Discussion

Current researches indicate that the acquisition of knowledge through educational materials is not, in itself, sufficient to produce behavior change in many of the individuals whose behaviors place them at risk of acquiring or transmitting HIV infection.

In Thailand, the Ministry of Education's strategy was originally to urge the students to learn more about AIDS via the school curriculum. However the non-school adolescents do not included in this program. This study showed that the possibilities of the educative intervention into the factory-based adolescent had various obstacles, and we learned both positive and negative lessons from these approaches.

The exhibition group and group education have the positive response of health behavior change continuum about AIDS in some items. Thus the further intervention should use the planned variations in messages, programs, and campaign. For behavior to change, information is necessary but often insufficient by itself to effect behavioral change. Becker and Joseph postulate that there may be a "threshold" effect: beyond the certain level, increases in knowledge or changes in attitude may not increase changes in behavior.[11]

The exhibition group and group education with the addition of peer counsellor to influenced the level of health behavior change continuum in some positives ways. It may be a suggestion that this type of intervention may be effective in enabling the workers to adopt some low-risk sexual and preventive activities, but it should be modified and sharpened to suit with the target population.

Therefore, it is important to utilize the other educational program in addition to this intervention; the small group skill training about safer sex or the entire program of adolescent education in implementing AIDS risk reduction program for the students. The contents which are important to the students to reach the health consciousness of AIDS prevention should be as the followings: the anatomy and physiology of the male and female reproductive system, the common adolescent medical problems, the choice of contraceptions, the unplanned pregnancy, Sexually Transmitted Diseases, AIDS, the sexual responses, the sexual dysfunction, how to choose their boy or girl friends, planned to be the parents, the psychology of the adolescents, the techniques of counselling etc. And the plan for evaluating the comparative success of the variation should be critical component.

Community approaches to prevent HIV infection provide information, skill training, and social environment that supports and sustains individual behavioral changes. In this efforts to change health-related behaviors, community program bring together a number of diverse program components. They can also direct intervention strategies and groups, thus influencing a broader audience than would be reached by more individual efforts.

The analysis of awareness and concern about AIDS of the two groups prior to intervention demonstrated the extraordinary high level of awareness and concern. This may indicate that for the workers, the mass media and other sources of information about AIDS had promoted adequate

perception. However, these interventions had some significant change in awareness and concern. The different educative intervention had made different changes in awareness and concern. It must be recognized that the designed education program for minority group may be limited by lower levels of educational achievement and limited capacity to comprehended message.

There were some significant change was detected in the some aspects of the levels of health behavior change continuum between two groups; knowledge, attitudes, and preventive behavior. Although it is possible that this intervention program is not capable of influencing all of these levels, this is likely since significant positive change was not achieved in all other areas surveys. An explanation may be that the workers who incapable of reducing or unwilling to reduce their sexual behavior and preventive behavior have not already done so as a result of the unpredictable mass behavior.

The failure to act to prevent the acquisition or spread of HIV infection cannot be blamed exclusively on individual. Communication problems, culture and religious barriers, poor access to health apathy, and misunderstanding have been contributed to spread of HIV among specific target group.

The AIDS prevention project is ongoing; in the future, an additional intervention program is planned, one that has a skills training component in addition to the group educational session. This will enable an evaluation of the differential efficacy of each component. The difficulty of developing valid measures of the level of behavior change was highlighted by the feed back obtained from the participants in focus group in which the measure were piloted. The significant positive correlations among the level of behavior change after the intervention suggest that tap into the educational model. Belief and behavior change are thought to require much more extensive intervention, including the examination of the social context in which the workers are exploring their sexuality. Social and behavioral research on the sexual practices and beliefs. for example is highly sensitive, culturally speaking. Yet it is vital to design of effective prevention strategies for specific target populations. Finally, these results demonstrate the importance and appropriateness of applying existing health promotion theory and research findings to the field of AIDS risk reduction. The health education and media strategies that used, and the factors unique to the workers that need to be considered.

Thailand is one of the few places in the world which has gone through the transition from agricultural to industrialized country. In present-day, where social values are changing rapidly, the transition taking place in sexual values is no exception. Unfortunately, however, sex education is still not generally accepted and assimilated in this society. Although when comparing the present circumstances with those of fifteen years ago, it is clear that definite if slow progress has been made.

Attitudes towards sexual behavior were also affected by the changes taking place, which in turn resulted in changes in the sexual consciousness and activities of young people. The traditional morality was no longer valid in this new society, and more and more people were calling for the establishment of "sex education". The integral adolescent program also need to identify the persons interested in sex education and began to act to create an organization that would fill this void.

Other concern is confidentiality in regards to adolescents. Adolescents need confidentiality when seeking any medical counselling; confidentiality is even more important when sexual issues are involved. And the questions continue to raised about the provision of adolescent reproductive health services without the notification to their employers or their relations.

The rapid changes taking place in regard to sexual attitudes and morals in society today are trend occurring not only in Thailand, but the world over. Under these circumstances, the gap between youth and adults in regard to sexual consciousness and sexual activity is great.There has however been no central source around which a dialogue could take place in order to promote a common understanding.

Most recently, and certainly not unrelated to tourism, the AIDS scare has drawn greater attention to adolescent sexuality issues.[12] Unfortunately, in the context of a deadly disease closely associated with homosexuality and intravenous drug use, the issue tend to be cast in a framework of behavioral deviance and associated health risks, rather than the normal developmental issues of adolescence. There is a danger here of seriously misdirected research priorities on adolescent sexuality. Still, AIDS is a disease with an etiology dominated by behavioral choices. This means that due to the concern over AIDS additional funds should come on line for research into behavioral aspects of adolescent sexuality.

The first major survey of youth sexuality in 1982[13] dealt with STDs in detail. A new national survey was recently reported on[14] and in this new study AIDS is a central issue along with other STDs. The government has been opposed to dramatic public discussion of AIDS, because of its fears that tourism would be effected. but it has not been opposed to research on AIDS, and has encouraged efforts inform those engaged in commercial sex.

Asian governments are faced with a number of general issues as they move toward policies in the arena of adolescent sexuality. One is the general public concern in many countries that provision of services only encourages youth to engage in sexual activity. Another is the dilemma in some countries whether to move toward a common stance toward all ethnic and religious groups, or to distinguish cultures within the society. Another is how to approve commerce in sex and those engaged in it. Whatever the directions taken on these and other issues, our claims are that "family policy" centered on the young is emerging. How, then, do we wee Asian society in the comparative context of the economically advanced countries. Unfortunately, the most common approach to classifying countries in regard to the prevalence and pattern of adolescent sexuality is unidimensional, with countries classified as traditional, modern, or somewhere in between. For example, Senderowitz and Paxman [15] suggest such a three way classification scheme. Their first type involves early marriage, with premarital sex disallowed; premarital pregnancy is "infrequent or likely to lead to socially sanctioned sensuousness unions" (as in Latin America and sub-Saharan Africa). Type two, found in the developed countries, frequently involves the onset of sexual activity often before marriage, in the mid to late-teens, often without contraceptive protection, with much unintended pregnancy, and not uncommon, abortion. Type three is intermediate between these and results from socioeconomic development acting against the "traditional restraints". Here, premarital sexual activity and pregnancy are increasing, and the use of abortion is also. However, contraception use is growing and teen fertility rates are falling.

This classification fails, we believe, because it is unilineal, evolutionary. It posits traditional pattern and a post-transitional one, with problems arising in between. Yet close examination of national settings indicates a far more complex, multidimensional reality. Within the Asian region, for example, Southeast Asia exhibits high levels of premarital sexual activity, and as in Latin America this reflects complexity in definitions of marriage and the marriage process. Also, pre-marital sex (recreational; experimental) is a growing phenomenon in developing country urban areas.

In present day, Thailand, where social values are changing rapidly, the transition taking place in sexual value is no exception. Attitudes towards sexual behavior were also affected by the changes taking place, which in turn resulted in changes in the sexual consciousness and activities of young people. The traditional morality was no longer valid in this new society, and more and more people were calling for the establishment of "sex education". Surveys include "survey on the sexual activity of youth" also need to identify the sexual behavior among the youth; students and non students. The sex viewpoints (sexual indicators) can be measured and are used to identify the standard sexual life-styles of the adolescents. We expected to develop criteria sets or control strategies for heterosexual transmission of AIDS among the youths from these sexual indicators.

The owners of the factories whose nature are European or other Western countries do agree and express willingness to join the quality of life program more than countries from Asia; Thailand, Japan, Taiwan, Malaysia etc. This program does not start with the consensus of the concerned person; owners, managers, supervisors, chiefs, and workers. The descriptive data of the factories was reported in Annex 1. The brain storming meeting gave the impression that the planned interventions are rather received and offered by the representatives of the factories. Although the meeting did not obtain the consensus for intervention, there were some differences in the opinion; how the quality of the intervention, extent of the program (Annex 2). In spite of that, they initially develop ideas about how to bring the AIDS education program into their factories.

Obstacles to the feasibilities of the program were the followings; Did they attend the program? Did they pay attention? Did they understand the message correctly? Did they believe and accept it? Did they thereafter use condoms?, Did they benefit from that behavior? The extent and severity of the obstacles arose because of the structures of the factories. The organization of the factories were profit-based purposes, so the nonparticipation of the owners or managers should be considered. This study is a pilot test, and to improve in planning programs we believe that the management by participation with the policy makers of the factories would be rethought and rejus-tified. The approaches to the policy makers will sharpened and formulate the appropriated program that suit and meet the needs of each factory. Our opinion, AIDS/STD only may not being an essential requirements. Their requests included the various parts of the family life education.

Oversights and problems are inevitable. The occurrence of some imperfections, If something does wrong, evaluation may allow an understanding of how and why the problem occurred. This meaning in turn can enable a change or adjustment that may forestall similar error in the future. An alternative coordination or cooperation is the implementation of AIDS/STD program via the Office of Provincial Social Welfare who took responsibilities of economic and medical well being for the workers. Nevertheless, more remains to be done.

We hope that this report will not only provide a foundation for the discussion of health education strategies for reducing the risk of AIDS, but will also prove useful information to local, regional, and national organization in developing the intervention programs among the workers.

Summary

The exhibition group and group education had some significant change in the level of health behavior change continuum: The exhibition group had some significant change more than group education in awareness and concern, and knowledge. However, the group education had some significant change more than the exhibition group in the true-false attitudes.

The pre-intervention and post-intervention evaluations had many different among many items of the levels of health behavior change continuum between both exhibition group and group education. However, the tendencies indicated that the exhibition group was slightly significant outcome in some items and some levels of health behavior change continuum more than the group education.

Overall, the exhibition group and group education had some significant change in the some levels and some items of health behavior change continuum, the approaches in the future should include information, skill training, and social environment that combined together with diversification of the program may be the alternative choice for the supports and sustains individual behavioral changes.