19 years age group who lived out side of their family more prone to have risk such as smoking, alcohol taking, and having sex with multiple partners and very low condom usage in sexual intercourse. Holhan J. (26) found that students who use to stay in dormitory had more sexual relationship than who live with parents.

Attitude towards Safe Sex Intention

Abraham L, Kumar (21) found that 34.7 percent of young man with liberal attitude towards sex had sexual intercourse and 19.6 percent of young men with traditional attitude towards sex had sexual intercourse. Burack R. (27) this study confirms that there remain many different factors involved in teenagers' decision-making processes, about their developing attitudes towards sex and their resultant behavior. Despite a lack of maturity, such opinions and attitudes are bringing about definite views and sexual behavior patterns in teenagers as young as 12 or 13 years old who are becoming fully sexually active. In particular teenage boys are becoming fully sexually active at a younger age than the girls and are taking risks in doing so. They are being influenced by peer pressure, condoning promiscuity and are declaring the intent to practice unsafe sexual intercourse. Their level of maturity would appear to be inadequate for them to comprehend the implications and consequences of their actions.

Parent's Education

A cross - sectional study was done by Pham Hung Luc (28) on knowledge, attitude, and sex behavior of Mahidol University students found Occupation of respondence's father found to associate with their sexual behavior. The respondednce's whose father was a worker is more likely to have negative behavior than whose father was business and government servant.

Parent Child Communication

A study done by Mehta (23), close parental supervision discourage adolescent sexual activity by regulating teenager's and provide opportunity to discus topics such as sexual restraint. Millan T, Valenzuela S, Vargas NA (29) found that 24 percent female and 40 percent of male did not talk about their problems at home. Instated they consult their friends.

2.7 Theoretical Model of the study

Having reviewed literatures it was clear that sexual behavior of people associate with many factors such as attitude, believes, norms, information and external factors. In this study conceptual framework based on theory of reason action (TRA).

Theory of reasoned action: Fishbein and Ajzen develop the theory of RA which emphasizes on the role of personal volition in determining whether a behavior will occur. In turn this “behavior intention” can best be predicted by the person’s expectancies regarding the out come of the behavior. To understand behavior intern, which is seen as the main determinant of behavior, the TRA looks at a person attitude towards that behavior as well as the subjective norms of people and group that could influence that attitude. (31)

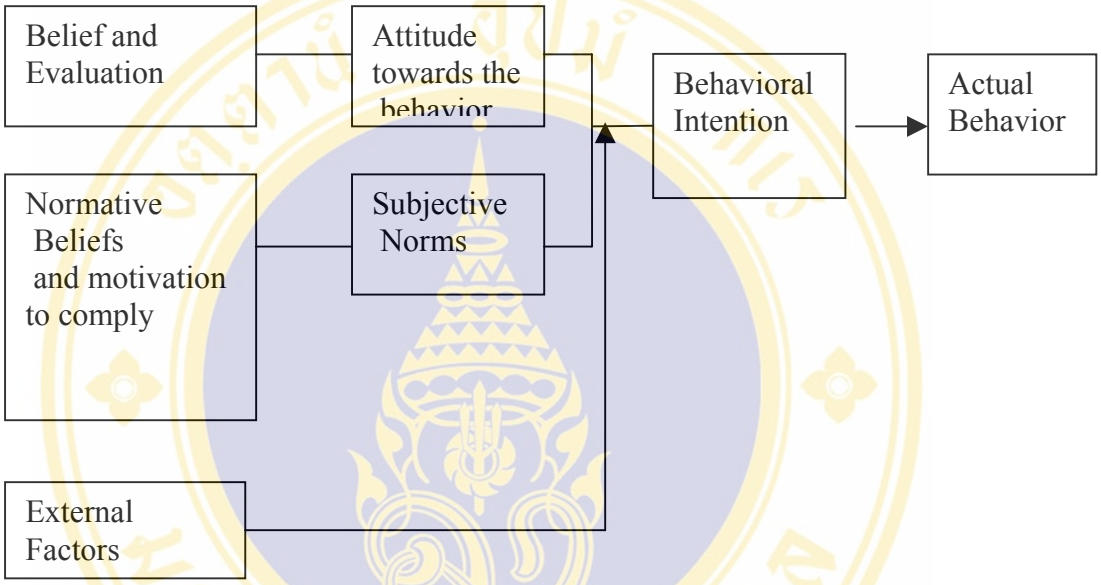

Figure 2 Theoretical Model

CHAPTER 3
RESEARCH METHODOLOGY

3.1 The Research Design

The research design of this study was descriptive analytic, objective of this study to determine the safe sex intention and associating factors of secondary school students in Nakhon Pathom province. Data was collected by using self-administered questionnaire.

3.2 Study Population

The target population of this study was the Mahidol Wittaganusorn secondary school located at Salaya sub district in Nakhom Pathom Provinve, Thailand. This school was located in between urbanized and semi urban area. Students are selected by a competitive examination from different areas of Nakhom Pathom Province and according to the director teachers pay more attention to provide sex education for the students.

3.3 Selection Criteria

i. A mix secondary school in Nakhon Pathom province
ii. A school situated in between urban and rural sector.
iii. A school in which any kind of sex education is provided.

3.4 Sample Size Calculation

Sample size

$$n = \frac{z^2 * p(1-P)}{d^2}$$

n = Estimated sample size

Z = Level of statistical significance set at 0.05 = 1.96

d = Absolute precision of the study = 0.06 p = 0.52 Anticipated proportion of safe sex intention in previous study

$$n = \frac{(1.96)^2 (0.52)*(0.48)}{(0.06)^2}$$

= **267**

Sample size of the study = 267

3.5 Sampling Frame

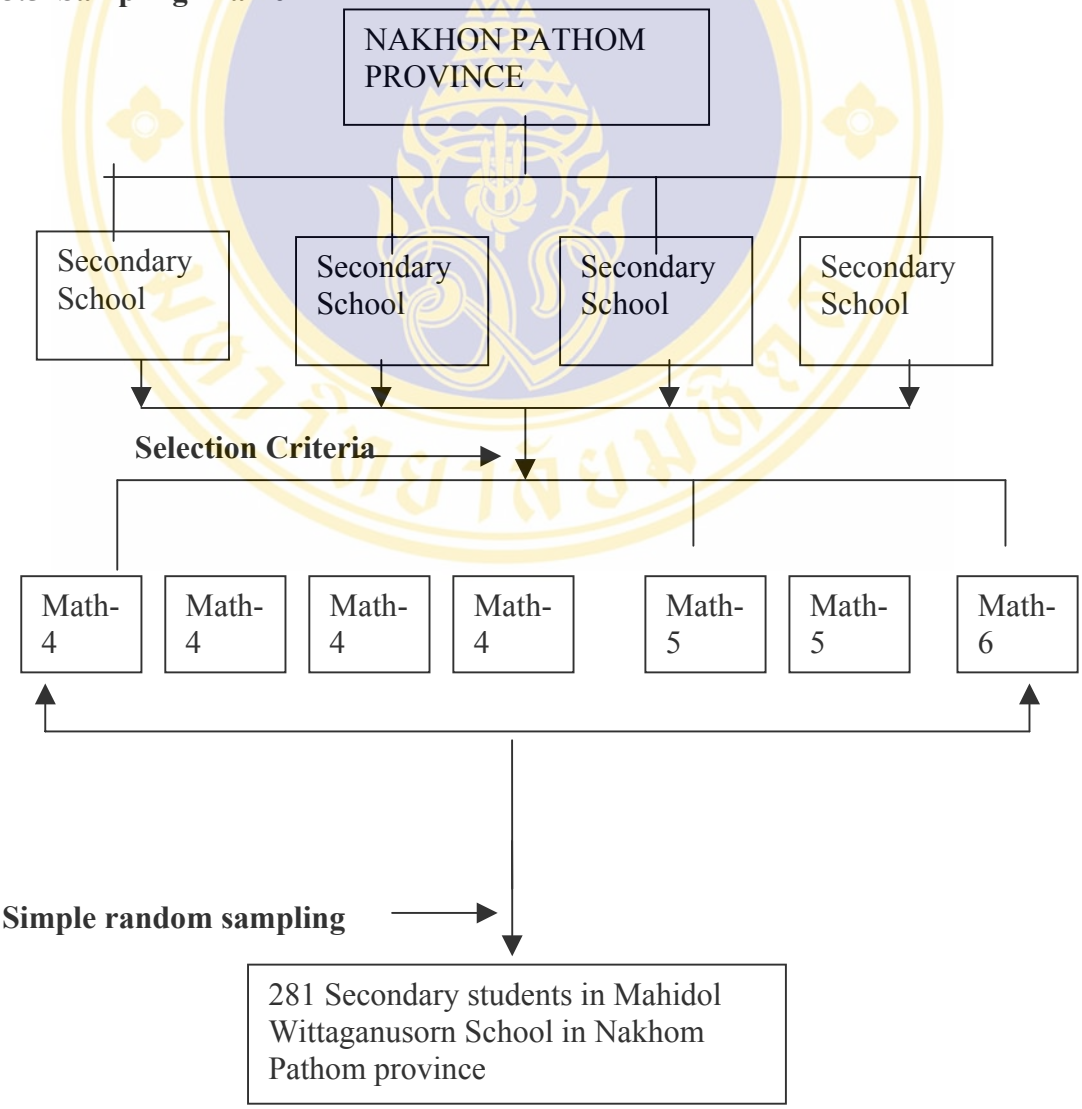

Figure 3 Sample Frame

3.6 Research Instruments

The structured self-administered questionnaire was developed according to the conceptual framework and objectives, which consisted four parts. The English version of the questionnaire was transferred to Thai language was pre tested and adjusted before the data collection.

Part 1: External factors include socio demographic and parents child communication

i Socio Demographic factors

Age, Gender, Grade, living style,

Age: divided in to two groups;

1) Age 13-15yrs
2) Age 16-19yrs

Gender: Male and Female

Grade: Mathayom 4

Mathayom 5

Mathayom 6

Living style:

1) Living in house with parents
2) Living in house without parents
3) Living in dormitory

ii. Parent child communication.

Parent Child Communication

This part comprised six questions base on communication between child and parent about child's sexual problems and sexual behavior towards prevention of HIV/AIDS. Respondents were asked to respond as "yes" or "no". Parent child communication was categorized in three groups according to the Bloom's criteria as "good", "moderate" and "poor'.

Part 2 : Attitude towards HIV/AIDS Prevention

Attitude toward Safe Sex

In this study attitude towards HIV/AIDS prevention refers student's beliefs and evaluation about their sexual behavior based on using condoms during each and every sexual intercourse, being abstinence, avoid premarital sex and stay with single and known partner. In addition, few general questions were included to the questionnaire. Attitude was measured by using eight (8) negative and ten (10) positive questions. Likert scale was used and attitude of respondents was categorized into three groups according to the Bast's ratting criteria as “good” “moderate” and “poor”.

For positive attitude questions the score given as follows

Strongly agree = 5 Score
Agree = 4 Score
Not Certain = 3 Score
Disagree = 2 score
Strongly Disagree = 1 Score

For the negative attitude questions the score given as follows

Strongly agree = 1 Score
Agree = 2 Score
Not Certain = 3 Score
Disagree = 4 score
Strongly Disagree = 5 Score

The total score was "90" for "18" questions

Subjective Norms

There were 12 questions about the subjective norms. According to the Fishbein theory questions of subjective norms includes two parts, in one part a statement was presented about norms of their parents, teachers and friends about respondents sexual behavior towards HIV/AIDS prevention. In second part respondent was asked to mention their agreement with their parents, teachers and friends norms. The total score of one question was a multiplication of scores of part

one and part two. Subjective norms of respondents were divided into three parts according to the Bast's ratting criteria as “good” “moderate” and “poor”.

eg: i Do you believe that your parents think that you should not have sexual intercourse before your get married.

a) Always√	b) Uncertain	c) Never
(Score 3)	(Score 2)	(Score 1)

ii. Do you agree with your parents.

a) Always√	b) Some time	c) Never
(Score 3)	(Score 2)	(Score 1)

Total score = 3 ×3

= 9

Part 4 : Safe Sex Intention towards HVI/AIDS Prevention

There were six questions on safe sex intention. Respondents were asked to respond about their safe sex intention as “always”, “uncertain” and “never”. Score was given as 3, 2, and 1 respectively. Safe sex intention was categorized into three categories according to Bast's ratting criteria as “good”, “moderate” and “poor”.

3.7 Validity and Reliability

3.7.1 Validity

Base on reviewing the relevant theories and research findings and according to the conceptual framework of the study, researcher set up the questionnaire and submitted to for correction and revision to advisers. According to the suggestions and advice of the advisers the questionnaire was revised and upgraded.

3.7.2 Reliability

The revised questionnaire was pre tested among 30 students in a school in Nakhon Pathom Province. The reliability of the questionnaire was calculated by using Cronbach Alpha Coefficient. Regarding the attitude, subjective norms and safe sex intention alpha value was found 0.637, 0.906 and 0.6721 for each and every question

respectively. This reliability test indicated that these questions on attitude, subjective norms and safe sex intention were fair enough to continue this study.

3.8 Data Collection

1. As a first step researcher contacted the Office of the Provincial Education through the AIHD office to get the permission for data collection by providing brief information of the study.

2. After obtaining the permission researcher contacted the director of the school through the AIHD office and two teachers were appointed as coordinators for data collection.

3. Researcher discussed with coordinators and made arrangements to select students using random sampling technique.

4. Finally the data was collected by using self-administered questionnaire.

3.9 Data Analysis

The self administered questionnaire was coded by using the computer Minitab program. The statistics used to analysis the data as follows.

1- Descriptive statistics: Percentage, mean, standard deviation were calculated to describe demographic characteristics and other background information of the respondents.

2– Association: Chi-square test and Fishexats test were used to test the association between the independent and dependent variables.

CHAPTER 4
RESULTS

This descriptive analytic study was to describe the socio demographic characteristics, the attitude, the parent child communication, subjective norms and safe sex intention of secondary school students and to identify the association between safe sex intention and socio demographic characteristics, attitude, parent child communication and subjective norms.

The results of this study are presented into six parts as follows

Part 1. Description of the socio demographic characteristics.

Part 2. Description of parent child communication towards HIV/AIDS prevention.

Part 3. Description of the attitude of respondents toward the HIV/AIDS prevention

Part 4. Description of subjective norms towards HIV/AIDS prevention

Part 5. Description of safe sex intention towards HIV/AIDS prevention

Part 6. Association between safe sex intention and socio demographic characteristics, attitude, parent child communication, subjective norms.

4.1 Characteristics of Variables

4.1.1 Socio Demographic Characteristics

The result in table 1 showed the general characteristics include age, gender, Grades (Mathayom) and living style of respondents. Two third of the respondents

were in age group 16-19yrs. The rest were in age group 13-15yrs. Male students slightly over than female.

Nearly one-half of the respondents (44.48%) mathayom 4 while 29.54 percent and 25.62 percent was mahtayom 5 and mathayom 6 respectively.

Two third of the respondents (64.77%) were living in dormitories and rest were living in their houses.

Table 3 Distribution of the Respondents by Socio Demographic Characteristics

General Characteristics (N=281)	N	%
Age Groups (years)		
13-15yrs	109	38.79
16-19yrs	172	61.21
$\bar{x}$ = 16 SD = 1.36	Min = 13 Max = 19	
Gender		
Male	145	51.60
Female	136	48.40
Grades (Mathayom)		
Mathayom 4	126	44.84
Mathayom 5	72	25.62
Mathayom 6	83	29.54
Living Style		
House with parents	89	31.67
House without parents	10	3.56
In dormitory	182	64.77

4.1.2 Parents Child Communication

Table 4 showed majority of respondents (71.89%) had poor parent and child communication, which 16.47 percent and 11.67 percent had fair and good communication respectively.

Table 4 Levels of Parent's Child Communication towards HIV/AIDS Prevention

Level of parents child communication (N=281)	N	%
Good	33	11.67
Fair	46	16.47
Poor	202	71.86

Score: Low =< 3.6, Moderate = 3.6-4.8, High => 4.8

Parents of child communicated on the topics of sexual activities less than 60% which considered as poor and more than 80% considered as good. Table 5 showed that initiation of discussion from parents were 55.52%, 37.37% 40.39%nd 37.37% and from child was 29.54%, 28.11% and 22.06% respectively.

Table 5 Item Analysis of Parent's Child Communication Towards HIV/AIDS Prevention

Statement	Yes Answers		
	N	%	Comment
1. Do your parents ever talk with you about avoiding sexual activities during school age to prevent HIV/AIDS?	156	55.52	**poor**
2. Do your parents ever talk with you about using condoms during sexual intercourse in future to prevent HIV/AIDS?	105	37.37	**poor**
3. Do your parents ever talk with you about avoiding multiple sex partners in future to prevent HIV/AIDS?	115	40.93	**poor**
4. Do you ever talk with your parents about your sexual problems?	83	29.54	**poor**
5. Do you ever talk with your parents about avoiding sexual activities during school age to prevent HIV/AIDS?	79	28.11	**poor**
6. Do you ever talk with your parents about using condoms during sexual intercourse in future to prevent HIV/AIDS?	62	22.06	**poor**

Score: Poor =<60%, Fair = 60%-80%, good => 80%

4.1.3 Attitude Towards The HIV/AIDS Prevention

Table 6 showed overall attitude of respondents towards HIV/AIDS prevention was rated according to Bast's rating criteria as good, fair and poor. Seventy percent of the respondents had good attitude, thirty percent had moderate attitude and no one had poor attitude.

In referring to the item analysis of attitude towards the HIV/AIDS prevention, table 5 showed that attitude of respondents being abstinence, stay with single partner and avoid premarital sex was very high.

Table 6 Level of Attitude Towards HIV/AIDS Prevention

Level of Attitude (N=281)	**N**	**%**
Good	196	69.75
Fair	85	30.25
Poor	00	00.00

Score: Poor =<43, Fair =43-66, good => 66

Table 7 Item Analysis of Attitude Towards HIV/AIDS Prevention

Attitude Statement	SA %	A %	NS %	DA %	SDA %	$\bar{x}$	SD	Com ment
1.Attitude about using condoms								
01 Using condoms during every sexual intercourse can prevent HIV infection.	36.30	47.33	11.39	3.56	1.42	4.14	0.86	**Good**
02.Asking partner to use condom means do not trust each other	12.81	14.95	14.95	28.83	28.4	3.45	1.37	**fair**
03. Using condom in proper way will be safer HIV infection.	41.99	40.93	13.52	2.85	0.71	4.20	0.83	**good**
04. One should always avoid having sex with a partner who refuses to use condom.	29.89	38.08	23.49	7.47	1.07	3.88	0.95	**good**
05. It is shameful to buy or carrying condom.	10.68	18.15	30.25	24.6	16.3	3.18	1.22	**fair**
2.Avoid premarital sex								
06. Being abstinence can prevent HIV infection.	42.70	38.08	12.46	5.34	1.42	**4.15**	0.93	**good**

Table 7 Item Analysis of Attitude Towards HIV/AIDS Prevention (cont.)

Attitude Statement	SA %	A %	NS %	DA %	SDA %	$\bar{x}$	SD	Comment
07. Avoiding sexual intercourse before marriage can prevent HIV/AIDS infection.	43.06	37.37	10.32	6.76	2.49	4.12	1.00	**good**
08. Not having sex with girl / boy friend make a person feel inferior among their friends.	10.32	12.46	10.68	20.28	46.26	3.79	1.40	**good**
3.Stay with single and known partner								
09. One should always refuse having sex with an unknown partner	63.70	17.44	9.61	3.91	5.34	4.30	1.13	**good**
10. Having sex with an unknown partner would always carry risk of getting HIV infection.	56.23	32.74	8.90	2.14	00.00	4.43	0.74	**good**

Table 7 Item Analysis of Attitude Towards HIV/AIDS Prevention (cont.)

Attitude Statement	SA %	A %	NS %	DA %	SDA %	$\bar{x}$	SD	Comment
11. Strict to a single sexual partner during sexual intercourse in present and future can prevent from HIV infection	26.33	32.38	27.76	12.10	1.42	3.70	1.03	**good**
12. Getting HIV is only happened to those who often have sex with prostitutes.	5.69	18.86	14.59	39.86	21.00	3.15	1.18	**fair**
13. Attending entertainment at night provide a chance to have sexual intercourse with unknown sexual partners.	28.83	46.98	17.08	4.63	2.49	3.95	0.93	**good**
14. Having multiple sexual partners increase the risk of getting HIV infection.	51.25	35.59	9.25	1.18	2.14	4.32	0.87	**good**
4.Genaral statements about HIV/AIDS								
15. Doing blood test cannot detect HIV infected person.	4.63	8.90	23.13	41.64	21.17	3.67	1.055	**fair**

Table 7 Item Analysis of Attitude Towards HIV/AIDS Prevention (cont.)

Attitude Statement	SA %	A %	NS %	DA %	SDA %	$\bar{x}$	SD	Comment
16. Touching a HIV infected person can get the disease.	7.47	11.39	21.35	38.08	21.71	3.55	1.17	**fair**
17. No one can get HIV infection by using utensils were used by a infected person.	15.66	26.33	27.40	22.42	8.17	3.18	1.18	**fair**
18. HIV can not be prevented by all kinds of means.	5.43	8.54	13.17	35.94	37.00	3.90	1.15	**good**

Score: Poor =<2.34, Fair = 2.34-3.67, good => 3.67

4.1.4 Subjective Norms

Overall subjective norms were rated according to the Bast's rating criteria, table 8 showed around seventy percent had good responds for subjective norms, thirty percent had moderate and a small percentage (4%) had poor respond for subjective norms.

In these study subjective norms of their parents, teachers and friends in relation the respondent's sexual behavior towards HIV/AIDS prevention were measured. Subjective norms were categorized into three groups good, fair and poor.

Table 8 Level of Subjective Norms towards HIV/AIDS Prevention

Level of Subjective Norms (N=281)	**N**	**%**
High	195	69.46
Moderate	73	25.94
Low	13	4.70

Score: Lower =<45, Moderate = 45-76, good => 76

The table.9, table 10 and table 11 showed number and percentage for each statement and the average score and percentage for each category, the highest score was for subjective norms was their parent's (61.55%), the lowest score was recorded for their friend's subjective norms (58.63%).

Table 9 Item Analysis of Subjective Norms of Parents

Subjective Norms Statement	**Never N (%)**	**Some time N (%)**	**Always N (%)**	$\bar{x}$	**SD**	**Com ment**
1.Norms of parents						
1.1 Do you believe that your parents think that you should not have sexual intercourse before your get married (Until you get permanent partner)?	12	76	193	7.6	2.22	**good**
1.2 Do you agree with your parent's opinion that they think that you should not have sexual intercourse before your get married (Until you get permanent partner)?	4.27	27.05	68.68			
2.1 Do you believe that your parents think that you should not have sexual intercourse without using condoms?	9	78	194	7.33	2.23	**good**
2.2 Do you agree with your parents opinion that they you should not have sexual intercourse without using condoms?	3.20	27.76	69.04			
3.1 Do you believe that your parents think that you should have an only one trustable sexual partner.	13	76	192	7.16	3.02	**good**
3.2 Do you agree with your parents opinion that think you should have a only one trustable sexual partner.	4.63	27.05	68.33			

Table 9 Item Analysis of Subjective Norms of Parents (cont.)

Subjective Norms Statement	**Never N (%)**	**Some time N (%)**	**Always N (%)**	$\bar{x}$	**SD**	**Comment**
4.I Do you believe that your parents think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?						
4.2 Do you agree with your parent's opinion that thinks you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?	64 22.78	104 37.01	113 40.21	5.72	3.02	**moderate**

Score: Lower =<3.7, Moderate = 3.7-6.2, good => 6.2

Table 10 Item Analysis of Subjective Norms of Teachers

Subjective Norms Statement	**Never N %**	**Some time N %**	**Always N %**	$\bar{x}$	**SD**	**Com ment**
2. Norms of teachers						
5.1 Do you believe that your teachers think that you should not have sexual intercourse before you get married (Until you get permanent partner).	23 8.19	85 30.25	173 61.57	7.15	2.54	**good**
5.2 Do you agree with your teachers opinion that they think you should not have sexual intercourse before your get married.						
6.1 Do you believe that your teachers think that you should not have sexual intercourse without using condoms?	15 5.34	79 28.11	187 66.55	7.49	2.44	**good**
6.2 Do you agree with your teacher's opinion that they think you should not have sexual intercourse without using condoms?						

Score: Lower =<3.7, Moderate =3.7-6.2, good => 6.2

Table 10 Item Analysis of Subjective Norms of Teachers. (cont.)

Subjective Norms Statement	**Never N (%)**	**Some time N (%)**	**Always N (%)**	$\bar{x}$	**SD**	**Comment**
7.1 Do you believe that your teachers think that you should have an only one trustable sexual partner?	17	69	195	7.49	2.44	**good**
7.2 Do you agree with your teacher's opinion that they think you should have an only one trustable sexual partner in future. .	6.05	24.55	69.40			
8.1 Do you believe that your teachers think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?	51	99	131	6.18	2.94	**moderate**
8.2 Do you agree with your teachers opinion think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?	18.15	35.23	46.62			

Score: Lower =<3.7, Moderate =3.7-6.2, good => 6.2

Table 11 Item Analysis of Subjective Norms of Friends

Subjective Norms Statement	**Low N %**	**Moderate N %**	**High N %**	$\bar{x}$	**SD**	**Comment**
3.norms of friends						
9.1 Do you believe that your friends think that you should not have sexual intercourse before your get married.	18 6.40	98 34.88	165 58.72	7.05	2.52	**good**
9.2 Do you agree with your friends opinion that they think you should not have sexual intercourse before your get married.						
10.1 Do you believe that your friends think that you should not have sexual intercourse without using condoms in future?	11 3.19	90 32.44	180 64.37	7.38	2.30	**good**
10.2 Do you agree with your friend's opinion that they think you should not have sexual intercourse without using condoms in future?						

Score: Lower =<3.7, Moderate =3.7-6.2, good => 6.2

Table 11 Item Analysis of Subjective Norms of Friends. (cont.)

Subjective Norms Statement	Low N %	Moderate N %	High N %	$\bar{x}$	SD	Comment
11.1 Do you believe that your friends think that you should have an only one trustable sexual partner in future.	12	83	186	7.37	2.41	**good**
11.2 Do you agree with your friend's opinion that thinks you should have an only one trustable sexual partner?	4.27	29.54	66.19			
12.1 Do you believe that your friends think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?	50	103	128	6.00	3.00	**moderate**
12.2 Do you agree with your friend's opinion that they think you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?	17.79	36.65	45.55			

Score: Lower =<3.7, Moderate =3.7-6.2, good => 6.2

4.1.5 Safe Sex Intention

Table 10 showed overall intention for HIV/AIDS prevention which was categorized into three groups according to Bast's ratting criteria, around two third of respondents had good intention to prevent HIV/AIDS, 35 percent had fair intention and 4.6 percent had poor intention.

In this study safe sex intention was defined as the intention of respondents to use condoms, being abstinence, avoid premarital sex and stay with single known partner to prevent HIV/AIDS. Table 11 showed that respondent's intention to stay with single known partner and avoid premarital sex to prevent HIV/AIDS was very high.

Table 12 Level of Safe Sex Intention towards HIV/AIDS Prevention

Level of Safe Sex Intention (N=281)	**N**	**%**
High Intention	169	60.14
Moderate Intention	99	35.23
Low Intention	13	4.63

Score: Lower =<10, Moderate =10-14, High => 14

Table 13 Item Analysis of Safe Sex Intention towards HIV/AIDS Prevention to Each Statement

Safe Sex Intention	Likely %	Uncertain %	Unlikely %	$\bar{x}$	SD	Comment
1.Stay with a single and known partner						
1.1 intent to refuse having sexual intercourse with an unknown partner.	73.32	21.44	5.34	2.80	0.609	**high**
2. 1 intent to stay with only one sexual partner.	66.19	30.60	3.21	2.62	0.546	**high**
2. Using condoms during sexual intercourse						
3. 1 intent to ask my partner to use condoms all the time when I have sexual intercourse.	69.04	25.62	5.34	2.63	0.582	**high**
4. 1 intent to carry condoms all the time when I go out.	31.67	44.48	23.85	2.07	0.742	**moderate**
3. Being abstinence to prevent HIV infection						
5. 1 intent to being abstinence to avoid HIV/AIDS.	63.35	26.69	9.96	**2.53**	0.670	**high**
4. Avoid premarital sex						
6. 1 intent not to have sexual intercourse before I get married.	54.45	29.54	16.01	**2.38**	0.747	**high**

Score: Lower =<1.67, Moderate =1.67-2.35, High=> 2.33

4.2 Association between Variables

In this study association between independent variables namely socio demographic, Parent child communication, attitude and subjective norms of the respondents and the dependent variable which is safe sex intention toward HIV/AIDS prevention was measured by using the chi-square test.

4.2.1 Socio Demographic Characteristics

4.2.1.1 Age group and Intention

A strong association (p<.001) was observed between age group and their safe sex intention towards HIV/AIDS prevention. According to the result in table 12 elderly age group had 51 percent good intention and 45.85 percent fair intention, while younger age group had 74.32 percent good and 20.28cent fair intention.

Table 14 Association between safe sex intention towards HIV/AIDS and Age groups

Age	Good Intention		Fair Intention		Poor Intention		x^2	P value
	N	(%)	N	(%)	N	(%)	(df)	
13-15 yrs	81	(74.32)	22	(20.28)	6	(5.50)	17.7	<0.003*
16-19yrs	87	(50.88)	78	(45.21)	7	(4.01)	(1)	

* P-value <0.01

4.2.1.2 Gender and Intention

Table 13 showed a strong positive (p<.003) association between gender and safe sex intention, Female respondent's had 68.38 percent good and 30.51 percent fair, where as the male respondents had 51.72 percent good intention and 40.69 percent fair intention.

Table 15 Association between safe sex intention towards HIV/AIDS and gender

Gender	Good Intention		Fair Intention		Poor Intention		x^2	P value
	N	(%)	N	(%)	N	(%)	(df)	
Male	75	(51.72)	59	(40.69)	11	(7.59)	11.74	0.003*
Female	93	(68.38)	41	(30.51)	2	(1.47)	(2)	

*P-value<0.01

4.2.1.3 Grade and Intention

Grade of the respondents had a strong association to safe sex intention towards HIV/AIDS prevention (P<.001). Result in table 14 also showed that the students in mathayom 4 had good intention nearly 76.19 percent, while in mathayom 5 and 6 had 54.17 percent and 39.76 percent respectively.

Table 16 Association between safe sex intention towards HIV/AIDS and grades (Mathayom)

Grade (Math Yom)	Good Intention		Fair Intention		Poor Intention		x^2	P value
	N	(%)	N	(%)	N	(%)	(df)	
Matha-4	96	(76.19)	25	(19.84)	5	(3.97)		
Matha-5	39	(54.17)	28	(38.89)	5	(6.94)	30.39	<.000*
Matha-6	33	(39.76)	47	(56.63)	3	(3.61)	(4)	

P-value<0.01

4.2.1.4 Living Style and Intention

Result in table 15 revealed that there was no any significant association between student's living style and the safe sex intention, however students living in dormitories had 60.11 percent good and 39.89 percent poor safe sex intention while students living in their houses had 58.18 percent good and 40.82 poor safe sex intention towards HIV/AIDS prevention.

Table 17 Association between safe sex intention towards HIV/AIDS and living style of respondents

Living Style	**Good Intention**		**Poor Intention**		**P value**
	N	**(%)**	**N**	**%**	
In dormitory	110	(60.11)	73	(39.89)	
In house	58	(58.18)	40	(40.82)	***0.238**

* Fishexacct's

4.2.1.5 Parent Child Communication and intention.

Table 16 showed that among the respondents those who had good communication had good intention 60.00 percent, fair communication and good intention 67.35 and poor communication with good intention 57.92 percent toward HIV/AIDS prevention. No significant positive association was observed.

Table 18 Association between safe sex intention towards HIV/AIDS and parent child communication

Parent child communication	Good Intention		Fair Intention		Poor Intention		x^2	P value
	N		N		N		(df)	
Good	18	(60.00)	12	(40.00)	0	(00.00)		
Fair	33	(67.35)	13	(26.53)	3	(6.12)	3.553	0.470
Poor	117	(57.92)	75	(37.13)	10	(4.95)	(4)	

4.2.2 Attitude and safe sex intention

Table 17 showed a strong positive association between attitude and safe intention (P- <.001). Among the respondents 66.33 percent had good attitude and good intention and 31.12 percent and 2.55 percent fair and poor intention respectively.

Table 19 Association between safe sex intention toward HIV/AIDS prevention and Attitude towards HIV/AIDS prevention

Level of Attitude	Good Intention N	(%)	Fair Intention N	(%)	Poor Intention N	(%)	x^2 (df)	P value
Good	130	(66.33)	61	(31.12)	5	(2.55)		
Fair	38	(45.88)	39	(44.71)	8	(9.41)	13.2	0.001*
Poor	0	00.00	00	00.00	0	00.00	(2)	

*P-value<0.01

4.2.3 Subjective norms and safe sex intention

Results in table 18 revealed that 76.80 percent of the respondents had good subjective norms and good intention and 21.84 percent had poor subjective norms and good intention. Only 23.20 percent had good subjective intention with poor intention.

Table 20 Association between safe sex intention toward HIV/AIDS prevention and subjective norms towards HIV/AIDS prevention

	Good Intention		Poor Intention		
Subjective Norms	**N**	**%**	**N**	**%**	**P Value**
Good	149	(76.80)	45	(23.20)	
Moderate	19	(21.84)	68	(78.16)	**0.115***

* Fishexact's

CHAPTER 5
DISCUSSION

In developing countries sex education in schools are not provided and they do not know no how access to information about HIV/AIDS or opportunities to develop life skills that they need to turn this information to action. In addition to individual characteristics of themselves, they are also influenced by other young people and make vulnerability and behaviors of significant adult in their lives, such as parents, teachers and service providers. The wider context which they live, learn and work, including social values and norms, policies, legislations and their economic situation are also very important. However, Thailand faced two waves of HIV during 1984 and 1989. Rapid changing economy, new technology and urbanization make these teenagers more vulnerable for HIV/AIDS epidemic in Thailand.

The purpose of this study was to detect safe sex intention and describe the factors affecting safe intention of secondary school students in Nakhon Pathom Province Thailand. Secondary school students consist of grade (Mathayoms) 4 to 6. All students were age range between 13 to 19 years. This is period between child and adulthood. This is a more sexually active age range experimenting, and taking risk are common characteristics of during their life.

5.1 Safe Sex Intention among Secondary Students in Nakohom Pathom Province

Two third of respondents had good intention towards HIV/AIDS prevention and only four percent had poor intention. Intention to stay with single known partner was higher when comparing using condoms, being abstinence and avoids premarital sex. Intention to use condoms and avoid premarital sex was relatively low among the study population. This finding compatible with the attitude of respondents towards HIV/AIDS prevention because respondents had good attitude to stay with single and

known partner and being abstinence and low attitude for using condoms and avoid premarital sex.

In previous studies (Pipal Bhadur Chety 2000) carried out among high school students revealed 96% of respondents have high level of positive intention towards HIV/AIDS prevention. Another study (Jutta Arenth 1999) among vocational training students found that nearly two third of respondents have high positive intention towards HIV/AIDS prevention. A study (Sin Sovann 1999) carried out among secondary school students in Cambodia revealed 84% of high school had high intention and main factor that attribute to safe sex intention of students was condom use towards HIV/AIDS is different from this study.

An intervention research led by Elaine A. Borawske in the department of epidemiology and bio statistics western reserve university in America had observed students had high safe sex intention to be abstinence to prevent HIV infection.

5.2 External Characteristics of Respondence

Two third of the respondents (61.21%) were in age group 16-19yrs. The rest (38.79%) were in age group 13-15yrs. Male students slightly over than female. Nearly one-half of the respondents (44.48%) mathayom 4 while 29.54 percent and 25.62 percent was mahtayom 5 and mathayom 6 respectively. Two third of the respondents (64.77%) were living in dormitories and rest were living in their houses. Parents of child communicated on the topics of sexual activities less than 60% which considered as poor and more than 80% considered as good. Initiation of discussion from parents were 55.52%, 37.37% 40.39%nd 37.37% and from child was 29.54%, 28.11% and 22.06% respectively.

5.3 Attitude towards HIV/AIDS Prevention

Attitude of respondents towards HIV/AIDS prevention, Seventy percent of the respondents had good attitude, thirty percent had moderate attitude and no one had

poor attitude. Attitude of respondents being abstinence, stay with single partner and avoid premarital sex was very high.

5.4 Subjective Norms towards HIV/AIDS Prevention

Thirty percent had moderate and a small percentage (4%) had poor respond for subjective norms. In these study subjective norms of their parents, teachers and friends in relation the respondent's sexual behavior towards HIV/AIDS prevention were measured. The highest score was for subjective norms was their parent's (61.55%), the lowest score was recorded for their friend's subjective norms (58.63%).

5.5 Association between Safe Sex Intention and Socio Demographic Characteristics

The study students were in the age range from 14 to 19 years. The mean age was 16yers. In this study it was revealed that younger age group had good safe intention than elderly age group. Further majority of respondents had good intention to stay with single and known partner and being abstinence to prevent HIV infection than using condoms and avoid premarital sex. Studies conducted past on safe sex intention toward HIV/AIDS prevention among high school students (Khaing Sabai Latt 1999), safe sex intention towards HIV/AIDS prevention among students of vocational raining school (Jutta Arenth 1999) and high school students in Cambodia revealed that more elderly age group had high intention than younger age group.

With advancing the age teenagers gaining more knowledge and experiences directly involve them to develop their intention. Nowadays, children whose parents must seek work in the cities to be raised by various family members and may be subjected to conflicting messages about sexual behaviors. Some children are left in the care of siblings without adult supervision, thus increasing opportunity for sexual activity. The effectiveness of traditional family expectations and structures in shaping sexual beliefs, expectation and behaviors appears to have been substantially weakened by population movement. Therefore well plan sex education system is essential to

provide necessary information and opportunity to practice their knowledge toward HIV/AIDS prevention.

Concerning the gender both male and female equally represented the target population. Female students had good intention than male students. This findings compatible with previous studies on safe sex intention among school students revealed that female students had high intention than male students. Stereotype gender role place young women and less extend to young men, at risk of HIV infection. Young women in many pert of the developing world have little control over, how, when and where sex takes place. In perhaps the majority of countries, there are strong pressure on young unmarried women to retain their virginity may persuade them to develop good intention towards being abstinence and avoid premarital sexual intercourse, which will prevent them from risk of HIV infection.

Total study population represented three grades (Mthayoms), but more than two third of the respondents were from mthayom 4. Respondents from mthayom 4 had good safe sex intention than mathayom 5 and 6 and observed a significant positive association between grades and safe sex intention. Since population is not equally distributed this result cannot be generalized.

More than half of respondents were living in dormitories. Those who were living in dormitories had good safe sex intention towards HIV/AIDS prevention, but there was no significant association between safe sex intention and living style of students. In previous study done among students in vocational training schools (Jutta Areth 1999) found majority of students staying with their parents and had good intention and observed a positive relationship.

Nearly two third of students did not have any communication with their parents about their sexual and related problems towards HIV/AIDS prevention, and no significant positive association had been observed between parent child communication and safe sex intention. Initiation of discussion from parents side was

obviously higher than from child mostly, parents were more likely to warn their child to avoid having sex, during the school age and avoid having multiple sex partners.

This revealed that students received information about sexuality and HIV/AIDS from other sources. This result was similar with previous studies done about sexual behavior among secondary students in Bangkok found that more that 60% of students received information about their sexual problems and HIV/AIDS from other sources and very few get information from their parents. Another study (Jutta Arenth 1999) done among student in vocational training school found that parents were the least source of information about sexuality and HIV/AIDS.

Although no studies were found about parents child communication and safe sex intention in Thailand, a study done among secondary school students in India (M.S.Selvan, M.W.Ross, P. Parker, 2005) revealed a statistical significant positive association between parent child communication and safe sex intention.

5.6 Association between Attitude towards HIV/AIDS Prevention and Safe Sex Intention

In general more than two third of respondents had good attitude towards HIV/AIDS prevention and none of the respondent belonged to the poor attitude category thus a significant positive association between attitude and intention was observed. However thirty percent of respondents had fair attitude still to be strengthen towards good attitude. Majority of respondents had strong attitude of being abstinence and stay with single known partner towards HIV/AIDS prevention. Even though respondent had good attitude for using condom during sexual intercourse to prevent HIV infection, their answers for question "whether they shameful to carry or buy condoms" were very vague mean that they may not use condoms since they are reluctant to buy and carry it.

Although majority of respondents agreed that premarital sex should be avoided to prevent from HIV infection, considerable amount of students mentioned

that not having sex with girl and boy friends make them feel inferior among their friends, this meant peer pressure may motivate them to have premarital sex.

Attitude in general how to deal with a HIV/AIDS patient was tested by suing four general statements revealed relatively low score, indicate they do not concern about it. In a study (Jutta Arenth, 1999) among vocational training students revealed 77% of respondents had good attitude and significant association between attitude and safe sex intention. Another study done (Kin Viratey) among factory workers in Nokhon Pathom Province had revealed that 56% of respondents had good attitude towards safe sex intention.

5.7 Association between Subjective Norms and Safe Sex Intention

Around seventy six percent of respondents had good subjective norms mean positive responds their parents, teachers and friends thinking about their safe sex behavior but no a significant positive association had been observed between subjective norms and safe sex intention. Parent's norms about student's safe sexual behavior seem to be important because highest average score was reported for parent’s norms. The lowest score was observed for friend's subjective norms; mean that respondents did not concern about their friends norms. Respond for teachers norms were in between these two.

Even though no previous studies found to have used subjective norms as an independent variable in Thailand, there were studies done about norms and safe sex intention in the world have found some positive associations. According to the article published in Journal of adolescent by Dr Dexter Voicing adolescent who reported low teacher connectedness were two times more sexually active and have multiple sexual partners. However, as it was discussed earlier when there was no direct communication with children and parent about children's sexual problems and facts about HIV/AIDS, a problem exist was how children perceive their parents thinking or norms. One possible explanation was indirect communication about these matters

between children and parents and observation of children about their parent's behavior.

CHAPTER 6
CONCLUSION AND RECOMMENDATION

Conclusion

This study was carried out to determine safe sex intention towards HIV/AIDS prevention among secondary students and factors which were associated with safe sex intention to prevent HIV/AIDS

Three hundred students were selected for this study. Out of three hundred students 281 were selected after cleaning the data.

1. Sixty percent of respondent had good intention towards HIV/AIDS prevention. Their intention to being abstinence and stay with single known partner was higher than other means.

2. Two third of the respondents were in age group 16-19yrs. The rest were in age group 13-15yrs. Male students slightly over than female. Nearly one-half of the respondents mathayom 4 while 29.54 percent and 25.62 percent was mahtayom 5 and mathayom 6 respectively.

3. Majority of respondents were living in dormitories. Around seventy percent of respondents did not have a good communication with their parents about their sexual problems towards HIV/AIDS prevention.

4. Seventy percent of respondent had good attitude towards HIV/AIDS prevention. There was a significant positive association between attitude and intention. Their attitude for being abstinence, stay with know single partner and to avoid premarital sex was very high.

5. Similar with attitude seventy percent of respondents had positive responds to their parents, teachers and friends norms. Respondents concern about their parent's norm was higher than their teachers and friends.

6. Younger age group had higher intention than elderly age group towards safe sex intention. Female student's safe sex intention was higher than male found a significant positive association.

Those who had good attitude had good intention towards safe sex intention found a significant positive association.
Seventy six percent of the respondents had good subjective norms had good intention.

Recommendations

The following specific recommendations derived from the findings of this descriptive study.

To prevent HIV/AIDS among teenagers measures could be taken in three ways.

1. To health policy makers and health planners.
2. To education policy makers and education planners.
3. To parents of students.
4. Recommendations for further studies.

1. To health policy makers and health planners.

Since secondary students had good attitude to being abstinence, stay with single partner and good responds to parents and teachers norms. Students also had had good intention to prevent HIV/AIDS. Health policy makers and planners should use this information and strength the student's attitude and intention further by properly plan health education and providing them opportunity to develop their skills for safe

sex behavior. Similarly they should address the weaknesses such as relatively low attitude to use condoms and avoid premarital sex to prevent HIV/AIDS.

2. To education policy makers and education planners

It was found that respondents concern about people having HIV infection and AIDS was relatively low. And also found that parent child communication towards student's sexual related problems was very poor. But respondents had high positive responds to their parents and teachers norms. It is time for policy makers and planers in education to consider for including sex education and HIV/AIDS control program to the school curriculum and also it would be useful to create an environment where students are able to discuses with teachers about their sexual and related problems.

3. To parents of students

According to the finding of this study parents child communication about their sexual and related problems towards HIV/AIDS prevention was very poor. It is recommended to encourage parents to discus with their children about their sexual and related problems and make them to talk about their problems with parents.

Recommendations for further studies

To explore the regional deferent of safe sex intention of secondary students towards HIV/AIDS prevention similar studies should be conducted in every region to compare the results.

In order to identify the relationship between intention and behavior a study should be conducted see the association between safe sex intention and safe sex behavior.

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APPENDIX

APPENDIX

QUESTIONNAIRE

SAFE SEX INTENTION TOWARDS HIV/AIDS PREVENTION AMONG SECONDARY SCHOOL STUDENTS NAKHON PATHOMN PROVINCE THAILAND

To be filled by Respondence

Instructions.

- Please do not write your name on this
- Information of this questionnaire will be used for academic purposes only, we guarantee the confidentiality of your information. Therefore, please feel free to answer questions based on the truth and your real feelings.
-

Part 1:

External factors.

Please fill in the blank and put (√) in the answer as you think is true.

1. Age: […..]. Years.

2. Gender. […..]. Boy
[…..]. Girl

3. Which ‘mathium” your are attending.
Mathium 4 ( )
Mathium 5 ( )
Mathium 6( )

4. With whom do you currently live?

[…..].At home with parents

[…..] . At home without parents.

[…..].Dormitory

[…..].Other (specify……..)

Part 2

Attitude towards safe intention of HIV/AIDS prevention

Please fill in the blank and put (√) in the answer as you think is true.

SA = strongly agree, A = agree, NC, = no comment, D = disagree,

SD = strongly disagree

Statement	SA	A	NC	D	SDA
05 Using condoms during every sexual intercourse can prevent from HIV infection.					
06. Avoiding sexual intercourse before marriage can prevent from HIV/AIDS infection.					
07. One should always refuse having sex with an unknown partner					
08. Being abstinence can prevent from HIV infection.					

Statement	SA	A	NC	D	SDA
09. Having sex with an unknown partner would always carry risk of getting HIV infection.					
10.Asking partner to use condom means do not trust each other					
11. Strict to a single sexual partner during sexual intercourse in present and future can prevent from HIV infection.					
12. Not having sex with girl / boy friend make a person feel inferior among there friends.					
13. Doing blood test cannot detect HIV infected person.					
14. Getting HIV is only happened to those who often have sex with prostitutes.					
15. Using condom in proper way will be safer from HIV infection.					
16. Touching a HIV infected person can get the disease.					
17. One should always avoid having sex with a partner who refuses to use condom.					

Statement	SA	A	NC	D	SDA
18. It is shameful to buy or carrying condom.					
19 No one can get HIV infection by using utensils were used by an infected person.					
20. Attending entertainments at night provide a chance to have sexual intercourse with unknown sexual partners.					
21.HIV cannot be prevented by all kinds of means.					
22. Having multiple sexual partners increase the risk of getting HIV infection.					

Part 3

PARENT CHILD COMMUNICATIONS TOWARDS SAFE INTENTION FOR HIV/AIDS PREVENTION

Please put the tick mark (√) in most appropriate answer.

23. Do you're parents ever talk with you about avoiding sexual activities during school age in order to prevent HIV/AIDS?
a) Yes b) No

24. Do you're parents ever talk with you about using condoms during sexual intercourse in future to prevent HIV/AIDS?
a) Yes b) No

25. Do your parents ever talk with you about avoiding multiple sex partners in future to prevent from HIV/AIDS?
a) Yes b) No

26. Do you ever talk with your parents about your sexual problems?
a) Yes b) No

27. Do you ever talk with your parents about avoiding sexual activities during school age in order to prevent HIV/AIDS?
a) Yes b) No

28. Do you ever talk with your parents about using condoms during sexual intercourse in future to prevent HIV/AIDS?
a) Yes b) No

Part 4

Subjective norms towards safe sex intention in order to prevent HIV/AIDS

29. i Do you believe that your parents think that you should not have sexual intercourse before your get married (Until you get permanent partner)?
a) always ( ) b)sometime ( ) c) never ( )

ii. Do you agree with your parent's opinion that they think that you should not have sexual intercourse before your get married (Until you get permanent partner)?
. a) agree ( ) b) uncertain ( ) c) disagree ( )

30. i. Do you believe that your parents think that you should not have sexual intercourse without using condoms?
a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your parents opinion that they you should not have sexual intercourse without using condoms?
. a) agree ( ) b) uncertain ( ) c) disagree ( )

31 i.Do you believe that your parents think that you should have a only one trustable sexual partner.
a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your parent's opinion that think you should have an only one trustable sexual partner.
. a) agree ( ) b) uncertain ( ) c) disagree ( )

32. Do you believe that your parents think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?
a) always ( ) b) sometime ( ) c) never ( )

Ii.Do you agree with your parents opinion that think you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?

. a) agree ( ) b) uncertain ( ) c) disagree ( )

33.Do you believe that your teachers think that you should not have sexual intercourse before you get married (Until you get permanent partner)?
a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your teachers opinion that they think you should not have sexual intercourse before your get married.

.

a) agree ( ) b) uncertain ( ) c) disagree ( )

34. Do you believe that your teachers think that you should not have sexual intercourse without using condoms?

a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your teacher's opinion that they think you should not have sexual intercourse without using condoms?

. a) agree ( ) b) uncertain ( ) c) disagree ( )

35. I. Do you believe that your teachers think that you should have an only one trustable sexual partner?

a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your teacher's opinion that they think you should have an only one trustable sexual partner in future? .

a) Agree ( ) b) uncertain ( ) c) disagree ( )

36. Do you believe that your teachers think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?

a) always ( ) b) sometime( ) c) never ( )

ii. Do you agree with your teachers opinion think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?

. a) Agree ( ) b) uncertain ( ) c) disagree ( )

37.Do you believe that your friends think that you should not have sexual intercourse before your get married.

a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your friends opinion that they think you should not have sexual intercourse before your get married.

. a) agree ( ) b) uncertain ( ) c) disagree ( )

38. Do you believe that your friends think that you should not have sexual intercourse without using condoms in future?

a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your friend's opinion that they think you should not have sexual intercourse without using condoms in future?

.

a) agree ( ) b) uncertain ( ) c) disagree ( )

39. Do you believe that your friends think that you should have an only one trustable sexual partner in future?

a) always ( ) b) sometime( ) c) never ( )

ii. Do you agree with your friend's opinion that think you should have an only one trustable sexual partner.

. a) agree( ) b) uncertain ( ) c) disagree ( )

40. Do you believe that your friends think that you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?

a) always ( ) b) sometime ( ) c) never ( )

ii. Do you agree with your friend's opinion that they think you should not have sexual intercourse forever if there is risk of getting HIV/AIDS?

. a) Agree ( ) b) uncertain ( ) c) disagree ( )

Part 5 SAFE SEX INTENTION TOWARDS HIV/AIDS PREVENTION.

Please make (√) in the box where most appropriate.

41. I intend to refuse having sexual intercourse with an unknown partner.

Likely ( ) Uncertain ( ) Unlikely ( )

42.I intend to ask my partner to use condom all the time when I have sexual intercourse.

Likely ( ) Uncertain ( ) Unlikely ( )

43. I intend to stay with only one sexual partner.

Likely ( ) Uncertain ( ) Unlikely ( )

44. I intend to carry condoms all the time when I go out.

Likely ( ) Uncertain ( ) Unlikely ( )

45.I intend not have sexual intercourse before I get married?

Likely ( ) Uncertain ( ) Unlikely ( )

46. I intend being abstinence to avoid HIV/AIDS?

Likely ( ) Uncertain ( ) Unlikely ( )

THANK YOU FOR YOUR COOPERATION. THIS IS THE END OF THE QUESTIONNAIRE

BIOGRAPHY

NAME	W.K.W.S.Kumarawansa
DATE OF BIRTH	February 18, 1966
PLACE OF BIRTH	Dambulla, Sri Lanka
INSTITUTION ATTENDED	Faculty of Medicine University of Peradeniya, Sri Lanka M.B.B.S, 1996-1997 ASEAN Institute of Health Development Mahidol University, Thailand 2005-2006. Master of Primary Health Care Management
FELLOWSHIP	JICA and TICA
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