PREVENTIVE BEHAVIOR ON HIV/AIDS AMONG VOCATIONAL STUDENTS IN NONGKEAM DISTRICT THAILAND

RAM SHARAN GOPALI

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PRIMARY HEALTH CARE MANAGEMENT FACULTY OF GRADUATE STUDIES MAHIDOL UNIVERSITY

2007

COPYRIGHT OF MAHIDOL UNIVERSITY

Copyright by Mahidol University

Thesis
entitled

PREVENTIVE BEHAVIOR ON HIV/AIDS AMONG VOCATIONAL STUDENTS IN NONGKEAM DISTRICT THAILAND

.....
Mr. Ram Sharan Gopali
Candidate

.....
Assoc. Prof. Boonyong Keiwkarnka
Dr. P.H.
Major-Advisor

.....
Lect. Jutatip Sillabutra
Ph.D.
Co-Advisor

.....
Prof. M.R. Jisnuson Svasti
Ph.D.
Dean
Faculty of Graduate Studies

.....
Assoc. Prof. Sirikul Isaranurug
M.D., Dip. Thai Board of Pediatrics
Chair
Master of Primary Health Care Management
ASEAN Institute for Health Development

Copyright by Mahidol University

Thesis
entitled

PREVENTIVE BEHAVIOR ON HIV/AIDS AMONG VOCATIONAL STUDENTS IN NONGKEAM DISTRICT THAILAND

was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Primary Health Care Management

on
March 29, 2007

.....
Mr. Ram Sharan Gopali
Candidate

.....
Assoc. Prof. Adisak Sattam
Dr.P.H.
Chair

.....
Lect. Jutatip Sillabutra
Ph.D.
Member

.....
Assoc. Prof. Boonyong Keiwkarnka
Dr. P.H.
Member

.....
Prof. M.R. Jisnuson Svasti
Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Sirikul Isaranurug
M.D., Dip. Thai Board of Pediatrics
Director
ASEAN Institute for Health Development
Mahidol University

Copyright by Mahidol University

ACKNOWLEDGEMENT

It is indeed my prestigious privilege to express my deepest thanks and appreciation to my major advisor Assoc. Prof. Boonyong Keiwkarnka for his enthusiasm, constant guidance and valuable suggestion from the beginning to the end of the session. I am very much grateful for his sincere effort, which he has provided to me.

I am also indebted to my co-advisor Dr. Jutatip Sillabutra for her continuous inspiration, precious suggestion and valuable directions all through the course as well as during my thesis period.

I would like to express my gratitude to Assoc. Prof. Sirikul Isaranurug Director ASEAN Institute for Health Development and course Director Research Methodology for systematic approach to develop research protocol.

I would like to express my deepest gratitude to Dr. K. Osuga RIT Japan, and RIT family, with out their efforts and supports; I would never get this opportunity. I would also like to express my deepest thanks to my sponsor Japan Anti-Tuberculosis Association for providing me an opportunity to attend this course.

My special thanks to my academic advisor Dr. Shafi Bhuiyan who always guide me during my entire study period.

I will never forget the enthusiasm and kindness of all the professors, lectures, staffs of MPHM office, Library, Computer section and ASEAN house.

I will never forget my Nepali friends and seniors from Bangkok and Salaya who always support me morally to accomplish my course.

I would also like to thanks Technology Mubankru School family and coordinator Chalasak for providing me an opportunity to collect data for my study.

Finally, I am indebted to my beloved brother Megh, my loving wife Nisha, Son Lovin and daughter Lisa for their dedication and encouragement on me throughout my study period in Thailand.

Ram Sharan Gopali

Copyright by Mahidol University

PREVENTIVE BEHAVIOR ON HIV/AIDS AMONG VOCATIONAL STUDENTS IN NONGKEAM DISTRICT THAILAND

RAM SHARAN GOPALI 4937994 ADPM/M

M.P.H.M. (PRIMARY HEALTH CARE MANAGEMENT)

THESIS ADVISORS:BOONYONG KEIWKARNKA, Dr. P.H., JUTATIP SILLABUTRA, Ph.D.

ABSTRACT

A Cross sectional descriptive study was conducted to investigate HIV/AIDS preventive behavior among vocational students in Nongkeam district, Thailand. The objective of this study was to identify the socio-demographics, knowledge, perception, cues to action and preventive behavior. This study was conducted in February 2007. Two hundred and sixty six vocational school students were selected in this study.

The results of this study revealed that a majority of the respondents had high knowledge about HIV/AIDS transmission and how to prevent it. However only 22 percent of respondents correctly answered how long it takes for a person infected with the HIV virus to develop full blown AIDS. They also had correct perceptions of severity, susceptibility, benefits and barriers to HIV/AIDS prevention behavior. More than half of the respondents said they presently use and will continue to use condoms during sexual intercourse. The majority of the respondents got information from television and parents, therefore media and personnel influence have a strong affect on respondents about HIV/AIDS preventive behavior. The overall results showed that 69.92 percent had good preventive behavior of HIV/AIDS.

There were significant associations between the following factors and HIV/AIDS preventive behavior, gender, age and radio use. More than two-thirds of respondents had a high level of perception on HIV/AIDS preventive behavior. The information gained from television and parents is very effective in changing respondent's behavior on preventive behavior of HIV/AIDS.

KEY WORDS: VOCATIONAL STUDENTS / RISK BEHAVIOR
PREVENTIVE BEHAVIOR

77 pp.

Copyright by Mahidol University

CONTENTS

	Page
ACKNOWLEDGEMENT	**iii**
ABSTRACT	**iv**
LIST OF TABLES	**viii**
LIST OF FIGURES	**x**
LIST OF ABBREVIATIONS	**xi**
CHAPTER	
1 INTRODUCTION	
1.1 Rationale and justification of the study	1
1.2 Adolescents in Asia	5
1.3 Adolescents in Thailand	5
1.4 Vocational Students Sexual Behavior	5
1.5 Adolescents and Sexual Behavior	6
1.6 Justification in terms of PHC Management	7
1.7 Research Questions	8
1.8 Research Objectives	8
1.9 Conceptual framework	9
1.10 Operational definition	10
1.11 Limitation of the study	12
2 LITERATURE REVIEW	
2.1 The Global HIV/AIDS Pandemic	13
2.2. Theoretical Model	17
2.3 The Process of Adolescents and Sexual Activity	20
2.4 Sexual Partners and Relationship	21
2.5 Related studies	23

Copyright by Mahidol University

CONTENTS (Cont.)

Page

3. RESEARCH METHODOLOGY

3.1 Study design 26
3.2 Study population 26
3.3 Sample size calculation and sampling Tools 26
3.4 Sampling Technique 28
3.5 Sampling frame 28
3.6 Research Instruments 30
3.7 Data Collection 30
3.8 Method of the data Analysis 31

4. RESULTS

4.1 Frequency and percentage distribution of Independent and dependent Results Variables 32
4.2 Association between the Independent factors and Preventive Behavior 46

5. DISCUSSION

5.1 Preventive Behavior on HIV/AIDS 56
5.2 Socio-demographic factors 56
5.3 Knowledge about HIV/AIDS 57
5.4 Perception of risk for HIV/AIDS 57
5.5 Cues to action 58
5.6 Association between Gender and HIV/AIDS Preventive Behavior 58
5.7 Association between Age and HIV/AIDS Preventive Behavior 59
5.8 Association between Knowledge about HIV/AIDS and HIV/AIDS Preventive Behavior 59
5.9 Association between Perception of risk for HIV/AIDS and HIV/AIDS Preventive behavior 60
5.10 Association between cues to action and HIV/AIDS preventive behavior 60

Copyright by Mahidol University

CONTENTS (Cont.)

Page

6. CONCLUSION AND RECOMMENDATION

6.1 -Conclusion 62

6.2 Recommendation 64

REFERENCES 65

APPENDIX 70

BIOGRAPHY 77

Copyright by Mahidol University

LIST OF TABLES

TABLE		Page
1.	Average age group of vocational school 2 years in Bangkok	6
2.	Facts about HIV/AIDS in the South-East Asia Region	15
3.	Estimated number of adults and children living with HIV/AIDS End of 2003 and 2005	17
4.	Number and percentage of respondents by socio-demographic Characteristics	34
5.	Number and percentage of Respondents Related to HIV/AIDS Correct answer by items	37
6.	Number and percentage distribution of respondents by level of knowledge about HIV/AIDS	38
7.	Frequency, percentage, Mean, SD and Comments of Respondents according to perception about HIV/AIDS	40
8.	Number and Percentage Distribution of Respondents with Regard to Level of Perception about HIV/AIDS	42
9.	Number and percentage Distribution of Respondents by Cues to Action about HIV/AIDS on Media	42
10.	Number and Percentage Distribution of respondents by Cues to Action about HIV/AIDS on Personnel Influences	44
11.	Frequency and Percentage Distribution of Respondents by Items of Prevention Behavior about HIV/AIDS	42
12.	Frequency and Percentage Distribution of Respondents by items of Prevention behavior about HIV/AIDS	45
13.	Frequency and Percentage Distribution of Respondents by items of Prevention behavior about HIV/AIDS being Faithful	45
14.	Frequency and Percentage Distribution of Respondents by items of Prevention behavior about HIV/AIDS being Abstinent	46

Copyright by Mahidol University

LIST OF TABLES (Cont.)

TABLE Page

15. Frequency and Percentage Distribution of Respondents by items of Prevention behavior about HIV/AIDS being Use of Condom 48
16. Association between the Independent factors and preventive behavior 49
17. Association between knowledge and preventive behavior 49
18. Association between Severity and preventive behavior 50
19. Association between susceptibility and preventive behavior 50
20. Association between perception of benefit and preventive behavior 51
21. Association between perception of barrier and preventive behavior 52
22. Association between Perception about the Severity, Susceptibility 53
23. Association between cues to action and preventive behavior 55

Copyright by Mahidol University

LIST OF FIGURES

Figure		Page
1.	Global AIDS epidemic 1990 – 2003	4
2.	Proportions of HIV infections in different population group by region, 2005	4
3.	Conceptual frame work	9

Copyright by Mahidol University

LIST OF ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
HIV	:	Human Immune Virus
UNAIDS	:	The Joint United Nation Programme on HIV/AIDS
WHO	:	World Health Organization
STD	:	Sexually Transmitted Disease
MSM	:	Men who have Sex with Men
IDU's	:	Injecting Drug User's
ART	:	Anti Retroviral Therapy
PLWHA	:	People Living with HIV/AIDS
HBM	:	Health Belief Model
AIHD	:	ASEAN Institute for Health Development

Copyright by Mahidol University

CHAPTER 1
INTRODUCTION

1.1 Rationale and justification

Acquired immune Deficiency syndrome (AIDS) is the most severe consequence of the infection with Human Immunodeficiency Virus (HIV). HIV/AIDS are invariably fatal diseases with no curative drug or vaccine available as yet to treat it and have infected millions of people around the world. An estimated 38.6 million (33.4 million – 46.0 million) people worldwide were living with HIV in 2005. An estimated 4.1 million (3.4 million -6.2 million) became newly infected with HIV and an estimated 2.8 million (2.4 million -3.3 million) lost their lives due to AIDS (1).

Twenty two years after the first clinical evidence of AIDS was reported, it has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. Worldwide HIV/AIDS is the fourth biggest killer (1).

In many parts of the developing world, the majority of new infections occur in young adults. About one third of those currently living with HIV/AIDS are 15-24 years of age. Most of them do not know they carry the virus and many millions more know nothing or too little about HIV to protect themselves against it (1).

The number of people living with HIV continues to rise, despite the fact that effective prevention strategies exist. All the estimates in this report are based on updated estimation methodologies and the latest available data. Hence current estimates can not be compared directly with previously published estimates. UNAIDS and the World Health Organization (WHO) have produced country-specific estimates for HIV every two years since 1998. During that time, the methods and assumptions used to make these estimates have been continually evolving (2).

Copyright by Mahidol University

UNAIDS and WHO have revised their global estimates of the number of adults living with HIV, particularly in the sub-Saharan region. These new estimates are the result of more accurate data from country surveillance, additional information from household surveys, and steady improvements in the modeling methodology used by UNAIDS, WHO and their partners. This has led to lower global HIV estimates for 2003, as well as for previous years. Although the global estimates are lower, this does not mean the AIDS epidemic is easing off or being reversed. The epidemic continues to expand (2).

There are massive challenges in determining the exact prevalence levels of any diseases all figures are estimates based on available data. While the facts on HIV have been more accurate than many infectious diseases, there are those who would argue that UNAIDS and WHO have sometimes underestimated the epidemic, and at other times inflated the HIV numbers. The reality is more complex since global estimates are based on country estimates which themselves are derived from country surveillance systems. These systems collect data on HIV infection levels in different groups, but data are incomplete and their quality has varied (2).

In many countries, vast populations in rural areas are not well covered by surveillance. Because of social and political prejudice, many surveillance systems also bypass the population groups most likely to be exposed to HIV, such as injecting drug users, sex workers and the gay population-homosexuals. By 2002, only 36% of low- and middle-income countries had a fully implemented surveillance system; however, 58% of countries with a generalized epidemic (where HIV prevalence is above 1%) had such a system (3).

The three most-commonly-used sources of data on HIV/AIDS are sentinel surveillance systems that undertake periodic surveys among specific population groups; national population-based surveys; and case reports from health facilities. Each type of data has strengths and weaknesses. If more sources can be tapped, a more detailed picture can be pieced together and more accurate estimates achieved. In sub-Saharan Africa, the virus is spreading throughout the general population in many countries, and estimates are based largely on information gathered from pregnant

Copyright by Mahidol University

women attending selected antenatal clinics. Recently, several countries have conducted national population-based surveys with HIV testing, some of which have been Demographic and Health Surveys. Examples include Burundi, Kenya, Mali, Niger, South Africa, Zambia and Zimbabwe. The data from these surveys have suggested that previous estimates based on sentinel surveillance were too high. However, all data are subject to possible biases (3).

The assumption that HIV prevalence among pregnant women is equivalent to the prevalence among both men and women in the surrounding communities may not be valid in all countries.

Data from antenatal clinics do not fully represent remote rural populations, and there are few data to help adjust for this bias.

In household surveys in some countries, people who refuse to participate, and those who are not at home when the survey team passes, may well have higher levels of HIV infection.

Copyright by Mahidol University

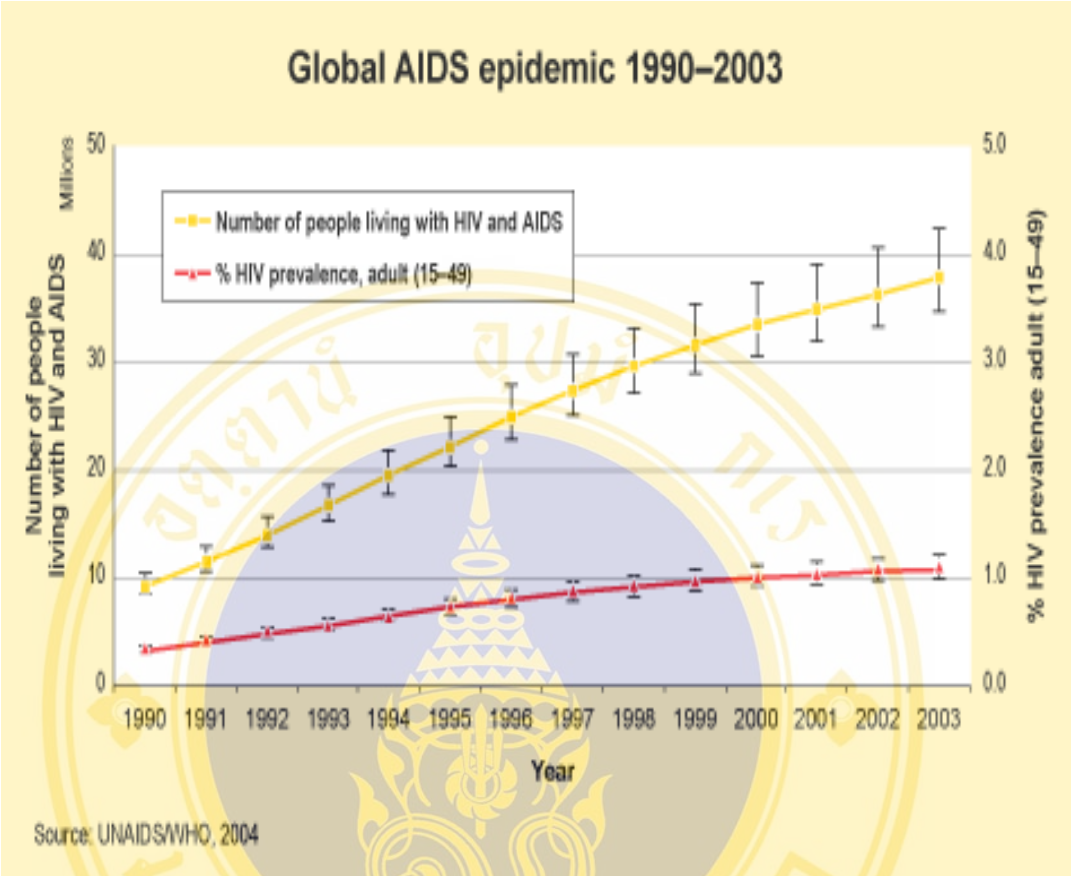


Figure 1 Global AIDS epidemic 1990 -2003

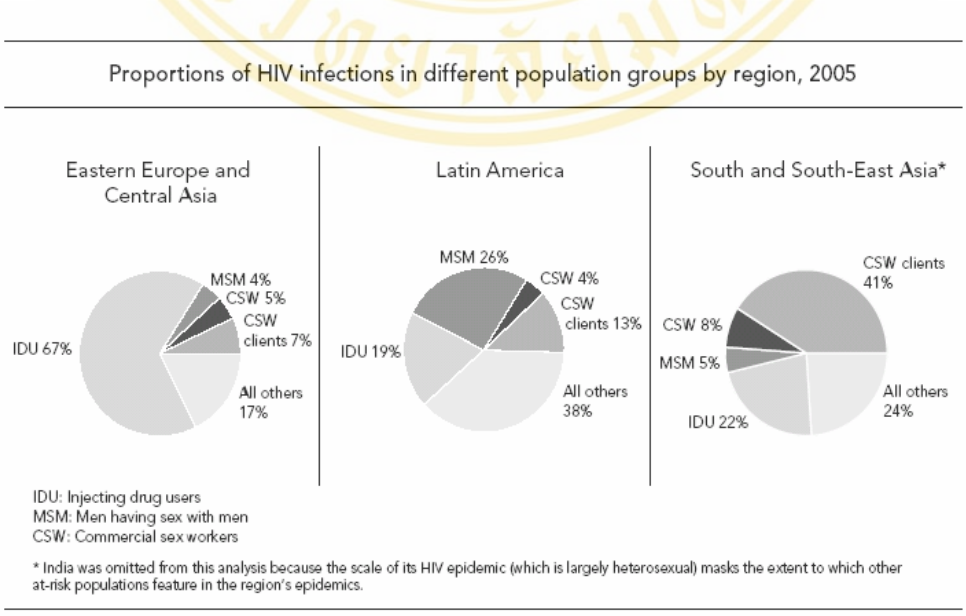


Figure 2 Proportions of HIV infections in different population groups by region, 2005

Copyright by Mahidol University

1.2 Adolescents in Asia

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 (27).

1.3 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 (28).

1.4 Vocational Student Sexual Behavior over the past five years

There is a trend among vocational students for increasing condom use in first time sexual encounters over the past 5 years. Condom use during sex with lovers or committed partners in this group is increasing among females and decreasing among males. Condom use in each sexual encounter for those vocational students with partners who are friends and with acquaintances are declining in both cases for males, but 100% of females in this category used condoms. Safe-sex condom use among female vocational students is declining while among males it is increasing.

Copyright by Mahidol University

Sexual behavior in exchange for goods or money is increasing among vocational students and consistent use of condom is declining among male students and increasing among female students with this behavior (32).

An indication of sexually transmitted infections is increasing while HIV blood testing is declining for this group (32).

Table 1 Average age group of Vocational school 2 year in Bangkok

Characteristics of population	Number	Average age	Standard Deviation	Minimum age	Maximum age
Female	406	16.9	0.8	15	21
Male	500	17	0.99	16	25
Total	906	33.9	1.79	31	46

Source: The Behavioral Surveillance Survey of 4 target groups in Bangkok, 2006.

1.5 Adolescents and Sexual Behavior

Although, national-level surveys tend to suggest that premarital sex is less common in Asia, more focused in depth studies on adolescents 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 percents of male and 11 percents 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 boy friend 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's men had sexual intercourse with sex workers. A large number of sexually experienced 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

Copyright by Mahidol University

partners. In India, although traditional norms oppose premarital sex, some studies indicate a growing trend towards premarital sexual activities among adolescents. The 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 sexually 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 percent of young people were engaged in premarital sex. Similarly, a study in Nepal border towns found that less than 65 percent of unmarried men aged 18-24 ever used a condom during sexual intercourse with non-regular sex partners, including commercial sex workers (36).

1.6 Justification in terms of PHC Management

The idea of community participation in health first appeared in the early 1970s as it became clear that the basic needs in Southern countries could only be met through greater involvement of local people themselves. From the 1980s onwards, the international donor community and national governments began to pay more attention to people's participation, along with related issues such as good governance and democracy. The Harare declaration on the health district in 1987 marked a milestone and acknowledged the importance of community participation as a pillar for primary health care. Reasons for this were that community participation was supposed to be cheap, and related to this were arguments of efficiency, and encouragement of greater self-reliance and better governance with the embodiment of the principle of subsidiary and decision making and control being vested at the lowest level. It was also recognized that the modernist models of development will not be embraced and consolidated until effective demand for primary care services can be articulated by the relevant sections of the society.

Copyright by Mahidol University

1.7 Research Questions

This study has two main research questions as follows:

(1) What is the HIV/AIDS preventive behavior among Vocational students in Mubankru school Nonghkeam district, Bangkok, Thailand?

(2) What factors are related with adopting of HIV/AIDS preventive behavior among vocational students in Mubankru school Nonghkeam district, Bangkok, Thailand?

1.8 Research Objectives

1.8.1 General Objective

To investigate the preventive behavior among vocational students, attending in a Mubankru vocational school of Nonghkam district, Bangkok, Thailand.

1.8.2 Specific Objectives

1. To describe the preventive behavior among vocational students who are attending in the study in Mubankru school of Nongkeam district Bangkok, Thailand.

2. To assess socio-demographic factor knowledge, about HIV/AIDS, perception of HIV/AIDS and cues to action among vocational students in Nongkam district Bangkok, Thailand.

3. To describe HIV/AIDS preventive behavior by socio-demographic characteristics, knowledge, perception and cues to action in the Mubankru school of Nongkeam district Bangkok, Thailand.

Copyright by Mahidol University

1.9 Conceptual framework

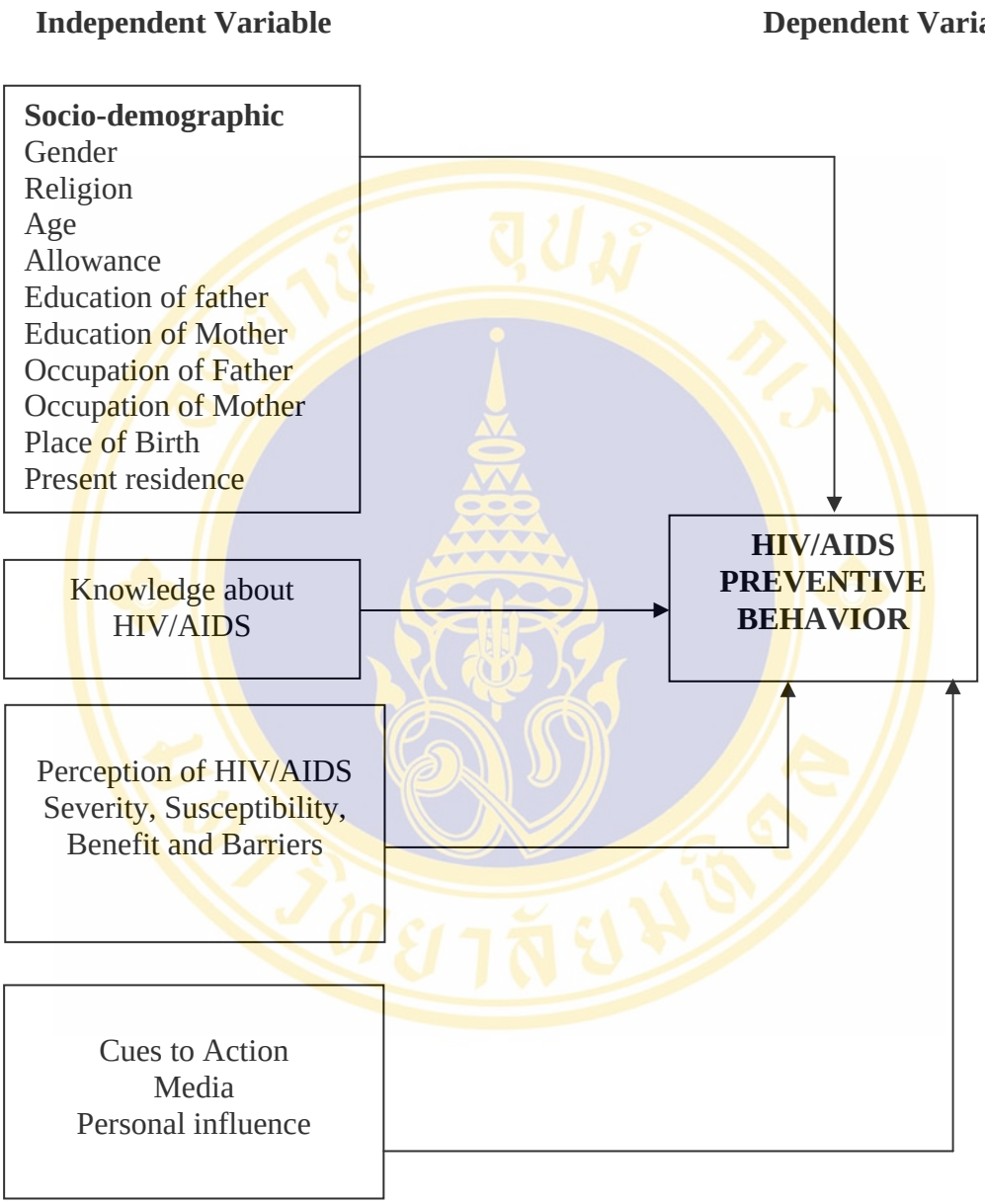


Figure 3 Conceptual Frame work

Copyright by Mahidol University

1.10 Operational Definition

1.10.1 Gender

In this study, Gender refers to how many male and female were participate in this study.

1.10.2 Religion

In this study, Religion refers to what is the religion of the respondents which are Categories in Buddhist, Muslim, Christian and others.

1.10.3 Age

In this study, Age refers to what is the number of respondents in age group of 15-17 years and 18-20 years.

1.10.4 Allowance

In this study, allowance refers to from whom actually the respondents get allowance

1.10.5 Education of the Father

In this study, education of the father refers to the level of respondent's father's education.

1.10.6 Education of the mother

In this study, education of the mother refers to the level of respondent's mother's education.

1.10.7 Occupation of Father

In this study, occupation of respondent's father refers to what is the main occupation of the respondent's father.

1.10.8 Occupation of Mother

In this study, occupation of respondent's mother refers to what is the main occupation of respondent's mother.

Copyright by Mahidol University

1.10.9 Place of Birth

In this place of birth refers to where the respondents were actually born. Whether it is inside of the Bangkok or outside the Bangkok.

1.10.10 Present residence

In this study, present residence refers to where the respondents are actually live with at the present.

1.10.11 Preventive behavior

In this study preventive behavior is abstinence, be faithful, condom used or intending to use condoms.

1.10.12 Knowledge about HIV/AIDS

In this study it means understanding HIV/AIDS, the mode of transmission, high risks group, risk factor and how to prevent the transmission of HIV/AIDS. Knowledge of the young people about mode of transmission causes sign and symptoms, management, prevention, risk group and risk factors.

1.11 Perception of HIV/AIDS

1.11.1 Perception of severity

In this study, it is discernment of HIV infections and AIDS sternness among vocational students. It is cognitive imagination by student on the severity of HIV infections and AIDS.

1.11.2 Perception of susceptibility

In this study, it is also cognitive imagination about perception for getting HIV infections and AIDS.

1.11.3 Perception of Benefit

In this study, it is applied to aggregations of all gains and cost benefits of actually engaging in the preventive behavior.

Copyright by Mahidol University

1.11.4 Perception of barrier

In this study, it means the burden and non profit received by doer, which engaging in the preventive behavior. Such as not using the condom during sexual encounters, being promiscuous that is having extra marital affair and multiple inconsistent sex partner.

1.11.5 Media

In this study, Media refers to from what source of media (Radio, Cinema, Television, Printed materials and others) the respondent's get information about HIV/AIDS.

1.11.6 Personnel Influence

In this study, Personnel Influence refers to from what source of personnel influence (Parents, Teachers, Peers, health Personnel, others Individuals) the respondent's received information about HIV/AIDS.

1.12 Limitation of the study

Target population is only the selected vocational school. This population doesn't present the whole population of vocational students. Since the data collection method is in self administered procedure, we can not control the quality of data. There is also a chances that some might not fulfill whole the questionnaire.

Copyright by Mahidol University

CHAPTER 2
LITERATURE REVIEW

2.1 The Global HIV/AIDS Pandemic

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in 1981, infection with human immunodeficiency virus (HIV) has grown to pandemic proportions, resulting in an estimated 65 million infections and 25 million deaths (1). During 2005 alone, an estimated 2.8 million persons died from AIDS, 4.1 million were newly infected with HIV, and 38.6 million were living with HIV (2). HIV continues to disproportionately affect certain geographic regions (e.g., sub-Saharan Africa and the Caribbean) and subpopulations (e.g., women in sub-Saharan Africa, men who have sex with men [MSM], injection-drug users [IDUs], and sex workers). Effective prevention and treatment of HIV infection with antiretroviral therapy (ART) are now available, even in countries with limited resources (2). Nonetheless, comprehensive programs are needed to reach all persons who require treatment and to prevent transmission of new infections.

In this issue describe the prevalence of HIV infection among MSM in Thailand, HIV-related practices at chest clinics in Guyana, and HIV-related risk behaviors among high school students in the United States.

2.1.1 Asia

Adult HIV prevalence is lower in Asian countries than in countries in sub-Saharan Africa, and the epidemic in most Asian countries is attributable primarily to various high-risk behaviors (e.g., unprotected sexual intercourse with sex workers, IDUs, or MSM and injection-drug use). Of the 8.3 million HIV-infected persons in Asia, 5.7 million live in India, where the prevalence varies by state. Approximately 80% of HIV infections in India are acquired heterosexually. Recent data from four

Copyright by Mahidol University

Indian states indicated a decline in HIV prevalence among pregnant women aged 15--24 years, from 1.7% in 2000 to 1.1% in 2004 (*4*). In China, where 650,000 IDUs account for approximately half of persons living with HIV infection; in contrast, the epidemics in Thailand and Cambodia have been driven largely by commercial sex. In Thailand, HIV prevalence in pregnant women declined from 2.4% in 1995 to 1.2% in 2003. However, HIV prevalence among MSM in Bangkok increased from 17% in 2003 to 28% in 2005 (5). Only 16% of persons in need of ART in Asia received it in 2005 (3).

2.1.3 HIV/AIDS in the South-East Asia Region:

Although the HIV prevalence rate is still low in South-East Asia, it is one of the most rapidly growing HIV/AIDS epidemics globally. Because of the largest population base and presence of several factors that enhance the spread of HIV, including poverty, gender inequality and social stigma, the South-East Asia Region is likely to increasingly suffer the brunt of the epidemic(9)

An estimated 6.7 million people are living with HIV/AIDS in South-East Asia (2005); it is the second highest number of cases in the world after sub-Saharan Africa.

It is estimated that less than 10 percent of infected persons are aware of their HIV status.

While HIV/AIDS cases are now being reported by all countries in the Region, 4 countries, namely India, Thailand, Myanmar and Indonesia, account for 99% of the total burden in the Region.

India, with 5.1 million HIV/AIDS cases, is second only to South Africa in terms of the numbers. Six states in the country, namely, Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu bear the highest burden.

The majority of HIV infections in the Region occur through unprotected sex between men and women.

Throughout the Region, injection drug use is adding to the rapid spread of the

Copyright by Mahidol University

epidemic. Around half of injection drug users have already acquired the infection from HIV in Nepal, Myanmar, Thailand, Indonesia, and Manipur and Nagaland states in India.

An estimated 950,000 persons living with HIV/AIDS in the Region urgently require antiretroviral treatment. The number of people on treatment doubled during 2004 and nearly 163,000 persons are receiving antiretroviral treatment as of December 2005.

Tabel 2 Facts about HIV/AIDS in the South-East Asia Region

Country	Estimated number of PLWHA at end 2001	Estimated number of PLWHA at end 2004	HIV prevalence in 2004	Estimated number of AIDS cases	Estimated number of people receiving ART in public and private sectors by		
					Dec-03	Dec-04	Dec-05
Bangladesh	n/a	13,000	<0.2	<1000		5	
Bhutan	n/a	<100	<0.1			5	6
DPR Korea	n/a	n/a	n/a				
India	3,970,000	5,130,000	0.9	770,000	14,000	28,000	55,000
Indonesia	58,000	110,000	0.1	11,500	1,350	2,500	3,300
Maldives	n/a	<100	<0.1			0	
Myanmar	280,000	330,000	1.2	46,500	1,200	1,500	3,700
Nepal	45,000	61,000	0.5	7,800	75	75	210
Sri Lanka	2,200	3,500	0.1	<500	25	25	44
Thailand	**630,000**	**570,000**	**1.5**	**114,000**	**20,667**	**50,752**	**100,000**
Timor Leste	n/a	n/a	<0.1				
Total (rounded)	**5.0 million**	**6.2 million***		**950,000**	**37,500**	**85,000**	**163,000**

The AIDS cases and deaths are largely under reported in SEAR, except in case of Thailand where almost 90% are reported.

Copyright by Mahidol University

The number of people living with HIV/AIDS (PLWHA) is estimated based on nationally reported surveillance data and based on some assumptions and available tools. These estimates therefore reflect the completeness and quality of data in each country. (Thailand for example, the accumulated PLWHA figure was adjusted based on the new assumptions). The surveillance data, the underlying assumptions as well as the tools to estimate PLHA are, however, improving every year. Data on number of deaths are estimated using software tools.

To strengthen HIV/AIDS surveillance in all member countries, the Regional Office is supporting initiatives through the development of protocols, capacity building, and development of training modules and organization of "training of trainers" workshops.

2.1.4 HIV/AIDS Situation in Thailand

The number of new infections has fallen from a peak of around 140,000 a year in 1991, to around 21,000 in 2003. This remarkable achievement came about mainly because men used condoms more, and also reduced their use of brothels. However, Thailand's epidemic has been changing over the years. There is mounting evidence that HIV is now spreading largely among the spouses and partners of clients of sex workers and among marginalized sections of the population, such as injecting drug users and migrants.

Despite Thailand's indisputable success, coverage of prevention activities is inadequate. This is especially the case among men who have sex with men, and injecting drug users; their infection levels remain high. In Bangkok, over 15% of men who have sex with men who were tested in a 2003 study were HIV-positive, and 21% had not used a condom with their last casual partner.

Many young Thai men avoid brothels because they are afraid of contracting HIV. However, the drop in commercial sex patronage appears to have been accompanied by an increase in extramarital and casual sex. Young Thai women also appear more likely to engage in premarital sexual relationships than earlier generations (Van Landingham and Trujillo, 2002). In Chiang Rai province, a study

Copyright by Mahidol University

among vocational students revealed that only 7% of males surveyed said they had ever bought sex, but that almost half the students (male and female) were sexually active. Behavioral surveillance between 1996 and 2002 shows a clear rise in the proportion of secondary-school students who are sexually active. It also shows consistently low levels of condom use.

Table 3 Estimated number of adults and children living with HIV/AIDS, end of 2003 and 2005

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS.

	2003	2005
Adults (15+) and Children	590 000	580 000
Low estimate	320 000	330 000
High estimate	900 000	920 000
Adults (15+)	570 000	560 000
Low estimate	310 000	320 000
High estimate	880 000	900 000
Children (0-14) (%)	17 000	16 000
Low estimate	5300	5400
High estimate	38 000	38 000
Adult rate (15-49) (%)	1.4	1.4
Low estimate	0.7	0.7
High estimate	2.1	2.1
Women (15+)	220 000	220 000
Low estimate	99 000	100 000
High estimate	350 000	370 000

Source: 2005 Report on the global AIDS Epidemic

2.2 Theoretical Model

2.2.1 The Health Belief Model

The Health Belief Model (HBM) was initially developed in the 1950s by a group of social psychologists in the US public Health Services in an effort to explain the widespread failure of the people to participate in programmes to prevent or to detect disease (Hochbaum, 1958: Rosen stock, 1960, 1966, 1974). Later the model was extended to apply to people's responses to symptoms (kirscht, 1974) and to their behavior in response to diagnosed circulatory compliance with medical regimens

Copyright by Mahidol University

(Becker, 1974). Over three decades, the model has been one of the most widely used psychological approaches to explaining health – related behavior.

Although the model evolved gradually in response to very practical programmatic concerns that will be described later. Its basis in psychological theory is provided as an aid to understanding its rationale as well as its strengths and weaknesses.

2.2.2 Components of the Health Belief Model

Over the years since Hochbaum's survey, many investigations have helped to expand and clarify the model and to extend to beyond screening behaviors to include all preventive actions to illness behaviors and to sick-role behavior (see summaries in Becker, 1974; Becker and Maiman, 1980; Janz and Becker, 1984; Kirscht, 1974; Rosenstock, 1974). In general it is now believed that individuals will take action if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition; and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits.

2.2.3 Knowledge about HIV/AIDS

According to David Ostrow, et al, knowledge about HIV/AIDS has been seen to play a role in motivating initial behavioral change, particularly in persons who see themselves as being at relatively low risk and are initially less informed about the disease and result of HIV transmission.

Knowledge alone, however, does not ensure long term sexual behavior change. A study of the self-reported behaviors of Chicago gay men, who were thought to be relatively well informed about HIV/AIDS, showed that level of knowledge was related to several behavioral outcomes when analyzed cross-sectionally. However a later longitudinal analysis of the same cohort failed to show any such significant relationships. This study suggests that education that aims solely to increase

Copyright by Mahidol University

knowledge would appear to be limited in its ability to induce and maintain modifications in sexual behavior.

In the HIV/AIDS Risk Reduction Model, Knowledge of HIV transmission behavior was thought that it might primarily influence the first stage of the change process (problem perception). It suggests the possibility that some people may have extensive knowledge, perceive their sexual behavior to be problematic, and are moving towards, but have not attained behavioral change.

2.2.4 Perceived Susceptibility

This dimension refers to one's subjective perception of the risk of contracting a health condition. In the case of medically established illness, the dimension has been reformulated to include acceptance of the diagnosis, personal estimates of susceptibility and susceptibility to illness in general.

2.2.5 Perceived Severity

Feeling concerning the seriousness of contracting an illness or leaving it untreated include evaluations of both medical and clinical consequences (e.g. death, disability and pain) and possible social consequences (such as effect of the conditions on work, family life and social relations). We have come to label the combination of susceptibility and severity as perceived threat.

2.2.6 Perceived Benefit

While acceptance of personal susceptibility to a condition also believed to be serious (perceived threat) produces a force leading to behavior, the particular course of action that will be taken depends upon beliefs regarding the effectiveness of the various actions taken in reducing the disease threat, termed the perceived benefits of taking health actions. Thus as individual exhibiting an optimal level of beliefs in susceptibility and severity would not be expected to accept and recommended health action unless that action was perceived as potentially efficacious.

Copyright by Mahidol University

2.2.7 Perceived Barriers

The potential negative aspects of a particular health action, or perceived barriers, may act as impediments to undertaking the recommended behavior. The individual engages in a cost-benefits analysis where in the they weight action's effectiveness against perceptions that may be expensive, dangerous (having negative side effects or iatrogenic outcomes), unpleasant (painful, difficult, upsetting, inconvenient) time-consuming and so forth. Thus the combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (less barriers) provide a preferred path of action (Rosenstock, 1974).

2.2.8 Cues to action

In various early formulation of the Health Belief Model (HBM) the concepts of clues which trigger action were discussed and may ultimately prove to be important, but they have not been systematically studied.

2.2.9 Other Variables

Diverse demographic, socio-psychological and structural variables may effect the individual's perceptions and thus indirectly influence health-related behavior. Specifically, socio-demographic factors, particularly educational attainment, are believed to have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits and barriers.

2.3 The process of Adolescence and Teen Sexual Activity

Knowing the importance of young people, UNAIDS choose their 1998 campaign for young people. Decremented, (20) describes adolescence as follows:

"Adolescence is a time of growth and experimentation, a period marked by establishing autonomy and confronting new challenges. It is a time in which many adolescents will initiate sexual behavior that increases the possibility of HIV infection."

Copyright by Mahidol University

According to WHO, young people are those aged 10-24 years. It is period of human development marked by numerous psychological and social issues together with behavioral changes. Since they are still in a phase of decision making and experimentation it is easy to prevent HIV/AIDS infection. At the same time, this is a time when they become the most vulnerable to HIV infection and transmitted diseases.

2.4 Sexual partners and Relationships

According to the national survey of adolescent in the United states in 2001, most teenage girls aged 15-19 who describe their first sexual experience as voluntary knew their partners fairly well, 73 percent say their first sexual partner was someone they were going steady with, while 20 percent say the first encounter was with a friend or someone they dated occasionally. The percentage of 9^{th} -12^{th} grade students who report having had four or more sexual partner has declined in recent years from 19 percent in 1991 to 14 percent in 2001. However, males (17%) and more likely than females (11%) to report having had four or more sexual partners. Sixty-three percent of sexually active females aged 15-19 had partners who were within two years (Older or Younger) of their age; 28 percent had partners who were three to five years older (28). The younger a girl is when she has sex for the first time, the greater the average age difference is likely to be between her and her partner (27).

2.4.1 HIV Transmission and Prevention

There are four routes of HIV/AIDS transmission. This includes sexual intercourse, contaminated instruments, unsafe blood transfusion and prenatal transmission from mother to fetus or newborn infants.

2.4.2 Sexual Transmission

HIV can be transmitted from an infected person to his/her partner. Sexual transmission may occur from man to women, from women to men and from man to man.

Copyright by Mahidol University

2.4.3 High at-risk behavior associated with sexual transmission of HIV/AIDS

Having many sex partners

Having sex with people who have many sex-partners.

2.4.4 Ways to prevent HIV sexual transmission

By having no sexual relations with others (abstinence)

By only having sex with uninfected partner (being faithful).

2.4.5 Ways to reduce risk of HIV infection via sexual transmission

By using condom correctly through out sexual penetration (i.e. vaginal, oral and anal). “Throughout” mean from start to finish.

By reducing the number of sex partners and by using and/or insisting that the sexual partner uses condom.

By not having sex with people who have many sex partner.

2.4.6 Transmission through contaminated instrument

HIV contaminated instruments are, usually needles, syringes or other skin piercing instruments (e.g. sharp pointed objects for tattooing). Transmission through HIV contaminated needles and syringes can occur when these utensils are not properly sterilized before re-use. This is a common situation among injectable drug users (IDUs) in developing countries, where needles, syringes, as well as instruments for dental procedures and minor surgery are widely used in many places (from local market to poorly funded government clinics) and not properly sterilized or decontaminated/disinfected before re-use (7).

2.4.7 Transmission through blood

HIV/AIDS transmission through infected blood and blood products has almost disappeared in industrialized countries following the introduction of screening methods in 1985, and with the implementation of self exclusion of at-risk people from donating blood. Still, some small risk exists due to “false negative” HIV test among blood donors during the “window period” of initial infection (7).

Copyright by Mahidol University

2.4.8 Prenatal Transmission

Transmission of HIV infection from a woman to her child may occur before, during or shortly after delivery. The risk that an infant will be infected by an HIV infected-mother is reported to be 14-32% in developed countries and 25-48% in under developed countries. Transmission shortly after delivery can also take place via breast-milk.

2.4.9 High risk, high vulnerability

A variety of factors place young people at the centre of HIV vulnerability. These include lack of HIV information, education and services; the gambles many of them must take in order to survive; and the risks that accompany adolescent experimentation and curiosity. (31)

2.4.10 Early Sexual debut

Most young people become sexually active in their teens, and many before their 15th birthday. Factors such as increasing urbanization, poverty, exposure to conflicting ideas about sexual values and behavior, and the breakdown of traditional channels are encouraging premarital sexual activity among adolescents.(31)

2.5 Related Studies

2.5.1 Socio-demographic Factors

Human are born with biological differences between the sexes, either male or female. Their roles, responsibilities and feelings are controlled by environments, culture or the society they live. Many literature authors have documented that there is male –female differential in health behavior. According to Mehta (1999) the male-female differential in sexual activity may explained by the existence of double standards regarding sexual relations in most developing countries. Based on the literature review of existing research literature, it can be summary that gender is likely to be associated with their sexual behavior. Males are more prone to high risk behavior than females.

Copyright by Mahidol University

Occupation and education of parents an indicator their financial status which affects their ways of life. Result study of Haohan (1996) indicate that monthly allowance was statistically significant correlated with sexual behavior, (48) explored risk behavior is high among those with high allowance. Review of existing literature has conclusion that monthly allowance is correlated with behavior among students or adolescents. This shows that students with high monthly allowance have more spending power to visit entertaining places or freedom of spending money for their enjoyment.

Many studies showed that students who lived by themselves or dormitory are free from rules imposed by their family, living atmosphere and environment easily leads to sexual behavior. Haohan found that students who used to stay in dormitory had more sexual relationship than those who lived with parents. Based on the review of existing research literature, student's present address is likely to be associated with their behavior.

2.5.2 Knowledge on HIV/AIDS

Different studies show that although a person has a good knowledge and attitude, also peoples are aware of the basic facts about AIDS but more complex issues are often misunderstood or misinterpreted. The AIDS in the World survey states that misconceptions and misinterpretations are common in AIDS information's programs and become barriers to adapting preventive attitude and behavior. However, there is evidence that even with complete and accurate informations, adoption of preventive is far from assured. It is also a well known fact proved in different studies that the majority of population knew about routes of transmission and prevention, but misunderstanding and false belief are common, as other people belief that by living with HIV/AIDS patient will infect them of these disease. (Tammara, dated not specified).

Copyright by Mahidol University

2.5.3 Perception of HIV/AIDS

Perception is the expression of knowledge and understanding which may be the specific thought, concept or impression. It is the expression that the ability of the brain can interpret the meaning or understanding about various objects. Perception is also a fundamental learning.

A study by Kladsawas K (49) among Thai students in Songkla town found that 73.1% of those had a overall good perception of HIV/AIDS, and the rate of perceived susceptibility on HIV/AIDS increased to 86.8%. It is different that the rate of perceived severity and perceived benefits of preventive behavior were lower at 59.8% and 57.7%, respectively. However, another study by Tamura M (50) on HIV/AIDS preventive behavior among adolescents in Bangkok revealed that the good perception of HIV/AIDS was 58.2% and the perception of susceptibility and severity rate were 75.3% and 52.2 %, respectively.

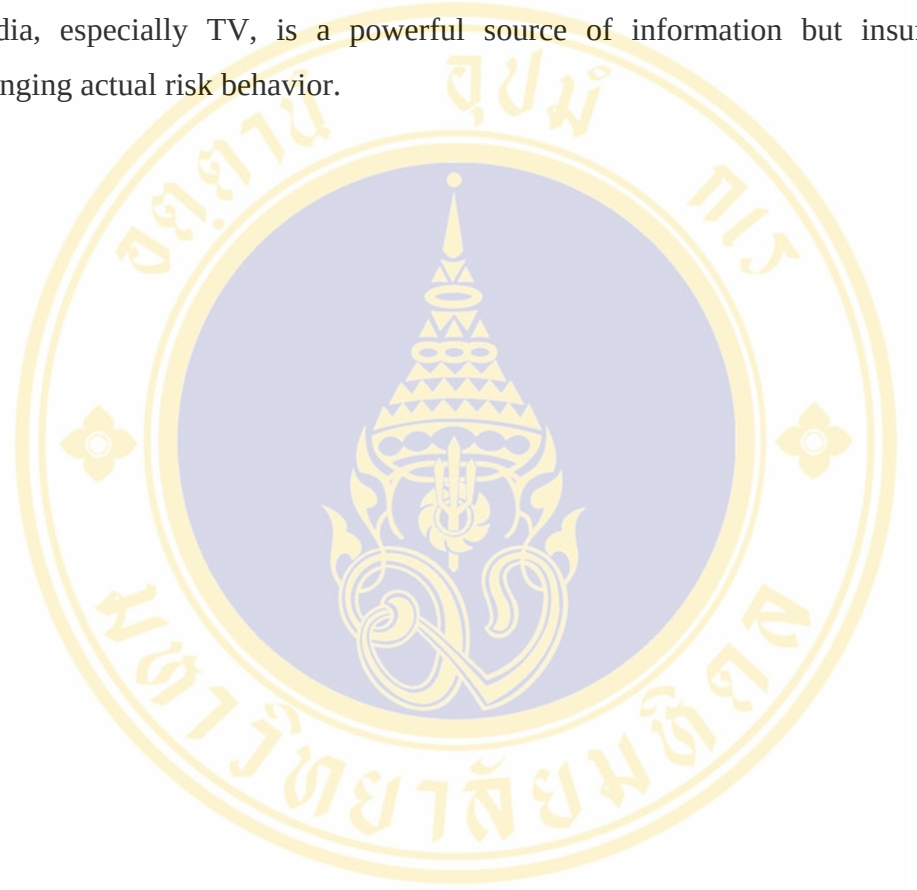
2.5.4 Cues to action

Information sources are cues to action. These information can be given through health personnel, teachers, family members, it also includes mass media with radio, television and newspapers are the most important as well as valuable source of information about HIV/AIDS. Inter-personnel and friends also play role in reminding this source of information.

Case Studies in several settings suggested that peers remain the main source of information sexuality. Among secondary students in Nairobi and Homa Bay, Kenya, 35 percent of female and 51 percent of males reported frequent discussions of sexual matters with their peers (51). Among college students in Hanoi and Ho Chi Minh City, Vietnam, over 90 percent of young people reported that they were most comfortable discussing sexual and productive health with peers of their own sex, while far fewer reported discussion with their partners (52)

Copyright by Mahidol University

Studies in Thailand and Japan (53) have found that the most common source of HIV/AIDS information was through TV, followed by radio and newspaper, and then health workers, and lastly by friends and family members. On the other hand, a study in (54) showed that the primary information sources were radio and newspapers followed by friends and health personals. Stancombe (55) has shown that the mass media, especially TV, is a powerful source of information but insufficient for changing actual risk behavior.



Copyright by Mahidol University

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Study design

The study design was a cross sectional descriptive study, which aims to discover the intension of vocational students in Nongkam district, Bangkok Thailand towards preventive behavior on HIV/AIDS, as well as to determine socio-demographic characteristics, their knowledge, perception and cues to action on HIV/AIDS in the prevention of HIV/AIDS.

3.2 Study Population

The target population for this study was vocational students in Technology Mubankru School in Nongkeam district Bangkok, Thailand.

3.3 Sample Size

The required sample size estimation was based on the following formula

Equation: To find sample size with proportion, according to the Wayne W. Daniel. A Foundation for analysis in the Health Sciences (29)

$$n = \frac{Z^2 P (1-P)}{E^2}$$

Where:

n = estimated sample size

α = level of statistical significance, the statistical significance was set at 0.05,

Therefore Z = 1.96

E = absolute precision of the study, it was set at 0.06

P = 0.52 Anticipated proportion of safe sex intention in previous study (28).

Copyright by Mahidol University

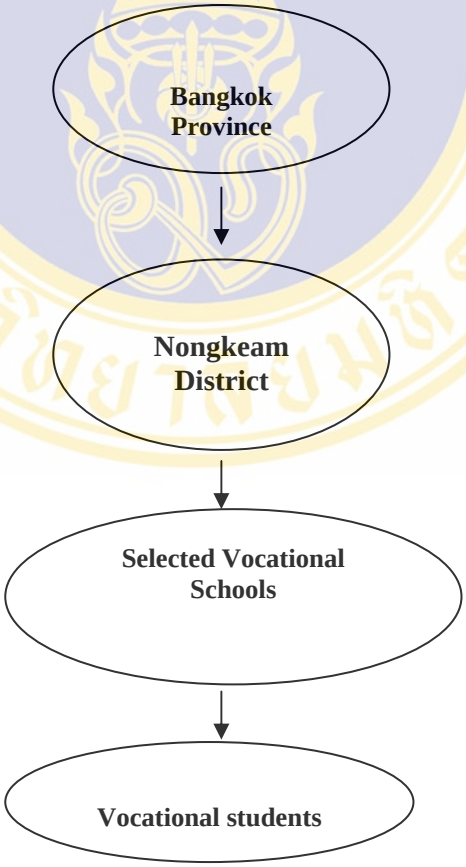
$$n = \frac{(1.96)*(1.96)*0.52\ (1-0.52)}{(0.06)*(0.06)}$$

$$= 266$$

3.4 Sampling technique

The researcher was accompanied by AIHD staff for the translation and coordination with the vocational school Head. The numbers of students were identified in the vocational school. The purposive technique was applied for the sample selection.

3.5 Sampling frame



Copyright by Mahidol University

3.6 Research Instruments

The research instrument in this study for data collection is through self administrated structured questionnaire. The questionnaire was prepared in five parts and pre-tested in the similar vocational school to measure the reliability test. The score of reliability test was 0.56 After the revision some questions were modified and used to collect the data in the study area.

Part I: Socio – demographic characteristics

This part consist of questionnaire consisted of questions dealing with age, sex, religion, education, education of father, education of mother, occupation of father, occupation of mother, hometown and present residence.

Part II: Knowledge on HIV/AIDS

This part included 10 questions, which is divided into levels of knowledge. It will be calculated according to the Benjamin Bloom criteria.

High Level = if the score is > 80%

Moderate Level = if the score is 60% - 80%

Low Level = If the score is < 60%

Part III: Perception towards HIV/AIDS

Perception in this study divided in perception of severity, susceptibility, benefit and barrier towards HIV/AIDS prevention behavior includes question with maximum score 25. Students were asked to agree, not sure and disagree with the perception of severity, susceptibility, benefit and barrier. Expressed in the question by using best rating criteria. (Agree, Not sure, Dis-agree).

Copyright by Mahidol University

Perception of severity, susceptibility, benefit and barrier were divided in three levels: high, moderate and low groups based on the Best's group rating criteria from total of perception.

High Level = 60-75

Moderate Level = 42-59

Low Level = 25-41

Part IV: Preventive behavior on HIV/AIDS

This part includes 6 questions, dividing in to three categories to measure abstinent, be faithful and use of condom. The rating criteria for the preventive behavior is good if the total score is between 10-18, and not good, if the total score is between 1-9.

Part V: Cues to action

This part includes media information and personal influence to prevention behavior of HIV/AIDS.

3.6 Pre-test

Before collecting main data from the respondents, same questionnaire was use for the pre-test in the similar vocational school. Thirty respondents were selected for collecting the information. The score of reliability was 0.56 and some questionnaire was modified.

3.7 Data Collection

Data was collected by means of conducting self-administrated structured questionnaire on the sample population which was closely supervised by the Co-coordinator of the school and representative from the AIHD and researcher. The questionnaire was first prepared in English and later translated in to the Thai version.

Copyright by Mahidol University

3.8 Data Analysis

After examination and correction of each returned questionnaire, collected data was processed by statistical programme by entering in to EPI data. After entering all the data to the EPI data, it was transferred to excel file and from excel to mini tab and the data was analyzed. The outcome of the study was presented as follows:

Descriptive statistics was used for frequency and percentage distribution of socio-demographic, which includes age, sex, religion, education, occupation of father and mother, hometown and present address. In this part it also includes level of knowledge, perception and cues to action. Chi-square test was used to describe relationship between independent variables and dependent variables. The critical significant level was set at 0.05.

Copyright by Mahidol University

CHAPTER 4
RESULTS

This study was conducted to describe Preventive Behavior on HIV/AIDS among Vocational students in Nongkeam district, Bangkok Thailand. The data was collected from 266 vocational students through self-administered structured questionnaire on February 2007.

All distributed questionnaire were fully completed by the respondents. The results of the study were described according to socio-demographic factors, knowledge, perception, cues to action and prevention behavior of HIV/AIDS.

The results are presented in the form of tables by using frequency and percentage to describe the students' characteristics, their cues to action, knowledge, perception and prevention behavior of HIV/AIDS of being abstinent, being faithful and use of condom. The latter are shown by using chi square test for determining the association between dependent variables and independent variables.

4.1 Frequency and percentage distribution of Independent and dependent Variables

4.1.1 Socio demographic factors

According to gender in table 4, it shows that two-thirds of the respondents (70%) were male while 30 percent was female.

Analyzed data found a majority of the respondents in this study was Buddhist, which is (98.50%). The remaining were 2 Muslim (0.74%), 1 Christian (0.38%) and 1 others (0.38%).

The age of the respondents, about 25 percent was in age of 17, and about 15 percent was in age of 18. The age group between 15-17 years was 80.08 percent

Copyright by Mahidol University

and 18-20 years was 19.92 percent. The mean of the age group is 16.6165 and standard deviation was 1.06202.

It was found that the majority of the respondents (95.84%) get allowance from parents. A small percentage (2.67%) receive their allowance from relatives, and about 1.50 percent of respondents use their own money that earn from their work.

Regarding the education level of the respondent's father, 0.75 percent was no schooling and 46.99 percent were primary school. About 28 percent were high school graduates and about 15 percent were graduated from vocational school. The education level of the respondents father that higher than university graduate were about 6 percent. 2.63 percent were others which are some kinds of training on education and does not know actual education level of their fathers.

Regarding the education level of the respondent's mother, 2.26 percent had no schooling, 57.14 percent were primary school, 22.93 percent were high school graduates, 9.77 percent graduated from vocational school, 5.26 percent were University graduated, 1.13 percent were post graduated and 1.50 percent were others source of some special training on educational programme and respondents don't know the level of education of their mother.

With respect to the occupation of the respondents father, more than two-thirds (56.77%) were engaged in labor work, 24.06 percent were business, 9.40 percent were government employee, 3.38 percent were agriculture and 6.39 percent were engaged other occupation.

With respect to the occupation of the respondent mother, almost two-thirds (52.26%) were engaged in the labor work, 30.83 percent were business, 4.14 percent were government employee, 4.14 percent were agriculture and 8.65 percent were engaged in other occupation.

Regarding the birth place of respondents it is almost equal, 51.88 percent of respondents were born in Bangkok, and 49.22 percent were born outside of Bangkok.

It was also found that the majority of respondents (85.34%) live with their parents, while 1.13 percent lives in dormitory. Only 5.64 percent live in rental accommodation and 7.89 percent live with relatives.

Copyright by Mahidol University

Table 4 Number and Percentage of Respondents by Socio-Demographic Characteristics.

Socio-Demographic Characteristics	Number (266)	Percent (%)
Gender		
Male	185	69.55
Female	81	30.45
Religion		
Buddhist	262	98.50
Muslim	2	0.74
Christian	1	0.38
Others	1	0.38
Age		
15-17 years	213	80.08
18-20 years	53	19.92
Mean = 16.6165, SD = 1.06202		
Source of allowance		
Parents	255	95.86
Relatives	7	2.64
Others (Self working)	4	1.50
Education Level of Father		
No schooling	2	0.75
Primary School	125	46.99
High School	74	27.82
Vocational school	41	15.41
Graduate	11	4.14
Post graduate	6	2.26
Others	7	2.63
Education Level of Mother		
No schooling	6	2.26
Primary School	152	57.14
High School	61	22.93
Vocational school	26	9.77
Graduate	14	5.26
Post graduate	3	1.13
Others	4	1.50
Occupation of Father		
Business	64	24.06
Laborer	151	56.77
Government Employee	25	9.40
Agriculture	9	3.38
Others	17	6.39

Copyright by Mahidol University

Table 4 Number and Percentage of Respondents by Socio-Demographic Characteristics (Cont.).

Socio-Demographic Characteristics	Number (266)	Percent (%)
Occupation of Mother		
Business	82	30.82
Laborer	139	52.25
Government Employee	11	4.14
Agriculture	11	4.14
Others	23	8.65
Place of Birth		
Inside Bangkok	138	51.88
Outside Bangkok	128	48.12
Side of Present Residence		
Parent house	227	85.34
Dormitory	3	1.13
Rental accommodation	15	5.64
Other (relatives)	21	7.89

Copyright by Mahidol University

4.1.2 Level of Knowledge on HIV/AIDS

Table 5 shows that the majority of respondents (90.98%) answered correctly about the causative agent of HIV/AIDS. A majority of respondents (93.23%) answered that HIV/AIDS can be transmitted by engaging unprotected sexual intercourse with a person who has many sexual partners. A large majority (88.72%) correctly answered that one can determine whether or not a person has been infected with HIV/AIDS by taking specific HIV blood test. Only 22.18 percent of respondents answered correctly about the length of time it takes from the point a person is infected with the HIV virus until a person develops full blown of AIDS.

A slightly more than three quarter of respondents (75.19%) knew that adolescents who do not use condoms with their regular partners and or casual sexual contacts are at high risk for contracting HIV/AIDS. A large majority of the respondents (80%) answered correctly that HIV positive mother can infect her fetus with HIV virus from maternal to fetal blood supply.

According to the result of respondents, 81.95 percent answered correctly by contaminated instruments needles syringes or other skin piercing can transmit HIV/AIDS. It also showed that majority of respondent answer correctly (81.95%) that HIV/AIDS can not be cured. 47.74 percent and 46.62 percent could answer that HIV/AIDS can be treated by using Anti retro viral therapy and can be prevented by regular health check up respectively.

Copyright by Mahidol University

Table 5 Number and Percentage of Respondents Related to HIV/AIDS Correct Answer by Items.

	Knowledge Statement	Correct Answer		Comment
		Number (266)	Percent (%)	
1	What is the causative agent of HIV/AIDS?	242	90.98	Good
2	Which one is correct about the transmission of HIV/AIDS?	248	93.23	Good
3	Which method used in to determine whether or not a person has been infected with HIV?	236	88.72	Good
4	How long does it takes for a person to develop full-blown AIDS from the time that He/She is infected with HIV Virus?	59	22.18	Poor
5	Which one the following groups are at high risk for contracting HIV/AIDS?	200	75.19	Moderate
6	How HIV/AIDS transmit?	218	81.95	Good
7	How HIV/AIDS be cured?	220	82.71	Good
8	How HIV/AIDS be treated?	127	47.74	Poor
9	How HIV/AIDS can be Prevent?	124	46.62	Poor
10	How HIV/AIDS positive pregnant woman infect her fetus with the HIV virus?	233	87.59	Good

Score: High = > 80%, Moderate = 60% - 80%, Poor = < 60%

Copyright by Mahidol University

Table 6 shows the level of knowledge according to percent score. A percent score of more than 80 percent indicated a “high level of knowledge”; while a 60 to 80 percent indicate moderate score and less than 60 percent indicated a “low level of knowledge”. In this study, slightly more than two-thirds of the students (68.80%) had moderate level of knowledge, 23.68 percent had a high level of knowledge and only 7.52 percent had a low level of knowledge.

Table 6 Number and Percentage of Respondents by Level of Knowledge about HIV/AIDS.

Level of Knowledge (score)	**Number (266)**	**Percent (%)**
High Level	63	23.68
Moderate Level	183	68.80
Low Level	20	7.52

Score: High = > 80%, Moderate = 60%-80%, Low = < 60%

4.1.3 Level of Perception on Prevention of HIV/AIDS

Table 7 shows frequency and percentage distribution of respondent’s perception in regard to the prevention of HIV/AIDS. In this table, the frequency and percentage of each question are given. In regards to the perception of severity, 46.99 percent of the respondents are not sure, whether HIV/AIDS is a curable disease. More than eighty percent (85.34%) agree that HIV/AIDS is a serious social and health problem. 84.96 percent of respondents agree that AIDS make every infected person suffer with it physically. Only 56.02 percent of respondents agree that caring AIDS patients are much costly. 87.59 percent of respondents agree that AIDS will make people die before suitable age.

Regarding to perception of susceptibility, 87.59 percent of the respondents agree that sharing syringes with multiple partner has high chances of transmitting HIV, 80.83 percent of respondent agree with using condom during sexual intercourse reduce sexual gratification. The majority of respondent (83.83%) agree that multiple sexual partners increase risk of HIV virus infection.

Copyright by Mahidol University

Regarding perception of benefit to preventive behaviors on HIV/AIDS, 80.08 percent of respondents agree that using condom, during sexual intercourse can prevent the transmission of HIV/AIDS and other sexually transmitted diseases. 62.78 percent of respondent agree that avoidance from pre marital sex can reduce the risk of HIV virus infection and 74.44 percent of respondent agree that consistent condom usage is a good model for adolescents and young adults to prevent HIV/AIDS.

Regarding perception of barrier to preventive behavior on HIV/AIDS, only 26.69 percent of respondent agree that you can save money for other expenditures by not using condom. 46.24 percent of the respondent are not sure sexual partner feel unhappy and uncomfortable when using condom. 44.74 percent of respondent are not sure use of condom makes loose sexual potency or masculinity. While 56.39 percent of respondent disagree putting on condoms during sexual intercourse is time-consuming.

Copyright by Mahidol University

Table 7 Frequency, Percentage, Mean, SD and Comments of Respondents according to Perception about HIV/AIDS.

Statement	Agree	Not sure	Dis agree	mean	SD	Comment
Severity of HIV/AIDS	(%)	(%)	(%)			
1. HIV/AIDS is a curable disease	13.16	46.99	39.85	2.26	0.67	Mod.
2. HIV/AIDS is a serious social health problem	85.34	12.78	1.88	1.16	0.42	Low
3. AIDS make every infected person Suffer with it physically.	84.96	12.78	2.26	1.16	0.43	Low
4. Caring AIDS patients are much costly	56.02	37.97	6.02	1.50	0.61	Low
5. AIDS will make people die before Suitable age.	87.59	10.15	2.26	1.14	0.41	Low
6. Infected with HIV virus people can not live like normal person	50.75	36.84	12.41	1.61	0.69	Low
7. People have chance to get HIV virus, if people have wounded and Contract directly to others blood.	77.44	20.68	1.88	1.24	0.47	Low
8.Only one sexual intercourse without condom it may cause you to have HIV virus	63.53	30.08	6.39	1.43	0.61	Low
9. Sharing the syringes with multi partner has high chances of Transmitting HIV.	87.59	11.28	1.13	1.13	0.37	Low
10. Having sex with someone who we know well, it no needs to use condom	19.92	19.17	60.90	2.40	0.80	Good
11.Using condom during sexual intercourse reduce sexual gratification.	80.83	16.92	2.26	1.21	0.46	Low
12. Use of condom every time with sexual partner is untruthful to him/her	17.67	30.08	52.26	2.34	0.76	Moderate
13. Multiple sexual partners increase risk of HIV virus infection	83.83	13.91	2.26	1.18	0.44	Low
14. Using condom, during sexual intercourse can prevent the transmission of HIV/AIDS and other sexually transmitted diseases.	80.08	18.42	1.50	1.21	0.44	Low

Copyright by Mahidol University

Table 7 Frequency, Percentage, Mean, SD and Comments of Respondents according to Perception about HIV/AIDS (Cont.)

Statement	Agree	Not sure	Dis agree	mean	SD	Comment
Perception of Benefit to Preventive Behavior on HIV/AIDS	(%)	(%)	(%)			
15. Single use of syringe can help to prevent HIV	62.78	28.95	8.27	1.45	0.64	Low
16. Having condom in the pocket is good due to its easy pick and convenience	63.53	29.32	7.14	1.43	0.62	Low
17. Avoidance from pre marital sex can reduce the risk of HIV virus infection	62.78	31.20	6.02	1.43	0.60	Low
Perception of Benefit to Preventive Behavior on HIV/AIDS						
18. Using condom during sexual relation every times make us not to worry about HIV infection	74.44	23.31	2.26	1.27	0.49	Low
19. Consistent condom usage is a good model for adolescents and young adults to prevent HIV/AIDS	74.44	22.56	3.01	1.28	0.51	Low
Perception of Barrier to Preventive Behavior on HIV/AIDS	27.82	46.24	25.94	1.97	0.73	Moderate
20. Sexual partner fell unhappy and uncomfortable when using condom						
21. Use condom makes loose sexual potency or masculinity	19.55	44.74	35.71	2.15	0.72	High
22. Making love with only one partner is boring	21.80	31.58	46.62	2.24	0.79	Moderate
23. Putting on condoms during sexual intercourse is time consuming	13.53	30.08	56.39	2.42	0.71	High
24. Consistently purchasing condoms for use during sexual intercourse will affect family resources	23.68	33.08	43.23	2.19	0.79	Moderate
25. You can save money for the other expenditures by not using condom	26.69	28.95	44.36	2.17	0.82	Moderate

Score: High = mean 2.36-3, Moderate = mean 1.68 – 2.35, Low = mean 1-1.67

Copyright by Mahidol University

The table 8 shows the number and percentage and distribution of respondent with regard to level of perception about HIV/AIDS. More than two-third of respondent (65.79%) have high level of perception. Whereas 33.08 percent of students have a moderate level and 1.13 percent only have a low level of perception about HIV/AIDS.

Table 8 Number and Percentage Distribution of Respondents with Regard to Level of Perception about HIV/AIDS.

Level of Perception	**Number (266)**	**Percent (%)**
High Level	175	65.79
Moderate Level	88	33.08
Low Level	3	1.13

Score: High =60 -75, Moderate = 42-59, Low = 25-41

4.1.4 Cues to action

Regarding the cues to action in table 9, the result shows that almost all students (100%) received information from media; nearly two-thirds of respondent (64.66%) have received from television whereas only 3.76 percent have received information from cinema.

Table 9 Number and Percentage Distribution of Respondents by Cues to Action about HIV/AIDS on Media

Cues to action	**Number** (266)	**Percent** (%)
1. Media		
- Radio	29	10.90
- Cinema	10	3.76
- Television	172	64.66
- Printed materials	36	13.53
- Others	19	7.14

Copyright by Mahidol University

Regarding to the cues to action from personnel influence, the respondent indicated that 51.13 percent have received information from parents, whereas only 5.26 percent received information from other individual's on prevention behavior of HIV/AIDS.

Table 10 Number and Percentage Distribution of Respondents by Cues to Action of HIV/AIDS on Personnel Influences

Cues to action	Number (266)	Percent (%)
2. Personnel Influence		
- Parents	136	51.13
- Teachers	23	8.65
- Peers	32	12.03
- Health Personnel	61	22.93
- Other Individuals	14	5.26

4.1.5 Preventive behavior on HIV/AIDS

Among the 266 respondents, 51.88 percent of them replied that they refuse having sexual intercourse with unknown partners.35.71 percent do not refuse having sexual intercourse with unknown partners and 12.41 percent replied not sure about having sexual intercourse with unknown partners.32.33 percent of the total respondents answered that being not to have sex to avoid HIV/AIDS in terms of being abstinent. Similarly, 38.72 percent answered that they don't stop having sex not being abstinent and 28.95 percent does not know about being abstinent. 36.84 percent answered that they do not want to have sexual intercourse before they get married. 31.20 percent answered no for having sexual intercourse before they got married and 31.95 percent answered they are not sure. Among the total respondents, 25.19 percent carry condom all the time when they go out, where as 29.70 percent do not carry condom when they go out and 45.11 percent not sure about carrying the condom when they go out. 54.51 percent of respondents answered that they stay with only one partner where as 26.69 percent do not stay with one partner and 18.80 percent does

Copyright by Mahidol University

not know of being faithful. There was also a answer given by the respondents that 43.61 percent ask their partners to use condom all the time when they are having sexual intercourse but 42.86 percent answered that no for asking their partner to use condom all the time when they are having sexual intercourse and 13.53 percent answered not sure about asking their partners to use condom all the time when they are having sexual intercourse.

However, table 11 showed among the total respondents, 69.92 percents have a good preventive behavior on HIV/AIDS, and 30.08 percent have poor knowledge on prevention behavior of HIV/AIDS.

Table 10 Frequency and Percentage Distribution of Respondents by Items of Preventive Behavior about HIV/AIDS

Prevention Behavior	Number (266)	Percent (%)
1. Do you refuse having sexual intercourse with unknown partner.		
- Yes	138	51.88
- No	95	35.71
- Not sure	33	12. 41
2. Do you being not to have sex to avoid HIV/AIDS		
- Yes	86	32.33
- No	103	38.72
- Not sure	77	28.95
3. Do you not to have sexual intercourse before you get married		
- Yes	98	36.84
- No	83	31.20
- Not sure	85	31.95
4. Do you carry condom all the time when you out		
- Yes	67	25.19
- No	79	29.70
- Not sure	120	45.11
5. Do you stay with only one partner		
- Yes	145	54.51
- No	71	26.69
- Not sure	50	18.80
6. Do you ask your partner to use condom all the time when you are having sexual intercourse		
- Yes	116	43.61
- No	114	42.86
- Not sure	36	13.53

Copyright by Mahidol University

Table 11 Frequency and Percentage Distribution of Respondents by Items of Preventive Behavior About HIV/AIDS

Prevention Behavior	Number (266)	Percent (%)
Good	186	69.92
Poor	80	30.08

Score: Good = >Mean, Poor = ≤Mean

4.1.6. Preventive behavior on Being faithful, abstinent and use of condom

Table 12 shows that among total respondents, 82.33 percent have a good preventive behavior on being faithful for the preventive behavior on HIV/AIDS. Like wise Table 13 shows that 84.96 percent of respondents have a good preventive behavior on being abstinent and Table 14 shows that 83.33 percent of the respondents have a good preventive behavior on use of condom.

Table 12 Frequency and Percentage Distribution of Respondents by Items of Prevention Behavior on HIV/AIDS being Faithful.

Preventive Behavior (Being Faithful)	Number (266)	Percent (%)
Good	219	82.33
Poor	47	17.67

Score: Good = >Mean, Poor = ≤Mean

Table 13 Frequency and Percentage Distribution of Respondents by Items of Prevention Behavior on HIV/AIDS being Abstinent

Preventive Behavior (Being Abstinent)	Number (266)	Percent (%)
Good	226	84.96
Poor	40	15.04

Score: Good = >Mean, Poor = ≤Mean

Copyright by Mahidol University

Table 14 Frequency and Percentage Distribution of Respondents by Items of Prevention Behavior on HIV/AIDS being Use of Condom

Preventive Behavior (Use of Condom)	Number (266)	Percent (%)
Good	223	83.33
Poor	43	16.17

Score: Good = >Mean, Poor = ≤Mean

4.2 Association between the Independent factors and Preventive Behavior

4.2.1 Association between socio-demographic characteristics and preventive behavior

Table 15 shows that the results of the analysis between socio-demographic characteristics and preventive behavior. The results shows that there is a significant association between gender and preventive behavior on HIV/AIDS was statistically significant, (p-value =<0.001). The preventive behavior among female respondent was lower (44.44%) than that of male students (81.08%).

The analyzed data also shows that statically there is no significant association between religion and preventive behavior on HIV/AIDS. (P-value = 0.824).

The results showed that students more than 17 years of age likely have higher percentage (83.03%) of the preventive behavior than the age below 17 years of age (66.67%). There was statistically significant association between age and preventive behavior on HIV/AIDS. (P-value = 0.020).

There is also a no statistically significant association between source of allowance and preventive behavior on HIV/AIDS among the vocational students.

The result demonstrated that education of respondent's father with respect to the preventive behavior on HIV/AIDS, The respondent father who graduate higher than primary school is (71.22%) higher than who graduate the primary school (68.50%). Chi-square test also showed that there was no statistically significant association

Copyright by Mahidol University

between a respondent's father's education level and preventive behavior on HIV/AIDS. (P-value = 0.629).

Regarding respondents mothers education, with respect to the preventive behavior on HIV/AIDS, The respondents mother who graduate lower than primary school (65.82%) is lower than who graduate primary school (75.93%). Chi- square test also showed that there was no statistically significant association between education level of mother and preventive behavior on HIV/AIDS (p-value = 0.078).

Observed distributed of preventive behavior of respondents according to father and mothers occupation showed that, the majority of them are 69.54 percent and 69.06 percent are working as a labor respectively. The analyzed data did not find any statistical significant association between respondent's parent's occupation and preventive behavior on HIV/AIDS. P- Value of the father was 0.874 and mother was 0.749.

The result indicated that those respondents born within the Bangkok and out of Bangkok almost have a same percentage on preventive behavior on HIV/AIDS which are 70.92 percent and 68.80 percent respectively. There is no significant difference between places of birth. (P-value = 0.706).

The result also showed that, those respondents who presently not live with parents (79.49%) have more knowledge on preventive behavior on HIV/AIDS than those respondents who stayed with parents have 68.28 percent. There is no statistically significance difference between present living place.(p-value = 0.159).

Copyright by Mahidol University

Table 15 Association between the Independent Factors and Preventive Behavior

Socio-Demographic Characteristics	Preventive Behavior				X^2	df	P-Value
	Good	%	Poor	%			
Gender							
Male	150	81.08	35	18.92	35.956	1	0.000**
Female	36	44.44	45	55.56			
Religion							
Buddhist	183	69.85	79	30.15	0.050	1	0.824
Non-Buddhist	3	75.00	1	25.00			
Age							
15- 17 years	142	66.67	71	33.33	5.396	1	0.020*
18- 20 years	44	83.02	9	16.98			
Source of allowance							
Parents							
Others	182	70.54	76	29.46	1.557	1	0.212
	4	50.00	4	50.00			
Education level of Father							
≤ Primary school	87	68.50	40	31.50	0.233	1	0.629
Higher than Primary school	99	71.22	40	28.78			
Education Level of Mother							
≤ Primary school	104	65.82	54	34.18	3.114	1	0.078
Higher than Primary school	82	75.93	26	24.07			
Occupation of Father							
Labor	105	69.54	46	30.46	0.025	1	0.874
Other than Labor	81	70.43	34	29.57			
Occupation of Mother							
Labor	96	69.06	43	30.94	0.102	1	0.749
Other than Labor	90	70.87	37	29.13			
Place of Birth							
Inside Bangkok	100	70.92	41	29.08	0.142	1	0.706
Outside Bangkok	86	68.80	39	31.20			
Present residence							
Parents house	155	68.28	72	31.72	1.987	1	0.159
Other than parents	31	79.49	8	20.51			

* P-Value < 0.05
** P-Value < 0.001

Copyright by Mahidol University

4.2.2 Association between knowledge and Preventive Behavior on HIV/AIDS

Table 16 showed the association between knowledge and the preventive behavior on HIV/AIDS. The chi-square test found that there was no statistically significant association between level of knowledge where, (p-value =0.826). The result also shows that there is no big difference between the knowledge and preventive behavior on HIV/AIDS.

Table 16 Association between Knowledge and Preventive Behavior on HIV/AIDS

Knowledge	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
High	38	71.70	15	28.30	0.382	2	0.826
Moderate	125	70.22	53	29.78			
Low	23	65.71	12	34.29			

4.2.3 Association between perception of severity and preventive behavior

Table 17 shows that, there was no statistically significant association between perception of severity and preventive behavior on HIV/AIDS (p-value = 0.130). The respondents who have good knowledge on HIV/AIDS (76.19%) demonstrate higher preventive behavior on HIV/AIDS than moderate knowledge on HIV/AIDS (67.03%) .

Table 17 Association between Severity and Preventive Behavior

Severity	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
High	64	76.19	20	23.81	2.292	1	0.130
Moderate	122	67.03	60	21.43			

Copyright by Mahidol University

4.2.4 Association between susceptibility and preventive behavior

Table 18 showed that respondents whose level of susceptibility of perception was moderate had good preventive behavior on HIV/AIDS (70.33%) higher than those who had high level of Susceptibility of preventive behavior on HIV/AIDS (69.71%). The result showed that there is no significant association between perception of susceptibility and preventive behavior on HIV/AIDS (P-value = 0.130).

Table 18 Association between Susceptibility and Preventive Behavior

Susceptibility	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
High	122	69.71	53	30.29	2.292	1	0.130
Moderate	64	70.33	27	29.67			

4.2.5 Association between perception of benefit and preventive behavior

Table 19 showed that respondents who had high level of perception of benefit had good preventive behavior on HIV/AIDS (68.83%). The respondents who had moderate level of perception of benefit had a good preventive behavior on HIV/AIDS (77.14%).The result showed that there was no significant association between perception of benefit and preventive behavior.(P-value = 0.318).

Table 19 Association between Perception of Benefit and Preventive Behavior

Perception of Benefit	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
High	159	68.83	72	31.17	0.998	1	0.318
Moderate	27	77.14	8	22.86			

Copyright by Mahidol University

4.2.6 Association between perception of barrier and preventive behavior

In table 20, the result showed that the respondents who had a moderate level of perception of barrier had good on preventive behavior (77.14%) . Those respondents who had good perception of barrier had not good on preventive behavior (68.83%). It also showed that there was no significant association between perception of barrier and preventive behavior on HIV/AIDS. (P-value = 0.318).

Table 20 Association between Perception of Barrier and Preventive Behavior

Perception of Barrier	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
High	159	68.83	72	31.17	0.998	1	0.318
Moderate	27	77.14	8	22.86			

4.2.7 Association between Perception about the severity, Susceptibility, benefit and barriers and preventive behavior on HIV/AIDS

The table 21 illustrates the association between perception of risk for HIV/AIDS and HIV/AIDS preventive behavior. The chi-square test found that there was no statistically significant association between perception of severity, susceptibility, benefit and barrier of HIV/AIDS preventive behavior. P-value = 0.271. Respondents whose perception of risk for HIV/AIDS high showed more (87.50%) HIV/AIDS preventive behavior in compare to moderate perception showed (69.38%) preventive behavior of HIV/AIDS.

Copyright by Mahidol University

Table 21 Association between Perception about the severity, Susceptibility, benefit and barriers and preventive behavior on HIV/AIDS

Perception	Preventive behavior		DF	P-value
	Good	Not good		
	n	n		
High	7	1	1	0.249 f
Moderate	179	79		

f = fisher exact test

4.2.8 Association between cues to action and preventive behavior

Table 22 shows the results of the analysis between cues to action of media and the preventive behavior on HIV/AIDS of 266 respondents attending vocational school in Nongkeam district, Thailand. The data illustrate that respect to the association between radio message and the preventive behavior on HIV/AIDS there is statistical significance (P-Value = 0.024).

The analyzed data finds that there was no statistically significant association between students who got information about HIV/AIDS from cinema and students who did not got such information from cinema with respect to the preventive behavior on HIV/AIDS, (P-Value = 0.996). Preventive behavior on HIV/AIDS is quite likely to be same among those who does not received from the cinema (69.92%) compare to those who received information from cinema (70%).

Concerning the association between media television and preventive behavior on HIV/AIDS, both group including those who received information about HIV/AIDS and its preventive behavior, it is likely to be same on their preventive part where information from the television 72.67 percent and no information from television 70.77 percent. The chi-square test shows that there is no statistically significant association between media information from television and preventive behavior on HIV/AIDS. (P-Value = 0.074).

Copyright by Mahidol University

Those students who received information from printed materials had a higher preventive behavior on HIV/AIDS (72.22%) than those students who do not received any information (69.57%) from printed materials on HIV/AIDS. The chi-square test shows that there was a no statistically significant association between those receiving information from printed materials and the preventive behavior on HIV/AIDS. (P-value = 0.747).

Regarding information obtained from others which is classified as internet and without internet, without the internet group has a high preventive behavior on HIV/AIDS (70.04%) in compare to the had a internet (68.42%). The chi-square test result shows that there was not a statistically significant association between those receiving information from internet and preventive behavior on HIV/AIDS. (P-value = 0.882).

Table 22 Association between Cues to Action Media and Preventive Behavior

Cues to Action	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
Media							
Radio	15	51.72	14	48.28	5.127	1	0.024*
Without Radio	171	72.15	66	27.85			
Cinema	7	70.00	3	30.00	0.000	1	0.996
Without Cinema	179	69.92	77	30.08			
Television	172	72.67	47	27.33	5.208	1	0.074
Without Television	14	42.42	19	57.58			
Printed Materials	26	72.22	10	27.78	0.104	1	0.747
Without Printed Mat.	160	69.57	70	30.43			
Internet	13	68.42	6	31.58	0.022	1	0.882
Without internet	173	70.04	74	29.96			

*P-Value < 0.05

Copyright by Mahidol University

Regarding personnel influence, illustrated that respondents whose parents talked about HIV/AIDS lower preventive behavior on HIV/AIDS (64.71%) than those respondents who did not talked on HIV/AIDS preventive behavior (75.38%) with the parents. The chi-square test showed that there is statistically no significant association between discussing on HIV/AIDS with parents and good preventive behavior. (P-value = 0.058).

The analyzed data also did not find any statistically significant association between teachers influencing on preventive behavior on HIV/AIDS. Where, P-value = 0.663. Those respondents who were influence by the teachers have slightly higher preventive behavior on HIV/AIDS (73.91%) in compare to those respondents who did not influence by teachers (69.55%).

The analyzed data indicated that respondents whose peers served as reminders had a higher preventive behavior on HIV/AIDS (84.38%). Those whose peers did not served as reminders in this capacity (67.95%). The analyzed data however did not have statistically significant association between peers acting as reminders and the preventive behavior on HIV/AIDS. (P=value = 0.057).

Regarding health personnel acting as reminders, respondents who claimed to have poor preventive behavior on HIV/AIDS (67.21%) in compare to the respondents who were not reminded by health personnel (70.73%). Chi –square test shows that there was not a statistically significant association between health personnel acting as reminders and preventive behavior on HIV/AIDS (P-value = 0.057).

Regarding individual personnel acting as reminders, respondents who claimed to have individual serves in this capacity had a higher preventive behavior on HIV/AIDS (92.86%) than those respondents who were not reminded by individuals (68.65%). Chi-square test showed that there was not a statistically significant association between individuals acting as reminders and preventive behavior on HIV/AIDS. (P-value = 0.05

Copyright by Mahidol University

Table 23 Association between Cues to Action Personnel Influence and Preventive Behavior

Cues to Action	Preventive Behavior				χ^2	df	P-value
	Good		Poor				
	n	%	n	%			
Personnel Influence							
Parents	88	64.71	48	35.29	3.604	1	0.058
Without Parents	98	75.38	32	24.62			
Teachers	17	73.91	6	26.09	0.190	1	0.663
Without Teachers	169	69.55	74	30.45			
Peers	27	84.38	5	15.63	3.612	1	0.057
Without Peers	159	67.95	75	32.05			
Health Personnel	41	67.21	20	32.79	0.277	1	0.599
Without Health Per.	145	70.73	60	29.27			
Individuals	13	92.86	1	7.14	3.695	1	0.055
Without Individuals	173	68.65	79	31.35			

Copyright by Mahidol University

CHAPTER 5
DISCUSSION

This study was conducted in the vocational school 266 vocational students are chosen to be the aims of respondents. This study is to describe the preventive behavior among vocational students, socio-demographic factors Knowledge about HIV/AIDS, Perception of HIV/AIDS and cues to action. This study also finds the association between socio demographic characteristics, knowledge, perception and cues to action towards the HIV/AIDS preventive behavior.

5.1 Preventive Behavior on HIV/AIDS

In this study, 51.88 percent replied that they refuse having sexual intercourse with unknown partners. 38.72 percent not to have sex to avoid HIV/AIDS in terms of being abstinent. 36.84 percent answered that they do not want to have sexual intercourse before they got married. 29.70 percent do not carry condom when they go out. 54.51 percent answered that, they stay with only one partner. 43.61 percent ask their partner to use condom all the time when they are having sexual intercourse. However, among the total respondents, more than two-thirds (69.92%) have a good preventive behavior on HIV/AIDS. The reason for this could be that the regular campaign and advocacy activities carried out by NGO,s and Government could be one why majority of them have knowledge on HIV/AIDS preventive behavior.

5.2 Socio-demographic factors

In this study, more than two-thirds of the respondents were found to be male (69.55%) and 30.45 percent were female. Among total respondents, (98.50%) were Buddhist, 0.74 percent Muslim, 0.38 percent Christian and 0.38 percent was others. The majority were in the age of 16 years old (45.49%). The source of allowance found to be that (95.86%) received from their parents. 46.99 of respondent's father

Copyright by Mahidol University

has primary education like wise 57.14 percent of respondent's mother also has only the primary level education. About 50 percent of the respondent's father andrespondent's mother were working as a labor. Regarding the birth place of the respondents, it was almost similar that 51.88 percent were born within Bangkok and 49.22 percent were born outside of the Bangkok. The majority of the respondents (85.34%) were live with their parents.

5.3 Knowledge about HIV/AIDS

According to the number and percentage distribution, the level of knowledge on HIV/AIDS 63 (23.68%) respondents have high level of knowledge, 183 (68.80%) respondents have moderate level of knowledge and 20 (7.52%) have a low level of knowledge on HIV/AIDS. Although the level of moderate knowledge is more than two-thirds, there are some parts like incubation period, 59 (22.18%), ARV treatment for HIV positive people 127 (47.74%) and method of prevention part 124 (46.62%) where more than half could not answer correctly. More detail in level of knowledge can study from table 5.

5.4 Perception of risk for HIV/AIDS

With regard to number and percentage distribution of respondents the level of perception about HIV/AIDS among total respondents, slightly more than two-thirds, and 65.79 percent have a good level of perception. Whereas 33.08 percent of students have a moderate level and 1.13 percent only have a low level of a perception on HIV/AIDS. The more detail on perception part can be study from table 7.

5.5 Cues to action

Regarding the cues to action from Media, 64.66 percent of respondents got information from Television as a main source of information and regarding the cues to action from personnel influence 51.13 percent received information from respondent's parents. The more detail on each items can be study from table 9 and table 10.

Copyright by Mahidol University

5.6 Association between Gender and HIV/AIDS Preventive Behavior

In this study, more than two-thirds of the 185 respondents were male (69.55%) and rest 81 were female (30.45%). From the result showed the number of respondents who have high preventive behavior on HIV/AIDS than female. The level of preventive behavior is vast different between male (81.08%) and female (44.44%).

There is a statistically significant association between gender and preventive behavior. (P-value <0.05). Similar previous study, (7) also found association between gender and preventive behavior on HIV/AIDS.

5.7 Association between Age and HIV/AIDS Preventive Behavior

In this study, majority (80.08%) of the respondents are in the 15-17 years of age group. The level of preventive behavior between two groups 15-17 years (66.67%) and 18-20 years (83.02%) is quite widely different.

There is a statistically significant association between HIV/AIDS Preventive Behavior and Age of the respondents (P-value < 0.05). The reason for the significant result could be that the age group (18-20) years of age is sexually active group. The similar study which was studied (7) also has a significant association with preventive behavior.

From the result, numbers of male have good preventive behavior than the female. However there is a trend showed by other studied that 100 percent female vocational students use condom during their sexual intercourse while not all the male vocational students use condom in their second time sexual intercourse (32). Similarly, the age groups of 18-20 years have a good preventive behavior compare to age group of 15-17 years. The overall result on this study showed that religion, source of allowance, education level of father, education level of mother, residence and side of present residence does not have any statistically significance association with HIV/AIDS preventive behavior.

Copyright by Mahidol University

Gender may also involve biological factors that can influence the probability of infection. Female and minority adolescents are particularly at risk of HIV infection (Rotheram-Borus & Koopman1991). The sociobehavioural patterns however are complex. In a national probability sample, Catania et.al 1992 found that males were more likely to report having multiple sexual partners, but that women were more likely to have a high risk primary sexual partner Aral et al 1991. Similarly, found that men aged 18 and 19 are more likely to report having had more than one sex partner in the preceding year.

5.8 Association between Knowledge about HIV/AIDS and HIV/AIDS Preventive Behavior

In this study, there was no statistically significant association between knowledge and HIV/AIDS preventive behavior. The reason could be that level of knowledge among the total respondents was almost similar in all three categories high, moderate and low. This finding may due to, although the students have high level of knowledge, there are many factors apart from knowledge influencing like curiosity and feeling of love.

Initially there was a strong belief on the part of health educators that adequate knowledge about HIV/AIDS would lead to a reduction of risk behavior. This assumption is true, in sense that for an individual to change their behavior it is necessary to know the behavior is risky. However despite the knowledge of the youth about the risky and consequences the number of young people do not seem to behave accordingly and the level of knowledge seems to have limited influence on safe sex practice. This is confirmed by many other studies where the level of knowledge is not relevant for behavior change.

A trend to use condom among vocational students is increasing in first time sexual encounters over the past five years. Condom use during sex with lovers or committed partners in this group is increasing among females and decreasing among males. Condom use in each sexual encounter for those vocational students with

Copyright by Mahidol University

partners who are friends and with acquaintances is declining for males. Safe sex condom use among female vocational students is declining, while among males is increasing. Consistent use of condom is declining among male students and increasing among female students with this behavior (32).

5.9 Association between Perception of risk for HIV/AIDS and HIV/AIDS Preventive behavior

In this study, it showed that there is no statistically significant association between perception of risk for HIV/AIDS and HIV/AIDS Preventive behavior. (P-value = 0.271). The analyzed data showed the gap between high and moderate level of perception is highly different with each other.

In Thailand, many young Thai men avoid brothels because they are afraid of contracting HIV. However, the drop in commercial sex patronage appears to have been accompanied by an increase in extramarital and causal sex. Young Thai women also appear more likely to engage in premarital sexual relationships than earlier generations (36). In Chiang Rai province, a study among vocational students revealed that only 7% of male's respondents said that they had ever bought sex, but almost half of the students, both male and female were sexually active. Behavioral surveillance between 1996 and 2002 shows a clear rise in the proportion of secondary school students who are sexually active. It also shows consistently low level of condom use.

5.10 Association between cues to action and HIV/AIDS preventive behavior

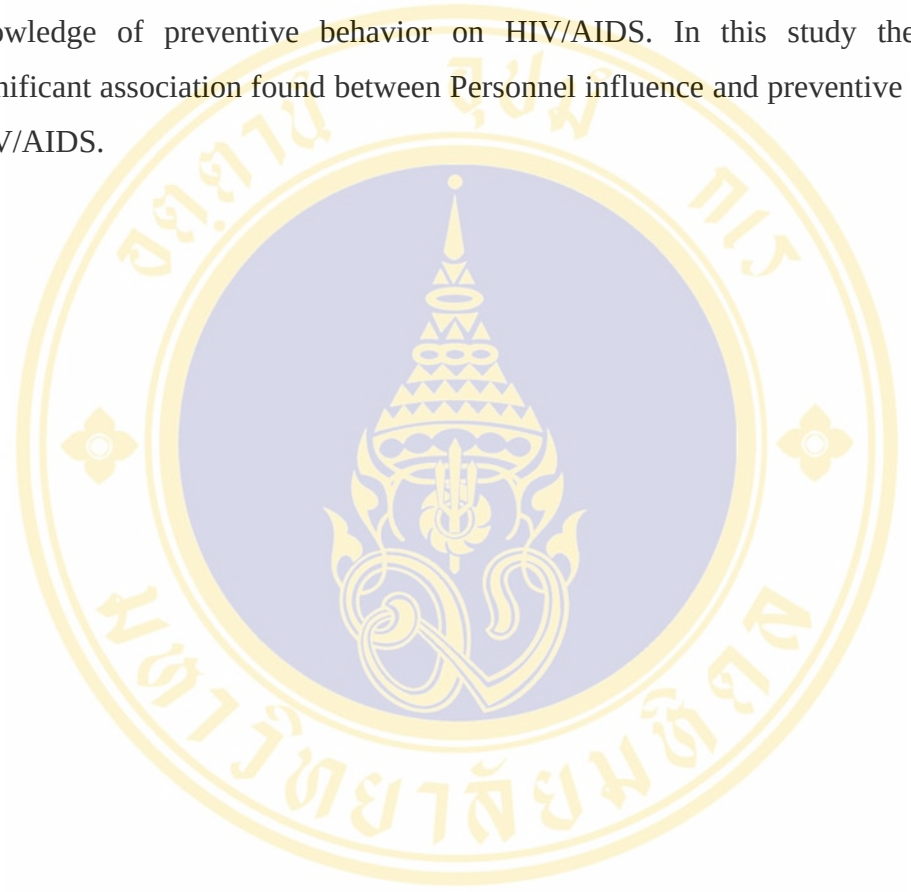
Although printed materials are the highest media to preventive behavior on HIV/AIDS for vocational students, the descriptive result shows that Television have no significant association with preventive behavior on HIV/AIDS.

There is statistically significant association between Radio and preventive behavior on HIV/AIDS. (P-value = 0.024). Young people appear to prefer to obtain information on different aspects of the predominant source of information on

Copyright by Mahidol University

HIV/AIDS, though this is not necessarily the case for other aspects of sexual health. Among Adolescents factory workers in Thailand, over 70 percent obtained HIV/AIDS information from television and radio.

It was found that there is no significant association in Preventive behavior on HIV/AIDS. In personnel influence non-parents individuals have more good knowledge of preventive behavior on HIV/AIDS. In this study there was no significant association found between Personnel influence and preventive behavior on HIV/AIDS.



Copyright by Mahidol University

CHAPTER 6
CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study was carried out to determine the factors of which are associated with HIV/AIDS preventive behavior among vocational students of Nongkeam district, Thailand. This study aimed to describe preventive behavior on socio-demographic factors, knowledge about HIV/AIDS, Perception of risk for HIV/AIDS, and cues to action. The research design of this study was descriptive cross-sectional study. The target population was vocational students. The total studied sample size for this study was 266 vocational students. Self-administrative questionnaire was used as a research instrument. Data was analyzed by using statistical methods, chi-square and descriptive statistic.

The results in this study showed that more than two-thirds of students were male, quite majority of them are living with parents and get allowance from them. The age of study population was between 15 to 20 years old, and majority of them were Buddhist. Almost more than half of the respondent's father and mother's main occupation is labor. After this, business is common in both father and mothers occupation which is nearly one –third of the total participated respondents. Regarding the birth place of the respondents, it is slightly more born in Bangkok. The majority of the respondents were live with their parents. Gender, Age and Radio have statistically significant association with HIV/AIDS preventive behavior. (P-value < 0.05).

1. Among the 266 respondents, (51.88%) of them replied that they refuse having sexual intercourse with unknown partners. 35.71 percent do not refuse having sexual intercourse with unknown partners and 12.41 percent replied not sure about having sexual intercourse with unknown partners.

Copyright by Mahidol University

2. Concerning the socio-demographic factors, majority of the respondents were male, most of the respondents had religion Buddhist, more than three-quarters of respondents are between the age group 15-17 years. Majority of the respondents received allowance from parents. The majority of the respondent's parents have a primary education only. The major occupation of the respondents parents are l work. Almost equal percent of respondents are born inside and outside of the Bangkok.

3. In this study Gender and Age had statistically significant association with HIV/AIDS preventive behavior with P-value < 0.05. Religion, source of allowance, education level of father and mother, occupation of father and mother, place of birth and side of present residence are not statistically significant association with HIV/AIDS preventive behavior.

4. In this study, more than two-thirds of the respondents have moderate level of knowledge, 23.68 percent have high level of knowledge and only 7.52 percent have a low level of knowledge on HIV/AIDS preventive behavior. There is no statistically significant association between knowledge and HIV/AIDS preventive behavior. The study also found that more than two-thirds of the respondents have high level of perception and only 1.13 percent has a low level of perception. There is also statistically no significant association between perception and HIV/AIDS preventive behavior. Regarding cues to action in this study, almost all the respondents received information from media and personnel influence. More than two-thirds of them received information from television and 51.13 percent received information from parents. There is statistically significant association between radio and HIV/AIDS preventive behavior. (P-value = 0.05).

Copyright by Mahidol University

6.2 Recommendation

Based on the findings of this research the following recommendations are suggested:

6.2.1 Recommendation for Implementation

1- Since studies showed Radio to be the most important media of getting information on preventive behavior of HIV/AIDS, organization working for HIV/AIDS has to dispense more information through this form of media.

2- Since the level of knowledge is moderate, some interventions should be conducted by involving organizations in order to increase adolescents knowledge on HIV/AIDS.

6.2.2 Recommendation for further study

1- Since this study was cross sectional descriptive, only quantitative information was collected through structured questionnaires on HIV/AIDS preventive behavior. To obtain more information about HIV/AIDS preventive behavior, qualitative techniques are needed to get in-depth information.

2- This study was conducted only in one vocational school. It can not represent the general vocational school students. In future, research should be conduct among several vocational school.

Copyright by Mahidol University

REFERENCES

1. UNAIDS. Report on the global AIDS epidemic. Geneva: UNAIDS; 2004.
2. World Health Organization. The world Health Report 2004: Changing History. Geneva: WHO; 2004.
3. UNAIDS. AIDS epidemic update December 2004.Under Embargo until 1200 GMT, 23 November 2004. Geneva: UNAIDS; 2004.
4. Global data on HIV/AIDS, TB, Malaria and more. Available from: http://www. Globalhealthfacts.org [Accessed 2006 Dec 10]
5. Law SD et al. Impact of HIV infection on the epidemiology of tuberculosis in a peri urban community in South Africa: the need for age specific interventions.
6. Vichea C. HIV preventive Behaviors Among High School Male students in Phonm Penh City, Cambodia: An application of Health Belief Model. [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 2005
7. Zolaiha. HIV/AIDS prevention Behavior Among Adolescents in High School of Jakarta, Indonesia. [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 2005
8. Thuong NH. Determinants Related to the Utilization of Voluntary Counseling and HIV Testing service in Vietnam. [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 2006
9. UNAIDS/WHO report on global HIV/AIDS epidemic. Geneva: UNAIDS; 1998
10. HIV and young people: The threat for today's youth report on the global AIDS epidemic. [Online]. 2004. Available from: http// www.unaids.org/bangkok. [Accessed 2006 Nov 25]
11. Joint United Nations Programme on HIV/AIDS(UNAIDS). HIV/AIDS and young people hope for tomorrow. Geneva: The programme; 2003.

Copyright by Mahidol University

12. WHO Tuberculosis, frequently asked questions by AIDS workers. [Online] Available from: http://www.searo.who.int/en/section10/section373.htm [Accessed 2006 Nov 14]

13. World Health Organization. HIV/AIDS in Thailand [Online] Available from: http://www.searo.who.int/search/searchresult.asp [Accessed 2007 Jan 3]

14. Ostrow D. et al. Knowledge about HIV/AIDS. [S.l. : s.n., n.d.]

15. South East Asia. HIV and AIDS statistics. Avialable from: http://www.avert.org [Accessed 2006 Dec 24] 2006

17. Clinical Trails in HIV/AIDS : What you need to know. Third printing, May 2004:Beverly Deutsch

18. UNAIDS. scaling up access to HIV prevention, treatment care and support. [Online] Available from: http://data.unaids.org/pub/Report/2006/20060807 Universal%20Access_TheNextSteps_en.pdf [Accessed 2007 Jan 15]

19. Almond B (ed.). AIDS: a moral Issue : the Ethical, legal and social Aspects 2nd ed. Hamshire: Macmillan Press; 1996.

20. Narain JP(ed). AIDS in Asia : the challenge A head. New Delhi: World Health Organization, Regional Office for South-East Asia; 2004

21. University of London, UK. AIDS and Adolescence. [S.l. : s.n.]; 1997

22. Basset M. Woman and AIDS Research Program ; Female Sexual Behavior and the Risk of HIV infection an Ethonographic study in Harare Zimbabwe. Zimbabwe : The Progamme; 1994.

23. Bhende AA. Evolving a model for AIDS prevention Education among under privileged Adolescence girls in Urban India. India: Women and AIDS Research Program; 1995.

24. Studies, knowledge, Attitudes and Behavior of secondary (High) school students concerning HIV/AIDS in Enugu, Nigeria 2000. New York: American Elsevier; 2002.

25. Deborah Helitzer-Allen. An Investigation of Community; Based Communication Networks of Adolescents Girls in Rural Malawi for HIV/STD Prevention Messages, 1994.

26. Joint United Nations Programme on HIV/AIDS(UNAIDS). HIV/AIDS and young people hope for tomorrow. Geneva: The Programme; 2003

Copyright by Mahidol University

27. National survey of adolescents in the United states in 2001. [S.l. : s.n., n.d.]

28. Kumarawansa W.K.W.S. Safe sex intention towards HIV/AIDS Prevention among secondary school students of Nakhon Pathom Province,Thailand [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 2006

29. Daniel WW. Biostatistics: a foundation for analysis in the health sciences. 8th ed. New York : Wiley; 2004.

30. Chim S. Knowledge, Attitude and Practice of Cambodian Pregnant Women on HIV/AIDS Prevention. [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 1996.

31. HIV/AIDS HIV/AIDS and Adolescents young People, a window of hope in the HIV/AIDS pandemic

32. Isaranurug S, Thepthien B, Chompikul C, Wongsawass S. The Behavioral Surveillance Survey of 4 Target Groups in Bangkok, 2006. Nakhon Pathom:
ASEAN Institute for Health Development, Mahidol University; 2006

33. UNAIDS. AIDS epidemic update. Geneva: UNAIDS; 2005.

34. UNAIDS, World Health Organization. Facts and figures about HIV/AIDS in the South-East Asia Region AIDS Epidemic update Dec 2005. Geneva: UNAIDS; 2005.

35. Europian Union, World Health Organization, UNICEF, UNAIDS. Epidemiological Facts sheets on HIV/AIDS and sexually Transmitted infection August 2006. Geneva: World Health Organization; 2006

36. W. Indralal De Silva. Emerging Reproductive Issues among Adolescents in Asia; 1998. Available from : http://www.hsph.harvard.edu/takemi/rp [Accessed 2006 Dec 30]

37. Youth and HIV/AIDS Today World Bank teams up with UNESCO to promote HIV/AIDS discussion among youth December 10, 2002. [S.l. : s.n.]; 2002

38. Sherr L, (ed). AIDS and Adolescents. Amsterdam, The Netherlands: Harwood Academic; 1997

Copyright by Mahidol University

39. Phuphaibul R. Health Promotion for Early Adolescents : phase I Identification of Health Issues and Module Development. Bangkok: Centre for Nursing Research ,The Department of Nursing, Faculty of Medicine Ramathbodi Hospital, Mahidol University, Thailand; 2002.

40. Friedman HL. Changing patterns of adolescent sexual behavior: Consequences for health and development. Geneva: Department of Adolescent Health, World Health Organization; [n.d.]

41. Mbizyo MT, Bassett MT. Reproductive health and AIDS prevention in sub-Saharan Africa: the case for increased male participation. Zimbabwe: Department of obstetrics and Gynaecology, University of Zimbabwe Medical School; [n.d.]

42. MCcauley AP, Salter C, Kiragy K, Sendro, Witz J. Meeting the needs of Young Adults. Baltimore, Maryland: John Hopkins school of Public Health; [n.d.]

43. Kitamura K. Every child should be a wanted child. Thinking about adolescent sexual conscious ness and behavior in Japan.

44. Haffajee F. Sex and the schoolgirl in South Africa: special focus: AIDS and Children. [S.l. : s.n., n.d.]

45. Kang BS. Adolescent's sexual problems in Korea. Integration. 1990: Jul;(24): 33-6.

46. Sherr L, editor. AIDS and Adolescents. Australia: Hardwood Academic ; 1997.

47. Ayu Anggraeni Dyah Purbasari. HIV/AIDS at Risk Behavior Among Students in Jakarta Polytechnic of Health Indonesia [M.P.H.M. Thesis in Primary Health Care Management]. Nakhon Pathom: Faculty of Graduate Studies, Mahidol University; 2006.

48. Tamara Aboagye Kwarteng Rob Moodie. Community action on HIV, A Resource Manual for HIV Prevention and Care. Australia: Australian Agency for International Development; (n.d.).

49. Kladsawas K. Preventive behaviors toward human immunodeficiency virus infection of junior high school students in Songkla province [M.S. Thesis in Epidemiology] . Bangkok: Faculty of Graduate Studies, Mahidol University;2001

Copyright by Mahidol University

50. Tamura, M. HIV/AIDS preventive behaviors among adolescents in Khong Toey community congested area, Bangkok [M.P.H. Thesis in Public Health]. Bangkok: Faculty of Graduate of Studies, Mahidol University; 2000.
51. Nyamongo I. Investigation into condom acceptability, sexual behavior and attitudes about HIV infection and AIDS among adolescents student in Kenya. Nairobi, Kenya, Institute of African Studies: University of Nairobi; 1995.
52. Vu QN. Survey on young adults reproductive behavior: KAP study. Hanoi: National Committee on Population and Family Planning; 1995.
53. Kitaura H, et al. Knowledge and attitude of Japanese dental care workers toward HIV related Disease. J Dent 1997; 25(3-5):279-83.
54. Uch C, et al. Extramarital Relation and Perception of HIV/AIDS in Nigeria. Health Transit Rev 1994; 4(2):111-25
55. Stancombe. Qualitative research findings on young heterosexuals: the 1994 communication environment in the context of sexually transmitted diseases including HIV/AIDS.[s.1.:s.n.];1994

Copyright by Mahidol University

APPENDIX

Copyright by Mahidol University

APPENDIX A

QUESTIONNAIRES

PREVENTIVE BEHAVIOR ON HIV/AIDS AMONG THE VOCATIONAL SCHOOL STUDENTS IN NONGKAM DISTRICT BANGKOK, THAILAND

Dear Friends,

Before you answer the questions below, I would like to thank you for responding in this study and I apologize myself for taking your time.

Please answer the following questions, or mark in the □ with a √ kindly completes all questions honestly as your answers will be confidential and anonymous.

Part I: **General Characteristic**

1. **What is your Gender?**
   □ 1 = male □ 2 = female
2. **What is your religion?**
   □ 1 = Buddhist □ 2 = Muslim
   □ 3 = Christian □ 4= other (specify) _____
3. **Age:** Kindly indicate your age at the time of your last birthday:_____years
4. **From whom do you get allowance?**
   □ 1. Parent's □ 2. Relatives
   □ 3. Loan for study □ 4. Other specify_____
5. **What is the education of your father?**
   □ 1= No schooling □ 4 = Vocational School
   □ 2= Primary school □ 5 = Graduate
   □ 3 = High school □ 6 = Post graduate
   □ 7 = Other Specify_____
6. **What is the education of your mother?**
   □ 1= No schooling □ 4 = Vocational School
   □ 2= Primary School □ 5 = Graduate
   □ 3 = High school □ 6 = Post graduate
   □ 7 = Other Specify_____

Copyright by Mahidol University

7. What is the occupation of your Father?

□ 1= Business □ 4= Agriculture

□ 2= Laborer □ 5=Other Specify_____

□ 3= Government Employee

8. What is the occupation of your mother?

□ 1= Business □ 4= Agriculture

□ 2= Laborer □ 5=Other Specify_____

□ 3= Government Employee

9. Residence: Kindly indicate where do you born_____

10. At present whom do you live with?

□ 1= Parent house □ 3 = Rental accommodation (house, room)

□ 2= Dormitory □ 4 = Other Specify_____

Part II: Knowledge about HIV/AIDS:

To answer the following questions select the most appropriate choice according to your knowledge/Understanding of HIV/AIDS

Please make the answer with only one check (X) in the □ according to your understanding.

11. What is the causative agent of HIV/AIDS?

□ A Virus

□ A Bacteria

□ A parasite

□ A Fungi

12. Which one is correct about the transmission of HIV/AIDS?

□ By hugging a person infected with HIV/AIDS.

□ By having unprotected sexual intercourse with a person who has many sexual partners.

□ By using drinking glasses or other utensils commonly used by an HIV/AIDS infected individuals.

□ By being bitten by a mosquito after it has just bitten an HIV/AIDS infected person.

Copyright by Mahidol University

13. Which method used in to determine whether or not a person has been infected with HIV?

□ By specific HIV blood tests □ By specific HIV urine tests

□ By specific HIV X-ray tests □ By looking at his/her physical appearance

14. How long does it takes for a person to develop full-blown AIDS from the time that he/she is infected with the HIV virus?

□ Within 1 week □ Within 1 month

□ Within 6 months □ more than 1 year

15. Which one the following groups are at high risk for contracting HIV/AIDS?

□ Homosexuals who consistently use condoms

□ Commercial sex workers who consistently use condoms

□ IDUs who do not share needles and syringes

□ Adolescents and young adults who do not use condoms with their regular Partners and/or casual sexual contacts

16. How HIV/AIDS transmit?

□ By having no sexual intercourse

□ By contaminated instruments like needles syringes or other skin piercing

□ By partner who uses condom

□ By not having sex with people who have many sex partners

17. How HIV/AIDS be cured?

□ By a vaccine □ By antibiotics

□ By an operation □ Can not be cured

18. How HIV/AIDS be treated?

□ By using Anti Retro Viral Therapy (ARV)

□ By treatment immunological system

□ By killing the virus

□ By consuming high levels of vitamins and minerals

19. How HIV can be Prevent?

□ By reducing the number of sex partner

□ By reducing the sharing of syringe with others

□ By regular health check up

□ By safe blood transfusion

Copyright by Mahidol University

20. How HIV positive pregnant woman infect her fetus with the HIV virus?

- From maternal to fetal blood supply
- During a caesarian Delivery
- By breast-feeding the infant after delivery
- By cuddling and kissing the newborn baby

Part III: Perception about the Severity, Susceptibility, Benefits and Barriers to HIV/AIDS interventions.

No	Statement	Agree	Not Sure	Disagree
	Severity of HIV/AIDS			
21	HIV/AIDS is a curable disease			
22	HIV/AIDS is a serious social and health problem			
23	AIDS make every infected person suffer with it physically			
24	Caring AIDS patients are much costly			
25	AIDS will make people die before suitable age			
26	Infected with HIV virus, person can not live like normal person			
Susceptibility of HIV/AIDS				
27	People have chance to get HIV virus, if people have wounded and contact directly to other's blood			
28	Only one sexual intercourse without condom, it may cause you to have HIV virus			
29	Sharing the Syringe with multi partner has high chances of transmitting HIV.			
30	Having sex with some one who we know well, it no need to use condom			
31	Using condom during sexual intercourse reduce sexual gratification			
32	Use of condom every time with sexual partner is untruthful to her/him			
33	Multiple sexual partners increase risk of HIV virus infection			

Copyright by Mahidol University

34	Using condoms, during sexual intercourse, can prevent the transmission of HIV/AIDS and other sexually transmitted diseases (STDs)			
35	Single use of syringe can help to prevent HIV.			
36	Having condom in the pocket is good due to its easy pick and convenience			
37	Avoidance from pre marital sex can reduce the risk of HIV virus infection			
38	Using condom during sexual relation every times make us not to worry about HIV infection			
39	Consistent condom usage is a good model for adolescents and young adults to prevent HIV/AIDS.			
Perception of Barrier to Preventive Behavior on HIV/AIDS				
40	Sexual partner fell unhappy and uncomfortable when using condom			
41	Use condom makes loose sexual potency or masculinity			
42	Making love with only one partner is boring			
43	Putting on condoms during sexual intercourse is time-consuming			
44	Consistently purchasing condoms for use during sexual intercourse will affect family resources			
45	You can save money for other expenditures by not using condom			

Part IV: Cues to Action about HIV/AIDS
Please mark (√), after you have read the questions below.

46. From what media of information have you learned to prevent HIV/AIDS?
□ Radio
□ Cinema
□ Television
□ Printed materials
□ Others (Specify) _____

Copyright by Mahidol University

47. Who are the persons that influence you to preventive behavior on HIV/AIDS?

□ Parents
□ Teachers
□ Peers
□ Health Personnel
□ Other Individuals (Specify)_____

Part V: Preventive Behavior

Please make the answer with only one check (√) in the □ according to your understanding.

No	Statement	Yes	No	Not sure
48	Do you refuse having sexual intercourse with unknown Partner.			
49	Do you being not to have sex to avoid HIV/AIDS.			
50	Do you not to have sexual intercourse before you get married.			
51	Do you carry condoms all the time when you out.			
52	Do you stay with only one partner			
53	Do you ask your partner to use condom all the time when you are having sexual intercourse.			

Copyright by Mahidol University

BIOGRAPHY

NAME: Ram Sharan Gopali

DATE OF BIRTH: March 12, 1973

PLACE OF BIRTH: Makwanpur district, Nepal

INSTITUTE ATTENDED: 1998-2000
University of K.U.
Bachelor in Arts with social science

2006-2007
Mahidol University, Thailand
Master of Primary Health Care Management
ASEAN Institute for Health Development

FELLOWSHIP: Japan Anti-Tuberculosis Association
Tokyo, Japan

PRESENT POSITION: RIT/Field Research Officer (Nepal)
Japan Anti-Tuberculosis Association
Research Institute of Tuberculsis.
C/O National Tuberculosis Programme
Kathmandu, Nepal

Copyright by Mahidol University