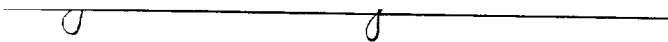


ABSTRACT OF THIS THESIS OF

Chulanee Thianthai for the degree of Master of Arts in Anthropology presented on May 22, 1998. Title: AIDS and Adolescents: Perspectives by Gender and Class on Sexual and Drugs Behavior.

Redacted for Privacy

Abstract approved: _____


Nancy R. Rosenberger

Much-needed research on Thai adolescents (age 15-19), the fastest growing group of AIDS victims in Thailand, this study differentiates risk behavior among classes, unlike most AIDS research in Thai society, and focuses on how gender and economic factors among adolescents influence their risk-behavior patterns leading to the contraction of HIV/AIDS. Using ethnographic methods focusing on class and gender, I identified several risk-taking behaviors.

Each class in Thai society tends to be at-risk from a different level of sexual relationships and drug use. The lower class seems to be the most at risk because of having many sexual partners, having unprotected sex, and sharing needles while, those in the middle class use only personal screening for their sexual partners and also sharing needles. Although the higher class is less at risk compared with other classes, a few do visit prostitutes and consume drugs. Class is also correlated to the level of knowledge and education about AIDS. Although each received the same health education provided through the same source and same health text, adolescents in each class catch the message differently. My research data showed that adolescents of the higher class showed a more complete knowledge about AIDS.

There are also many patterns of HIV/AIDS risk-taking behaviors that correlate to cultural gender differences. Although all classes appear to adhere to the ideal norm of virginity being the best sexual-practice, in reality, this only applies to members of the upper class. The middle and, especially, the lower classes do not apply this norm to themselves at all: They practice premarital sex, even though they may verbalize the ideal norm. Other studies have focused on gender relations according to this ideal Thai norm; however, this ideology does not match the reality.

In conclusion, with the lack of research in this area, Thai adolescents are being placed at greater risk. Thus, I make recommendations for further research and prevention methods. For example, health education should be more up-to-date and explain to adolescents the connection between sexual relationships and AIDS rather than focusing primarily on the reproductive process. Further, parents, schools, and teenagers themselves can visit with health professionals at the hospitals and anonymous clinics to learn more about STDs, especially, HIV/AIDS. If put into practice, these recommendations will positively reduce the spread of AIDS in Thailand.

**AIDS and Adolescents: Perspectives by Gender and Class
on Sexual and Drugs Behavior**

By

Chulanee Thianthai

A THESIS

Submitted to

Oregon State University

**In partial fulfillment of
the requirements for the
degree of**

Master of Arts

Presented May 22, 1998

Commencement June 1999

Master of Arts thesis of Chulanee Thianthai presented on May 22, 1998

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Chulanee Thianthai, Author

Acknowledgement

This research would not have been started and completed if not for these following people who have given their contribution in teaching, encouraging, and supporting me all through my period of study. First, I deeply would like to thank Dr. Nancy Rosenberger who has taught me since the beginning of my study at Oregon State University, in understanding the importance of gender and how it can ^{make} made a differences in a person's life. She also was the first person who ^{make} make me see how I can contribute my abilities to the society through medical anthropology, which inspired me later on to choose this field as my specialization. She provided me with a variety of research that has been done, methodology, and skills necessary for one who wants to make use of medical anthropology. In addition, she taught me economic anthropology, showed me different approaches toward economic and class awareness, and has enlightened my thought that class would be a very interesting issue that should not be neglected from Thai culture. Not only do I owe her those teaching contributions, but she also is the one who helped me select this thesis topic. As an advisor, she has always been supporting, encouraging, and especially patient in waiting for my development to grow; she is the best kind of advisor that one could ask for. Second, I would like to thank Prof. Court Smith who taught me the theory course in anthropology and guided me through with his useful questions in class. Third, Prof. Chunhuei Chi, my minor professor in public health, has always been helpful since the period of my internship in public health which related to this topic. He taught me two courses (International Health and Organization, Financing and Delivery of Health Care) that gave me insightful understanding of public health. Especially, I find all of the knowledge that he taught is very applicable for me to

use in the future. I would also like to thank Professor Laura Rice who is willing to show her enthusiasm to accept my request and be a part on my committee. Moreover, I would like to thank Dr. John Young who taught me the course Uses of Anthropology.

Although not one of the professors who has taught me academically, my parents should be given all of the credit for their dedication, their love and their support in every way and everything I do. Despite the fact that they are in a very different field than I am, they always show their enthusiasm for everything I learn and are eager to find more information concerning my interests to share with me. My dad has always been a good role model for me as a person who always seeks for knowledge. I especially want to thank my mother who always searched for every bit of information from scraps of a small article in the newspaper to seeking out the specialists in my field to consult with. Also, my grandmother who always asks me when I am going to finish my writing, helping me be meticulous through my work. My writing tutors from the OSU Writing Center who I work closely with Sue, Kristy, Lynne, and Janet always supported and helped me to overcome the written language barrier, that most who the mother tongue that is not English have. Last, I would like to thank my friend, Sarun Tejasen, who helped me with graphs. Without any one of the persons I mention above I would not have finished this most satisfying thesis, I have planned.

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AIDS and Adolescents: Perspectives by Gender and Class on Sexual and Drugs Behavior

CHAPTER ONE: INTRODUCTION

This research emphasizes the manner in which HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome) is now spreading widely around the world, especially in developing countries like Thailand. I have endeavored to explore the way in which different economic backgrounds and gender differences have created various patterns of HIV/AIDS risk-taking behavior. The specific objectives are: 1) to find general patterns of HIV/AIDS risk-taking behavior among Thai adolescents 2) to explore different tendencies of risk-taking behavior among Thai adolescents, classified by economic class (i.e. high income, middle income, lower income) 3) to examine different viewpoints on the issue of HIV/AIDS risk-taking behavior classified by gender differences; and 4) to formulate a viable strategy to reduce the scope of this problem, one that could be tested and implemented by future researchers. These objectives build upon my working hypothesis, that adolescents are especially at risk among the age groups in Thailand and that gender and economic status create different patterns of AIDS risk-taking behavior among adolescents in Thailand. Many dimensions and factors can contribute to AIDS as AIDS affects adolescent risk behaviors. This research focuses on gender and economic factors of individual Thai adolescents because these appear to be particularly salient differences in their lives.

Taking this as an assumption, the question that guides this research is: In what ways do gender and class differences influence AIDS risk behavior?

This section will provide the basic facts and statistics, introducing what AIDS is, how the global situation is being affected by AIDS, and why adolescents are especially at-risk from AIDS. The reader will gain an overview of the problem.

The AIDS Epidemic

AIDS is the abbreviation that stands for acquired immuno-deficiency syndrome. It is not a single disease; it is the end stage of infection with HIV, characterized by a cluster or syndrome of life threatening symptoms (World Health Organization 1994). While people with AIDS can be helped with medicines, there is as yet no cure, and most people die within a short period of time. HIV (Human Immunodeficiency Virus) can be spread through sexual intercourse. This makes HIV infection basically a sexually transmitted disease (STD). Therefore, like other STD, HIV can be transmitted through infected blood (such as through needle sharing), blood products, transplanted organs, tissues, and bodily fluid (such as sperm), and from mother to child. Often people are not aware that they might have HIV because during the first 8-10 months no symptoms are shown. Therefore, it rapidly spreads from one person to another.

Every single act that is unprotected sex such as having intercourse without using a condom with an HIV-infected person, exposes the uninfected partner to the risk of HIV infection. The level of risk varies by many factors, such as the sex and age of the

uninfected partners, the types of sexual act, the stage of illness of the infected ones, and the severity of the HIV strain involved.

The HIV/AIDS pandemic is comprised of many separate epidemics (even within a single country). Each epidemic has its own starting period and involves different types and frequencies of HIV-risk behaviors (WHO 1992). The different types of HIV-risk behavior involve the distribution and number of people with multiple sexual partners, both heterosexual and homosexual, and intravenous drug users who share injection equipment (See Figure 1).

Global HIV infections in 1993

Modes of transmission

Sexual intercourse	70-80%
Mother to child	5-10%
Needles-sharing by drugs users	5-10%
Blood transfusion	3-5%
Accidental needles-sticks to health care workers	less than 0.01%

*** Statistics from AIDS images of the epidemic by WHO 1992**

AIDS in Thailand

The first case of AIDS in Thailand was reported in September 1984. Early cases were generally confined to Thai homosexual males returning from abroad. This was followed by an explosive spread of HIV infection among injecting drug users (IDUS) in 1987 and 1988. The virus then spread to male and female prostitutes and their clients with the result that heterosexual transmission became increasingly important. By 1991

many provinces started reporting cases of prenatal transmission. In 1985, Thailand initiated blood screening and since 1989 every unit of donated blood is screened for HIV. The HIV/AIDS epidemic is more advanced in the capital and northern part of Thailand, and the largest number of AIDS cases are reported from that part of the country. Heterosexual intercourse is the most common important mode of transmission.

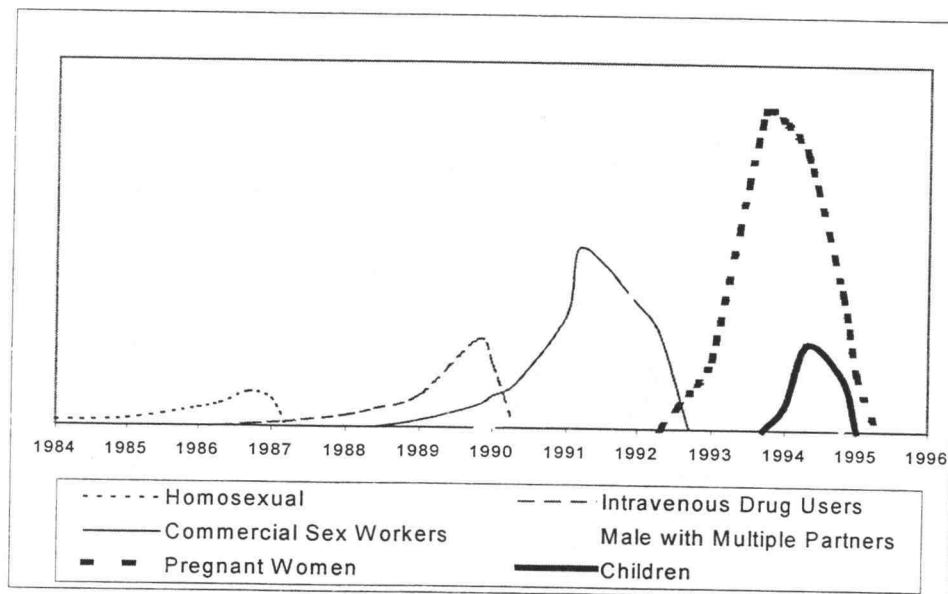
By the 1990's most of the Thai people had become aware of AIDS through mass media campaigns and health education in schools. Almost every Thai knows about how AIDS is transmitted, and how to prevent themselves from receiving it. There are still many people however, who do not follow the preventive methods and who practice risk behavior. This causes increasingly higher rates of HIV/AIDS infected patients each year.

Thailand had three sub types of HIV-1 (HIV-1 which is Human Immunodeficiency Virus which mostly occurred in humans rather than in animals). The first one is called B_{mn} . B_{mn} is a type of virus that mostly spread in the Western world via homosexual and bisexual men. The second one is called B_{thai} . B_{thai} is nearly like the first virus, but it is mostly found in the drug-addicted people who share needles. The last type of virus is the newest one called E. E is a type of virus spread by heterosexual men and women and is the most common form in Thailand. Presently in Thailand, new approaches have been considered for this reason. New programs approaches consider how to treat the infected patients, how to guide them to live happier lives and how to educate the community to live with HIV patients.

In figures 1-4 the reader will find the statistics that show the HIV epidemic in Thailand. During the late 1990s, males with multiple partners, commercial sexual

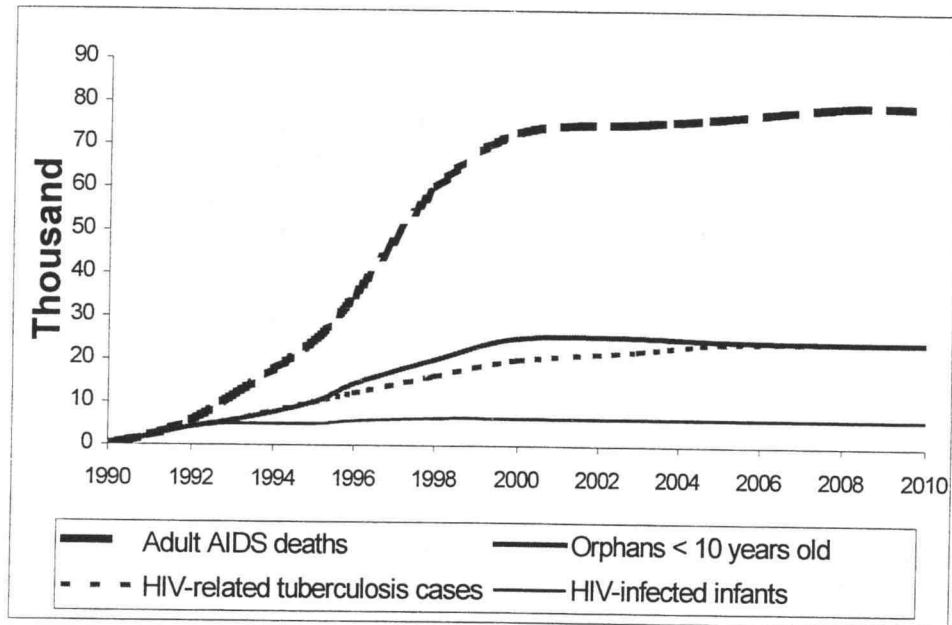
partners and intravenous drug users were among the fastest growing groups of HIV/AIDS victims (Fig 1). As you can see, the fastest growing group was pregnant women who are the new victims. Over 75,000 adult AIDS deaths are projected before the year 2000. The numbers studied show no sign of decreasing (Fig 2). The ratio of males to females infected every year is more than quadruple. This might be due to the fact that males are more likely to engage in risk behaviors such as multiple sexual partners, homosexual behavior, and intravenous drug use (Fig 3). The number of new AIDS cases is rapidly becoming equal to the number of current AIDS cases (Fig 4). The highest number of AIDS cases occurred among heterosexuals. The two most significant causes of AIDS transmission were heterosexual intercourse and intravenous drug use. In each case the number of males is higher than females (Fig 5).

Figure 1. The HIV Epidemic in Thailand



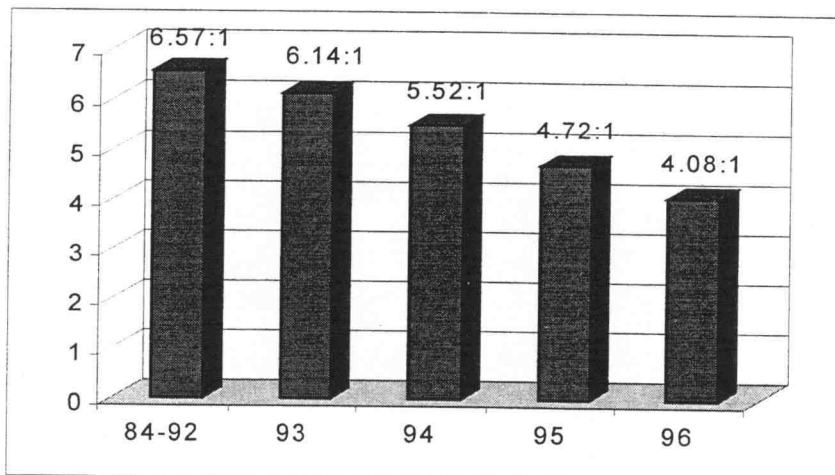
***Statistic from Program on AIDS, Chulalongkorn University, 1996**

Figure 2. Annual of AIDS Health Impact Estimated and Projected on the Basis of Bse Line Scenario : Thailand, 1990 - 2010



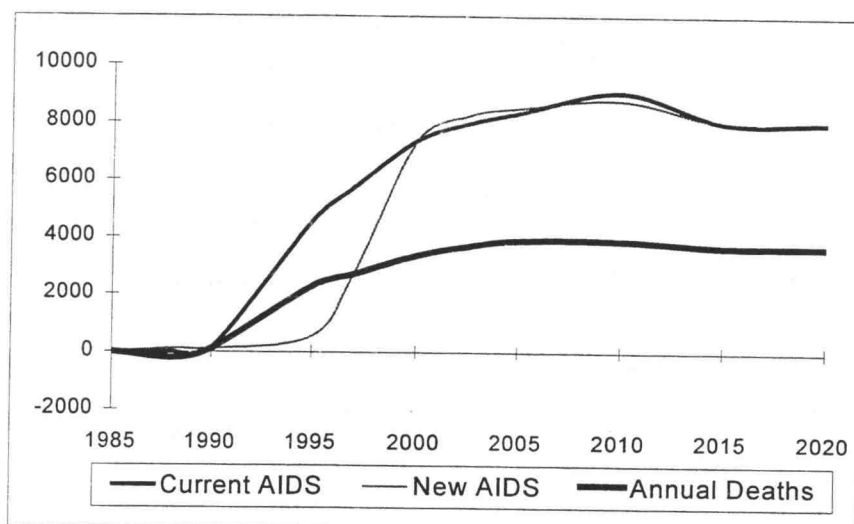
*Statistic from Program on AIDS, Chulalongkorn University, 1996

Figure 3. Male to Female Ratio of AIDS Cases reported from 1984-1996



*Statistic from Program on AIDS, Chulalongkorn University, 1996

Figure 4. AIDS Projection in Thailand from 1990-2020



*Statistic from Program on AIDS, Chulalongkorn University, 1996

Figure 5. The number of AIDS cases in men and women by risk factor

	1984-89	1990	1991	1992	1993	1994	1995	1996	1997	Total
Sexual Intercourse	59	88	400	1,298	5,053	10,687	15,900	18,318	12,507	64,310
Homosexual men	18	2	5	8	49	98	187	188	100	655
Bisexual men	5	4	4	1	8	33	89	143	56	343
Heterosexual men	33	72	354	1,143	4,325	8,965	12,769	14,136	9,500	51,297
Heterosexual women	3	10	37	144	656	1,516	2,762	3,705	2,752	11,585
Drug Users	10	22	43	137	506	875	1,265	1,014	535	4,407
Men	10	21	43	134	494	855	1,246	998	520	4,321
Women	0	1	0	3	12	20	19	16	15	86
Blood Transfusion	2	1	4	10	8	9	10	1	2	47
Men	1	1	3	8	5	3	7	0	2	30
Women	1	0	1	2	3	6	3	1	0	17
Transferred from AIDS infected mother	4	15	73	137	461	770	894	1,054	671	4,079
Boys	1	10	38	65	257	400	469	575	350	2,165
Girls	3	5	35	72	204	370	425	479	321	1,914

*Statistics from <http://www.moph.go.th/ops/epi/indexaids.htm>

AIDS and Adolescents

AIDS is linked with adolescents because at this age in life many start having sexual relationships without HIV education, and therefore they use no protection. Also, many are involved in trying new drugs that might include drugs by injection. Frequently, these kinds of activities first occur during adolescence, which is why adolescents are one

of the groups that are most likely to have a high risk of getting HIV/AIDS. The period of adolescence is defined as the progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity, the development of adult mental processes and adult identity, and the transmission from total socioeconomic dependence to relative independence. The statistics from Family Care International Report (WHO 1992) have shown that approximately half of all HIV infections thus far have occurred in men and women younger than 25. Data from developing countries recently indicate that up to 60 percent of all new HIV infections are among 15-24 year olds, with females outnumbering males by a ratio of two to one.

Health problems among the adolescent population have shifted dramatically in the last decade from solely physiological causes to those influenced more by social and cultural factors. Circumstances of cultural change have created major problems among Thai teenagers. The major problem, which is gaining importance, is in regards to AIDS. Research studies have documented that adolescents' health problems in Thailand have rapidly increased for three reasons. First, the trends of modernization and westernization have brought new values among teenagers. These values include practicing sex at a young age before marriage. Without the knowledge of prevention, they have little concern for practicing safe sex. Second, the amount of alcohol and drug use is high. Alcohol can lead to having unsafe sex because at the time that they are drunk they will have little concern for safe sex. Sharing needles among their friends can also lead to AIDS. Third, teenagers who are born in this decade are exposed to the growing factory of commercial sex services, which may lead to risk behaviors. In Thailand these are the main causes conducive to AIDS acquisition. More in-depth research is needed to

determine how various groups are at-risk. Attention must be focused on doing more studies about adolescents in relation to contraction of AIDS.

Current Risk Behaviors among Thai Adolescents

In today's adolescent generation, sexual relationships can begin as young as 15-17. Most adolescents are not aware of the risk factors that can lead them to contract sexually transmitted diseases, especially AIDS. With the rapid growth in the sexual industries, many types of places also provide sexual services such as bars, pubs, discotheques, barbers, hotels, and brothels. Therefore, sexual relationships among male adolescents not only are limited to their girlfriends, but also sometimes involve prostitutes. The growing sexual industry can influence and encourage adolescents to take risks. In addition, measures such as how to use a condom and how to practice safe sex might not have been introduced to them through health education yet. Furthermore, some male and female adolescents are also engaged in drugs through injection. Usually needles are shared among friends. Therefore, there are many risk factors facing teenagers today. Below are some of the statistics that show the facts about the current situation mentioned above.

Figures 6-8 indicate the statistics that show the risky behaviors among Thai adolescents. Among the younger generation, both female and male, there is a trend to engage in sexual intercourse at an earlier age than the previous generations (Figure 6). Among 15-19 year olds, 22.8 percent reported they never used a condom. Among those who did not answer, it is likely that many also did not use condoms (Figure 7). By far the most common form of drug use is injection. Drug users who use needles frequently use

other methods as well. The use of shared needles is an extremely risky behavior for the transmission of HIV/AIDS (Figure 8). This overview has given general trends concerning AIDS in Thailand, particularly in relation to adolescents.

Figure 6. Percentage of Sexually Experienced Respondents Reporting First Intercourse Before 18 years of age by Gender and Current Age

Gender	Current Age			
	19 – 28	29 - 38	39 - 49	TOTAL
Male	66.1%	59.3%	45.8%	58.1%
Female	39.4%	36.9%	31.4%	36.0%
TOTAL	52.0%	46.1%	37.2%	45.5%

***Statistics from A Report of the 1990 Survey of Partner Relations and Risk Infection in Thailand**

Figure 7. The Percentage of Condom Use among Thai Adolescents Who Use Commercial Sex Services.

Age (years)	Condom Use			
	Every time	Sometime	Never	No answer
* 15 – 19	54.5	6.2	22.8	16.5
20 – 24	75.0	7.6	3.9	13.6
25 – 29	72.1	11.4	10.0	6.5
30 – 34	85.3	0.0	14.7	0.0
35 – 39	90.1	9.9	0.0	0.0
40 – 44	55.4	38.9	5.7	0.0
45 – 49	31.5	0.0	68.5	0.0

***Statistics from A Report of the 1990 Survey of Partner Relations and Risk Infection in Thailand**

Figure 8. Route of Administration of Principle Drug

Route of Administration		Receiving Drugs at Clinic	Inject	Oral	Inhale/Sniff	Inject/Smoke	Inject/Smoke /Oral
Bangkok	No.	113	18,825	668	190	138	1
	%	-	73.0	2.6	0.7	0.5	0.0
Central	No.	232	15,823	769	198	104	0
	%	-	60.7	2.9	0.8	0.4	0.0
North	No.	17	6,447	558	128	105	4
	%	-	47.8	4.4	1.0	0.8	0.0
Northeast	No.	2	1,770	328	567	40	1
	%	-	43.3	8.0	13.9	1.0	0.0
South	No.	2	8,612	37	42	76	0
	%	-	77.8	0.6	0.4	0.7	0.0
Foreigner	No.	0	96	7	0	11	0
	%	-	19.5	1.4	0.0	2.2	0.0
Total	No.	366	51,573	2,367	1,125	474	6
	%	-	63.8	3.0	1.4	0.6	0.0

***Statistics from A Report of the 1990 Survey of Partner Relations and Risk Infection in Thailand**

As the problem of AIDS has worsened and become more widespread, many studies have been carried out. However, there are still many gaps in the studies that need to be filled. My attempt is to try to fill in some of these missing parts. My research will be an anthropological study of how gender and economic factors among Thai adolescents (age 15-19) influence risk-taking behavior patterns leading to the contraction of the HIV/AIDS.

CHAPTER TWO: LITERATURE REVIEW

My research utilizes knowledge appropriate to the discipline of medical anthropology to analyze in-depth the relationships between gender, class, and the acquisition of the AIDS virus. My general theoretical interests focus on cultural values, in this case, those which underlie the multiple sexual patterns. I pay special attention to literature concerning the target group of adolescents, which has particular characteristics that are linked to emerging sexuality. I also focus on aspects of social psychology which illuminate for the reader adolescents' process of finding a better understanding of their behaviors.

I have divided the literature review into five sections. The first section concentrates on the literature that shows how anthropology has dealt with AIDS, especially through the sub-field of medical anthropology. The second section deals with Thai literature concerning cultural values and gender perspectives, which contribute to the spread of AIDS. The third section stresses how anthropologists view gender perspectives. The fourth section centers on class perspectives. The last section demonstrates the literature emphasizing a variety of factors that affect adolescents' health, and how health programs have been promoted among adolescents.

Anthropological Contributions to AIDS

Anthropology is literally the study of human beings. Anthropologists are concerned with identifying and explaining typical characteristics (traits, customs) of particular human populations. Therefore, anthropological studies can show us why

people are the way they are, both culturally and physically. They use ethnographic methods to seek the understanding of how and why people of today differ in their customary ways of thinking and acting (Melvin and Carol Ember 1996). Like other disciplines, anthropology, knowledge and methodology can contribute to the betterment of society. Displayed below are some examples of anthropological ways to deal with the AIDS epidemic.

We can see that, since the first AIDS case occurred, AIDS has had a great impact among humans. AIDS spreads from certain types of human sexual behaviors, causes social change among societies, and has left its impact among the ones who are infected with AIDS, as well as others who are surrounded by AIDS-infected people. Many anthropological studies have helped to understand the various aspects of the human behavior relevant to AIDS. Many anthropologists are inspired to show how anthropological knowledge can contribute to understanding the crisis of AIDS.

In the following, I have divided the articles into two groups. The first part is a set of articles that shows how anthropological knowledge can contribute to knowledge about the AIDS epidemic. Many contributions are based on how anthropology can search for insightful information, what suggestions are made concerning the victims, and how AIDS impacts them. The second part will introduce research on at-risk groups not frequently focused on, such as women, adolescents, drug users, and hemophiliacs.

AIDS has become a focus of study in almost all disciplines. The subjects related to AIDS include international politics, inequality in economics, health care, disease, and suffering. Lindenbaum's article (1997) shows how every discipline has been affected AIDS and sheds light on what has changed with the advent of AIDS in the world.

She stresses that, after the concept of the “risk group” became well known to the world, people started to realize that AIDS could affect anyone in any country or continent. The AIDS pandemic has given people the opportunity to examine the way they think, talk, and write about people unlike themselves. AIDS has arisen at a time when all the scholars are questioning whether Western models are really adequate and whether they project dominant universal views. Apparently, AIDS has given the opportunity for gays, Haitians, Africans, and others to speak for themselves. AIDS then provides an opening for many contributors to question the special role of science in the construction of world culture. Voices from various disciplines, both central and peripheral, dominant and subservient positions, joined in a common discussion about the way science is produced, theories are constructed, and knowledge is disseminated.

Awareness has been created that not only does science contribute to the study of the AIDS epidemic, but the social sciences, like anthropology, contribute greatly as well. I selected the following seven articles that display how anthropology has contributed to the study of AIDS in various ways.

First an article written by Bolognone (1990) stresses that social scientists and medical anthropologists can encourage a complete understanding of the complex social issues surrounding AIDS. Medical anthropology covers a range of approaches to understand AIDS from insight into beliefs about AIDS etiology, to the social and cultural impact of the disease on high-risk populations. For example, an ethnographic approach to the study of the lifestyles of heterosexuals with multiple sexual partners may give insight into the unknown aspects of sexual behaviors that carry the greatest risk for developing AIDS. Therefore, medical anthropology is equipped to investigate the

interrelationships between cultural traits and aspects of health and disease. Moreover, anthropologists can conduct research in the area of the social impacts of AIDS on society. This kind of research might include the awareness of AIDS, the diffusion of information, education, social support teams, health care, economic impact, and the effect on the lifestyles of people who have had experience with the illness of AIDS. It seems that anthropology can cover a lot of useful issues and can play many roles to be beneficial to society because AIDS concerns cultural change. Due to that fact, anthropology then becomes involved with AIDS because the anthropologists' job includes every issue that concerns cultural and human behaviors.

Like Bolognone, Marshall and Bennett (1986) also wrote about the different steps anthropologists can use to contribute to society and AIDS. They explain that since the year 1981, professionals representing a wide range of disciplines have examined the biological, epidemiological, and sociocultural aspects of disease. There is unanimous agreement in the scientific and professional community today that, in the absence of a vaccine or a cure, reduction of risk behavior remains the strongest deterrent against further spread of the disease. Anthropologists have the opportunity to make a unique contribution to these preventive efforts. Anthropology's theoretical and methodological skills provide society with interpretive frames and analytical tools for careful observation and examination of human behavior in natural settings. Ethnographic, meaning-centered studies can facilitate a deeper understanding of risky and preventive behavior in the context of human relationships.

They suggest that there are two directions that anthropological contributions have taken in studying AIDS. First, anthropologists have gathered empirical data on behavior

and attitudes that place certain people at increased risk for AIDS. Second, anthropologists have done research on the meaning of AIDS within particular cultural contexts. These two directions are both illustrated in the research undertaken in this thesis. I have gathered data on adolescents' behavior and attitudes, including multiple sexual partners, that place them at increased risk for AIDS in the cultural context of Bangkok.

Marshall and Bennett point out that sexual contact is the most common route of HIV transmission. Therefore, there is a need for further investigation of heterosexual and homosexual practices, and the cultural norms that regulate sexual behavior in general. It is important to continue and expand research on such populations, including categories of people who have been found increasingly to be at risk, such as children, IV drug-users, adolescents, and women. In the course of such research, anthropologists can help redefine the notion of "risk group" and the concept of "risk" itself. Although the "risk-group" idea is useful, in reality, all people are at relative risk as a result of particular behaviors.

Anthropologists are being encouraged to study societies that are particularly vulnerable to the spread of HIV. Ideally, such studies would be placed in the hands of policy-makers and would be planned in such a way that the results could be used in the developing country's appropriate preventive programs. Therefore, study within particular cultures are important because one health plan cannot fit all societies. The challenge of the AIDS pandemic will be met by sustaining the impetus to increase interdisciplinary and intercultural collaboration. Therefore, not only can anthropological knowledge help

the society, but also other disciplines, such as health science, psychology, and the behavioral sciences, will help develop health plans.

Another point of view comes from Farmer's (1992) book. He wrote about the accusation regarding AIDS in Haiti. Contrary to Bolognone, Marshall and Bennett who discuss AIDS on a pandemic level, Farmer is more specific, limiting his discussion to Haiti. This book is an example of how an anthropologist views the relationship of AIDS in connection to politics, economics, and social aspects in a particular culture, Haiti. It shows an anthropologist searching for what the target group perception towards AIDS is and where AIDS actually comes from. It also identifies the Haitians' and outsiders' points of views, as well as clearly presenting how AIDS can affect ones' life in political, economic, and social aspects.

This story describes in depth from the Haitian point of view a spreading epidemic called SIDA (which is another name for AIDS), and its socio-economic, political, and international relations. The story describes the picture of the relationships by using life histories of the people who have acquired SIDA to explain how they view the disease.

Starting from the history of the country, Farmer shows that Haitians have acquired SIDA through sexual contact with homosexual foreigners from the United States. Economics have become an important factor that connects Haiti to other developed countries, such as the United States and Europe. Haiti is well known for its cheap labor and its beauty. As Haiti's tourism has grown, more foreign exchange has come to the country, reinforcing of prostitution and homosexual behavior. This has led to the spread of the deadly disease.

After a period of time, Haitians tried to immigrate to the United States and settle here. Not long after that time, an incident of AIDS was reported in the medical literature that affected many Haitians. The U.S. Center for Disease Control (CDC) has determined the "high- risk groups", the so-called "Four - H Club", which consists of homosexual men with multiple partners, hemophiliacs, hard drugs taken intravenously, and Haitian immigrants. This has had a huge effect on the Haitians living in the U.S. The Haitian were labeled as the original AIDS carriers. They became undesirable persons to associate with. For example, they lost their jobs, their stores become bankrupt, and even their families were targeted, and evicted. As time passed by, Haitians have been more and more discriminated against by Americans. Not only are they domestically affected, but also internationally because of the toll AIDS took on the tourism business.

On the other hand, from the Haitians' point of view at the community level, the belief is that SIDA is a sickness of jealousy. It is believed to be caused by sorcery, that another person has sent to the victim. When Haitians view the economic factors, it is believed that the victim makes another person jealous of him/her because the victim has gotten a raise or a new position, makes more money, or receives more property. Usually, the person who is assumed to be the sender of SIDA is the one who has lost something in the incident or could gain something if the victim were dead. These causes make sense to the people because, in this society, the socio-economic statuses are usually the same. Therefore, if one becomes wealthier or could struggle above the basic standard, it is believed to be abnormal, and due to that, he/she is being spotlighted by others. At the macro level of politics, it is believed that the victims are the Haitians, and Americans sent SIDA because they did not want Haitians to live in, or immigrate to their country.

In conclusion, this book has presented the Haitians' view of the suffering. The circumstances generated by the spread of the epidemic of SIDA have caused not only physical suffering from the disease, but also suffering due to discrimination. Falsification by others has affected Haitian lives deeply.

Kreniske (1997) centers on how anthropological knowledge can reflect the social nature of a disease. This study is an example of how anthropologists' work can identify the relationships among sexual beliefs, sexual practices, sexual workers, and how these relate to the spread of HIV/AIDS.

As in Farmer's study, Kreniske also deals with a small isolated population, the Bateys. This research clearly describes the lives of the *batey*, who are the immigrant workers working in the sugar industry of the Dominican Republic. The writer describes the bateys' sexual beliefs and practices, which usually start as early as 12 years old. In the bateys' community, sexual work is common. Sexual work means that one will have sex in exchange for money. It is obvious that the cane workers receive minimal salaries, therefore, a single man often obtains the services of a woman for the night, and may share a girl with several men. As a result, sleeping with one woman who has a disease can transmit the disease to six to eight people within a night. As Marshall and Bennett have pointed out, the common route of HIV transmission is through sexual contact. In this situation, there is a definite need for further investigation into the cultural norms that regulate the batey sexual behavior. Through investigation the discovery was made that the bateys believe that covering the penis during sexual intercourse is a ridiculous, humorous, and unnatural thing to do. Therefore, men are likely not to use condoms. Also, when one contracts a disease from other persons, he is not concerned about how he

became infected. On the other hand, they are socialized to perceive disease as part of the fate of an individual and that it was meant to be.

Streefland (1995) demonstrates other ways that anthropological research can contribute to AIDS control in developing countries. Streefland provides insight into the population target groups' concerns in the developing countries. He pointed out that the first concern was raising people's perceptions and expectations through knowledge. The articles written by Farmer and Kreniske also discuss developing communities, which would benefit greatly from AIDS education. This knowledge that they have collected would support health care staff in counseling AIDS patients and their family members.

The second concern regards the social and economic problems caused by the epidemic. This includes the disintegration of families and the emergence of a large number of orphans, drastic changes in the demographic composition of villager and rural society with pressure on agricultural systems, and the collapse of supportive structures among friends, relatives, and neighbors.

Anthropologists may try to contribute directly by working for or with a community or action-group. They may cooperate with public health officers in charge of services providing home care and counseling for AIDS patients, or work with epidemiologists wanting background information on the organization of local commercial sex activities, or phrasing of a questionnaire in culturally appropriate language. Both the Haitian and the Batey populations would be helped by anthropological contributions, such as health care and counseling. Therefore, anthropologists can carry out interdisciplinary studies side by side with other professionals and create better solutions to the complex problems of AIDS.

Therefore, these articles anthropological research show how methods such as ethnographic methods and life history collecting can reveal on human behaviors and beliefs concerning AIDS. These techniques will help to find the meaning of AIDS, how people define risk groups, transmission behaviors and risk activities, and the cultural, social, as well as physical impact on the victims and people surrounding them. Above all, these techniques provide insights into the facts within particular cultures. These important facts are beneficial to the society and the people because they can help reduce risk behaviors and help bring more understanding to create health programs that fix them.

Gorman (1986) shows how subcultural anthropological knowledge can contribute to the public health sector. He emphasizes how anthropology can challenge and reinforce anthropological knowledge of the crisis of AIDS. AIDS provides unique anthropological opportunities to explore the subcultures of homosexuals, heterosexuals with multiple sexual partners, IV drug users, and the sexual behavioral patterns of many cultures. His intent is to understand the respective parameters of health, disease, and culture that occur for each population.

He believes that in the future control of AIDS must be based on a thorough understanding of the behaviors that place people at-risk and of the social and cultural factors that influence this behavior. Sophisticated prevention programs must be developed to address not only the special needs of the populations at highest risk, but also the needs of the general population who must be informed without creating a panic. We must be concerned about cultural sensitivities, which is a task that anthropologists are uniquely fitted to undertake.

Anthropologists can also use their knowledge in contributing to the solution to AIDS-related problems in the area of prevention. They can help develop effective programs and new models for understanding how populations respond to health crises. Moreover, they can be involved in the policy-making areas, joining with the public health sector in giving information about human behaviors.

Des Jarlais (1990) also emphasizes the importance of anthropological knowledge by sharing with other sectors those factors that contribute to the spread of HIV. He indicates a different way of examining anthropological knowledge. This writing shows that public health efforts in aiming to reduce the spread of the AIDS virus will require an understanding of the “transmission” behavior from the perspective of those in the different increased-risk groups. Social scientists then can take over this important role in trying to help others develop an empathic understanding of risk-related behaviors, so that effective risk-reduction programs may be instituted. For example, anthropologists can study people who have AIDS or people who have been affected by AIDS (such as the family or children of those who have AIDS). These populations should not be left out of the study or treatment system because they also need psychosocial support to sustain their lives as happy human beings.

Like Farmer, Bond, Kreniske, Susser, and Vincent (1997) discuss anthropological contributions to AIDS, but they limit their research to Africa and the Caribbean. This article is useful because it helps anthropologists who have never done research in the developing countries to prepare for what to expect when doing fieldwork on AIDS in these countries. Also, it provides a guide to common behaviors that relate to HIV.

Moreover, they describe how anthropological work can help contribute to public health, as well as the health policy sector.

They emphasize that one of the anthropologist's duties is to collect data that concerns human interactions from three different areas: health professionals, health administrators, and patients. In this research, the authors chose the African and Caribbean regions because they are the poorest countries to manifest the HIV epidemic. They suggest that the findings in this research may address other problems in developing countries, such as Thailand, India, and Poland.

They raise many interesting points concerning understanding HIV infection in poor countries. First, the researchers might find common characteristics of the countries, such as: income inequality, land reform, the alienation of peasants from the land, labor migration, colonial and post-colonial patterns of industrial exploitation, the resulting proliferation of informal settlements, gender hierarchies, and the increasing separation of children from their formal family connections. Therefore, anthropologists should also pay attention to these types of social and cultural factors and search for ways in which they may relate to HIV. These factors are important to see the macro picture of the spreading of the HIV virus.

Second, when looking at a micro picture, anthropologists should be concerned about the sexual behavior and the changing social conditions in third world countries. Sexual behavior, especially heterosexual, is the major source of HIV transmission. Anthropologists have also been called on to find out what causes changes in sexual behaviors to happen. Usually anthropologists have found out that sexual behavior is

conditioned and effected by the changing social organization, economic expectations, and historical events, even by HIV itself.

Third, they found common facts about women and HIV infection in the developing countries. Most women are affected by the gender hierarchies found in different contexts, such as: being disadvantaged in the prevention and treatment of HIV, being limited in their sexual freedom and authority to tell men to use protection, having to accept the fact that males can have more sexual partners, which should not be seen as a privilege, but rather as a common practice. As a result, the rate of women in the developing countries being affected by HIV is statistically higher than the rate for men.

In this second part I will show that anthropological knowledge applies not only to the general population or to particular cultures, but anthropology also has special application to the study of women, adolescents, drug users, and hemophiliacs. These particular populations are often placed in the center of analysis in research because of their vulnerability to AIDS.

Akeroyd (1997) is concerned with the socio-cultural aspects of AIDS in Africa, including gender and socioeconomic issues. In her article, she emphasizes how women are more often becoming the victims of AIDS. She believes that cultural factors are linked, especially to patterns of gender relations and subordination of women, and to social and kinship bonds. Women and children are commonly said to be more exposed to the transmission than men. Through the sex ratio, women under 25 years are the most infected with HIV/AIDS, especially young married women. More women are dying and at an earlier age than men. As a result of this, women who are prostitutes are in the spotlight to be taken care of because of their risk behavior. Therefore, other women, such

as housewives or young females who are also at-risk, are not being carefully protected. More studies should emphasize all women, not only prostitutes, who are the victims of AIDS.

Moreover, the “risk groups” are labeled as female prostitutes, “street” youths, male long-distance truck drivers, miners, military, and paramilitary groups. The commonalities of these different groups are urban residences, low socioeconomic status, their mobile or transient character, forced segregation of the sexes, and alienation or marginalization. These point to some of the social and economic circumstances which underlie risky sexual behavior. In reality, unknown to the public view, AIDS also affects upper class people who do drugs. This elite group consists of the urban educated ruling classes, the bureaucrats, technocrats, and businessmen.

This study shows that there are still many groups of people who are being left out of studies and who should be included of because they also are high risk. Target groups should be extended by looking at gender and socioeconomic factors, to include not only the well known groups who exercise the risk behavior, but also those who have not been traditionally considered to be at risk.

Reid (1997) takes gender analysis further by suggesting how society should place and view the importance of women because their needs are unequally met. This article encourages people to change their point of view by putting women in the center of their analysis to make improvements in women’s lives. When society views these issues, they should be concerned and look into what women’s positions are, what they are doing, what their aims are and where they want to be in order to bring about the changes they want. Therefore, the writer suggests that other institutions (financial institutions, social

institutions, health institutions, etc.) or groups of people, including men, should draw the analysis primarily on the basis of how they relate to women. Moreover, they should consider how their analysis can contribute to achieving women's goals.

When looking at sexual relationships that affect women's diseases in the developing world, the situation can be improved by three main measures. First, there should be a reduction of the number of sexual partners. Second, people should be encouraged to use condoms. Condoms use skills are rare among the majority of women. Only women who are in the sexual service sectors are skilled. Third, the concept of faithfulness in relationships, preserving virginity, and self-restraint should be spread among the members of the society. The statistics have shown that 1,500 faithful women in Africa, who have no sexual partners other than their husbands, are infected by sexually transmitted disease through their husbands. These three reasons are why there are many more infected women in Africa than men.

Condom usage, faithfulness, and preservation of virginity can be achieved by culturally and socially constraining every person in the society, not only men or women. At present, 60%-80% of women who are infected through others' behaviors, are being blamed as being the source of the transmission. It is not fair for only the women to be blamed. What would be helpful would be an anthropological study of social and sexual behavior as described by Bolognone.

Not only women, but adolescents are among the vulnerable target groups. Weiss, Whelan, and Gupta (1996) wrote an article about the vulnerability and potential of adolescents to contract HIV/AIDS in the developing world. They became inspired by the statistics concerning HIV among adolescents. They found out that around half of all HIV

infections occur in men and women under age 25. Moreover, in many developing countries recent data indicate that approximately 60% of all new HIV infections are among 15-24 year olds, with females out-numbering males by a ratio of two to one. This fact corresponds with Reid's article about the vulnerability of women.

They raise the point that social expectations about virginity do not necessarily protect young women from STDs and HIV/AIDS. This kind of incident is supported by norms that dictate that "good" women should not know about sex, or the functioning of their sexual and reproductive organs. In societies that promote such a culture of silence, girls are reluctant to seek information for fear they will be suspected of being sexually active. Some young men and women agree that carrying condoms can make a girl appear promiscuous. For example, a woman stated "People will think she must be having sex with the whole world."

Furthermore, promoting virginity does not necessarily result in protecting girls from the risk of infection. Usually societies in the developing world will emphasize that more concerning virginity lead to a failure to provide young women with information and services. Among boys' groups questioned about virginity, no boys mentioned shame and abandonment as a result of losing one's virginity. Many social norms deny young women the right to access the tools of disease and pregnancy prevention. Not only this bias of access, but gender differences in socialization can also contribute to HIV/STD vulnerability. In most societies, gender relations are characterized by unequal balance of power between women and men. Women have less access than men to education, training, and productive resources, such as land and credit. As a result, men are more

likely than women to initiate and control sexual interactions and decision-making, which has implications for vulnerability to HIV infection among women.

Adolescents know something about AIDS, but they do not think they are at risk. Therefore, instead of feeling vulnerable themselves, they tend to believe that AIDS is a disease of the “outsider.” The term outsider would cover bargirls, prostitutes, homosexuals, and truck drivers. Weiss et al. then suggest that in these countries they should broaden HIV/AIDS education to include a discussion of sexuality, relationships, and gender roles.

Campbell (1995) focuses on male gender roles, sexuality, and the implications for women’s AIDS risk and prevention. This article starts by describing facts about why women are still at risk from today’s inaccurate health promotion. She believes that health promotion focuses on individual change because the assumption is that individuals will respond to health information given to them. Therefore, the information they gain will determine the decision they make concerning their health. Most of the health programs concerning AIDS are not relevant to a majority of many women because they fail to treat sexuality in a social context. They do not recognize that despite the risk, women may be limited in their ability to act on information provided to them. Women are not always aware of the past or present risk behavior of their partners. As a result of this, they do not think they are at risk. Even so, the prevention efforts often focus on changing the behavior of women rather than that of men. Campbell believes that the misguided attempts of health programs should be changed, because too often they work through women to get men to change their behavior and rely too much on individual control without acknowledgement of sociocultural constraints.

The second part of the article moves to a focus on facts about injection drug users and hemophiliacs. Drug users are usually identified in one or both of the two settings: drug treatment centers and prisons. Seventy-five percent of drug users in United States are male. Many men in prison engage in consensual sex with other men and return to a heterosexual life after release. Also, clean needles and bleach are not distributed to IDUs because of the concerns for security. Therefore, the facts about drug users will affect the innocent women outside the prison and change them to victims. Moreover, 25% percent of women who were studied confessed that a male sex partner or family friend introduced them to drug injection.

On the other hand, the facts about hemophiliacs can affect both sexes. Hemophiliacs including transfusion recipients, are the ones who become the victims because of blood transfusion. There can be risks from hemophiliacs through them having sex with other people. Hemophiliacs are more knowledgeable about health because of their own illness. For hemophiliac adolescents, they have more risk-taking behavior due to the difficulty in changing their sexual behavior.

This article includes a new point of view toward health programs. Moreover, it stresses the little known facts mentioned about the injection of drug users and hemophiliacs. All of these will be useful in determining the routes of transmission of AIDS virus, as spotlighting sexual activities alone does not suffice.

As we can see from all of the research above, anthropological knowledge and methods are equipped to see the relationship between cultural factors and human disease. Moreover, anthropology and its methods show how a group of people become at risk through their behavior and beliefs, and most of all, how disease will affect their lives.

Although some articles also suggest that anthropologists can work effectively by themselves, their research will be more effective if they join with other professionals in different fields to work on helping to reduce the problem.

Among those contributions to anthropology research, only a few choose to focus on the socioeconomic relation to health conditions in adolescents and women. If, for example, research focuses on women, most would neglect certain groups of women who are also at-risk, such as women who are not prostitutes. Even the literature that does focus on women does not show the processes or methods used in advising individuals to safeguard themselves. My research is composed of the three rarely chosen focuses: adolescents, women, and socioeconomic status. None of the previous research has chosen to focus on these three categories in relation to acquiring AIDS. I will take a further step in my study by giving advice to adolescents concerning how their behaviors put them at risk and how they can protect themselves from being at risk.

Gender Perspectives

Many gender values influence how the concept of AIDS is approached. This will center on the critical cultural concept that women are subordinate to men. This model places women as victims of the sexual patterns in society. Male carriers can see women as victims through their limited sexual freedom or/and through receiving unwanted diseases. Therefore, the research below explains the theories that show why women are being treated unequally.

The sexuality of males and females is considered to be fundamentally different by both Thai men and Thai women. Men are widely perceived as having a natural and

driving need for sex that requires frequent outlet as well as sexual relationships with their girlfriends. In contrast, women think that having sex relates to trust and love. Therefore, women's feelings, such as being understanding of male desires, being emotional in love, and not being knowledgeable about sexual practices, can lead to the contraction of HIV/AIDS. The following case studies relate to the model described above.

The first section below deals with articles explaining the basic concepts related to sexuality. The second section shows the methodology that researchers can use to gain insight on the different genders. The third section displays many articles that center around women who are at-risk for AIDS.

Boonmongkon (1997) describes concepts such as sexuality, gender, and sexual desire. She states that *sexuality* may be thought about, experienced, and acted on differently according to age, class, ethnicity, physical ability, sexual orientation and preference, religion, and region. Therefore, sexuality does not have the same significance for all women in any given historical period or culture. There may be important differences between women in relation to class, race, age, ethnicity, sexual identity and body image. Sexuality relates to the concept of *gender*, a crucial division which is fundamental to the construction and maintenance of the power relations between women and men. Our *sexual desire* may seem to be "normal", but our sexual responses are actually learned. We learn not just patterns of behavior, but also the meanings that are attached to such behavior.

Many anthropologists have given attention to how social construction has shaped sexuality. They look at how human sexuality is articulated with economic, social, and

political structure, what the relationships between sex and power are, and what the relationships among sex and class, gender, race, age, health and the economy are.

Strong and De Vault (1994) further discuss sexuality concepts and show how these concepts are linked with being at-risk for AIDS, describing many concepts such as gender theory, gender roles, sex stereotypes, and gender studies. They also use many examples that concern sexuality.

They describe *gender* as both a biological term meaning different sex and a sociological term meaning femininity and masculinity. The social term often is what people who study about gender are concerned with. They usually absorb the basic concepts of *gender theory*. Gender theory relies on the hypothesis that each culture determines the content of gender roles in its own way. Therefore, biology creates males and females, but culture creates masculinity and femininity. They then look at the different processes of socialization between males and females. Lastly, they describe how the result of the process creates advantages and disadvantages for male and female.

According to Strong and DeVault, gender roles are defined as the societal expectations of how women and men are expected to behave in a particular culture. Gender roles also teach us how we should act sexually. Normally, gender roles view men and women as opposite sexes. Although this varies by social group, men generally are viewed as active, whereas women are passive. Therefore, men are sexually aggressive, women are sexually receptive; men seek sex, women seek love.

When looking into the concept of *sex stereotypes* we can see that a stereotype is a set of simplistic and over-generalized beliefs about an individual, a group of people, or an idea. Usually stereotypes especially sexual ones, are negative. Common sexual

stereotypes include: men are animals, nice women are not interested in sex, and virgins are uptight and asexual. These stereotypes are untrue and often mislead many people.

Another portrayer of stereotypes is the media. *Mass media* such as television is the most pervasive and influential medium affecting our views of sexuality. Television can form our sexual perceptions through its depiction of stereotypes and its reinforcement of norms, which may or may not be cultural rules or standards. There are five major television genres in which sexual stereotyping and norms are especially influential: situation comedies, soap operas, crime/action adventure programs, commercials, and music videos.

All of these categories—gender roles, sex stereotype, and mass media—guide personal perspectives of sexuality, and these perceptions can encourage risk behaviors leading to AIDS. Nowadays AIDS has become a disease that is directly related to the concern and perception of sexuality. Teenagers often have a sense of invulnerability; they may put themselves at great risk without really understanding what it means. When looking at the amount of alcohol consumption among teenagers, researchers have found that use of alcohol and drugs tends to reduce condom use. Therefore, this article not only points out lots of concepts centering around sexuality, but also it points out factors such as gender and age, and how they can later relate to AIDS danger.

Anthropologists not only use concepts to explain gender differences, also often use a cultural approach to explain them. A cultural approach to gender differences was taken by Ridgeway and Diekema (1992) who view gender roles as attached to many institutions in society. For example, it explains that people learn rules for interacting

with peers from peer-group interaction since childhood. During childhood peer groups are gender segregated. Furthermore, because it is a period of gender-role learning, the childhood subculture actively accentuates gender differences.

Strong and De Vault stated that men are active and women are passive, so too do Ridgeway and Diekema, who agree this develops during the development of peer groups. As a result, the cultural rules of interaction between men and women are different. Boys learn to use speech to assert positions of dominance and compete for attention. Girls on the other hand, learn to use speech to maintain relations of closeness and equality, to criticize in non-challenging ways, and to accurately interpret each other's speech. In adulthood, these different sub-cultural norms produce substantial differences between male and female same-sex interactions. Male groups focus around task and power concerns, whereas, female groups focus more on relationships. Therefore, gender-typed skills and beliefs are created by providing men and women with different experiences. This article gives us many theoretical points of view concerning gender, interaction and inequality, which relate to male and female status.

Sex differences, when examined by Amick, Sol Levine, Tarlor, and Walsh (1995), were and found to correlate with different health conditions. Relationships between gender, health and cigarette smoking were discussed. They suggest four hypotheses stressing that sex differences can cause different health conditions: first, risks acquired through different role stresses, lifestyles, and long term preventive health practices; second, different illness experiences and behaviors that stimulate awareness of symptoms and health-oriented action; third, different exposure to prior health care will influence a

lifetime of acquired risks, health behaviors, and health; and fourth, the differences between biological factors among men and women can cause different health conditions.

The internalized roles theory was used to analyze how sex differences can cause different health conditions. According to internalized roles theory, responses to stress and illness behaviors show that women experience more depression than men do. Not only do women experience depression more than men do, they also experience demoralization, unhappiness, and general dissatisfaction with life.

Another theory that concerns how gender effects health climes that men have more potential to have “acquired risk activities” than women. These acquired risk activities involved engaging in smoking, drinking, taking drugs, and visiting prostitutes. Therefore, any acquired risk activities are considered as risk behaviors that can affect one’s health condition. This process relates to both social and biological factors that are different between genders.

Unlike others, Garnon and Parker (1995) emphasize the methodology and techniques to find the differences in how sexuality is conceived. They suggest that while sexological theory is not universally agreed on, all theorists do think that there are fundamental differences between the sexuality of women and men. This difference can be implied as the genetic difference between the females and males. Feminist studies tend to emphasize the role of gender inequality in shaping the lives of women and men. Especially, we can see the inequality through the disparity of power in sexual practices of women and men.

Many studies concerning sexuality and sexual activities in relation to HIV/AIDS tell us that gender inequality and sexual oppression have been socially constructed. This

study focuses upon the social organization of sexual interactions, on the relationships between meaning and power in the construction of sexual experience, and the social rules involving sexual behavior itself. This attempt usually defines sexual experience in different social and cultural contexts. Therefore, it creates an assumption that sexual identities and behavior changes are influenced by social factors in society.

Moreover, the questions asked about sex have to be interpreted to center around the power between women and men. These questions include: How often one had sexual intercourse last month, who initiated the sex, under what conditions, could one partner or the other have refused the sex, why did you have the sex then, etc. Changes in patterns of negotiation often depend on distal effects—the level of education of women in the society, the rights of women to leave the home without a man's permission, and the availability of contraception.

Theorists and research that focus on sexuality in society then view sex by looking into the relationships between men and women, what kind of questions are asked in order to receive in-depth answers that reflect the sexual patterns, and how they affect negotiations.

Another research effort that emphasizing methodology (Orr and Langefeld 1993) relies on a health model in collecting data. They conducted research about factors associated with condom use by sexually active male adolescents at risk for sexually transmitted diseases. Their research starts by describing that more adolescents, especially males, are sexually active now compared to a decade ago. There is an increasing lifetime risk for unintended pregnancy and sexually transmitted diseases (STDs). They used the

questionnaires among 116 American adolescents age 15-19. The research shows that in the target group, males of age 15-19 years old have had 5.1 sexual partners and 1.9 partners over a 12 month period.

They linked “Health Belief Model” (HBM) with the condom use concept which stated that behavior based on the value of the outcome to an individual is related to the expectation that the action will result in the outcome. Especially, it is hypothesized that STD avoidance behaviors are influenced by an individual’s perception of three factors: the threat of STDs, the benefits of altering behavior to prevent STDs, and the barriers to these behaviors. These factors are in turn influenced by the subject’s attitudes and beliefs specific to STDs.

The result shows that there are many factors such as gender, attitudes, knowledge, other risks, and cognitive maturity that influence the use of condoms. From the gender factor, we can see that boys were more likely to use condoms during their most recent sexual encounter if they used them for the prevention of sexually transmitted infections. From the attitude factor, attitudes about condoms and STD risk activity influence condom practices. Moreover, attitudes about condoms were most highly related to, or influenced, by their use for contraception and less so for STD protection. From the knowledge factor, knowledge about the behavior apparently played a role in influencing behavior, but the extent of this influence was unclear. Many studies have not identified the relationships between adolescent’s sexual practices and knowledge. Therefore, it is still hard to separate knowledge from beliefs. Other risk factors are: having intercourse with other males, prostitutes, partners who use IV drugs, strangers, or individuals with multiple sexual partners. They observe that males who have had intercourse with people

other than the risks group were unlikely to use condoms. The cognitive maturity factor, observed that boys who did not use condoms at last coitus were less cognitively mature than those who did use condoms.

The last section is composed of a series of articles which discuss females as victims at risk for HIV infection. Vance and Pollis (1990) use feminist perspectives to view sexuality. They give a general overview about sexuality from the feminist perspective. Like, Garnon and Parker, they say feminists have generated an enormous body of work, which has analyzed and critiqued gender inequality. They believe that gender plays an important role in the construction of sexuality. Sexuality in our culture (human culture) is profoundly gendered; norms of sexual behavior differ for women and men, as do their actual experiences. Feminist perspectives emphasize how men are treating women; usually women are more subordinated, suppressed, and depressed with limited sexual rights. In short, this article introduces the perspectives of feminists on sexuality.

In contrast, Patton (1993) uses psychological perspectives to view women who are at risk from AIDS. She starts with defining "Risk-base" as the aim at getting an individual to perceive a particular practice as risky. Women nowadays are being put at risk in many ways. Usually, the original circumstances that make women to be at-risk begin with the fact that women are subordinated to men. Women might be sexually treated as totally passive and outside any discourse of choice or will. Heterosexual women are understood as partners of men rather than as agents of their own desires. Sex is more implicitly constituted as a man's right and a women's obligation. Women are

responsible both for protecting men from disease and for avoiding the consequences of transmission to a man's child.

From the male perspective, risk corresponds with women's not with particular heterosexual practices. Whereas, from the female perspective, a husband or boyfriend may be at-risk from someone else (a needle sharing partner, a homosexual partner, etc.). The logic of safe sex were difficult for a woman to perceive herself as at-risk. Most women have no perception that the man they have sex with might be infected. This is due to the fact that when women are having sex with men most women view themselves as engaging in "ordinary" or "normal" and, therefore, "safe" heterosexual intercourse. Usually people will think that having heterosexual intercourse is not risky except with a certain heterosexuals drug users, sex workers, and people of color. In reality risk can come from many other practices including having sex with a "normal" person. Therefore, while men fear for their sexual identity, their women partners need to fear contracting HIV.

Not only can anthropologists use psychological perspectives to analyze this issue, but also they sometime use regional characteristics and cultures to determine how women can be at risk. For example, Bruyn (1992) discusses women and AIDS in developing countries. She starts by pointing out that AIDS is largely spreading in developing countries. The impact of AIDS is particularly great on women in developing countries for four reasons. First, the stereotypes related to HIV/AIDS have meant that women are either blamed for their spread or not recognized as potential patients with disease. Two particular stereotypes usually held by people that related to AIDS were: AIDS is

homosexual disease and AIDS is a prostitute's disease. Therefore, people think that the group of at risk consists of homosexuals and prostitutes.

Second, women are at increased risk of exposure to HIV infection for reasons related indirectly and directly to their gender such as, the misbelief that using condoms will cause injury to women or even cause sterility, the bride wealth rates are high so young men often have multiple partners before marriage, etc.

Third, the psychological and social burdens are greater for women than men in a similar situation. Women carry a great burden when they are pregnant and enter their parenthood. Besides household responsibility, women are responsible for caring for her child and maintaining pleasure for her husband. Fourth, women frequently have low socioeconomic status and lack of power in gender negotiations; this makes it difficult for them to take preventive measures. One reason for this is because in some countries sex is not considered a topic to discuss between men and women or parents and children. By socialization processes women learn that they are subordinated to men and must respect their wishes. Even if they suggest the use of condoms, they often encounter the male's refusal. Therefore, the author suggested that more programs are needed for women, more access in health services should also be reachable for women, as well as more income opportunities for women. Moreover, she encourages more HIV/AIDS related research viewing women as victims. This article connects many factors and facts about women who are at-risk from AIDS in the developing countries.

Goldstein (1994) looks at AIDS and women in Brazil focusing on how they view sexuality in their lives. Women's perspectives on sexuality can be explored by examining what they think and say about sex and virginity. This research compares and

problematizes the public discourse of low-income urban women in Brazil. The result was drawn from sixty male and female factory worker interviewees. In Brazil, sexuality is defined in symbolic gender terms of sexual activity and passivity rather than in terms of homosexual identity. A problem arises at this point because many heterosexual men are engaged in homosexual activity without defining themselves as homosexual. Almost all of the homosexual relationships between men, they do not practice protected sex. Therefore, to teach heterosexual women about prevention methods and raise their awareness is difficult because they are not aware that their partner is homosexual.

When viewing how women think about sex, many of them say if they become involved with protected sex, they will be misjudged as girls who are experienced and are sexually active. They want to distinguish themselves as part of a group of 'good women' who do not engage in unpleasurable acts merely to please their husbands. Moreover, they think of their virginity as what brings a highly desirable price added to their value. When asked about the first time that had sex, they usually refer to this experience as losing one's innocence and honor. In conclusion, this article tells a lot about women's perspectives. This may be similar to the patterns of what women in other developing countries think about sexuality.

In conclusion, the articles above show how different gender roles can create different points of view toward sexuality and sexual behaviors. They agree on how gender roles develop from the socialization process that each culture has created. This has caused differences between women and men resulting in different beliefs, power/authority, rights, and behaviors. Usually, in many societies, inequality among different genders also occurred, causing different sexes to have different acquired risk

activities (Amick 1995). For example, in the articles above, most of the anthropologists and feminists are likely to focus only on how women are being victimized by the males' acquired risk activities. Some suggest at what point women are at risk, but most did not mention how women can help themselves to overcome their vulnerability. Most of the research usually implies that women are not competent or empowered to protect themselves. Therefore, these researchers suggest that the people surrounding these women should be the ones who change their behaviors. Unlike others, my research will provide suggestions concerning how women can learn to escape from being at risk, for women are truly the only ones who can help themselves. My recommendations will show how women can help themselves not to be vulnerable to AIDS.

Thai Literature Concerning Cultural Values and Gender Perspectives

Thai sexual behavior and the risk of HIV infection are closely linked together by Thai cultural values, especially those concerning gender. Many studies describe the relationships between Thai men and women to be one of the factors that encourages AIDS contraction. Four main focuses have been considered in relationships between Thai men and women: how each sex views his/her gender roles and sexuality, how Thai men customarily involve themselves with the use of sexual services as a cultural activity that fulfills their needs, how Thai women accept men who have multiple sexual partners and their limited authority in sexual relationships, and how we can improve the efficiency of promotion Thai adolescent's sexual health.

It is important to know and understand the basic relationships between Thai men and women before looking at how culture values have shaped gender roles, sexual

perspectives, and sexual patterns. I selected three articles that give the picture of the relationships and how they can lead to AIDS spreading in Thailand.

The first article is written by Fongkaew (1995). In her article, she emphasizes gender construction, socioeconomic transformation, and HIV transmission in Thai society. Fongkaew points out three interesting facts about Thai culture and how it shapes one's gender role. First, she refers to many long-held Thai values, such as the saying of "women are the hind legs of the elephant, and men, the front legs." This is the most popular saying relating to a well-behaved girl who involves herself in relationships with men, and she should always remember that she must obey men. She points out examples of many Thai sayings which reflect the concept of gender inequality, which limit female freedom, and control female sexuality. Also, women's attitudes are deeply shaped by a cultural norm that good women should not talk about sex. In saying this, daughters who have too much freedom or are thought to have had premarital sex, or are viewed as "loose"; they bring shame to their parents. Therefore, there is a fixed pattern that controls how women should behave and this was created and judged by the dominant male society, not by the women.

Second, she refers to the modern women's economic role in the era of economic development. Since World War Two, the position of Thai women as inferior relative to men has been reinforced by class inequality. Therefore, an increase in gender differences in social position, prestige, and power that selectively disadvantages non-elite women exists. These social and economic changes are associated with the balances of power between men and women. In addition, mass media shapes public opinion, personal beliefs, and even women's self-perceptions, to the extent that the beauty of a "modern

woman” is assessed by having fashionable dresses and a stylish coiffure. This effect influences some lower class girls to become prostitutes because they want to earn money for beautifying themselves.

Third, she points out that AIDS is stigmatized as a negative stereotype relating to certain categories of people, particularly prostitutes and homosexuals. This reflects sociocultural perceptions that distinguish between good and bad women, based upon their sexual behavior, and reflect moral shame on individuals with deviant behavior. This concept then creates an image of female prostitutes as primary carriers of HIV; a source of infection rather than a victim. In Thailand, AIDS and other STDs are labeled as “prostitutes’ disease”. Moreover, AIDS campaigns, addressed to men, urged them to be cautious about contracting AIDS by visiting prostitutes and transmitting the infection to their wives. Most girls who are not prostitutes are perceived of as not being at risk. Furthermore, condoms are associated with “bad girls”, therefore men and “good girls” will not encourage their partners to use condoms.

Like Fongkaew, Pattaravanich (1993) also shows the effect of cultural factors on safer sexual behavior among Thai adolescents. Pattaravanich linked adolescents’ sexual behavior and HIV with Thai culture through the socialization process. In her view, Thai men and women carry out their sexual roles very differently. The role of the male, who is the head of the family, is based on achievement and work outside the home, whereas the role of the female is based on the promotion of the family’s happiness, love and affiliation. Thai children are taught this concept, not only through their families, but also through the other agencies of socialization, such as the mass media, the education system, the occupational group, and the peer group. These institutions then closely influence the

concept of sexual behavior among Thai adolescents. The message being given to male adolescents concerning sexual behavior is that they have many partners, whereas females should not participate in sexual behavior. This concept also ties in with the attitudes toward sexual intercourse; females think that they can have only one partner, and their satisfaction concerning sexual intercourse should be based on love and trust. In contradistinction to females, males' satisfaction concerning sexual intercourse is based on pleasure and fun.

The view of sexual intercourse in Thai society is conservative compared to other societies. Although gender roles are an important influence on sexual behavior, conservative ideology delays sexual involvement, with most couples not engaging in intercourse before marriage. Therefore, if teenagers want to engage in, or are having sexual intercourse before marriage, they have to hide it from adults and society. Sexual education has not been adequately stressed at the adolescence stage. Usually knowledge is gained after marriage by actual experience. This later affects people's knowledge about protected sex and sexually transmitted diseases, especially AIDS.

Unlike the two articles above, Boonmongkon and Suvarnananda's (1997) study displays not only Thai cultural values and mass media roles, but also they add the term, "double standard value," to analyze the relationships between Thai men and women. Their study shows more in-depth facts concerning sexual behavior among Thai adolescents. They explain how sexuality and gender norms among Thai teenagers could cause many problems. They begin by describing the social sexual inequality that occurs in Thailand. Sexes serve as one of the most important bases for the power differential in the sexuality of women and men, reflected in the control of women's sexuality. This

study emphasizes the concept of the double standard based on the assumption that males have a greater desire and need for more sexual activity than females do. This causes most females to externalize their passive and non-initiative role taking. Women are taught that sex is disgusting and embarrassing. “Good” women should repress their sexual feelings and reactions, not displaying sexual pleasure or sexual desire, so they will not be accused of being like a prostitute who has sexual skills.

Heterosexual meanings have become central to gender symbolism involving “teen” and “adult” styles of femininity and masculinity. When viewed from Thai gender characteristics, we can see that gentleness, weakness, dependence, emotionality, and responsibility for taking care of the house and children characterize the Thai feminine stereotype. On the other hand, accomplishment, leadership, and responsibility to be the head and financial provider of the household characterize the masculine stereotype.

Moreover, Thai adolescents are being encouraged by mass media to experiment with their sexual attractiveness. Advertisements urge them to lure members of the opposite sex by the use of cosmetics and clothes. These messages tell them that being sexual is being modern. Therefore, adolescents are becoming sexually active at a younger age. This study concludes that girls need to be made aware of their own sexuality and trained in communication skills in order to promote their ability to negotiate safer sex.

Tunchaiyanone (1996) argue Boonmongkon and Suvarnananda’s idea of a double standard in with a more in-depth analysis of attitudes toward sexual relationships among modern Thai people. She states that now the effects of people who are HIV/AIDS infected are not limited to the risk groups only, but have already expanded to the

members in the family household. She describes the term double standard value as a sexuality value that posits that male power is more dominant than female power. It is usually acceptable for males to have sexual relationships with other women before or during their marriage. Moreover, females are viewed by as not needing to have sexual pleasure when involved in sex. They should not show their feelings about sex, even in their married lives. Females are the ones who respond to male sexual needs. Women's virginity has therefore become an important aspect in women's lives.

Males' and females' attitudes towards sex have changed rapidly. Women and men are divided into six large groups according to how they perceived sexual relationships. Men think that they can have sex with any kind of women. Men think that they can have sex with women who are not prostitutes. Men also think that it is normal to have sex occasionally with prostitutes. On the other hand, women think that they should not have sex before marriage. They should worship the romantic love with the man they are in love with, the man whom they then are willing to have sex with before marriage. Other females tend to change their attitudes about having sex with men who they love, but think they can also have sex with other men as well.

Knodel et al (1996) discuss how married Thai men and women interpret sexuality and sexual behavior in the context of their own lives. They asked about the views of Thai males and females toward premarital sex and extramarital heterosexual sex. Their findings from focus group discussions and in-depth interviews show that females and males view sexuality differently. Men think of sexuality as having a natural and driving need for sex that sometimes requires sexual service from prostitutes. On the other hand,

women view men's need in having sexual intercourse as a natural basic physiological need or instinct like hunger.

When one views premarital sex, what first comes to mind is premarital sex with prostitutes. Thai men and women recognize that visiting prostitutes is common in Thailand. Generally visiting prostitutes is among the most popular activities for single men. There is a strong consensus among women that shows little concern that their husbands had sex with prostitutes before marriage. The usual reaction of the wives was that she had little right to judge her husband for what had happened before her own relationship with him. Moreover, when asked about premarital sex with non-commercial sex relations, almost every Thai said it is now a common thing in Thailand, especially the ones who live in the urban area. This type of relationship usually refers to couples who had some commitment to each other such as girlfriends/boyfriends. The writers stressed that among teenage groups this relationship has become one of the ordinary activities they do.

Both males and females when asked about virginity, cared only for women's virginity; not a case mentioned the importance of male virginity. Virginity was the most important thing that both sexes wanted to keep (for women) or to get (for men) before they married. Both sexes also agreed that male satisfaction was a necessary element in successful relationships as a couple, and even more important in a married life. Commercial sex to women and men was not seen as an act that betrayed their relationships. Although some women were afraid of the sexually transmitted diseases, especially AIDS, they still preferred to satisfy their men and approved of this type of behavior. They thought that it was better than having other factors affecting their

marriage. These other factors were, for example, men having a steady minor wife, or having affairs with loose women and causing an ending to their relationships because who were not supportive.

Two other researchers did in-depth studies of gender roles and sexuality among certain target groups, such as poor urban residents who live in crowded areas in Bangkok. Balzer and Srionsri (1996) provide perspectives on the lives of lower-class adolescents who have deviant behaviors. They studied the out-going lifestyle of young women who range in age from 15-20, and who are known as and call themselves “wairoon gai taek”, teenagers with a broken heart”. They have a lifestyle that centers on going out, drinking, fighting, and looking for sexual liaisons. These young women often are promiscuous with boys, drinking, and drugs. They like to be with friends. Friends for them are their heroes. The reason they are labeled as broken heart teenagers is not because they are disappointed in love, but because they do not obey their parents anymore. They often runaway from home and skip classes.

Their usual activities are going out anywhere at anytime. Their motivation is not only for fun, but for making money as well. The meaning of going out to them is to show that they can have their own freedom to gain independence by entertaining themselves, socializing with friends, drinking, etc. They often engage in free sex referring to a product or service with no charge as well as to loose or display liberated sense of individuality or sexuality.

In conclusion, their behaviors involve a lot of risk behaviors that can harm their health, especially leading them to AIDS. The term which the society gave them seems to encourage their self-esteem in a negative way. Therefore, the authors suggested that the

society should pay more attention to this group of teenagers providing them a better life with positive opportunities.

A short article by Limsumphan (1996) supports Balzer and Srionsri's findings that poor Thai adolescents who live in an urban area are at risk. She describes how influential surroundings and social change have placed these adolescents at risk. An increasing urbanization seems inevitable over the course of economic development. In 1975, Bangkok's population was 4,700,000 and has since increased to 8,000,000. This demographic shift has been accompanied by major social and cultural changes such as environmental degradation, the rise in poverty, and a dramatic increase in slum areas. The relationships within families are affected by poverty, and poor sanitation, these encourage adolescent's pregnancy, prostitution, and ultimately the spread of sexually transmitted diseases, HIV/AIDS. Moreover, in slum communities, women and children are the most disadvantaged group of people because they lack educational opportunities. This places them at particular risk for disease.

Many studies in the past decade have chosen to focus on how Thai men customarily are involved in sexual services and why Thai women accept this type of behavior. These studies place emphasis on the multiple sexual patterns that leads to HIV/AIDS spread in Thailand. The 1990 survey of partner relations and risk on HIV infection in Thailand done by Thai Red Cross Society Program on AIDS (1992), indicates a lot of facts about Thai sexual patterns that lead to the risk of HIV infection. In short, they explain that the risk factor began from the rise of a well-attended sexual service industry. The sexual service industry has given Thai men unlimited freedom in searching for sexual fulfillment. Numerous studies have shown half of Thai men have

their first sexual experience with a prostitute and the majority of them have visited a prostitute at least once. Thai men and women recognize that visiting prostitutes is common in Thailand and generally view it as a normal activity among single males. Thai women have traditionally accepted this. Condoms were frequently used only with prostitutes and viewed as abnormal sexual practices as for Thai women, in general, they have less freedom to speak when it comes to sexual behavior and less to bargain with when it comes to the power of resistance. There is a strict code for good women to act as followers when it comes to sexual practice. It can be implied that Thai women who are not prostitutes would be unlikely to request the use of condoms. The relationships between Thai men and women has resulted in the spreading of AIDS through multiple sexual partners without protection. Therefore, not only men who sometimes used condoms when they visited prostitutes or/and had unsafe sex with other women, but also men who had unsafe sex with their girlfriends could also be at-risk too. This study clearly describes an over view of Thai sexual patterns which can lead to AIDS.

Other research done by individuals such as Archavanitkul and Chamsanit (1995) studies Thai male adolescents who use sexual services. As a result they give a broad picture about the development of the sex industry, including purchase of sex in modern times. In the first part of this article, the writers describe clearly the history of sex and how it relates to the current situation in Thailand. The writers state that there are three groups of people who play essential parts in upholding the sex trade in Thailand: sex entertainment business, sex workers, and male clients. The literature review reveals a lot of historical evidence affirming the existence of the sex trade in Thai society for the last 700 years. In 1960, the first prostitution suppression act was made legal; brothel owners

and prostitutes were taxed. Since then, both the size and the variety of services offered by the trade sector has expanded. There was then an effort to enforce the law that stops the exploitation of girls and women in the sex industry.

This pilot study aims to find out about sexual behavior of Thai male adolescents, particularly their commercial sex practices, their knowledge about sex, their views on premarital sex, and the purchase of sex. Questionnaires were distributed to 219 male students between the age of 17 and 24, in two vocational colleges. Also, in-depth interviews were conducted with eleven males and female students.

The result has shown that 29% had sought their first sexual experience with a sex worker and 40% have had sex with commercial sex workers. The most important factors that came out from this finding is that the peer group is the most influential factor encouraging men to have sexual experiences. Moreover, they view sex before marriage as a normal practice. Although, male and female adolescents' view toward sex is different. Male adolescents regard sex as something to be enjoyed. For them, having sex with girlfriends instead of sex workers means fewer chances of contracting STDs and AIDS. These young men often find sex with girlfriends more challenging than having sex with commercial sex workers. Meanwhile, female adolescents often lack necessary knowledge about sexual relationships, such as how to protect themselves from STDs and unwanted pregnancy.

Furthermore, it is obvious that young people today have paid lots of attention to the mass media. The message in the mass media sometimes often contains sexual acts or wrong values that say it is acceptable for men to have multiple sexual partners. Lately, there is more attention to providing health programs and advertisements concerning

health conditions. In the last part of the article, the authors suggest that it is essential that sex education in schools should be modernized so that it is appropriate to the lives of the young people of today.

Boonmongkon's (1997) article takes Thai adolescents sexual health analysis further by suggesting how it can be learned and improved. She gives much insight into the current situation of Thai adolescent's sexual behavior and provides many suggestions that would help reduce future problems concerning adolescent's sexual health. She describes the definition of sexual health as an integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love. Moreover, sexual health is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

Thai adolescents, both male and female, face enormous risks from STDs and HIV. In 1992, government statistics show that 47% of STD patients are in the age group of less than 15-24 years old. Half of the HIV cases among Thais are also in the age group of 15-25. There are many factors that encourage boys and girls to engage in premarital unsafe sex. For example, societal change and conditions such as migration, modernization, social net work, and peer group.

In Thailand, adolescents engage in sex at an early age and have little knowledge about or access to contraception. Usually teenagers who use contraception go to the drug store and buy them. This process became a problem because many were not comfortable in buying condoms in public, so as a result, teenagers do not use condoms. Moreover, no female teenagers would dare to purchase a condom for her partner because of the

forbidden norm. This is because of the existing norm that premarital sex among unmarried young women is unacceptable; thus and the use of contraceptive services is deemed culturally unacceptable and condemned.

Adolescents not only have sex with friends who are in their age group, but also have sex with adults. It is especially common for female adolescents to have sex with male adults. Considering from the perspective of gender and power relations, the situation in which female adolescents have sex with adults in both economic or casual encounters puts them at very high risk for unsafe sex practices.

The author lastly suggests that there should be many changes and new organizations to help reduce the risk taking among adolescents. First, National Plan and Policies should include adolescent's reproductive and sexual health policy in its plan. This can provide the overall framework on reproduction issues and sexual health problems, for promoting adolescents' health, defining priorities, making a compelling case for action, developing common targets, integrating plans, and monitoring and evaluating the implementation on the impact of these activities.

Second, there should be an attempt to establish adolescent friendly health clinics. These clinics should be able to provide full medication, psychosocial, reproductive and sexual health care for the teenagers. The clinic should be a friendly one step health clinic which is accessible, convenient, confidential, and culturally as well as socially sensitive to youth's sexual and reproductive health problems and needs. This is because it is difficult to attract the young people who require health services. Third, school-based health programs providing sex education should be improved to concentrate on sexuality among school boys and girls and reproductive health. They should provide peer-

counseling centers at schools and more information that support and understand the nature of adolescents.

Fourth, we need youth to be involved in advocacy for male role models and male responsibility for reproductive health problems of women. Therefore, protecting women's sexual and reproductive health should become the responsibility of modern Thai males. New forms of communication which fit a new social norm of what it means to be good men in modern Thai society should be established.

In conclusion, this study of Thai literature only discusses the ideal Thai norms. Literature on Thai sexuality over emphasizes the upper class "traditional" form which is not apparent in the practices of other classes. However, the upper class ideology has become the national ideology in theory. The middle class and the lower classes have developed their own practices, which does not match the upper class national ideology and therefore puts them more at risk.

Gender differences are evidently causing disparity among men and women in relation to social position, prestige, and power. Gender roles are shaped early in life through Thai culture. My research has revealed a paradigm shift among middle and lower class women toward premarital sex, an area of research not evident in Thai literature. The roles of women include subservience to men in terms of obedience, love, and loyalty. The women must not only obey her male partner, but also must love and remain loyal to him only, whereas the men may have multiple partners and visit prostitutes regularly. These factors may be responsible for the shift in thinking among middle and lower class toward the practice of premarital sex, whereas it is more acceptable and possibly the new norm. To retain the status of good women, women must

be virgins and must belong to one man solely. Condom use is not culturally accepted so not only do men not use condoms, but women, who, by adhering to cultural norms, see themselves as “good” women. Therefore, these various reasons the spread of AIDS is rampant.

Class Perspectives

My subsequent examination of class will demonstrate that members of different socioeconomic categories experience major differences in tastes, values, appearances, lifestyles, opportunities, environments and the chances of gaining significant amounts of both tangible and intangible property. Class influences choices, and therefore, class differences influence the various dimensions of AIDS and its relation to the entire population—how it is viewed and acquired. The following studies define class and give a clearer picture of how class differences affect and relate to AIDS.

Class can be defined in many ways. Fussell (1983) stresses that class should be defined by the tastes, styles, awareness, characteristics, activities, and language that one has or uses. He also believes that, class can be defined according to many criteria, usually depending on the class of the person who is defining it. For example, people from the lower class usually classify people into classes by the amount of money they have. Moreover, the middle-class categorizes people into classes by education and the type of work one does as well as the amount of money that one has. People from the upper-class group people into classes by taste, values, ideas, style, and behavior. In conclusion, for one to mutually place people into classes Fussell thinks that they should

be looking at styles, taste, and awareness because it is as important as money. Money that one has is rarely displayed for others to see, but one's style, taste, and awareness are shown at all times in the everyday life of a person.

Class then can reflect choice because one can freely choose to have his own style, prefer his own taste, and maintain his own awareness. When class reflects choice, we can see that people from each class have different tastes, styles, and interests, even in activities such as reading. People from the upper class in the United States are being drawn to more ideological publications such as Time magazines, the Wall Street Journal, and the New Yorker. Unlike the middle-class, they are attracted to the non-ideological periodicals, such as National Geographic, House and Garden, and Science Digest. The lower class likes to read TV guide and other entertainment magazines without much concern for substance. Not only do they choose to be interested in different things, they also believe in different philosophies. Therefore, their personalities and behaviors are different from those of people in other classes.

Viewed from an economic perspective, class can be divided into two classes; the rich and the poor, but from social perspective, there is a hierarchy of classes because people have many characteristics. These characteristics will show people how they are different and how they can be grouped into classes. For example, the middle-class characteristics are being anxious about offending, worrying about their own tastes and whether they are working for or against the middle class, showing different extreme types of personalities between male and female, and having an increased awareness about self-respect.

Class not only reflects the things people choose to do as outside activities, but also by words people use in their lives. Fussell believes that, regardless of the money one has and the concrete assets one owns, the language one uses can also reflect one's class. For example, when people from the upper-class want to shop for things they say, "I want to purchase that," whereas the middle and the lower class would use "I want to buy that..." The reason that people use different types of words in their language is because they are brought up in different types of schools, and they read different materials, so they become familiar with the types of language that surround them.

Pierre Bourdieu (1984) is another well known specialist in relation to discussions about class. He agrees with Fussell that people are different from each other, due to the various diversity of tastes they have. However, he emphasizes that the environment or surrounding society can create certain types of habitus, taste, the sense of necessity, and lifestyle one obtains. It is obvious that the cultural needs are the product of how one was brought up and educated, and the concept of taste is defined through class. Therefore, we can trace back that family and school has important functions to first build one's taste. It is because they both mark positive or negative sanctions, evaluate performance, reinforce what is acceptable, and discourage what is not. Because of this, they both influence a person's a sense of cultural investment.

The investment sense is the origin of one's cultural values. Habitus is also the result of this process. It is internally necessary for one to have a certain type of habitus, a way of life, which leads to unique practices and unique meaning-giving perceptions toward their everyday life. Habitus then leads to a set of logical thoughts. People who surround those who have a certain type of habitus then categorize those types of habitus

into classes. A person's tastes lies on the basis of what one views as necessary to acquire. The necessity that one uses to set his/her limit is based on the income that one can support to reach his/her goals. Therefore, income will associate with and reflect different consumption patterns as well as different lifestyles. He gives an example that people from the lower class will think that food is the most important thing they should struggle for, whereas people from the upper class seem to see the importance of clothing and cosmetics, which reflect their appearance and beauty.

In this research I have defined class through social perspectives, using tastes, habitus, and class-consciousness that people have. Tastes and habitus of adolescents classes are found to be very important in describing risk behaviors for AIDS and in recommending solutions.

Because class relates to many things in a person's life, such as taste, lifestyle, and activities, class then also becomes connected with their health conditions. Amick, Levine, Tarlov, and Walsh (1997) describe how class, work, and health relate to each other. They indicate that the connections of work, social class, and human well-being have been the focus of basic social science since the industrial revolution in the 19th century. Many studies have shown that being in the lower social class can affect the physical and mental health of a person. The incident above shows that social class is a powerful determinant of a multitude of factors that affect health. Social class relates to health in many ways, such as inability to obtain medical care, inadequate conditions of housing, limited individual resources, low income and low education, unstable jobs that threaten unemployment, and exposure to working with physical hazards and chemicals. These reflect the limited opportunities the lower class people have. People performing

biomedical research believe that there are three measures of social status that have been found to predict ones' health outcome: income, education, and occupation.

Moreover, class difference is caused by various factors. For example, the causes of class differences are as follows: the amount of money one has, the ability to provide a college education for one family members, the safety at home and at work, access to health care, the cause of one's death, and access to goods and services to show one's worthiness. Also, when one looks into this issue, he/she must keep in mind that it is a complex process to analyze because many factors socially and economically determine one's health condition.

Another article, by Williams (1990) added how class can relate to one health outcome. He uses the term socioeconomic status (SES) rather than class. He stated that socioeconomic status is associated with the social structure, personality perspectives, and especially health outcome. He believes that health behaviors, stress, social ties, and attitudinal orientations are critical links between social structure and health status. This perspective predicts that because social structures shape individual values and behavior, SES differential in morbidity and fatality are due at least in part to conditions of life that derive from an individual's structural position. These lifestyle characteristics and living conditions can be referred to as the psychosocial factors. Such factors consist of health behavior, stress in family, residential and occupational environments, and social integration or social support. These psychosocial factors and medical care are viewed as linked to social status and as intermediary in the association between SES and health outcome.

An example of the above statement is, that poor socioeconomic environments can impose socio-ecological stresses such as high rates of crime, unemployment, residential mobility, and marital instability, which can have harmful effects on the health status of area residents. Stressful life events such as unemployment, marital difficulties, divorce, and adult and infant morbidity and mortality are all associated inversely with SES. Moreover, he discovered that the people in lower social strata have limited access to social support and stable community ties. On the other hand, when discussing the limits of health education, health education campaigns achieve only limited success and are more effective in producing behavior change in the higher SES group than in the lower SES group.

Therefore, the first set of articles shows how economic differences reflect and result in the differences in tastes, values, beliefs, awareness, activities, and lifestyles (habitus). The second set of articles relates the above differences with how they can affect the health condition of a person from each class differently. In a thorough search of the literature, there was hardly any research which related the difference in socioeconomic status with the risk activities that can lead to acquiring AIDS. Moreover, no research before mine has centered on socioeconomic differences among teenagers that cause them to have different at risk activities. My data will show how adolescents' activities differ by class and how these activities relate to the process of acquiring AIDS.

Factors Effecting Adolescents' Health

The following articles deal primarily with adolescent behavior in relation to AIDS. In the first part I search for the relationships between the social psychology of

adolescents and their perception of sexuality. This part will link to theories that describe physical changes as well as emotional changes in the adolescent period. These articles will increase our understanding about teenager's behavior. The second part will focus on the description of teenagers' behaviors and how they relate to their sexuality. The third part centers on AIDS risk and prevention among adolescents. Also, the articles give some guidance on how adolescents' health should be promoted.

At the period of adolescence, there are many critical changes happening to a person. These changes will also influence one's health condition. Boonmongkon (1996), the author of the UNICEF Notebook on Programming for Young People's Health and Development, describes adolescence as the stage where the past achievements of a child's survival and development revolves. She points out that 30% percent of the world's total population are 10-24 and are concentrated in urban areas of developing countries. More than half of the new HIV infections occur among young people between age 15 and 24. This stage of life in both young girls and boys has a profound impact on the manner in which they are treated, the expectations of what they will or will not do, their access to information and other basic resources, and the way they become accepted as "adults" by society.

Boonmongkon strongly believes that adolescents are the group of people that should be given closest attention. Their nature and behavior depend on how they are shaped by the people and the environment surrounding them. If adults give supporting efforts and useful knowledge, teenagers will grow to be a more dependable group of people in the future.

This concept of placing the expectation on adults and the society in general create changes, is emphasized in detail on The National Commission on Adolescent Sexual Health Annual Journal (1997). This article adds a new perception to the period of adolescence, the reforming of social institutions, and recommending that health policy makers help educate adolescents sexual health. It describes adolescence as a period characterized by rapid changes and the need to achieve many significant development tasks such as physical and sexual maturation, independence, conceptual identity, functional identity, cognitive development, and development of sexual self-concept. It is a time in the life of a person with potential conflict and distress. Children who enter adolescence with the most social or psychological disadvantages are likely to experience the greatest difficulties. This may affect the health of children later on. The most common factors affecting the children behaviors and health conditions other than family and personal problems are poor education and limited economic opportunities.

There are many institutions that can help promote adolescent sexual health such as family, health care, and mass media. In families, parents are the primary sexuality educators of their children. They educate by what they say and how they behave. The most important thing is open communication which young people need. Parents can demonstrate value, respect, acceptance, and trust to their children. They can be the models of sexually healthy attitudes in their own relationships. The way they can try to discuss sexuality with their child can be the channel whereby they provide information on sexuality to children. Health care institutions are the second sector, which can help. Health care can provide teenagers with affordable, sensitive, and confidential sexual and reproductive health care services. This includes mental health counseling, STD

screening, and family planning. Last, mass media can urge those who work in providing programs to give more accurate information that helps adolescents gain insights into their own sexuality. These examples include steps that should be taken such as using condoms to prevent pregnancy and sexually transmitted diseases. They can stress the proper relationships between men and women. Mass media also provides ways for young people to obtain additional information about sexuality and related issues, such as listing addresses of support groups.

Brooks-Gunn and Furstenberg (1989) show how to study factors involving adolescents' health. They analyzed the relationships between aspects involving teenagers' lives and their sexual behavior. They grouped factors that relate to adolescents' sexual behavior into six groups. First, biological perspectives are the causes of how adolescents evolve through a stage in life where bodies and hormonal factors are changing. Second, parental influences on teenagers. Teenagers who have good communication with their parents, feel connected and have support from their parents are not likely to engage in early sexual activities. Third, the characteristics and personalities of individual teenagers alone can also make a difference in delaying sexual behavior and using contraceptives. Fourth, peer influences are one of the most important factors discussed because teenagers always pay attention to what one's peers are doing or what is normative in one's peer group. Fifth, academic perspectives in which doing well in school and having high educational aspirations make me less likely to have sex during adolescence than those who do not achieve in school. Last, social cognitive perspectives where culture and norms are geared toward sexual activities can determine the

postponement of when one will engage in sexual intercourse. Those who can be categorized into these perspectives are less likely to engage in premarital sex.

Brooks-Gunn and Furstenberg also did research and found five factors that cause teenagers to not use contraceptives. First, contraceptives were not used because intercourse was not planned. Second many teenagers still lack the knowledge about how to use the contraceptives. Third, many do not use them because of the negative attitudes related to contraceptive use, such as it is not natural and normal. Fourth, those who are in under-developed countries might not have access to contraceptives. Fifth, sexual partners thought that pregnancy was impossible at the time.

This article sets a good example for other researchers who want to study adolescent's sexual behavior. It suggests that the researchers should find factors that relate to adolescents' sexual behavior and gain insight on how adolescents view their sexual behavior. Researchers should also find what placed adolescents at risk, such as finding out why they did not use condoms. After the researcher has gathered this useful information, they then can contribute to the understanding of teenager's sexual behavior and future recommendations.

Some researchers chose to focus only on one institution and see how it related to adolescent's sexuality. Fine's (1988) main focus is to find out how the school became involved with sexuality, especially in adolescent females. In her research, she stresses that female adolescents are limiting their discourse of sexual desire because of the societal perspective. Usually sex educators leave out the sexual relationships and sexual acts feeling that they are promiscuous and immoral. They did not know that these have

important relation to AIDS. Therefore, she believes that sex educators should teach the positive side and process of sexual relationships.

In her study, she indicates that public schools are not widely open to viewing how sexuality is really interfering with every part of the student's lives. Not only does sexual education occur in the classroom, but it also occurs in the halls, lunchroom, and the library as well. The information above demonstrates how sexuality taught in schools involves four areas. First an approach of sexuality as violence, guides sex education toward seeing sexuality as sex-negative attitudes and contraception use to be negatively correlated. Teenagers who become involved with sexual behavior would be labeled as teenagers who have "bad" behavior. The author then suggested that sex education should be taught using more sex-positive attitudes, being more consistent, and more positive about contraceptive use. Second in an approach to sexuality as victimization, female adolescent sexuality is represented as moments of victimization that endanger them. Although young women learn about how they can become vulnerable in the male predator's world, they also learn to accept these roles. The author thinks that at first they should focus on avoiding on premarital sexual relation with men, victimization can be avoided too. Moreover, when they begin sexual relationships they should prepare themselves. Third, sexuality as individual morality, sexuality can be related to good values such as educating people to be modest and abstinent until marriage. This also can teach one to be in control of self and emotion. Moreover, sexual pleasure and desire for men as sexual objects still remains unlimited to women. Women are taught to lack the feeling of pleasure, sexual entitlement, and self-expression toward sexual issues.

In conclusion, her research shows that females voices and bodies are kept still and that sexuality is more essential in the dominant male language and point of view. The women should, therefore, try to regain their authorities and voices that are held back and express themselves in society.

When we know how easily adolescents can be at risk, adolescents' sexual behavior should be in the spotlight. With the exception of the articles already mentioned, not many studies have focused on adolescents' sexual behavior. Therefore, any study concerning this issue should consider how it relates to other aspects of teenagers' lives such as friends, families, and schools. My research has attempted to do so.

Boyer and Kegeles's study (1991) not only show different ways for researchers to gain better understanding of adolescents' sexual behavior, they also show how to create health prevention programs in the future, using a common health model. They start by presenting the significant facts that few teenagers have been diagnosed with AIDS, and the incubation period (the time from initial infection to the development of full-blown AIDS) is estimated to average eight years. Therefore, it is possible that most individuals in their twenties have AIDS. The sexual and drug activities of many teenagers place them at risk for HIV transmission. Sexually transmitted diseases are pervasive and a major cause of morbidity among sexually active teenagers.

They focus on two main risk factors, sexual intercourse and experimentation with alcohol and drugs, that are associated with adolescent HIV transmission. Adolescents can be involved in sexual activities as early as 12 years. A recent U.S. national survey found that 39% of females (age 18-24) have had three or more sexual partners within a one year time period. Although adolescents are aware that condoms are the best way to avoid

contraction of HIV, they hardly use them. Oral contraceptives were popular and used more often than other methods because of the fear of pregnancy.

Although knowledge about condom use is increasing, the use of condoms among teenagers remains low. Therefore, they suggest that effective prevention programs should be based on models and theories of risk behaviors. The AIDS Risk Reducing Model (ARRM) is presented as an example of such a social-physiological model. It characterizes people as either engaging in high-risk activities or as those who make an effort to alter those activities. There are three stages theorized to be necessary to reduce risky sexual activities. These are: (1) recognizing that one's activities make oneself vulnerable to contracting HIV; (2) making the decision to alter risky behaviors and committing to that decision; and (3) overcoming barriers to enacting the decision, including problems in sexual communication and seeking help when necessary to learn strategies to reduce risky behaviors. Every stage includes a number of constructs identified in prior research as important for engaging in "healthy" or low risk behaviors. Health programs should try to pinpoint ways to promote health awareness in order to reduce risk behaviors, focusing on the three main points above. Health programs must also provide strategies which are age appropriate, sensitive to cultural values, religious beliefs, sex roles, and customs within adolescent groups. They should evaluate these strategies to see if they reach their goal in preventing and reducing HIV risk behaviors. Last, understanding the facts about risk behaviors and using the Risk Reducing Model would help explain why adolescents take chances with risky behaviors, and find a better solution to the problem.

In summary, all of the articles indicate why attention should be given to adolescents because they are likely to be at risk. They suggest that social institutions such as family, friends, schools, health sectors, and the mass media can help adolescents since they can be effective channels to influence adolescents. The three main reasons that adolescents are at risk, are unsafe sexual intercourse, involvement in drug use, and the low percent of condoms used. Making the adolescents realize that some of their activities are at risk activities and providing information on how to escape from being at risk would help reduce the problem.

As we can see, most studies left out the important details on how to make their efforts happen in practice. My research begins to fill in the gap by describing the ability of each institution to become influential among the teenagers. Therefore, the reader that belongs to each institution will realize their power and use it later on. In addition, I will suggest more details for methods for each institution to use to be most helpful in taking charge and helping bring more awareness to adolescents.

CHAPTER THREE: METHODOLOGY AND PLAN

The data collecting process took place in mid July till mid September 1997. The data was collected in Bangkok, the capital of Thailand. In this research, I used various techniques in ethnographic methodology to help collect the data. Ethnographic methodology, which deals with the scientific description of specific human cultures, is based on participant observation and in-depth interviews. Usually, anthropologists do not choose to use a particular method when conducting fieldwork, but rather choose a variety of methods to try to obtain an overview of the picture. Therefore, in this research I also included secondary data from documents and statistics, formal interviews, focus groups, and in-depth interviews (May 1993). Many times conversations in the interviews will show similar domains, which will be analyzed later by the interviewer (Spradley 1978). This project integrated methods from adolescents, economic, and gender points of view from anthropology in order to holistically view the risk behavior patterns among Thai adolescents.

I defined class by one's level of education and income. I divided the classes within the target group into three separate sections and labeled them high income, middle income and low income. The classes are defined by participants' level of education and type of school attended. The high income group is represented by the adolescents who went to private schools; the middle income group were those adolescents who went to public schools or parochial schools; and the low income group represented adolescents who had dropped out of school because they lacked adequate finances to support their

education. Therefore, the lower class group was forced to acquire employment by their families, but many ran away from home and joined gangs.

Recruiting the Informants for Focus Groups Interviews

As mentioned before, I defined and classified the classes among teenagers by the types of schools and levels of education they had. To classify teenagers into these three classes I used three criteria: first their education (types of school), second factors of parents (income level, education level, and the type of occupation), third last names, which might divulge to which kin group they belonged. All of these criteria should be considered together. If one were high in all three, they would surely be among the upper class in Thailand.

I have used many ways to try to find the best representatives as key informants. For the upper class, I visited ten well-known private schools including those attached to two universities. In each school I selected only one or two students and asked if they would be willing to participate in my research. I told them the purpose of my research, the types of questions that would be asked and informed them of their right to anonymity in the research paper. If they were willing to be interviewed I would hand out my general questionnaire and ask for their phone numbers. If their qualifications were good as representatives of the group in their class I would later call them up to set an appointment for an interview. I judged their qualifications by the income of their parents and their parents' occupations.

For the middle-class group, I used similar processes, except I recruited four students from public schools and two from parochial schools. When I first asked one student to be my informant, he or she often wanted to participate only if friends could join too. I told them that my research would be more accurate if my informants came from different places. Therefore, this resulted in various types of answers. Each of the informants understood me, so I finally had informants who did not know each other before the interview.

Third, for the lower-class group, I went to find the informants in one of the famous slums in the heart of Bangkok. The first time I went to the slums and asked a group of teenagers, they refused to participate in the project. Then I spoke with a woman who was a vendor selling grilled fish in one of the narrow alleys about my trouble. She insisted on helping and told me that she would ask some of the teenagers in this slum for me. I later contacted her to see if she got the teenagers to participate. After that week, I went back to confirm she was able to assign six girls in her slum and six boys who lived near by to be informants. The condition that she suggested was that I compensate the informants for their time with money. Therefore, I gave the address where I would be interviewing and compensated the teenagers for their transportation. All of the informants from these groups showed up. I thought by doing this she would receive some commissions or some favors from the teenagers that she knew. Overall, every group interviewed consisted of six key informants, which was a total sample size of thirty-six people. Usually, seven were asked to come and one would not show up or cancel the appointment.

Research Techniques

The other 10% came from participant observation and collection of data from secondary documents and statistics. First, I tried to observe adolescents' behaviors and I tried to participate in the health programs for AIDS. These gave an overview and first-hand experience. Second, along with my work I started collecting secondary documents and statistics help me analyze the data and draw conclusions, reinforcing what I had observed. When I finished my internship in the hospital, I then conducted six focus groups. Lastly, I went on to do in-depth interviews, aiming to acquire the answers that I was curious about. Demonstrated below are details about each method I used in the research. While I used many methods to conduct my research, 90% of my data came through focus groups and in-depth interviews based on questionnaires.

Participant observation

To obtain background information, I used participant observation was employed to observe behavior in places where adolescents regularly gather, such as pubs, bars, and discotheques. I also traced the process of risk behavior leading to AIDS through observing the relationships between Thai men and sexual workers. From others describing the general scenarios, I was able to gain a bigger picture of the situation in Thailand. In addition, for one month, I volunteered to be the assistant to the counseling nurse for pregnant women who caught sexually transmitted diseases. This experience gave me another opportunity to observe behaviors in some adolescent pregnant women who have AIDS. This is not directly used in this research, but contributed a picture of might happen to these girls that I interviewed, especially the lower-class girls.

Focus groups

Focus groups were set up representing each class divided by gender, with 5-8 people in each. I used the method of quota sampling for informant selection. Therefore, my sample includes representatives from different genders and classes. Questionnaire 1 consisted of questions that could apply to gender and class, related to AIDS risk-taking behavior. In order to address how class and gender differences have different risk-taking behavior patterns, questionnaires were divided into six groups, as shown in the following chart. This questionnaire was used in the focus group.

	Male	Female
Upper class	*****	*****
Middle class	*****	*****
Lower class	*****	*****

* = One group of questionnaires.

Realizing that low-income people might not be literate, I decided to ask questions in the questionnaire orally and record the answers for them. As a result, the questions had to be adjusted and reworded in order to obtain their full understanding of the questions. I assured the readers that all the questions that were being asked of the lower class group contained the same meaning as other questionnaires that were given to other groups.

My questions in Questionnaire 1 provided information for four main themes (see appendix). The first theme relates to how different genders viewed each other in terms of sexual relationships. The second theme dealt with the activities that can lead adolescents

to have sexual relationships and to take drugs, who or what influences or encourages them to try those activities, and how each process happens. Moreover, I also asked if they had ever experienced or witnessed the incidents that related to sexual relationships or drugs. Especially, I asked about the types of drugs that were being consumed among their group and if they consumed them. The third theme centered around the concept of how they saw themselves at-risk or not, and at what level they thought they were at-risk. Why did they think they were or were not at risk, and what kind of people did they think would be at risk. The fourth section concerned questions such as where did they learn about these activities, what kinds of things did they learn about, how they viewed AIDS, what they knew about safe sex, and did they use any protection. Furthermore, I asked them if they had ever considered having AIDS testing, and if they had AIDS what they would do. An example of Questionnaire 1 can be viewed in the appendix section.

Questionnaire 2 was a general questionnaire (see appendix). It contains closed-ended questions used to screen the informants to see if they were qualified or not, in order to be in the focus group. The questions contained in Questionnaire 2 concerned personal information of the informant. Personal information that were asked are such as their name, age, religion, their position of the children in the family (eldest, middle, youngest), numbers of family members in the household, where they live (and do they live with parents or not), their current level of education, if they have the following relationships; lover, steady girlfriend/boyfriend, commercial sex worker, non-commercial sex workers, parents education levels and occupations, their family income, and their level of knowledge about AIDS. This questionnaire was answered by having the informants fill it out. Overall, Questionnaire 2 was used together with Questionnaire 1, to screen the

right people who qualified for the focus group interviews. An example of Questionnaire 2 can be viewed in the appendix section.

In-depth interviews Questionnaire 3 (see appendix). The Questionnaire 3 contained open-ended questions and would be a guideline for me to interview and ask questions of the key informants (see below). The questions contained in this questionnaire were the same as the questions asked among the focus group, but added more details about the meaning of lovers, steady girlfriends/boyfriends, commercial sex workers, and people who have sexual relationships just for fun. Therefore, I am the one who filled in the information (for each of the informants) after the informants answered me. An example of Questionnaire 3 can be viewed in the appendix section.

In-depth interviews

In in-depth interviews, I selected two or three key informants from each class for the purpose of gleaning more information. I called the informants at home using numbers they gave me and asked them to be my informants. These people were not the same members in the focus group. Usually they were the ones whose sisters, brothers, or cousins I knew well, so they also knew who I was and trusted me. Altogether I got 12 people who were willing to be interviewed. These people were distributed equally and covered the high income, middle income, and low income classes. I asked where it would be most comfortable for them to be interviewed. Usually the settings were a fast food restaurant in shopping malls but each place varied. The informants always chose a fast food restaurant near their homes. Therefore, the common places I ended up having the interviews were either in McDonalds, KFC, or Dunkin Donuts. This group of people were not participating in the focus group. Questions were asked according to the

questionnaire guidelines for in-depth interviews. While interviewing in the first part of the questionnaire, cards were used to elicit from adolescents how they describe the meaning of the words they saw.

I spent one month volunteering in a counseling institution, and three months doing participant observation, formal and informal interviews, handing out questionnaires, and gathering data from the focus groups. The final four months were used to collect secondary data from documents, which was analyzed later to see if any data had been left out. In sum, my research lasted nine months.

The Settings and the Atmosphere during In-depth Interviews

Each interview took less than an hour. I thought that most of the informants would come alone, however, the two upper-class informants brought their friends, too. Therefore, I took the opportunity to ask both of them at one time so they could compare their opinions. I noticed who my informants were by observing their appearance and reword comparing that to how they described themselves on the phone. In every case I arrived earlier than others to save the table at the corner where ~~no one~~^{none} could overhear our conversation. I thought this would make my informants comfortable with the discussion about sexual relationships and drug issues. I tried to break the ice in order to make the informants feel relaxed with me. I used the time to introduce myself and let them introduce themselves to me. Then I would go buy snacks and soft drinks for us. I would start out by asking how their day was and asked them what they were studying. I always tried to associate my experience with their interests to establish a relationship. Although I realized that the interview time was short, I thought it was important. This technique

really worked because some of the informants had a lot in common with me. Mostly they wanted to ask what my university life was like so they could prepare for the future. A few of the informants who did not have a chance to continue their studies, were interested to know about my experience abroad in the United States. I thought these interests created a good bond between the informants and me. I took time doing small talk for 15 minutes, then started the interview for half an hour.

The Settings and the Atmosphere during Focus Group Interviews

The setting of the focus group interviews was a research company office. This research office was being used as a small company and was built in a four-story townhouse. I rented a small room on the fourth floor with the recording equipment and a table to create an interviewing atmosphere. My interviews took place on the weekends when all teenagers were free from school and work. The room was air conditioned with one conference table containing eight seats. I set up a small table on the side where I placed snacks and soft drinks for my informants before I interviewed them. This was the time that I got to know them better, and they got to be familiar with other teenagers who were there on that day. I explained the purpose of my research for a second time to all informants. I asked everyone for consent to have the conversation recorded and everyone permitted me to do so. I also told them what types of questions would be asked and about their rights to be anonymous in my research. Then, I told them that if anyone was not comfortable with the interview they could freely leave now. Noone left the room.

I started with a friendly introduction, introducing myself and telling about what I am studying (anthropology). Also, I let everyone introduce themselves or tell a little

about themselves to others. My first set of question involved the kind of questions that are not too personal concerning sex. I later led to more in-depth personal questions which elicited the informants' personal perceptions in viewing the consequences of ordinary sexual activities. Everyone was given an equal chance to express their feeling or thoughts in the discussion. I tried to ask the ones who were less talkative to express their feelings. Some teenagers who were verbose ended up being the last to answer some of the questions. Each one was able to make their points. Sometimes they agreed and sometimes they disagreed. This caused them to separate into two groups on some of the questions.

I have found that not only did I collect an excellent set of data, but also the teenagers made new friends. Everyone enjoyed taking part in the conversation and liked to listen to others. In some of the groups the teenagers even exchanged their phone numbers afterwards. I interviewed two groups every Saturday. I did one focus group in the morning, then another focus group in the afternoon. These two belonged to the same class. I did the upper class group first, the middle-class, and the lower-class last. Each focus group interviewed lasted for three hours, including 15 minutes for snack time and a 10 minutes break during half of the interviews. I transcribed what I had recorded into writing scripts from Sunday till the next Friday.

The Characteristics of Each Focus Groups

The characteristics of the teenagers in each group were diverse. This is due to factors such as gender and class differences. Below I describe the characteristics of each

group as recorded during the discussion. This information will help create pictures of what happened and later will bring a better understanding as you read the data section.

The women from the upper-class group

The women from the upper-class group were the first group I interviewed. They came earlier than the appointed time. They all dressed in fashionable clothes as if they were out of the magazines. They did not seem to be arrogant or shy, but indeed they were confident as well as polite. Everyone was eager to know each other before the interview had started. They paid close attention to the questions that were asked and all of them were active participants. They always gave their opinion to the group members and this made the conversation seem active. Their answers often were filled with a sense of academic concepts. For example, many academic words were mentioned in their language such as westernized, socialized, and modernized. These are the types of concepts that higher level education had taught them in schools or many professionals and adults in the academic field would have used. Their answers also demonstrated how they maintain traditional values. Their group still is considered conservative, but I found that they accepted a lot of western values. This made them seem modern. When discussing sex and sexual relationships, they were active and openly shared their opinions and knowledge with enthusiasm. Although their conclusions about these issues were conservative, they still knew a lot about sex. During their discussion, they sometimes agreed on things and sometimes disagreed on things, but they always had their own reasons and thoughts. At the end of the section, I gave a chance for them to add or ask other questions. They criticized the health education system in Thailand and tried to find a way to improve it. Overall, this group was the most informative and cooperative group

compared to others. During the interview this group seem to be the most comfortable with me. I think it was because they viewed me as a well-educated woman like them. At the end of the interview, I also stressed that although you are unlikely to be at-risk, but there are ways you can be infected by AIDS by misjudging your future partners. After the conversation, they exchanged their phone numbers and were willing to help recruit more of their friends for me, but the number of my target was met already.

The men from the upper-class group

The men from the upper-class group were the second group I interviewed on that day. Some of them came earlier and were sitting and waiting outside of the room. Noone spoke to each other. Each of them had their own activities such as playing a video game, reading magazines, or reading textbooks. They seemed isolated from each other. They all seemed very polite from witnessing their language and their behaviors. When asked to introduce themselves they were very shy. During the first half of the section of interviews, they seemed to speak the least they could in answering questions. They did not give feedback to each other, but they paid close attention the responses of others. In the middle part of the interview, they started to comment to each other and shared their opinions. It seemed to me that there was some distance between the informants. From the overview of their answers, they seemed to be the most conservative and the most sensitive group when compared to other groups. For example, their answers showed that they cared for others feelings such as women's feelings and people who have AIDS. This group was among one of the most knowledgeable groups because they knew a lot about AIDS, even the percentages and statistics concerning AIDS. At the end of the interview, I also stressed that although you are unlikely to be at risk, but there are ways you can be

infected by AIDS by visiting prostitutes and misjudging your girlfriends not to be at risk. Therefore, I told them to use condoms for protection and have AIDS blood testing with the girls they are going to marry in the future.

The women from the middle-class group

The women from the middle-class group were the group with which I had the most trouble. Some were very shy and some were very out spoken. The ones who were shy would copy the answers from those who answered before them. I managed to ask those who like to copy others to answer first. Eventually the participation was more balanced during the discussion. I found that this group of girls was very creative. For example, when asked about how people could be at risk of contracting AIDS, they raised the point that people could be accidentally at risk by hospital mistakes such as being given the blood bottles that have not been checked. Some of their answers were different from other groups, such as when I asked what could be the characteristics of good men. Their criteria in judging would include how those people look and the education and upbringing of those people. They were more concerned with appearance of men than other groups. Overall, this group of girls were unique in their answers and sometimes showed they are concerned with material things. The personalities within this group varied, some being talkative, whereas others were quiet. Before finishing the interview, I would review their answers to determine what activities could lead them to be at risk from AIDS.

The men from the middle-class group

The men from the middle-class group were a group in which the members' ages varied the most. A few were nineteen, some were between seventeen to eighteen, and

one was fifteen. The older ones seemed to most actively express their opinions, whereas the youngest one was the one who mostly listened carefully and anxiously when discussing sexual relationships. However, they answered what they thought about their feelings or knowledge while responding to the questions confidently. Therefore, they all had their own judgments on things. This was the first group that admitted having direct experience in trying drugs or having premarital sex. In the first three focus groups, they often pleaded tactfully that they did not have these actual experiences, but acquired their knowledge from their friends. One of the boys in this group discussed other issues that he thought would be related to the question being asked. His amusing experiences caught everyone's attention. He once worked in a movie production house and was once a drug dealer himself, so his experiences were quite interesting to hear. Therefore, he is the dominant person who led the answers during the interview. For this group I emphasized the importance of using protection to keep oneself away from AIDS.

The women from the lower-class group

Women from the lower-class group came late. I waited for half an hour and thought they would not show up, but at last they did. They dressed very informally and seemed to be overly enthusiastic. Later, I found out that some of them had taken amphetamines before the interview. They were all answering questions at the same time. I finally managed to take control and gain order in the questioning process. They liked to give feed back to each other and were actively responsive to the questions being asked. During the conversation they liked to joke around and tease each other including me, which I thought was great because they felt comfortable with being interviewed. They used impolite words, but I did not mind; I tried to speak the same type of language that

they used everyday, in order to fit into the group. They admired my adaptation very much in adjusting to be like them; the relationship was established. They even asked me to go places afterwards with them. However, I did not go with them because I had limited time in Bangkok to finish this work, which was my priority. I told them the reason and they understood my responsibility. During the interview, I noticed that their language and jokes sometimes contained many sexual words that others in the society would define as rude and which should not be said. They openly talked about their lives with me. Especially they shared their experiences of running away from home, selling drugs and prostituting themselves. In their life stories, I caught a glimpse of how difficult family life was for them. While they told their life stories they did not show any sorrow, but I knew they were covering their feelings and trying to forget them. During the interview they frequently raised many points about how they had a hard time through their lives, yet always ended by saying that they try to search for happiness day to day by having fun with friends or doing drugs. At the end, I told them the importance of using protection, advised them to always have safe sex, and told them the danger from prostitution.

The men from the lower-class group

The lower-class group of men was the last group I interviewed. I have found this group to have obvious deviant behaviors. After two of them came in the room, they sat on the table, and I asked them to sit down. After that, I sat at the head of the table and they moved to sit in chairs. I also asked them to write their nicknames on the pieces of paper that I had given them. I noticed some of them were using aliases. One of the members was aggressive and liked to interrupt the conversation. Then as time passed he

changed to be the one who was the most informative and liked to give feedback on others' opinions. At first, this group did not talk much when asked about questions concerning drugs. On the other hand, they were very informative when asked about sexual relationships. Then I realized that they might be frightened if I knew they were drug dealers, and so I started to share my knowledge about drug selling and the buying system. I then stressed again that all of the informants should not be frightened because their real names will not be revealed. This made them interested in me and then I led into asking in-depth questions concerning drugs. During the interview, some of them drew on the pieces of paper I gave them to write their names down. I think they all meant well and wanted to contribute their knowledge to me. One of the boys in the group drew how he saw the system of drug buying and selling using three circles. This was a great idea that gave me a better understanding about the process. In exchange, after the interview was over I taught them the importance of using condoms and tried to raise their awareness that they could be at risk if they did not protect themselves. Overall, this group of men was faced with the experiences of a cruel world at a young age. They had been in and out of jail as if it were a part of their lives.

Limitations in Regards to Methods

Some methodological limitations in this research might effect the results. The first limitation is that I have selected informants who were chosen based on a quota system, not a sampling system. My experiment techniques have poor external validity. The sample size was small which could create sample bias.

The second limitation is reactivity, which concerned information among male groups. They might have been limited due to being shy and were not openly willing to discuss much about questions related to sexual activities with me. This is because I am a woman, and they may think it is awkward to discuss this matter.

The third limitation is the fact that the lower-class group, both boys and girls, knew each other before this interview. I have tried to recruit adolescents from different places and attempted to have unacquainted informants so that the answers would be varied. For the lower-class group, they would only come with friends for fear the police would catch them, so I had no choice in recruiting my informants.

CHAPTER FOUR:

THAI ADOLESCENTS VOICES: GENDER AND CLASS DIFFERENCES

My findings include four parts, all of which emerge from the interviews I did in 1997. The first part uses a gender perspective. Cultural values about gender, as described below, will later on give a clear picture of how AIDS and sexual patterns are related to gender values in Thai society. The second part uses class perspective. The third part concerns the social psychology of teenagers. The third part will show perceptions of being at-risk among Thai adolescents. Finally, suggestions for AIDS prevention will be discussed.

Cultural Values and Gender Perspectives

The Ideal Picture of Good Girls in the Frame of Cultural Value

There is an ideal model which both males of all class and female teenagers employed to show how good girls should act. Good girls would have the looks of being joyful, optimistic, humble, cute, and modest. They should be seen as naive people rather than curious ones. Good girls should have the types of personalities that involve being polite: talking politely, thinking politely and acting politely. Each day they should stay home, listen to what their parents tell them to do, and help their parents do chores around the house. Good girls are also expected to be in school and study hard as well as work hard at home. They are expected to learn and try to practice all the things that a future good housewife should do. They should know their duties and be very responsible for the tasks that they have been given. They should not hang out at night with their friends.

Moreover, good girls should not go out with men alone. They should have someone accompany them when they go out to save their reputations. Flirting, smoking, and drinking are prohibited for them.

These similar pictures of good girls were shown in each class from both genders when asked what they thought were the characteristics of a good girl. A woman from the upper-class:

They should love their parents and speak politely to others. They do not like to gossip about others, but like to help others instead.

A university man from the upper-class:

Not the type who like to scream, she should love herself and be conservative about letting men touch her, and does not like to hang out at night.

The most talkative woman from the middle-class:

They should be polite, tidy, good students, listen to their parents, not go out with men alone, talk nicely, work hard, should not flirt, should not drink or smoke, and if anyone persuaded them to do wrong they would not follow.

The most out-spoken man from the middle-class:

If I want to court with her, she would have to be hard to get and be difficult to talk to. If I stared at her she will scold at me. This type is good.

A woman who is the head of the gang from lower-class:

She should be polite, not like a tomboy, ^{who} which does not know how to behave like a lady. Although she does not have to be totally polite like the folded cloth. (Thai say good girls should be like folded clothes which are neatly kept) Sometimes it has to have some wrinkles in it.

Men from the lower-class all agree on the answer:

Good girls should work hard, study hard, and stay home.

When I asked if they thought good girls that nowadays have changed from the past picture, they agree that they believed that they have. A woman from the upper-class:

They should have self-confidence because in the new society, we have to be intent in doing things. If we are too polite, we cannot make up our mind to do things. It is not good. (Then she paused) When we do things, we should think before we do them. Because if we did it and the result were wrong, we would be disappointed. Really, we have to face the result that we have made. The most important thing is to think and try to do things the way we think is right.

A university man from the upper class:

They can contribute themselves to the society more than just only being a housewife.

One of the woman from the middle-class:

Be ourselves. Do not go chasing others. What others do we do not have to try to do and to be like them. We should have our own point of view.

Men from the middle-class jointly decided,

In the old days women would stay home, seeing boys and knowing them as friends was hard, and there were not many educational opportunities for themselves to have.

Women from the lower-class concluded,

If you said that the teens who go out are jerks...No! They are not. They are teens who want to open their eyes. They are the ones who explore experiences. If they did not have this chance, one day when they are out of the house, they might be fooled or deceived by others. Then what could they do about it?

Men from the lower-class all agreed on the answer,

Women should make up their minds and know the difference between right and wrong.

On the other hand, education and the changing world can make good girls be more independent and have lots of self-confidence. Imported western values have frequently shaped good girls to be more rational thinkers, more dignified, and sometimes have more leadership, instead of being the follower all the time.

Therefore, the pictures of good girls are tied closely to their looks, their personalities, and their behaviors. All of these are the main national Thai traditional values that teenagers of recent generation have been brought up with. They are called *ruk alatesa* ; knowing how to handle oneself properly in situations. Although, teenagers in general are likely to see and view things differently from the older generation, Thai teenagers are exceptions. Thai teenagers still get a lot of influence from the old fashioned and conservative style of thinking. Not many ideals have changed among the groups of teenagers when model of a good boy and a good girl is compared.

The Ideal Pictures of Good Boys in the Frame of Cultural Value

There are varieties of ideal models among the male teenagers on good boys. The higher and middle-class men seem to have the most conservative thinking, whereas the lower-class men seem to picture themselves more as being in the hardship of real life with liberal sexual attitudes. Moreover, higher and middle-class men have an ideal model more closely related to the women's ideal model in picturing good boys.

The higher and middle-class men and women view good boys as gentlemen. Good boys should have personality traits such as being polite, being self-confident and not

taking advantage of other people's rights. A charming personality can be a result of being a social person. They should be responsible and help take care of their parents. On the other hand, they should have their own lives, playing sports and hanging out with friends. Human relationships are considered important when viewing a picture of good boys who have everything in control. Good boys are not allowed to do drugs. When it comes to treating women, they should respect and treat them well by loving only one girl and not flirting around. Also good boys should not be involved in many sexual relationships with girls. Visiting prostitutes is something to be ashamed of.

From the above can be shown in their words responded when asked about what they thought were the characteristics of a good boy. A upper-class man:

He would act like a gentleman. He should have self-confidence. He should also be brave and express himself. He does not harm others in any way.

The youngest middle-class man:

He should socialize easily with others, but not too easily because he might be misjudged as an insincere person.

A woman in upper-class:

Men should be gentlemen. By assuming that they are gentlemen from the outside, they should not smoke or drink and especially gossip about women.

A very quiet woman from the middle-class:

He should look manly, look good, is not easily distracted, and when he goes out with a woman he should not touch her in front of the public.

A women in the lower-class:

He is not a licentious man or a kind of man that like to flirt with girls all the time.

On the other hand, men in the lower-class tend to picture good boys differently. Good boys can do bad things such as taking drugs and visiting prostitutes. Good boys can have as many sexual relationships as they want. They are not seriously concerned with promiscuity. When good boys have sexual relationships with other women, they do not have to be responsible for the consequences.

All the men in the lower class agreed on the answer of one of the men who first described the picture of a good boy. “He is naughty. He also sometimes does drugs. (Then he pauses and thinks) Actually, pure good men are hard to find now. If you imagine the kind of good men who do not do drugs, stay in schools, and act like good students, they are not here anymore.” As you can see from the answer above, a good boy is not judged by ordinary norms in society. On the other hand, they still know how a good traditional boy should be, but they believe it is hard to find a good boy like that in modern days. In conclusion then, the lower class is the only group that viewed the picture of good boys differently.

The Characteristics involving Premarital Sex

When asked what their thoughts were toward women/men who had premarital sex, women and men replied differently. Women view men who have sexual relationships before marriage to be normal and natural. They see men who have sex before marriage to be positive as long as men are not promiscuous. This concept is not only centered on a woman’s perspective, but men also think like this. On the other hand,

women view the other women who have sexual relationships before marriage negatively. They think that good girls should really keep their virginity until they are married. A common answer among the women groups was,

Girls who have sexual relationship before marriage can be good, but not as good as when she does not lose her virginity before marriage.

Although different criteria were used in each class to judge women after premarital sex, women can still be considered good after premarital sex in all classes.

The women in the upper-class

Women in the upper class think that women who have sex before marriage should be prepared in many ways. First, she should be ready and confident about herself because she has already taken a good look at her partner. Taking a good look at him means that she thinks she can be married to him in the future. Second, she should be financially stable or have finished a certain education level. Third, if anything goes wrong she will not regret it afterward. Fourth, above all of this she has to be a certain age, preferably 20 years old and up.

The women in the middle-class

Women in the middle class think that friends mostly influence women to have sex before marriage. It is normal to have sexual relationships before marriage because girls are expected to be emotional rather than rational when it comes to love. However, she should be faithful to her lover after having sex with him. The number of sexual relationships a woman has with different men can also be used to judge if she is a good or bad girl.

The women in the lower-class

Women in the lower class tend to think the least when it comes to sexual relationships with men. As long as a girl loves a man, it is all right to have sex with him. Sexual relationships without love are considered to be bad, but they are often practiced in this group.

If a girl in a certain class does not have the qualifications that her class of women considers proper, she should not consider having a sexual relationship before marriage. Middle class women view premarital sex negatively, ideally-speaking; however, in reality they accept the practice of premarital sex as the norm. The norm seems to be shifting toward premarital sex possibly because of outside factors influencing their societal structure, for example the influence of western cultures.

Men are concerned only about women who have sex before marriage. They are traditionally accepted by the whole society even if they have sexual experience before marriage. One of the quotes represented the males' point of view:

It is normal. It is a natural feeling that humans have. Men cannot be taken advantage of in sexual relationships; they have the advantage in every way.

They also think a woman who has sex before marriage is considered to be worthless and not as valuable as a virgin. There are two extreme ways that men respond to women who have sexual relationships before marriage. First, they are distrustful; they believe girls might have sexual relationships outside of their own relationship again. The girls will be then viewed as girls who like to fool around. Second, the men they love

might have deceived other girls. Today's men think that the number of women who have sex before marriage is increasing.

The Process Leading to Sexual Relationships before Marriage

The activities that lead girls to have sexual relationships before marriage are as follows. Men use their sweet talk to either court the girls they love or deceive the girls they want. They take the girls to places to get closer to them and earn their trust. The places or activities vary by the class that they belong to and the income they earn. The places are: movies, malls, restaurants, bars/pubs, discotheques, trips out of the city and rides either on men's motorcycles or in cars. The last thing that men do after they date girls is to take them to their house or their friends' house to show their intention and start their sexual relationship. For most cases, the sexual relationship starts when the girls love and trust their men.

From how the women have viewed this process, it seems that they are focusing on how men approached them in order to receive their trust. Then, when women trust men, it will allow them to have sexual relationships with the women. Below are responses to the question asked: What process lead women to having sexual relationships with men.

A woman from the upper-class:

Men build trust by making eye contact, acting like a gentleman, understanding and using sweet words to us. They make us think that they are trustworthy, defensible and can protect us. They show their willingness to be our boyfriends by showing their love, taking care of us, picking us up and dropping us off at places. Especially, they would not give up easily to catch our heart.

A woman from the lower-class:

Sometimes we know men for three days and end up sleeping with them. Men will respond to us first. If we like them, men will take us places and have dates with us. They will do anything to get close to you as soon as possible.

On the other hand, the activities that led men to have sexual relationships before marriage comes from other influences than just the girls. First, men might start drinking at night and then later this can lead them to visit prostitutes. Second, men might follow their friends to night places where their friends persuade them to hang out. When they find some girls who like nightlife they tend to have one night stands with those girls. Third, most cases of premarital sex are influenced by the mass media (magazines, books, televisions, videotapes, and etc.) or peer pressure (showing how it is cool to have girlfriends). When men are alone with women in a nice atmosphere, it encourages them to have sexual relationships. These activities are some of the examples of how men can be influenced to participate in sexual relationships. The following are responses of men. The most experienced man in the lower class who wanted to be like his friend who has several girlfriends answered:

I did not directly tell them I wanted to have sex, but I assumed they knew what I was thinking about. If they were not willing to sleep with me, they would not see me. They would just ignore me. If they interacted with me, they would come with me. Therefore, they also desired to have a sexual relationship with me. But, this has to be within a step by step process. You cannot suddenly have a sexual relationship all at once.

Another example showed that the most prevalent cases that occurred, were when teenagers at a party persuaded others to visit prostitutes as an after-party activity. One of

the men of the upper-class told about such an experience with of his friends at a late night party.

Yes, I have experienced seeing my friends ending up having sexual relationships, but I am only the follower. I did not try it. It started from when one of my friends told me there was a place where we could get girls. I wanted to know what this place was like so I followed them. We went as a group to a cocktail lounge half bar-like. There were many naked women there. It was up to the guys to pick which women they wanted to sit with. They talked for a while, had some drinks, and then went out to the hotels.

Class Perspectives

In the following section, we will see that class turns out to be an important factor because people with different economic status have different risk factors leading to AIDS. Class shapes people in many ways. People who come from different classes have different tastes, values, appearance, lifestyles, opportunities, environments and the differences in amounts of both tangible and intangible property. Class influences choices and perspectives. Therefore, class differences influence the various dimensions of AIDS and its relation to the entire population; how it is viewed and acquired. Following is the analysis of interviews which show why they have different level of risk for AIDS.

The men and women in the upper-class

Men and women in the upper class think that adolescents should not have many sexual relationships. People who have many sexual relationships and visit prostitutes are considered promiscuous. Virginity should be preserved until one marries. Virginity in women also has its own value; people who lose it also lose their value as a human, too. The main reason that women in this class focus on

virginity is because it can add self- pride and self-esteem to the women who keep it. A woman from the upper class expressed how she felt about women losing virginity.

Sometimes I do not feel good about a woman who decided to sleep with a man. I would wonder if she were really making a good decision. If she thinks she is making the right decision, what would happen if she later realized that she could not get her virginity back, and how would she carry on through her life.

Both groups concluded from discussions that people are socially viewed as morally good or bad based on why they decided to have sexual relationship. It is considered not wrong if one has sexual relationship because he or she is in love or has been deceived by another. One of the women in the upper class referred to the case of a man who loves a woman,

He could have sex with a woman, if he had been seeing her for a long time. This proved that he had done it because of love.

Also, a response from a man in the upper class shows that men today still deceive women,

If it was a case that a woman had been deceived or raped by a man, she should not be considered wrong. Actually, she should be given a lot of empathy.

Moreover, when asked how do they think women and men are different in regards to sexual relations, one man from the upper class replied,

The women are being taken advantage of because women are forced to be the one that can only love one man. Therefore, she is not permitted to even go flirting with other men. In this case, if she were a man, she still could flirt with many women. If she broke the society norm and flirted with other men, the society would accuse her of having hysteria.

Another man in the upper-class:

The women's side would be more disadvantaged because if a man had sex before, they would ask why, but if a woman had sex, they would question whether she were promiscuous.

What men and women in this class look for in their partners are ones who are gentlemen or lady-like in order to give them their trust. People who are respected should show responsibility as well as a secure mind of their own. Their control of mind would be an important thing that keeps them from doing bad things in their lives including having premarital sex and doing drugs.

Moreover, family becomes another important factor that can prevent teenagers from doing bad things. When asked about what they thought could protect them from AIDS, men and women in this group replied,

"I do not want to ruin my future and disappoint my family by doing bad things." (A man)

"A warm family" (A woman)

"My self confidence in myself." (A man)

"Believing in morals" (A woman)

"I have pride in myself, I will not be a slave by taking drugs." (A man)

Adolescents from an upper-class, who are addicted to drugs, normally are the ones who have personal problems. The most frequent cases come from family problems. One of the men in the upper class shared his friend's life story,

I have a friend who is addicted to amphetamines. Family problems have pressured her into taking drugs. Her parents have three children; she was the middle child. Other children in the family were outstanding students in school, but she was not. She could not do as well as her sister and brother so she felt inferior. She also was seeing bad friends who later then led her to drugs.

Still only a few take drugs which are administered by injection, such as heroin. They also have their personal needles and see taking drugs like heroin as a personal activity. Mostly they take the kinds of drug which make them hallucinate. Examples of these drugs are amphetamines and ecstasy. Ecstasy is a popular drug among this group of teenagers. It is more expensive than other types of drugs. They usually take it at night places when they are having fun in pubs or discotheques. Ecstasy can make one feel out of control with no consciousness, which can lead to many risk-taking activities afterwards. For example, these risk-taking activities include having sexual relationships without protection or trying other drugs (heroin or amphetamine by injection) by sharing needles.

The male and female adolescents in the middle-class

Male and female adolescents in the middle-class seem to view sexual activities as more normal in their everyday life than those in the upper class. Sexual activities among adolescents in modern times are considered natural and normal circumstances. From the discussion in this class, teenagers viewed the concept of having premarital sexual relationships nowadays as,

Sexual relationships are natural for this era among teenagers. They might love each other very much, but they have not finished school yet so they have sex. But in the real world from adults viewing them they might not be acceptable. (A woman)

I thought almost a hundred percent of teenagers had sexual relationships before marriage. Nowadays, when men are in seventh to ninth grades, they are expected to have sex already. Around my house lots of kids are like this. But in my generation at that age we do not know anything much until we reach high school. Within my friends who are juniors in high school, I guarantee eighty percent have had sexual relationships already. (A man)

This shows that they may know the ideal pattern, but they do not apply it to themselves at all. This is an important finding in general and in relation to AIDS.

There are many activities that can lead adolescents in the middle-class to have sexual relationships. Unlike the upper-class, men in this class visit prostitutes. Below is an example of a man who shared his friend's experience of visiting prostitutes,

They went there (brothel) and told me there are girls for only 100 baht. Also lots of levels of prices can be found there. Sometimes they have women who disguised themselves as vocational school students. The guys who visit here are abnormal guys. They wanted to sleep with students to make them feel proud of themselves. By sleeping with prostitutes who are disguised as college girls, men are less likely to be ashamed if they tell others. If they told others they slept with students, they would be very proud. There is another price for prostitutes who disguised themselves as, or are, students. It is around 1,500-3,000 baht.

Others activities start from knowing and being close to friends of the opposite sex and developing a sexual relationship later. Moreover, mass media has taken a very important part in this class to encourage adolescents to have sexual relationships sooner than their parents wish. Adolescents from this class most often absorb only the sense of romantic love in media messages, whereas adolescents from the upper class consume the news as well as the entertainment. Mass media can come from many forms such as radios, televisions, magazines, books, and videotapes. For example, a conversation in the interview showed that male teenagers in this class like to watch sexual videotapes and read nude magazines during their free time.

One of the men said,

If it is at night, I will take her to see a romantic movie. The reason I take her to see the movie is because it is dark...(he smiles with a sneaky face). Going to the movies and watching a romantic movie, in particular, is a good surrounding. I would start touching her a little bit. Then if she does

not mind I will put my arm around her shoulder, touch her legs, sniff her hair, and kiss her on the neck. It is just like in the movie.

These types of habits encourage them to be involved in sexual relationships. Sex is also an issue that is easily discussed with friends. Due to this circumstance, people who have sexual experiences seem knowledgeable and informative. Sexual experiences are discussed among male teenagers up to the point that they think those who have a lot of experiences in premarital sex are more skilled. Those who are more skilled believe that their sexual experiences can lead to a happy marriage in the future. If male teenagers know less about sexual relationships than their partners do, they feel they should be ashamed of themselves. Therefore, sex is another important criteria that measures how good a man is in his life. The most talkative man stated,

For a man, it is normal if he has had experience with many girls in the past. In the future he could be respected if he had more sexual experience. He could use his experience with his wife.

On the other hand, there are few consequences for women who are exposed to sexual issues. Although, they are aware of the topics around sex, they do not discuss it openly in public. Virginity is still an important essence that a woman should keep. The value that the middle-class women put on virginity is different from the value that the upper-class sees. For the middle-class, the virginity of a woman is a valuable thing because men in their class would regard her as more worthy if she were still a virgin. Therefore, the value of virginity in a woman in this class is based on how other men view her, not on how she views herself alone. One of the women shows this concept in her interview,

She will be viewed negatively from others. Especially men, will think of her as a bad woman. Her partners might be suspicious of her because she might have the potential of committing adultery later on.

Furthermore a man in this class explained what he would feel if his woman had lost her virginity before he had sex with her.

For an openhearted man it is O.K., but for me I might feel inferior. Why could I not have good stuff, why did I find a used one!

In love relationships, men also deceive girls. A few male teenagers confessed that they tried to deceive girls whom they want in order to have sexual relationships with them. The meaning of deceiving to them concerns the desire to have sexual relationships with a woman without showing her the truth that they do not really love her. During the interview, one man talked about how he had deceived a girl.

I can get a girl to sleep with within a day or no more than a month. I will try every trick I have to have her as fast as I can. Then, if I am bored with her and she is younger than I am, I will say "brother is bored with you, let's end now". Sometimes I just disappear and hide in my friends' house.

Not only are they involved in sexual relationships, but also teenagers in this class usually are involved with drugs. Peer pressure encourages this. There are many drugs that this group of teenagers consumes. For example, they do heroin by injection, marijuana, inhalants, and especially amphetamines. Amphetamines are the most popular drugs among this group of teenagers. This is maybe because they can afford the price of amphetamines. They have created many ways to take them. There are three basic processes that they use to consume amphetamines. The most popular process involves crushing the amphetamine pills, burning them up, and then inhaling the smoke. A second process is to empty half of the tobacco in a cigarette, crush the pills, and then stuff

amphetamines into the part of the cigarette they have emptied, and smoke it. A third process used by those who are addicted to amphetamines for a period of time is to dissolve amphetamines in water and inject the solution into their bodies. Many men in this class have done drugs. Even women in this class can explain in details that processes used to consume drugs.

There are many ways to do that. Usually they take the foiled paper inside the cigarette case and folded the inside foiled paper into a tray-like shape. Next, they place the amphetamines in the tray, light the cigarette under the tray to burn the amphetamine, and sniff the white smoke that comes out from the burning. That is all. (A woman)

The men and women in the lower-class

Men and women in the lower class usually start having sexual relationships at a very young age. For some cases sexual relationships even start before they enter their adolescence. Not only are they exposed to sexual relationships, but also to other factors. They believe that a good person can also do bad things such as doing drugs, visiting prostitutes, skipping school, and running away from home. Therefore, a person cannot be judged by the upper-class norms in this society. Below are examples from the discussion,

Nowadays, if someone asked if you ever smoked, and you answered “no never,” you are considered to be way out of style. (A woman)

Men sometimes have to try drugs. (A man)

I ran away from home for two years. After I ran away, I stayed with my friends. I learned more than I did when I was with my parents. We picked mangoes and ate them instead of rice when we had no money to buy food. We bathed by the public canal when we did not have places to wash ourselves. It was memorable. (A woman)

To be in the gang is the coolest thing for them. To try to practice and do what others do is not enough. One should practice and perform it. For example, in order to be fully knowledgeable one must have had sex and drugs. Once they have proven themselves, they are considered to be in style. Moreover, they treasure experience as the most important thing in their lives. It does not matter whether it was a good or a bad experience; they are amused by the challenge. They are the least concerned with virginity, but value freedom. They think that flirting and licentiousness are normal behaviors for both girls and boys in their class. Many one-night stands in sexual relationships have been carried out among both males and female teenagers in this group. Many have more than one sexual relationship at a time. They often change their partners. Sex to them is a normal and natural need that they are regularly involved in. They see sex as one of five necessities in life like food, clothing, shelter, and medicines. Therefore, sex to them is outspokenly discussed in their everyday lives. Sex has become a part of their language. For example, many jokes, stories and songs emphasized sexual activities for these teenagers.

They are exposed to these sexual activities by either a direct or an indirect form of communication. For example, they can learn in a direct way by seeing people having a sex in front of them. Many teenagers said that they witnessed the sexual relations sometime during their teens. Often they see their siblings with their partners. For example, a woman in the lower-class group mentioned after she was asked where she learnt about sex,

I learned about sex from the videotapes, books and magazines. Also, I saw it with my own eyes (seeing people having sexual relationships). It was so exotic.

Moreover, they can learn indirectly by watching sexual videotapes and reading magazines that contain sexual acts. A man in this class, after asked if his knowledge about sex had increased in these past few years stated,

What we learn about sex increases everyday. (He paused and laughs) It (the movie) changes titles everyday. We watch the video tapes so frequently that we even know the name of the producer who produces these kinds of movies. We remember him because he found many good-looking women to be on the scene. It is a foreign movie (US.) transcribed in Thai.

Almost every teenager in this class did not use a condom in their first sexual relationship. Moreover, they rarely use condoms later as well. Condoms are being used among men who want to visit prostitutes. Men usually trust their senses in screening girls and because of this, they do not usually use condoms. Below is a statement from a man who did not use condoms on his first sexual intercourse,

I watch a movie. It is like if we learn things, we should practice them too. The movies are like my theories, then after the movies I find a nice girl and practice what I have learned. I did not use a condom since I know she is clean. After that first time, I felt like I had finished the learning process and become knowledgeable.

Also, some of the girls that were interviewed said sometimes they enjoy prostituting because they can make easy money out of it.

Moreover, teenagers in this class are closely involved with drugs and sometimes sell them. There are many reasons why they are involved in selling drugs. First, by being the distributors they are given drugs for free. Second, they want to make money and buy drugs cheaply from the first-hand drug dealers. They said the reason that they first headed towards drugs is because they have family problems. Family members

pressuring and controlling their freedom are the reasons that made them get closer to friends who later led them to drugs. Third, they wanted to try new drugs, which are expensive, such as ketamines and ecstasy, so by becoming the distributors, they get them for free. There are many drugs that are popular among this group of teenagers. For example, they do heroin by injection, marijuana, inhalants, and especially amphetamines (by injection or inhalants). Amphetamines and inhalants are the most popular drugs among this group. This may be because these drugs are cheaper and easier to attain. The inhalants they are addicted to come from a general kind of glue which could be found in many stores. Needles are shared among friends. Sometimes a few men in the interview said they cleaned the needle with water before they used it with others, still it is irregularly done. Below are some of their experiences with drugs,

The amphetamines cost 120 baht. You can bargain for 105 baht, but really the cost of production is only 30 baht because they are made out of pesticides. The first buyer would buy it for the price of 45-60 baht. When you sell this drug again to the second-hand, they buy it at 75 baht. Then the third-hand, like us (us referred to the men in focus group), would sell at the price of 120 baht. Between friends we discount the price to a 100 baht per tablet. (A man)

I do inhalants. When I do them, I feel like I am in heaven. I would inhale them by putting some glue in a plastic bag, a can, or spin it around my thumb and sniff it. If I chose to use a plastic bag, I have to blow wind in so that the air inside will circulate. (A woman)

I usually do not use needles often because they are fast, intense, and would cause long addiction to the drugs you inject. I used one needle all around my group members then throw the needle away. Before I use it, I clean it with water first so I feel safe. (A man)

Class, Education and Their Links with AIDS

Class and level of education; class is also correlated to the level of knowledge and education about AIDS that adolescents have. Education is an important factor because it is the start, which later will bring along awareness and caution used to protect oneself. In this study, I am defining education in a general sense, including both school and attitude influences. Because of the education people receive, I assume their health education will differ. In Thailand, the same source of health knowledge is being stressed in different way towards the receivers. This varies by the type of schools and the environments that the students are in. Although the Ministry of Public Health produced all the books that teach health education, they are taught differently in different schools. Below are examples of how health education (especially focused at AIDS) has received attention differently in each class.

People from upper-classes are highly educated about AIDS. Not only do they know how AIDS is transmitted, but they can also creatively think from this knowledge about other ways that people can get AIDS indirectly. For example, a boy from the upper-class group mentioned that doctors also have some risk of being AIDS infected. Their knowledge goes to the point where they know that zidovudine (AZT) is a medicine that an infected mother can take to reduce the chances of her baby contracting AIDS. In the interview, half of the group knew even the percentages of the babies who will have a chance of not being infected by AIDS. Men from this class answered when asked about AZT,

Yes, I know about it (AZT) by name. It is a medicine that helps prolong the life of people who have AIDS, but it is very expensive.

I continued to ask if they know the percentage of the chance that babies who have infected mothers will not be infected by AIDS. They answered “around 40%”. The real percentage is 30-35%

Among the group of high-class girls, they commented on how school has only taught them about sex, not sexual relationships. The most informative girl stated,

In schools they teach us about sex, but not sexual relationships. It was taught in the health education subject. All they taught was about sex emphasizing the anatomy of our bodies and reproduction. They should also teach us about sexual relationships. Sexual relationships involve men with women doing sexual things like having sex. How to make love I mean. They did not teach us that. (All the group members laugh). Sexual relationships are how we get AIDS right? (She said with a very concerned voice).

From the above, we can see that this fact will effect how adolescents are at-risk because adolescents lack the important message of preventive knowledge that would lead them to avoid contracting AIDS. They also know many types of drugs in theory that health education has taught them about, but know little about the different ways they are actually consumed nowadays. When they were asked to explain how one consumes heroin or amphetamines, they cannot answer the question because they did not know how. Only a woman said,

Usually I witness people take ecstasy. It is pill-like and taken with drinks. They are most often being consumed at night places.

Overall, this group is very educated. They showed that they are concerned about the news that involves AIDS, and try to show their concern on how to improve health education in order to raise the awareness of AIDS.

The middle-class adolescents are educated to the level that they know how AIDS is transmitted. They are aware of accidental methods of transmission, such as the hospital making a mistake by giving them the wrong blood type transfusion that has not been checked for HIV. This risk factor can be applied to others as well. For example, professionals in medical sectors can accidentally be infected from the blood or wounds of patients who have AIDS. Among male adolescents, many sexual activities were carried on at times. Therefore, they know how to use condoms properly, but they never look at the manufacturing date of the condom. Condoms are being used only when they are not sure about the girlfriends they choose to sleep with. One only trusts his feelings or senses in screening a girl, and based on that judgment, decides to use a condom or not. Mostly having sex with girlfriends is considered safe because men believe that prostitutes are the only ones who can lead them to be at risk. Below is an example of what a man in this class said when asked about condom use,

I do not use protection at all because I do not let the girls I court go out of my sight. I have seen her before and I also check with my friends to make sure she is not the flirting type. I always trust my senses... you know when you see a girl and you feel that she is pure.

Overall, the middle-class group is educated to a certain point. They are more involved in sexual activities compared to the upper-class group. The health education concerning how to use condoms is achieved, but along with it, an awareness of details is still lacking. An example of these details is the condom manufacturing date. It should be emphasized that having sex with a girlfriend can also lead them to AIDS. The knowledge they have about drugs is at the same level as the adolescents in the upper-class, but they

are more exposed to it in their real lives. They still need to have more awareness about AIDS because they are more exposed to the activities that lead them to be at risk.

The lower-class group views AIDS as a deadly disease which is still far away from them. People who have AIDS are viewed negatively and are left out of the society. They assume that people who have AIDS are promiscuous. They deceive themselves with the idea that if they do not interfere with at-risk persons, they are not likely to get AIDS. When asked what AIDS meant to them, they replied,

AIDS is a virus that cannot be cured by medicine. It has another name for it "SIV". It is a disease that the society does not accept. (A woman)

I do not know much about it, but I know that the ones who have AIDS are promiscuous.
(A man)

AIDS is a kind of disease that is transmitted through sexual relationships. I feel that it is a frightening thing and the society detests it. (A women)

They are not aware that their behaviors, either involving sexual relationships or drug addiction, are the behaviors which are included in the at-risk group. Prostitution is the only thing that they are concerned about putting them at risk for AIDS. Although they know about this, men in this class still visit prostitutes, and women in this class might make easy money by prostituting part time. Usually no screening methods or protections have been used when selecting a sexual partner.

The findings show that the lower-class group should be more informed about AIDS: how it is transmitted, what could be the risk factors that can lead to AIDS, and how they can prevent it in themselves. Health education should emphasize that people who are prostituting are not the only ones who are in the at-risk group. Condoms should be distributed and people should be notified of usage in the prevention of AIDS. Also,

condoms should be encouraged to be used in any situation where sexual relationships occur. Therefore, more effort might be given to this group of teenagers in order to build their awareness about AIDS.

The Social and Institutional Influences on Thai Adolescents

From the interviews, we observed that many parts of the conversations involved the relationship of adolescents with family, friends, and the mass media. They centered on these three institutions differently. Following is the analysis of the psychological factors, which related to the relationships between adolescents and each institution.

Adolescents and Family

Adolescents and family: In this relationship, adolescents learn a great deal from their parents. *Translated cultural values* are transferred from parents to their children. These cultural values also include how they view the relationships between genders, sexual activities, everyday life activities, and goals in the future. Each class stresses different cultural values. The upper class seems to be the most conservative group of people, whereas the lower class seems to be the least conservative. Being conservative ties closely to the concept of how they live their lives and how they see sexual activities.

The upper-class think that sexual activities are something that should not be discussed and that are behaviors which one should hide. On the other hand, the middle-class seems to see it as one of the natural human behaviors, which has its own function and purpose. The lower class expands on this ideology to the point where everything in their lives can be related to sex in their language and attitudes. Sexual activities can be linked

to more than a natural desire—it can be an economic means to an end (sex for a person in this class will get them a man and his economic identity).

It is likely that the child who grows up in their class imitates the same characters as their parents when they were young. For example, one girl in the lower-class group told me that she likes to run away from home once in a while and hang out at night with her friends. Her mom understands her behavior because when she was her age, she did these kinds of things too. She mentioned that her mother started smoking when she was an adolescent. Therefore, she tries new drugs, just as her mother did as an adolescent, only the types of drugs are different in each era. Although, the girl said her mother still fought against these behaviors and tried to keep her within the set of rules she made, she thought it was unfair and would keep on breaking the rule of freedom like her mom did in the past.

Below are two statements, which a woman from the upper class and a woman from the middle-class made. They showed how family became a factor that can influence adolescents in a positive way.

When asked what they thought protected them from AIDS, a woman from the upper class replied,

The society that surrounds me is composed of good friends, good parents, and a good environment. I do not know how I would do bad things.

On the same question the middle-class woman said,

We protect ourselves from AIDS. We are taught by our parents since we were kids that humans have to love themselves first. Do not listen to your friends too much because ‘friends’ can stop seeing you within a day. Noone can love themselves as much as parents or oneself can.

Therefore, it shows that parents in each class have the ability to shape or influence their children to have the same cultural values as themselves. The process by which parents influence their child is either by direct communication between parents and their children, or by an indirect way of imitating the behaviors of their parents.

On the other hand, at some point every class shows the power of resistance between the relationships of parents and their adolescents. Although new generations evolve from the process of socialization, new generations still make their own identities. This struggle to establish identity has the force of resistance towards the older generation to show how it is different from them. There are not any teenagers who act or think completely the same as their parents.

In the discussion, a group of girls in the upper class said how they treasure one who preserves virginity till marriage; still they know more about sex and express it more openly than their parents. Their conclusions and criticisms about premarital sex have come down to the point that girls in modern times should have the opportunity to know more and be open towards the consequences of sexual relationships because such relations can lead to many sexually transmitted diseases or unwanted pregnancies. They think that parents or society should be more informative about sexual activities than hiding this important issue and viewing it as an embarrassing personal issue.

Resistance can also be seen in the girls in the lower class. They said in the interview that they wanted to do things on their own, not to follow all the things that their parents told them. They feel pressure from their parents as negative. The result of this is how they skip school and run away from home. Following is an example of how a

woman in the lower-class group explained how her parents' pressure makes her run away from home, and how she felt about running away from home.

When parents pressure me, they would say no going out, no seeing friends, and no telephone calls. They also forced me to study hard, come home early, and do chores. They fight and hit each other in front of me, they yell at me and tell me to be good and behave the rules all the time. ...At one point I believed that every child, if they were me, would not take this any longer. They will choose to let go of everything. (She paused and began to tell about running away from home). When we lived with friends we were living in a poor condition, but we had fun because we thought of it as a way to learn about life by ourselves. At least we choose what we want to do. If we did not have any money, we would not eat. We pretended we did not care about our hunger, we just talked instead...and we cherished that moment.

As human being, it does not matter if they are in their childhood or adolescence, they need the love from parents to support and fulfill their life. When men in the middle-class group were asked what would they like to add at the end of the interview, a man replied,

Parents should give their kids love, take time to talk with them, take time to play with them, so the kids will not love their friends more than their parents. Friends can lead you to bad things. Especially, if you are a girl, friends can be your lovers and they can trick you in many ways.

Adolescents and Friends

Peer pressure is the most important factor that pushes and encourages adolescents to try unacceptable activities such as premarital sex and drugs. The sense of belonging to the group, the importance of group approval, added to the personal desire to try new things, are the main factors that encourage these activities in the cases above.

Many men from the interview who visited prostitutes are being influenced by peer pressure. A man from the upper class responded,

I once went with my group of friends to the lobby of a good hotel. My friend pointed to a lady that was sitting there that she was a prostitute. She wore a sexy short dress and had thick make up on. One of my friends wanted to try her, so we all went to talk to her. That friend of mine who started it first, tried to persuade another friend to sleep with her. At last, he (the friend who was being persuaded) did.

Also, many adolescents who first become involved with drugs are influenced by friends surrounding them. In friendships, there can be a kind of power between friends. For example, men from the lower-class group think that if they do not learn or be like the other members in the gang, they will be left out. Therefore, the only power that they care about is the possible ostracism from their friends.

To be one of the group members also relates to what is considered in style. Therefore, if the group says that to be in style for them is to perform these unacceptable activities, it is likely that one would follow other group members. One example is a woman in the lower-class who described how she could convince her friends to try drugs, which she advertised to her friends as a cool thing to do,

I have taken some drugs. Back then I had one pack of amphetamine with me. In that time noone had played with this drug before. I was the first person who introduced it to my friends. I am a kind of person that knows everything first when new things come (she said it with pride). My friends asked me how to consume it, I told them all. I said, "Try some! It is good, it will make you run wild." If they said, "Yes!" I would teach them how. Noone ignored me. After that I told them they were all cool kids now.

The concept of being in style among teenagers also reflects the class that they are in.

Another example from a man in the lower-class showed this concept,

I have taken girls on my motorcycle for a ride. It is cool among the guys to show off to others that I have a motorcycle. Taking rides with girls is what we basically do on dates. We do not have to treat girls to dinners or spend our money on expensive things in order to be their boyfriends.

Adolescents and the Mass Media

There is a variety of mass media coverage which influences adolescents.

Television can influence adolescents through a series of dramas and images of movie stars. Newspapers, magazines, and cartoon books also influence adolescents by their pictures and articles. Radio and novels can influence adolescents by the meaning of the passages in songs or writings. Following are examples of the names of songs that teenagers said have some words that contain sexual acts. These songs are mostly from American and Thai modern pop rock songs.

“To become one.” (American song)
 “Only one night.” (Thai song)
 “Kiss her till she melts.” (Thai song)

All of these types of mass media encourage teenagers to obtain their sexual desire in real life.

Adolescence is the period when lots of imaginative thinking and imitation occurs. Therefore, mass media can be influential among groups of adolescents. Below are examples in which women in the middle-class explain how they learned about sexual acts.

There are some books like “180 ways to make love”. This book is in English; my friends and I only take a peak at the pictures in the bookstore. Mostly men buy this kind of book. It has many pictures showing how to do it. Japanese cartoon books also draw and highlight nudity or women in alluring poses. (Then she paused). Well, Thai cartoon books are more worse than the Japanese ones because they do not have the theme of the story, but just emphasize the sexual act in drawings.

Another woman in this class said

There are many nude videotapes in video shops that are for rent. Most nude videos are foreign videos. Many are from Japan, America, and

China. They are illegal, but still the stores have them. If you want to rent it you have to say “I want X rated movies” or “ask is there is anything new coming in?” They will get it from the back of the store.

Many interviews from groups of male teenagers in every class showed that the mass media is the first sector that encourages them to have imaginative thoughts leading them to have sexual desires. Mass media cannot only encourage adolescents toward sexual activities, but can also encourage them to try new drugs. This may not be the intent of the mass media, but how they post the news about new drugs often makes drug users want to try these new entries. A boy in the middle-class group once said that he knew about new drugs either from his friends or the mass media, and it made him know what they look like and how they are consumed. Before long, he could find these new drugs to try them.

Some of the findings also showed how Western values in the mass media sometimes transmitted messages concerning sexual activities. For example, the media makes it seem that it is alright to talk about sex in public and live together before marriage. The mass media should inform Thai teenagers about how to practice safe sex because what the mass media features at any point is only one side of the story. When groups of teenagers take on Western values as portrayed in movies without safe sex, it can encourage them to try activities that might lead them to AIDS.

The Concept of Being At-Risk among Thai Adolescents

The awareness of being at risk among adolescents is low in every group.

Adolescents view AIDS as a disease that centers on prostitutes or people with promiscuous behavior. People who are drug addicted or have sexual relationships with girlfriends are not considered as targets. Therefore, although they know a certain amount of information about how AIDS is transmitted, they still think it is far away in reality for them to be one of the victims.

In virtually every interview in each group people would assume they have no risk of being infected with AIDS. Below are the examples of teenagers in each class, as they replied to the question about whether they thought they were at risk.

I am 100% sure that I am not at risk from AIDS because I do not think I am at risk in any way. I am not involved in sexual relationship and drugs. There are 70% chances I will not do drugs. If I did any drugs, they would be the ones that are easily taken (swallowed by mouth). (A woman from the upper-class)

No, my family does not allow me to go out at night. If it were near our house they will ask me details, where and when and how, I will get home. Then my friends at school, they do not really go into drugs or sexual relationships much. It would be hard for me to get AIDS. (A man from the upper-class group)

No, because we are not involved with anyone. Noone is involved with drugs. Taking a blood test at the hospital cannot cause AIDS, can it? (A woman from the middle-class)

No, because I often used condoms, I am not promiscuous and I do not hang out much. Only sometimes women who I court will come and go as girlfriends. (A man from the middle-class)

No, we are not at risk because we are not promiscuous, but we have sex. (A woman from the lower-class)

No, I have unsafe sex but not often. (A man from the lower-class group)

All of these adolescents have the risk of being infected by this deadly disease, but from various means. The lower-class group might be the least aware and are less informed about AIDS than other classes, while most of the upper-class seems to have in-depth information about AIDS and think more about how it could spread to them.

CHAPTER FIVE: CONCLUSION

Discussion

Discussion on Gender

This thesis aims to provide insight on perceptions of how Thai adolescents in today are involved with premarital sexual relations and drug problems. The data show that different economic background and gender differences create different patterns of HIV/AIDS risk-taking behaviors. This research shows that adolescents' risk for AIDS vary according to sex and economic status. Therefore, the health plan Thai people are using right now is not as effective as it could be because it assumes one health plan fits everyone. In Thailand, there is no research that centers around economic status differences which affect health conditions and there is hardly any research that focuses on Thai adolescents. However, adolescents are seen as the population that is most effected and at-risk for AIDS.

When concentrating on the problem, we can see that during the last decade there are rapid social changes in Thailand. Cultural influences have become one of the major influences that relate to health conditions. The trends of modernization and westernization also encourage the growth of the sexual industry and change teenagers' values towards premarital sex.

The conclusion is divided into two sections. The first part concerns the finding that gender differences affect health differently. The second part focuses on the finding that differences in economic status affects risk-taking behaviors differently.

We can understand why Thai culture and social change during the last decade have influenced the problem by looking at how gender roles play a part in adolescents' lives. In Thai culture, Thai men and women do take differentiated roles in their lives. This dissimilarity in their gender roles influences them to view sexual relationships differently. The reason they perceive sexual relationships differently begins the day they are born. During childhood they are taught and socialized by Thai norms, the surrounding people, the environment they live in, and especially their parents. From looking at the women's gender roles, we can see how the ideal pictures of good girls and boys are linked with their future perception of sexual relationships. We can see that the ideal picture of a good girl creates a sense of innocence, obedience, and responsibility for what she has decided to do. The burden she carries on her which she has to be responsible for are from those who surround her such as parents, other women, and men. Parents want her to be a good daughter now in order to practice being a good housewife in the future. Other women want her to be as good as a perfect picture of how a lady should be. Men want her to be the same, as her parents want her to be. However, men will not be responsible if a woman decide to have sexual relationships with them. She who has sexual relationships with men can be seen later by the same men as worthless and as the one solely to blame. Not only are these ideas in the conscious mind of Thai girls when they discuss how they think good girls should act, but also men in every class who were interviewed thought the same at a certain level.

These characters and responsibilities of good girls such as being naive and not curious, especially about sex, can cause them disadvantages. Good girls lack knowledge

and awareness of the negative effects of having premarital sex. This lack of knowledge on the preventive methods and protection by using condoms might cause unwanted pregnancy, STDs and AIDS. Unlike women, men seem to have less burden and responsibility when sexual relationships occur. They are more open to the world, more sociable; they have and want more freedom and keen knowledge of how to achieve their goals. This includes knowing how to achieve sexual relationships with the girls they want. Yet, they still lack awareness about the need to use condoms and do not notice the harm that multiple sexual partners can bring.

In Thai culture, when women have sex, it is considered to be a disadvantage to them in contrast to men in the same situation. Whether men have sex or not, they still have the same value and feeling of worthiness in themselves. This is due to the fact that Thai culture places importance only on virginity in women. When talking about premarital sex, a woman's virginity is another important criteria to judge if a woman is good or bad. Women obviously have more to think about when they have sex. It is likely that women who have premarital sex are labeled as "bad." Women are concerned with this status, so they provide many other details and obligations for themselves in the situation. Therefore, women are limited and unequally judged by men when in sexual relations.

Furthermore, women and men see the process of "sexual relationships" in different ways. In most cases, men are the ones who start the sexual relationships; women are most likely to be emotional, loving, and trusting when it comes to a relationship. In exchange for expressing their love, women give men their virginity. On the other hand, men see sexual relationships as what they want and need without analyzing the

consequences in the future. They might have been influenced by factors like the mass media and friends who surround them and encourage them to have sex. Love can be a condition that relates to sexual relationships for men, but love may not be the first thing or the only thing that starts the sexual relationship in every case.

Before women decide to have premarital sex or after they end up having premarital sex, they obviously do not want to consult anyone or want anyone to know about it. This can lead to a dangerous stage where women are kept alone and are not provided with the knowledge of how to protect themselves when having sexual relationships. If they are found to have sexually transmitted diseases, they become too ashamed to admit it to others and deprive themselves of medication. This can also cause a period where the diseases can be spread from them to others.

Discussion on Class

This discussion aims at showing how Thai adolescents from different social classes can be placed at-risk for AIDS in a variety of ways. People from the upper-class seem to be the most conservative, self-confident, and individualistic. However, from the interview we can see that they are very much influenced by their parents. Combined with how their parents have taught them to be good with no family problems, the teenagers in this group are less likely to engage in sexual relationships and drugs. At this point, adolescents in the upper class have fewer risks compared to other classes when focusing on sexual relationships. However, they can still be at risk from their misconceptions that their sexual partners do not have AIDS. Misjudging a person they are with, trusting him/her, and having sexual relationships with that person also can lead them to AIDS.

This group of teenagers does not often take drugs. Only the ones who have family problems tend to try drugs. Also, the type of drugs that this group consumed is not by injection. The major types of drugs that are orally consumed include ecstasy and ketamine. Taking these types of drugs can lead to loss of consciousness and failure to use condoms during sexual activities which can lead them to AIDS. On the other hand, because they do not use intervenes drugs, they are less likely to be at risk when compared to other classes. Also, they usually take drugs by injection as an individual activity. This is because they are more individualistic and are concerned with privacy when it comes to the type of drugs they use by injection. Therefore, from both sexual relationships and the drug use, which can lead to AIDS, this group has little risk compared to other classes.

Mostly people from the middle-class are more realistic than the upper-class. They have higher risks compared to the upper classes when focusing on sexual relationships. More at-risk activities involving sexual relations among men occur in this group, such as visiting prostitutes, deceiving girls, and having frequently sexual experiences which believing they will fulfil their manly ego. Although, the at-risk activities are more than the upper-class group, it is still considered low in comparison to the lower class group. Moreover, they are less at-risk compared to the lower class because they usually use condoms. The way in which they can be at risk is from the lack of awareness that sexual relationships with girlfriends can also lead them to AIDS as well as sexual relationships with prostitutes. Mass media is the most influential institution among this group of teenagers. It has increased the amount of fantasizing among teenagers in this group about the concepts of romantic love including sexual acts.

The middle class has increased risks for drug use compared to the upper class because they use various types of drugs. Peer pressure is the important factor that encourages and influences them to begin trying drugs. The major types of drugs include heroin (injection/sniff), marijuana, and especially amphetamines. Those who are addicted to amphetamines for a long time will be likely to inject amphetamines into their blood stream. Sometimes to create the new taste of drugs, they will mix heroin with amphetamines and inject them. Doing drugs for people in this class is a group activity. When they are addicted to drugs and use the injection method, it is also likely for them to be sharing needles among members of the group. Therefore, the risk of getting AIDS for the middle-class group is greater than upper classes, but still lower than the lower class.

The picture of adolescents in the lower class reflects their feelings that they are experienced in a world which seems cruel and mean. In my opinion, they are too young to be experiencing things with this type of attitude. Mostly people from this class seem to be the most at risk, due to their unprotected sexual activities and drug usage, even addition. They have many sexual relationships at a time without protection or even screening their partners. They view the risks that they take as an adventure and make it more exciting, without knowing the damage it could cause them. Their lifestyles in liking to hang around outside home, drinking, doing drugs, visiting prostitutes, running away from home, and frequently changing sexual partners will expose them to more at-risk activities than other classes. By trusting their sense of screening sexual partners and therefore not using a condom members of the lower class cause themselves to be at great risks for AIDS transmission. These mentioned at-risk activities are mostly influenced by peer pressure. In relations, friends are the most important group of people in their lives.

This group of teenagers cherishes and values their friendships the most, but without realizing that following the deviant behaviors of their friends causes harm to themselves.

Friends also expose them to drugs. Not only does peer pressure encourage them to try and do drugs, but also friends often lead them to be later involved in selling drugs too. This group of teenagers is addicted to many types of drugs, such as heroin by injection, marijuana, inhalants, and especially amphetamines (by injection or inhalants). Doing drugs and sharing needles is a group activity commonly practiced in this group. They often have the misconception that the percent chance that can lead to harm from sharing needles is low and sometimes they incorrectly sanitize shared needles by cleaning them with water. In fact, needle sharing is one of the most dangerous ways that could lead them to AIDS. If the group activities of practicing needle sharing and multiple sexual partners continue, it is likely that the number of people who have AIDS will increase in this group.

It appears, therefore, that gender and economic differences would create different patterns of HIV/AIDS risk-taking behaviors. In addition, we can see in-depth details from the analysis of the different perspectives between men and women and also the different institutions which can encourage and influence the most in each class. This will influence recommendations below.

Figure 9. Values, Lifestyles, and Important Influences in Life Classified by Class and Gender

Class	Gender	Values	Lifestyles	Important Influences in Life
Upper	Men	S= Personal Issue WV= Valuable	Condom Use: with both prostitutes and girlfriends Ecstasy and Alcohol	Family
	Women	S= Love, Trust, Fidelity WV= Self-Pride, Self-Esteem	Condom Use: with boyfriends Ecstasy and Alcohol	Family
Middle	Men	S= Normal, Natural WV= Desirable	Condom Use: with both prostitutes and girlfriends Amphetamine, Intravenous Injection	Friends/ Mass Media
	Women	S= Normal, Natural WV= Worthiness	Condom Use: with boyfriends Amphetamine, Intravenous Injection	Friends/ Mass Media
Lower	Men	S= Freedom WV= Wanted	Condom Use: with girlfriends, prostitutes, one night stands Amphetamine, Intravenous Injection, Heroin Selling Drugs	Friends
	Women	S= Freedom WV= Nothing	Condom Use: with boyfriends, prostitutes, one night stands Amphetamine, Intravenous Injection, Heroin Selling Drugs	Friends

S = Values concerning sexual relationships

WV = Values concerning women's virginity

Figure 10. Self Concept of Risk, Risk Taking Behavior, and Reality Level of Risk Classified by Class and Gender

Class	Gender	Self Concept of Risk	Risk Taking Behavior	Reality Level of Risk
Upper	Men	No	Prostitutes Misjudging Sexual Partners Losing Consciousness, Drugs	Least
	Women	No	Trusting, Misjudging, Sexual Partners Losing Consciousness, Drugs	Least
Middle	Men	No	Personal Screening Sharing Needles	Average
	Women	No	Trusting and No Condom Use Sharing Needles	Average
Lower	Men	No	Multiple Sexual Partners No Condom Use Sharing Needles	High
	Women	No	Multiple Sexual Partners No Condom Use Sharing Needles	High

Significance

The cause of health problems among the Thai adolescent population has changed in the last few years. In the past, the factors that affected this population were mostly from physiological aspects, but now there is an increase in cultural and social factors that influence their illnesses. Circumstances of cultural change have created major problems among Thai teenagers, especially to AIDS. Previous research studies have documented that adolescents' health problems have rapidly increased due to three causes: modernization and westernization, including premarital sex; unsafe sex and the share of needles; the growing industry of commercial sex services. These three causes are the main reasons for AIDS acquisition. Therefore, more research is needed in this area.

As I explored many documents and research in Thailand, I found that many have been focusing on AIDS and adolescence. Only a few studies involve gender issues, you can rarely find research in Thailand that focuses on the difference between genders, which compares women and AIDS with men and AIDS.

Only my research has delved with more in-depth adolescents' voices into the process of becoming involved in sexual relations. My research delves into the ideal and the common practices of adolescents in regard the practices of adolescents' sexuality in reality and only consider their ideal norms. My research takes account their actual sexual behavior in relation to class.

To gain further insight into what research was available, I looked into literature from Thailand and from the United States. Most research up to now focuses on females victimized by males and their behavior. The main point seems to be the vulnerability of

women and their inability to defend themselves. My recommendations include the empowerment of women to protect themselves. This approach is unique to my thesis.

In a thorough search of the literature both in Thailand and the United States, there was hardly any research which related the difference in socioeconomic status with the risk activities that can lead to acquiring AIDS. Moreover, no research before has centered on socioeconomic differences among teenagers that cause them to change their at risk activities. It is important not to ignore class in Thailand because adolescents act differently according to class. Because a lack of information among this area of research I attempted with my research to fill the void.

Not only do I look into literature involving gender and class, but also the application of practices for social institutions to effect adolescents' behavior, information not previously discussed in detail by other anthropological studies that differ according to class. Thailand in particular needs to have this information.

In conclusion, in view of the lack of research dealing with health conditions in adolescents and women, I have chosen to focus on the particularly areas of adolescents, women, and socioeconomic status. Included in my research is advice concerning prevention of AIDS. Therefore, as an anthropological contribution to the understanding of the risk-taking behavior among Thai adolescents, my research has achieved a deeper understanding that shows that there are many different dimensions in risk-taking behavior among Thai adolescents. The differences of each of the risk-taking behavior patterns are created through different economic backgrounds and gender differences. Through my research, I feel that it will contribute to the society as a whole.

Limitations

The general search for literature review has been limited due to the time constraint of my academic program. The interview and observation research was conducted over a three-month period, rather than a more typical one-year period. Also, findings on sexual behavior or insight activities are based on information from the interviews, which were translated from Thai to English. This translation may not contain all the nuances of meaning in the original language. Further, it is too hard to do serious participant observation because it deals with personal issues and legal implications. Lastly, since little previous research has been done on these subjects, not as much data is available as a basis, and this limits comparison to other studies or suggestions for specific directions in this research.

Recommendations and Suggestions

The results in my data point out that the most effective way that will reduce the problem of AIDS spreading among Thai teenagers is to design more than one health plan and use the methodologies that fit the target group. Therefore, my recommendations and suggestions will vary based on gender and class analysis. The first part covers how to approach men and women about AIDS. The second part underlines how to convey a realistic message toward each socioeconomic groups by using appropriate channels. This will build more awareness among adolescents and show them how easily they can be at-risk. Not only can adolescents help themselves not to be vulnerable, but also the problem solving would not be successful without the cooperative efforts from many institutions. Finally, I will suggest in the last part how institutions that are influential to adolescents,

such as family, schools, friends, mass media, health education and the health sector can contribute to solving the problem.

Recommendations for Necessary Changes in Gender Beliefs and Action

I have the following recommendations and suggestions to make with an emphasis primarily on women. However, a part of this section will also cover suggestions for men as well. I believe that women should take actions to protect themselves because they are the most effective sources to help others as well as themselves. In the past, effort to reduce the spread of AIDS mainly focused on men to change their sexual behaviors in order to prevent women from being the victims. Nowadays, I believe that both women and men should take charge and have as much responsibility towards changing their behaviors. The ideal stereotypes of being “good girls and boys” do no harm for teenagers, as long as they also gain more awareness and information about AIDS. Teenagers should try to provide themselves with opportunities and search for health information/education concerning sexually transmitted diseases, condoms use, as well as how to have a happy sexual relationship. In particular, society should inform them about the process of how to engage in premarital sex and what they would have to face after having sexual relations. Societal disapproval is not a solution to the problem. Disapproval is counter-productive to young people taking responsibility for their own actions. Because common sense points of view on sexuality one different from the ideal point of view, disapproval has no impact on these adolescents.

Before all of the above can be put in action, we must change some of the incorrect Thai beliefs and reinforce the beliefs that would protect teenagers from AIDS. The perspective should be enforced that knowing more about condoms does not mean that he/she is sexually skilled, but rather well educated and knowledgeable about protecting themselves. Moreover, learning about sex education and asking questions concerning this issue is normal and appropriate.

If teenagers decide to have premarital sex, they should know how to protect themselves because of consequences in the future. Men should be willing to take the responsibility for taking care of woman if she is pregnant. Furthermore, men should be aware of the risk behaviors that can lead them and their partners to acquire AIDS. Women should know that they should take care of themselves and be aware of the transmission of diseases, especially the right of refusal to leave the man who wants to have unprotected sex with them. Moreover, women should know that virginity is not the only important thing in today's world that determines their value. There are many other important things that determine value, such as the intention to gain an education, their achievements in schools/life, and their self-worth as a good person. Both men and women should be encouraged to be faithful toward their sexual partners, especially among Thai men who have multiple sexual partners. This value of faithfulness will build trust in the right way to help prevent the spreading of AIDS.

Recommendations for Males

One of the important factors that has caused the spreading of AIDS in Thailand is males' sexual behavior. Thai men have more sexual freedom than women because they

can have more than one sexual partner, whereas Thai women are expected to be faithful to only one sexual partner. In order to reduce the spreading of AIDS in Thai society, male sexual behavior, including male attitudes, has to be changed.

Starting from the socialization process in their childhood, little boys should be taught to respect their mothers, sisters, as equal to other males in the family. Seeing the women having so many burdens, both the responsibilities inside the home and in the working environment to help feed the family, those little boys should be urged to help out the female members. There should not be an assumed gender role responsibility, such as women always being responsible for household jobs or always being the head of the family. Then when these little boys grow up to be young men, parents should teach them about their expected responsibility in sexual relationships. From the beginning, parents should teach and show how important it is for one to be seen as a valuable person by being faithful to only his/her partner. This creates a lasting trust in the relationship. Parents should also teach that using condoms does not mean that there is no trust in the relationship. They should also teach boys that if they decide to have more than one sexual partner, then they should use condoms. This shows that they care for their partners' health as well as their own.

Not only can the family help encourage these changing values, but school and education can also take a part in educating them on how to use condoms properly. Health education can then reinforce the useful skill of condom use and include it as a part of male sexual behavior in practice. Indirectly, teachers can also carry on the parents' intentions by teaching their male students to be responsible, to help others, and especially

to respect women. The mass media can create a sense of being “modern gentlemen” by using condoms with their sexual partners to show that they care.

By the time their students are old enough to be involved in the sexual relationships, they would have learned good basic values to have happy lives, good relationships with their partners, and especially be good role models for their future sons.

Recommendations for Necessary Changes in Class-based Beliefs and Action

My findings in relation to class prompt me to make the following suggestions. The data indicating the correlation between class and education implies that the most useful suggestion would vary by the level of education.

Upper-class teenagers, should be taught not to be so trusting and to be aware of worst case scenarios on a daily basis to build their level of awareness. Upper-class women are not well instructed about the motivations of young men in terms of sexual relationships. Drug education, specifically for the upper-class teenagers, include the process of how drugs are consumed on realistic levels rather than only theory. Since family is the most influential institution they would be the most effective educators.

For the middle-class teenagers, they should be taught that personal sexual screening is not enough and makes them vulnerable to risk. They should be encouraged to use condoms every time they have sex. Drug education should include more about the danger of sharing needles and the dire consequences of drug use. Providing alternative activities would be helpful to keep their mind off sex and drugs. Middle-class teenagers, are more influenced by mass media and friends so they should be incorporated into the educational process.

Unlike the other classes, the lower-class education should include a thorough working knowledge of AIDS awareness. Condom usage should be explained and condoms freely provided. Considering that lower class teenagers are more out-going, emphasis should be placed on sexual relations within their lifestyles. Screening techniques should be emphasized since they do not screen their sexual partners well. By teaching these teenagers about the bad effect of drugs, they can be made aware of how certain drugs can be easily addicting. Dealing drugs can be reduced if the teenagers are made aware of the consequences of selling drugs, such as prison terms, fines, and being forced out of their community circle, including family and relatives. Sharing needles in this class is also extensive, so education regarding sharing needles should be included. In the case of lower class teenagers, friendships tend to be the most important factor, so friend teaching friend would be the most effective methods of communicating this data. Therefore, friend helping friend programs would be useful if conducted.

Conclusions and Recommendations on How to Reach People in Each Class Regarding Changes in Their Attitudes toward Condom Use

According to the finding in Chapter Four, when asked about the knowledge of teenagers in each class, the results showed that adolescents, both in the upper and the middle classes, have adequate knowledge about STDs and AIDS. They are well aware of how AIDS is transmitted and how condom use can help reduce the AIDS infection, but their attitudes about condom use still keeps them from using them every time they have sexual relationships. This problem can easily be overcome by raising more awareness, starting from sex education in schools. Sex education can help open up teenagers' points

of view by showing how AIDS can happen to them. Health educators in schools are also important people who can convince and make adolescents perceive condom use as an important tool to protect themselves. Mass media can advertise and promote condom use to adolescents, creating a sense of a person who uses condoms as one who is knowledgeable, rather than promiscuous.

For the lower class adolescents who drop out of schools, the knowledge about sex education seems to be the cause of STDs and AIDS spreading. The Ministry of Public Health can contribute to the health knowledge of adolescents in the shape of comic/cartoon books, posters, and information from speakers in the community to show how condom use is relevant and how they can be used properly. Also, they can reach the lower class people by providing mobile health units services like the ones they use for blood donations that go to urban slums and the low-income community or the neighborhoods where these adolescents live. Also, they can train health educators to teach these teenagers as in the usual street teachers' program for educating homeless teenagers. In this case, the street teachers will teach sex education and provide free condoms. They can also establish a non-profit-organization for counseling in the vicinity where adolescents like to hang out and give counseling to them, including counseling for their sexual problems. The above suggestions may help to provide suitable solutions to reach adolescents in each class.

Figure 11. Recommendations by Class and Gender

Class	Gender	Recommendations
Upper	Men	Condom use with both prostitutes & girlfriends↑ Awareness about drugs/alcohol ↑
	Women	Naivete`↓ Awareness about drugs/alcohol↑
Middle	Men	Personal screening + more awareness + condom use↑ Sex/sharing needles
	Women	Naivete`↓ Awareness about condom use/drugs/sharing needles↑
Lower	Men	Condom use↑↑↑↑ Awareness about screening techniques/sharing needles↑ Sex/Drugs education ↑↑↑↑+ Prosecution by Law ↑
	Women	Condom use↑↑↑↑ Awareness about screening techniques/sharing needles↑ Sex/Drugs education ↑↑↑↑+ Prosecution by Law ↑

↑ = Should Increase, ↓ = Should Decrease

Recommendations for Social and Institutional Change

I suggest that sex and drug studies in schools that are covered in health education should be taught in a more up-to-date fashion. Also, risk taking should be emphasized so that adolescents can see how AIDS is involved in their everyday lives. Therefore, if the health sector or educators are aware of this situation that can lead to AIDS, they can then understand and try to find protective measurements which will fit in each age group of adolescents. Moreover, health education should not only teach about sex education with a focus on reproductive issues alone, but should also cover the issues of sexual relationships that are related to AIDS. The educators should also be trained to open up their views toward sex education and see how it is relevant to the problem. Training becomes an important process because a lot of Thai attitudes towards sex are still negative. More information should be included about the type of drugs-related as well as stress which causes damage to the body. Pictures of people who have suffered from being addicted to drugs can be used effectively. Videotapes could be one of the best media that could get to adolescents, providing more information about sexual relationships and lives of drug-addicted people.

Another important issue involving health educators is to link AIDS to health education, especially in sex and drug behavior, and use examples that can occur in the students' lives. By educating adolescents in realistic ways that make them see how AIDS is involved in their everyday lives, adolescents would have more awareness by which they can protect themselves from AIDS. In addition, the health sector alone can create friendly health clinics in addition to general clinics. These friendly health clinics should provide full medication, psychosocial, reproductive, and sexual health care for teenagers

* Before this page, the whole 19 pages of conclusion part doesn't have any citation. None!

✦ (Boonmongkon 1997). This could be the most effective way to educate our Thai adolescents. It appears, therefore, that many changes should be made in the health education information, health educators and the health plans (see below).

It appears that adolescence is a period characterized by many rapid changes, both biological and psychological changes. Also, there is a huge amount of need to accomplish many significant developmental tasks that adolescents have been given, such as gaining peer approval and school achievement (Haffner 1995). During adolescence, one faces a time of great conflict and distress. It is likely that an adolescent who is entering this period with social or psychological disadvantages would experience the ^{*curiosity,} greatest difficulties. These difficulties can easily cause problems, such as premarital sex ^{a difficulty} without protection or drug addiction, if people who surround adolescents are not aware of and trying to prevent the problems. Therefore, not only can health education encourage and build awareness among adolescents, but family, friends, and mass media can also be other sectors that help.

Parents can be a good example by teaching children about sex and drugs. They should be looking after the children, spending time with them, talking to their children everyday, asking about the new things in life that the child experiences, and especially give them love, which adolescents need. Also, they should be aware that they are the ones who are most influential to their children. This is because family is the first institution and the longest lifetime involvement institution that humans will have since they are born till death. Therefore, parents can take a part by doing their duty in teaching their children. This teaching and socializing process will never end and should not stop,

even if the children have grown to be independent adolescents. The issue that the parents can teach their children also covers providing knowledge about sex. Parents are the most efficient people to educate their children because they are the first people who the children learn to trust, can trust unconditionally through their lives, and have already experienced what adolescents need to learn in sexual relationships (see below).

Good friends can help encourage their friends to avoid doing at-risk things, such as having premarital sex, and taking drugs. They can encourage other friends to spend time with many useful hobbies and sports than to take the at-risk activities. They can also be good counselors for their friends by communicating problems. In Thailand, there are hardly any peer-counseling program or centers in schools (Boonmongkon 1997).

Counseling can be established from the teenagers who want to volunteer and who can help manage the program/center. Teens who volunteer for counseling would be the most appropriate people that other teenagers could communicate with because of the same age and life experiences.

Mass media should screen any messages that concern sexual activity and drugs for the society. More programs or advertisements about AIDS awareness should be introduced into the society. This process can be done through many channels that teenagers can use including the packaging of the products, posters, billboards, radio, and television. On television programs, such as cartoons, comedies, soap operas, crime/action adventure movies, commercials, and music videos should be screened and edited for inappropriate language, action, and messages that show improper sexual fantasies and desires (see below).

Books, novels, cartoons books, and magazines, all imported and domestic, should also be screened on the same process. On the other hand, the domestic publications should be encouraged to start putting messages that provide protection and information about AIDS.

Last, I concluded that if health sectors can coordinate with these three institutions (family, friends, mass media) to be the channels that help distribute health education and awareness about AIDS contraction, it will make the most effective force to help reduce the problem. This is because in order to encourage AIDS awareness and reduce the number of people who are affected, everyone should be able to give a helping hand. Every sector is as important as others. Therefore, when these sectors are joined together, the AIDS problem will no longer be a non-preventable deadly disease which people need to fear.

Recommendations on How to Convince People in Government or Other Sectors of the Appropriate Methods for Teaching Adolescents about Using Condoms

Promoting the use of condoms in Thai society is much needed, due to the wide spread of STDs and AIDS. The health sectors can help promote condom use in an appropriate way, without promoting increased sexual activities among adolescents. The following are some suggestions on how the health sectors can provide such programs.

This can be done in such a way that every time the health sectors want to promote condom use, they can always add a sense of values, such as faithfulness with their partners, caring and being responsible for their partner's health as well as their own, and respecting their partner's right to refuse sexual relationships if condoms are not used.

In practice, in order to organize the right sex education plans, the Ministry of Public Health should send its staff to other developed countries such as America, to see how their sex education is taught without incorporating their value system which may not be compatible with Thai values. In addition, the health sectors can conduct research surveying adolescents' opinions on what they think should be taught in sex education, which are relevant to AIDS and STDs concerns. By this procedure the health sectors would become aware of what is still lacking in their health education and what needs to be changed. This education should include the potential consequences of premarital sex. Lastly, they can train the health educators to learn how to use condoms properly and provide free information where condoms are distributed.

Direct communication through health educators and health plans are not the only way to help create awareness about AIDS in Thai in the society; the mass media can also help. The mass media can show statistics or present information in a very attractive manner. Television commercials can show how critical this situation is right now, and therefore, that condom use is crucial in this area.

In conclusion, as each sector emphasizes proper values regarding sexual relationships while being conscious of the fact that over-promotion of condom use may encourage additional sexual activities, the government and health sectors will promote a wise approach to condom use.

Figure 12. Recommendations and Suggestions for Social Institutions

	Recommendations and Suggestions for Social Institutions
Health Education	Up-to-date, Including sexual relationships and AIDS in everyday lives
Health Sector	Friendly Health Clinics, Provide/Promote AIDS Programs for Public
Parents	Teach about sex/drugs in movies/life experiences, Visit AIDS Programs Give love + personal time
Friends	Participate in Activities Volunteer / Peer-counseling
School	Training ▶ Health Educators/ Peer-counseling/ Field trips to AIDS Program
Mass Media	Screening ▶ Sexual Acts & Messages Advertise ▶ AIDS Awareness
*Themselves	Self-motivation for more knowledge: “It can happen to you!”

List of Recommendations in Detail

1. Thai teenagers can provide themselves with health information and learn more about STDs by going to the health sectors, such as clinics and hospitals, and asking for publications to read concerning this issue. On the other hand, they can just make an appointment with professionals such as doctors and counseling nurses who are able and available to provide information about STDs and condom use. Those are the persons who can answer their questions very effectively.
2. Best of all, the teenagers can just go to the Thai Red Cross Center and the Anonymous Clinic located on Aungreedunung road and ask for more detailed information with free condoms.
3. For more information especially for condom use and contraceptive services, teenagers can go to Meechai center. This service is free of charge and will also provide protection method for free.
4. Society including teachers, parents, friends, families/relatives, and co-workers can inform teenagers about the process of how one can easily engage in premarital sex and the negative impact from these unprepared sexual activities. They can teach the teenagers by their own life experience or that of their friends who have had trouble in life because of premarital sex. They should also inform the teenagers that if they end up having premarital sex they can always come and consult with them if they have problems. On the other hand, parents can also share their real life experience or others people's experiences they know (not mentioning those person's real names) about sexual relationships with their children to acknowledge to them how good sexual relationships could be.

5. Families can provide information on how to teach sex education to their children from the same source as mentioned above. In addition, they can also try to borrow or search for videotapes about sexual relationships from the public hospital, anonymous clinics, etc. They can sit and watch with their children. Afterward the children can ask their parents questions. If the parents cannot answer a question, they can write down and consult with the health professions for the right answer. For the lower class parents, they can set up a group of parents and ask for these kind of services from the Thai Red Cross Center, Anonymous Clinics, or public hospital like Chulalongkorn Hospital. Those institutions would gladly provide this service for free, if they know before hand.
6. If affordable, parents can rent the videotapes called “Kra ja ru deeng sa,” “Pee Sey La Dog Mai,” “Nam poot,” or “sead die” to watch with their children. The videotape “Kra ja ru deeng sa” and “Pee Sey La Dog Mai” are stories about a young girl and a boy who engage in premarital sex and end up having problems afterwards. “Nam poot” and “Sead die” are the stories about teenagers’ lives who have been involved with drugs and show how it has cost them their lives at the end. All of the videotapes are up-to-date with acting by popular actors and actresses who can be very attractive for adolescents to see. However, these videotape come in a very inexpensive price, if rented at the right store near home.
7. Parents as well as health educators in school and health professionals should be the ones who provide knowledge about using condoms properly and other contraceptives measures. If parents and school health staff do not know much about the issue in detail, they can bring their children to the health center and

make appointments ahead to see the professionals who can educate the children.

This can come in the form of taking a field trip. After the trip, they should inform the children that they are willing to provide condoms and contraceptives at anytime.

8. Schools, parents, and friends should provide and inform other teenagers about a variety of activities they can spend their time on such as camping, playing sports, playing musical instruments, and especially, setting up a volunteer club to help non-profit organizations such as homes for the elderly, childcare centers, foster homes, etc. Moreover, working part-time jobs such as tutoring younger children, helping them do their homework, and teaching them Math and English can also be enjoyable as well as profitable. These activities will bring a memorable lifetime experience with great enjoyment and are in demand.
9. Schools should encourage students or recruit staff to set up a peer counseling center or program in the school (Boonmongkon 1997). Also, health sectors should establish a center and program like the friendly health clinics located in the slum areas, the low-income areas of residents, as well as in the rural neighborhoods and urban shopping malls. A friendly health clinic can also be located next to drug stores, coordinating with one another and providing information for teenagers. This friendly health clinic should be equipped to provide not only knowledge and advice, but also condoms and contraceptives for free.
10. Friends helping friends programs should also be established in schools by forming as one of the general clubs like a sports club. This is where friends can

consult with friends during their free time at schools. The service can also include the telephone hot line for these who do not want to be noticed in person. If the club wanted to expand, during the weekend the teenagers who had experience can write a proposal to the Government or the Ministry of Public Health and ask for funding to set up a center outside school. This center should be located in the places that teenagers often hang out such as shopping malls, tutoring schools, and entertaining places (discotheques and popular restaurants). They should be a non-profit organizations which cooperate with professional counselors.

11. The Ministry of Public Health should provide another curriculum for the health educators at schools in addition to the former one they provided for students. They should emphasize in the curriculum that a sexual relationship is a very m important issue and normal to discuss because the more informative they are, the more beneficial it will be for the teenagers. The training should be done before they go out to schools and teach the students.
12. The censoring institution in Thailand called “Kor Bor Vor” can help screen mass media especially television programs and videotapes to edit out the sexual act, especially to edit out the language that can lead to sexual desire. They should provide this service both for domestic and international programs. More law preventing inappropriate messages and taking away the license of the video store that carry sexual explicit videos are also recommended.

BIBLIOGRAPHY

Akeroyd, Anne V. 1997. Sociocultural Aspects of AIDS in Africa: Occupational and Gender Issues. *AIDS in Africa and the Caribbean*, 11-30.

Archavanitkul, Kritaya and Varaporn Chamsanit 1995. *Male Adolescents Who Use Sexual Services and Their Value toward Prostitution.*

Balzer, Edmonda and Ratchanee Srionsri 1996. The “Going-Out” Lifestyle of Wairoon Gai Taek. *Paper presented at the 6th International Conference on Thai Studies theme 3 “Family, Community, and Sexual Subcultures in the AIDS Era”.*

Benjamin C. AmickIII, Sol Levine, Alvin R. Tarlove, and Chapman Walsh 1995. *Society and Health.* Class, work, and health, Oxford University Press, New York.

Benjamin C. AmickIII, Sol Levine, Alvin R. Tarlove, and Chapman Walsh 1995. *Society and Health.* Gender, Health and Cigarette smoking. Oxford University Press, New York.

Bolognone, Diane 1990. AIDS: A Challenge to Anthropologists. *Medical Anthropology Quarterly*

Bond, George C., John Kreniske, Ida Suser, and Joan Vincent 1997. The Anthropology of AIDS in Africa and the Caribbean. *AIDS in Africa and the Caribbean*, 3-9.

Boonmongkon, Pimpawan 1996. Youth Health for a Change. *A UNICEF Notebook on Programming for young People’s health and Development.*

Boonmongkon, Pimpawan 1997. *Adolescent Sexual Health: Lessons Learned and New Directions.* Paper presented in Seminar on “ Future Needs of Thailand in Population and Reproductive Health” Bangkok, Thailand.

Bourdieu, Pierr 1984. *Distinction: A Social Critique of the Judgment of Taste.* Cambridge, MA. Harvard University Press.

Boyer, Cherrie B. and Susan M. Kegeles 1991. AIDS risk and prevention among adolescents. *Soc. Sci. Med.* Vol. 33, No. 1, 11-23.

Brooks-Gunn 1989. Adolescent Sexual Behavior. *American Psychologist* Vol.44 No. 2, 249-257.

Bruyn, Maria De 1992. Women and AIDS in Developing countries. *Soc. Sci. Med.* Vol. 34, No. 3, 249-262.

Campbell, Carole A. 1995. Male Gender Roles and Sexuality: Implications for women's AIDS RISK and prevention. *Soc. Sci. Med.* Vol. 41, No. 2, 197-210.

Des Jarlais, Don C. 1986. Social Science and AIDS. *Medical Anthropology Quarterly*

Farmer, Paul 1992. AIDS and Accusation: *MAITI and the Geography of Blame.* University of California Press.

Fine, Michellel 1988. Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire, *Harvard Educational Review*, Vol. 58, No. 1, 29-52.

Fongkaew, Warunee 1997. Sexuality, and Gender Norms Among Thai Teenagers: Problems and Solutions. *Community-Based Programs for Adolescent Sexual Health and Domestic Violence Against Women*, 100-128.

Fongkeaw, Warunee 1995. Early Adolescent Girls in Transition in a Peri-urban Northern Thai community: Perceptions of Gender Role and Sexuality. *A Thesis proposal*, University of Washington.

Fussell, Paul 1983. *A guide through the American status system: Class.* Rockefeller Center New York. Simon & Schuster.

Goldstein, Donna M. 1994. AIDS and Women in Brazil: The Emerging problem. *Soc. Sci. Med.* Vol. 39, No. 7, 919-929.

Gorman, Michael 1986. Anthropology and AIDS. *Medical Anthropology Quarterly.* Vol. 17(2), 31-38.

Haffner, W. Debra 1995. *Facing Facts: Sexual Health for American's Adolescents*, Sexuality Information and Education Council of the United States.

Kitsiripornchai, Suchai, Kamuan Ungchusak, Lauri E. Markowitz, Carl J. Mason, Weerachai Leucha 1996. Sexual Behavior Among Young Thai Men. *Thai AIDS Journal*, 79-90.

Knodel, John, Mark VanLandingham, Chanpen Sengtienchai and Anthony Pramualratana 1996. Thai views of sexuality and sexual behavior, *Health Transition Rev.* Chulalongkorn University Press 6, 1996, 179-201.

Kreniske, John 1997. AIDS in the Dominican Republic Anthropological Reflections on the Social Nature of Disease. *AIDS in Africa and the Caribbean*, 33-50.

Limsumphan, Suwan 1996. Cultural Dimension of Control and Protection of Sexual life: The Case of Female Adolescents in Urban Poor Communities of Bangkok. *Thesis proposal* Faculty of Social Sciences and Humanities Mahidol University.

Lyttleton, Chris 1996. Health and Development: Knowledge systems and local practice in rural Thailand. *Health Transition Review* 6, 25-48.

Marshall, Patrica A. and Linda A. Bennett 1986. Anthropological Contributions to AIDS Research. *Medical Anthropology Quarterly*, 3-4.

May, Tim 1993. *Social research: Issues, Methods and Process*. Open University Press.

Millstein, G.Susan, Petersen, C. Anne and Nightingale, Elena O. 1993. *Promoting the Health of Adolescents: New Directions for the Twenty-first Century*.

Orr, P. Donald and Langefeld, D. Carl 1993. *Factors Associated With Condom Use by Sexually Active Male Adolescents at-risk for Sexually Transmitted Disease*, Paper presented at annual meeting of the Society for Pediatric Research, Balimore.

Parker, Richard G. and John H. Gagnon 1995. *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World*.

Pattaravanich, Umaporn and Chanya Sethaput 1993. Information Provided by Rural Mothers to Their Daughter Concerning Reproductive Health. *UK/Thai Collaborative Research Development in Reproductive and Sexual Health Proceedings of the Symposium on The Mahidol-Exeter British Council Link*, 85-99.

Patton, Cindy 1993. 'With Champagne and Roses': Women at Risk from/in AIDS Discourse. *Women and AIDS: Psychological Perspectives*, 165-187.

Reid, Elizabeth 1997. Placing Women at the Center of Analysis. *AIDS in Africa and the Caribbean*, 159-164.

Ridgeway, Cecilia L. and David Dickema 1992. Are Gender Differences Status Different? *Gender, Interaction, and Inequality*, 157-176.

Sittirai, Werasit, Praphan Phanuphak, Barry Jean, Jim Brown 1992. *Thai Sexual Behavior and Risk of HIV Infection*. Institution of Population Studies, Chulalongkorn University Press.

Soonthorndhada, Amara 1996. *Modernity, Sexual Meaning: The Rhetoric of Adolescent Reproductive Health Implications*, Ford Foundation & UNFPA.

Spradley, James P. 1979. *The Ethnographic Interview*. Harcourt Brace Jovanovich College Publishers.

Streefland, Piekr H. 1995. Methodological and Management Issues in Applied Interdisciplinary AIDS Research in Developing Countries. *Human organization* Vol. 54, No. 3, 335-339.

Strong, Bryan and DeVault Christine 1994 *Human Sexuality*. University of California, Santa Cruz. Mayfield publishing company.

Tangcohnlatip, Kanchana and Nicholas Ford 1993. Husbands' and Wives' Attitudes towards Husbands' Use of Prostitutes in Thailand. *UK/Thai Collaborative Research Development in Reproductive and Sexual Health Proceedings of the Symposium on The Mahidol-Exeter British Council Link*, 117-131.

Tunchaiyanone, Suchela 1996. *AIDS Situation in Thailand: the Changing Meaning of Sexuality*.

Vance, Carole S. and Carol A. Pollis 1990. Introduction A Special Issue on feminist Perspectives on Sexuality. *The Journal of Sex Research* Vol. 27, No. 1, 1-5.

Weddle, Karen D., Patrick C. McKenry and Geoffrey K. Leigh 1988. Adolescent Sexual Behavior: Trends and Issues in Research. *Journal of Adolescent Research*, 245-257.

Weiss, Ellen, Whelan Daniel and Gupta Rao Geeta 1996. *Vulnerability & Opportunity: Adolescents and HIV/AIDS in the Developing World*. International Center for Research on Women.

Williams, David R. 1990. Socioeconomic Differentials in Health: A Review and Redirection. *Social Psychology Quarterly* Vol. 53, No. 2, 81-99.

APPENDICES

Questionnaire 1

Gender Difference:

- 1.1 What do you think are the characteristics/ qualifications of a good woman?
- 1.2 What do you think are the characteristics/ qualifications of a good man?
- 1.3 What do you think are the characteristics of good woman/ of good man involving sexual relationships?
- 1.4 What do you think of women having sex before marriage? (ask women)
 - 1.5 What do you think of men having sex before marriage? (ask women)
- 1.6 What do you think of men having sex before marriage? (ask men)
 - 1.7 What do you think of women having sex before marriage? (ask men)
- 1.8 In what way should men and women do things sexually – or different ways? (ask women)
 - 1.10 Do you think this situation is natural/fair? (ask women)
- 1.9 In what way should men and women do things sexually – or different ways? (ask men)
 - 1.11 Do you think this situation is natural/fair? (ask men)

Activities that lead to AIDS:

- 2.1 If friends (of your class/ around you) have sex, what activities lead them to that?
- 2.1 Are there activities which, if you followed them, seem like they might lead you into sex?

(Interviewer have prompts ready-smoking, drinking, going to parties,
associated with older kids, and with other places like bar, pub)

- 2.2 If friends (of your class/ around you) take drugs, what activities lead them to that?
- 2.2 Are there activities which, if you followed them, seem like they might lead you into drugs?

(Interviewer have prompts ready-smoking, drinking, going to parties, associated with older kids, and with other places like bar, pub)

3. The concept of being at risk:

- 3.1 Do you think you are at risk for AIDS? How? and Why?
- 3.2 What activities do you think put people (your friends) to be at risk?
- 3.3 What protects you from AIDS?

4. Their knowledge about AIDS:

- 4.1 Where did you learn about sex?

(Interviewer prompt-friend, parents family, school, movies/magazines, and etc.)

- 4.2 What kinds of things did you learn (sex)?

Do you believe it?

Do you follow it?

How have your beliefs changed?

- 4.3 Where did you learn about drugs?

(Interviewer prompt-friend, parents family, school, movies/magazines, and etc.)

- 4.4 What kinds of things did you learn (drugs)?

Do you believe it?

Do you follow it?

How have your beliefs changed?

Questionnaire 2

DATE _____ TIME _____ PLACE _____

FIRSTNAME _____ LASTNAME _____

INDICATE YOUR POSITION AS ONE OF THE CHILDREN IN THE FAMILY

ONLY CHILD ☐ ELDEST ☐ YOUNGEST ☐ OTHERS

NUMBER OF ALL THE FAMILY'S MEMBER RESIDENTS IN YOUR
HOUSEHOLD (INCLUDED YOURSELF) _____

WHO DO YOU LIVE WITH? _____

IF NOT PARENTS PLEASE INDICATE _____

IF YOU HAVE TROUBLE WHO WOULD YOU GO TO? _____

WHERE DO THESE PEOPLE YOU DEPEND ON LIVE? _____

THE NAME OF SCHOOL THAT YOU GO TO: _____

YOUR OCCUPATION: _____

CURRENT LEVEL OF EDUCATION THAT YOU RECEIVED: _____

MARRIAGE STATUS MARRIED SINGLE

IF SINGLE, PLEASE INDICATE IF YOU HAVE A RELATIONSHIP
IN THE FOLLOWING: _____

1.1 FAN (LOVER/ POPPY LOVE)

1.2 STEADY GIRLFRIENDS/BOYFRIENDS (MARRIAGE)

1.3 COMMERCIAL SEX WORKERS

1.4 NON COMMERCIAL SEX WORKERS (STRANGERS, PEOPLE WHO YOU MET
THAT WOULD HAVE SEX WITH YOU WITHOUT BEING PAID)

NATIONALITY: _____

RELIGION: _____

HOW OFTEN DO YOU PARTICIPATE IN RELIGIOUS ACTIVITIES? _____

HOW MUCH DO YOU ACCEPT THE BELIFE OF YOUR RELIGION?

☐ VERY MUCH

☐ SOMEWHAT

☐ A LITTLE

THE LEVEL OF EDUCAITON OF MOTHER: _____

MOTHER OCCUPATION: _____

THE LEVEL OF EDUCATION OF FATHER: _____

FATHER OCCUPATION: _____

PARENTS:

☐ MARRIED

☐ SEPARATED

☐ DIED

FAMILY INCOME PER MONTH

☐ LESS THAN 500 BAHT

(\$1 = 39.5 BAHT)

☐ 1,001 – 5,000 BAHT

☐ 5,001 – 10,000 BAHT

☐ 10,001 – 50,000 BAHT

☐ 50,001 – 100,000 BAHT

☐ MORE THAN 100,000 BAHT

KNOWLEDGE ABOUT AIDS

HIGH

MIDDLE

LOW

Questionnaire 3

1. Gender Difference:

a) Please explain the meaning of these concepts

*Fan (Lover/ Puppy love)	*Steady girlfriends/boyfriends (Marriage)
*Commercial sex workers	*Non commercial sex workers (strangers, people who have sex without paid)

↑ Card held by interviewer

- b) Which concept relates to you the most at this time?
- c) How are these concepts related or not related to sex?
- d) What do you think of women having sex before marriage?
 - 1) What do you think of men having sex before marriage
 - 2) What other things do you think are different for women and men as regards to sexual relations?
 - 3) Do you think this situation is natural/fair?
- e) What age do you plan to have sex? and why in that period?
- f) If you were going to have sex, what would be the first thing that you worry about?
and Why?
- g) What would be your motivation to have sex?
- h) If you have sex with someone, how would you perceive yourself?
 - 1) How would you perceive your partner?

2. Activities that lead to AIDS:

- a) If friends (of your class/ around you) have sex, what activities lead them to that?
- b) How does that process work?
- c) Are there activities which, if you followed them, seem like they might lead you into sex?
- d) Do you feel that your friends influence you to have sex?

(Interviewer have prompts ready-smoking, drinking, going to parties, associated with older kids, and with other places like bar, pub)

- e) If friends (of your class/ around you) take drugs, what activities lead them to that?
- f) How does that process work?
- g) Are there activities which, if you followed them, seem like they might lead you into taking drugs?

(Interviewer have prompts ready-smoking, drinking, going to parties, associated with older kids, and with other places like bar, pub)

- h) Do you feel that your friends influence you to take drugs?

If friends, what would they think of people in their group when they take drugs?

- i) Have you ever witnessed people of your same socioeconomic level buying or taking drugs?

If so, please give examples.

- j) Have you ever heard of these drugs?

Amphetamine Cocaine Heroin Valium

Marijuana Ecstasy Inhalants Ketamine

← Card held by interviewer

- 1) Which drugs do you or your friends take?
 - 2) How would they take it?
 - 3) Is it hard to get or not?
 - 4) Do you know where you can get these drugs?
3. The concept of being at risk :
- (a) Do you think you are at risk for AIDS? How? and Why?
 - (b) What activities do you think put people (your friends) to be at risk?
4. Their knowledge about AIDS :
- (a) Where did you learn about sex/drugs?

(Interviewer prompt-friend, parents family, school, movies/magazines, and
etc.)
 - (b) What kinds of things did you learn (sex/drugs)?
 - 1) Do you believe it?
 - 2) Do you follow it?
 - 3) How has your belief changed?
 - (c) Please explain what AIDS is.
 - (d) Please explain what safe sex is.
 - (e) If you were going to have sex, would you plan to use any protection? and What is that?
 - (f) If you were going to take drugs, how would you plan to use any measure in protecting yourself? and How?
 - (g) Have you considered having a HIV/AIDS test?
 - 1) When/ In what occasion?

2) Where?

(h) If you knew you had AIDS, where would you go to get treatment?