AIDS Prevention Strategies for Rural Families in Northeastern Thailand

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Abstract

The project AIDS Prevention Strategies for Rural Families in Northeastern Thailand aimed to find effective strategies for AIDS education for rural families to promote non-risk behavior, non-discrimination while supporting care for individuals with HIV/AIDS in their families and in the community; to provide opportunities for family members, community leaders and HIV/AIDS organizations to cooperate, exchange ideas, and to participate in campaigns at the community level; and, to find appropriate media to improve the knowledge, understanding and awareness of HIV/AIDS among rural families. Data was collected through interviews by questionnaires, group discussions and in-depth interviews in two districts in the target province. A comparison of pre-and post test data analyzing knowledge of HIV transmission, AIDS prevention and treatment, attitudes and motivations, prevention behavior and women's empowerment all showed a significant improvement in all the above areas for the trial population.

Key word : HIV/AIDS, Rural Family, Women's Empowerment

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New estimates show that infection with the human immunodeficiency virus (HIV) which causes AIDS is far more common in the world than previously thought. UNAIDS and WHO estimate that over 30 million people were living with HIV infection at the end of 1997. That is one in every 100 adults in the sexually active ages of 15 to 49 worldwide. Included in the 30 million figure are 1.1 million children under the age of 15. About one-fifth have thus far developed AIDS, of these over

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90 per cent have died[1]. HIV is spreading sometimes spread quite rapidly to new communities and countries around the world. The overwhelming majority of HIV infected people (more than 90 per cent) live in the developing world, and most of these do not know that they are infected[2].

An explosion of HIV has recently occurred in Southeast Asia, where within only a few years more than 6 million people have already been infected. Of great importance, the largest proportion of HIV infections by the year 2000 would be in Asia and Oceania (42 per cent), compared with 31 per cent in sub-Saharan Africa and 14 per cent in Latin America and the Caribbean[2].

In Thailand, the first case of AIDS was reported in 1984[3]. Since then HIV has been spreading rapidly among male drug users, and commercial sex workers. Transmission of HIV is then from men to families, and it has made a high incidence of HIV infection among women and children. By early 1997, more than 850,000 people were already infected[4], an additional 81,187 developed AIDS, 66,102 were men and 15,076 were women. Altogether, 21,418 of the people who died had AIDS[5].

The impact goes far beyond these statistics. AIDS is a unique pandemic. Unlike malaria, measles or polio, it particularly affects young and middle-aged adults; AIDS is a disease of human groups-families, households, couples and its demographic and social impacts multiply from the infected individual to the group. In the most affected areas, infant, child and adult mortality is rising, and life expectancy at birth is plummeting, for example, life expectancy in Botswana rose from under 43 years in 1965 to 61 years in 1990. Now, with between 25 per cent and 30 per cent of the adult population infected with HIV, life expectancy is expected to drop back to levels last seen in the late 1960s. By the end of the decade, Zimbabwe will see 10 years wiped off the life expectancy of a child born in 1990. In Uganda, one study in a rural area measured the life span of the population as a whole and compared it with that of the people who were not HIV-infected. It concluded that where some 8 per cent of the population was HIV-positive, the presence of AIDS in the community cut overall life expectancy by 16 years. Developing nations have made great strides in increasing infant and child survival in recent decades. These gains, too are threatened by HIV. Already, a quarter more babies under 12 months old in Zimbabwe and Zambia are dying than would be the case if there were no HIV. By 2010, Zimbabwe's infant mortality rate is expected to rise by 138 per cent because of AIDS, and its under five mortality rate by 109 per cent[1].

A decade of global experience has demonstrated that HIV prevention at the community level is entirely possible, but only if three key elements are in place : information/education, health/ social services, and a support social environment. Programs with commercial sex workers, adolescents, homosexual men, have all produced dramatic increases in both knowledge about HIV/AIDS and behavior changes. As one example, AIDS Education and Intervention Trials among Youths in Factories : A Pilot project, showed that most people in the groups which received AIDS education and intervention had better knowledge, attitudes and behavior related to AIDS prevention than the groups which had not yet received the intervention[6].

The combination of these three elements in creative, innovative and courageous ways has proven their ability to slow HIV transmission. Information and education are the first requirements. Most important is the involvement of target groups.

Prevention programs that target the general population have attempted to reach the vast majority of people, through the use of the mass media. The impact of the media has been well documented, although some countries continue to report low levels of knowledge about safer sex techniques[7]. Over the past decade, awareness about AIDS has increased dramatically in the general population. Individuals aware of HIV and AIDS often report some risk behavior changes, usually a reduction in the number of sexual partners and greater care in choosing partners[8]. The decrease in new infections in Thailand is the outcome of concurrent and sustained prevention efforts aimed at increasing condom use among heterosexuals, boosting respect for women, discouraging men from visiting sex workers, and offering young women better education and other prospects to discourage their entry into commercial sex.

HIV prevention needs of the general population differ depending on the country and community. In communities with a high HIV prevalence, a campaign whose objective is raising awareness about risk and promoting safer sexual behavior would be appropriate. In low prevalence countries, raising undue fear may be counterproductive.

Generally, urban youths are more at risk than rural youths because they tend to begin intercourse earlier and because the prevalence of HIV is higher in the cities[9]. Only 26 per cent of the developing countries and 43 per cent of industrialized countries included messages designed to help people to assess their own risk. General population campaigns to reduce discrimination have generally been neglected. This is a major omission, since fear of discrimination often discourages individuals from seeking prevention and care services[10].

Since the reported AIDS cases represent HIV transmission that occurred many years ago, heterosexual transmission is currently the most prevalent mode of HIV transmission in Thailand. In 1998, of the total number of AIDS cases, 42.6 per cent were labourers and 21.7 per cent were farmers. Most of these people were from rural areas, 28.8 per cent were aged 25 to 29, and 4.9 per cent were children under the age of four[5]. It is estimated that each year a large number of newborns being born to mothers with HIV will die early while the others will very likely be orphaned. Ominously, HIV is spreading from urban to rural areas, where most of the Thai population lives.

Therefore, there is a strong need to provide education and intervention on HIV/AIDS to these groups, yet models of education and intervention for rural families are still lacking. So the team sought to develop and test education and intervention models suitable for this population.

Objectives

There were many objectives in the study:-

1. To find effective strategies for AIDS education for rural families :

1.1 To change HIV risk behavior.

1.2 To live with people with HIV/AIDS without discrimination.

1.3 To give support and care to AIDS patients in families and in the community.

2. To provide opportunities for family members, community leaders and AIDS organizations to cooperate, exchange ideas, and to participate in campaigns against AIDS at the community level.

3. To find appropriate media :

3.1 To improve knowledge.

3.2 To ensure better understanding.

3.3 To create awareness of AIDS for rural families.

Methodology

The duration of the project was 18 months and the project site was two districts in Khon Kaen Province, northeastern part of Thailand, Kranoun District and Munjakeeree District. The target population was approximately 1,000 persons. Cooperation of the community leaders was obtained in advance. The data of this study were collected through interviews by questionnaires, group discussions and in-depth interviews of the individuals from the 2 districts mentioned above. The study group was divided into two groups, the sample in Kranoun District as the trial (implementation) group and that in Munjakeeree District as the control group. Data collection was conducted twice in each group, in the former, data was collected before the AIDS education campaign (Pre-test) and in the latter, data was collected after the AIDS education campaign (Post-test).

After Pre-test in the trial group, an AIDS education campaign was provided :

1. Training workshops for the different target groups ; the men's group, the women's groups and the youth groups.

2. AIDS educational media: audio cassettes which would be used both inside and outside the home, (even though the main purpose for the tapes was community broadcasts), calendars and posters with movie stars popular with the target population. All media produced was distributed to all of the sample populations, in every household, in every village and to the person in charge of the public broadcast system and to everyone who participated in the training.

3. Women's empowerment : the intervention focusing on women's groups which were subsequently developed included the provision of alternative ways for housewives to talk to their husbands and children about their behavior, and correction of misunderstandings about HIV/AIDS. The messages were given in the dramatic form of the traditional Northeastern community music theater.

RESULTS

The samples of the trial group consisted of 648 respondents in the Pre-test and 90 respondents in the Post-test, and the samples of the control group consisted of 323 respondents in the Pre-test and 50 respondents in the Post-test. When data collection was completed, data analysis was undertaken which gave the following results.

1. Characteristics of Sample Populations

The control group was comprised of 323 persons, 52.9 per cent male and 41.7 per cent female. The average age of this group was 28.3 years and most of this sample population had finished primary school. 67.2 per cent of this sample population was married, most with 2 children. The most common methods of contraception in this group were female sterilization and vasectomy. The average income of the group was 2,442.80 Baht/month. 57.6 per cent of this population were farmers.

The trial group was comprised of 648 persons, 51.9 per cent male and 48.1 per cent female. The average age of the group was 27.2 years. Most of this sample population had finished primary school. 66.6 per cent of this sample population was married, with 2 children. Their contraceptive methods also included female sterilization and vasectomy. The average income of this group was 2,233.30 Baht / month. 71.8 per cent of this population were farmers.

As can be seen, the sample characteristics of the control group and the trial group populations were quite similar.

2. Knowledge of AIDS and HIV transmission

In the Pre-test, the question which was answered incoorrectly most often by the control group was whether HIV/AIDS can be transmitted by mosquito bite. In the Post-test, however, a greater percentage of the control group answered this question correctly, i.e. 22 per cent *versus* 42 per cent. In comparison, the scores of the trial group rose from 26.7 per cent in the Pre-test to 76.6 per cent in the Post-test. (Table 1).

3. Knowledge of AIDS prevention and treatment

The question which was answered incorrectly by the control group and the trial group before the intervention trial was AIDS prevention can be achieved by having sex only with people who dress well and look chean. The results of the Pre-test and Post-test of the control group show that they had misinformation and misunderstanding of HIV/AIDS especially concerning "Taking antibiotics every time before having sex can prevent HIV infection". As for the other questions, the question which was answered incorrectly by the control group and the trial group before the intervention trial was, "What a person should do if they suspected that they had been infected with HIV". 70 per cent of the control group and 71.1 per cent of the trial group suggested that the person have their urine tested, while 60 per cent of the control group and 64.4 per cent of the trial group suggested having a stool examination. After the intervention trial. 64 per cent of the control group still suggested undergoing a urinalysis and 58 per cent a stool examination. The trial group by comparison had only 27.8 per cent suggesting a urinalysis and 22.2 per cent a stool examination (Table 2).

4. Attitudes and Motivations

The attitudes about AIDS prevention behavior were namely the attitudes held about sexual behavior. Both before and after the intervention trial, the control group showed incorrect attitudes about sexual behavior by reaching an average score of only 50 per cent for 4 questions. In comparison, the trial group's score was also less than 50 per cent in the Pre-test but went up to 80 per cent in the Post-test after the intervention trial.

In examining attitudes of personal behavior concerning HIV/AIDS, in the question, "If a neighbor is infected with HIV would you cut all ties with that person?", 52 per cent of the control group answered that they would cut all ties in both the Pre-test and Post-test. Among the trial group, 45.6 per cent answered that they would cut all ties, while only 21.1 per cent answered in the same manner in the Post-test. As for attitudes concerning commercial sex visits, both the control group and the trial group showed a good attitude in the Post-test about drinking alcohol and not participating in commercial sex afterwards, stopping commercial sex visits, and increasing condom use with commercial sex - visits.

In terms of motivations which would promote awareness about the problem of AIDS, it was found that after the intervention trial the answers of the control group and the trial had only slightly changed because they had already answered appropriately in the Pre-test.

5. AIDS Prevention Behavior

In the Pre-test and in the Post-test, both the control group and the trial group indicated condom use lower than 40 per cent and the availability of condoms for themselves or for their sexual partners was lower than 30 per cent. On the other hand, more than 50 per cent stated that they had previously warned their friends, acquaintances and

Table 1. Knowledge about HIV transmission.

Knowledge about HIV transmission	Control group								Trial group							
	Pre-Test				Post-Test				Pre-Test				Post-Test			
	Total No	% Yes	% No	Don't Know	Total No.	% Yes	% No	Don't Know	Total No	% Yes	% No	Don't Know	Total No	% Yes	% No	Don't Know
1. Eating with someone with HIV	50	18	64	18	50	8	88	4	90	24.4	58.9	16.7	90	3.4	96.6	0
2. Drinking from the same glass as someone with HIV	50	30	56	14	50	22	72	6	90	32.2	54.5	13.3	90	5.6	93.3	1.1
3. Living in the same house as someone with HIV	50	30	60	10	50	28	68	4	90	43.3	46.7	10.0	90	3.4	96.6	0
4. Sharing clothing with someone with HIV	50	30	58	12	50	18	76	6	90	42.2	44.5	13.3	90	9.0	89.9	1.1
5. Working together with someone with HIV	50	26	66	8	50	14	82	4	90	21.1	68.9	10.0	90	4.5	94.4	1.1
6. Using the same toilet as someone with HIV	50	44	44	12	50	34	62	4	90	45.6	47.8	6.7	90	6.7	98.3	0
7. Making merit with someone who has HIV	50	14	78	8	50	4	92	4	90	18.9	74.4	6.7	90	3.4	96.6	0
8. Sharing needies with someone with HIV	50	88	8	4	50	96	2	2	90	97.8	0	2.2	90	97.8	2.2	0
9. Studying in the same room with someone with HIV	50	12	78	10	50	8	90	2	90	10.0	83.3	6.7	90	4.5	95.5	0
10. Having sex with someone with HIV	50	92	4	4	50	92	6	2	90	98.9	0	1.1	90	100	0	0
11. A wife from her husband who visited a sex worker only once	50	88	4	8	50	82	14	4	90	93.3	2.2	4.4	90	96.6	3.4	0
12. From a mother who has HIV to her unborn child	50	92	4	4	50	94	6	0	90	97.8	0	2.2	90	94.4	5.6	0
13. Mosquito bites	50	70	22	8	50	54	42	4	90	70.0	26.7	3.3	90	21.1	76.6	2.2

Table 3. How to convince husbands not to visit sex workers and levels of impact on the husband's behavior.

	Control group									Trial group									
	Pre-Test (N = 27)				Post - Test (N = 27)					Pre - Test (N = 27)					Post - Test (N= 27)				
	High	Med	Low	Very Low	High	Med	Low	Very Low	No Answer	High	Med	Low	Very Low	No Answer	High	Med	Low	Low Very	No Answer
1 Don't give money	35.5	35.5	23.3	5.9	42.9	32.1	3.6	10.7	10.7	45.9	20.8	20.8	10.4	2.1	45.9	10.4	14.5	27.1	2.1
2. Instill concern for children and wife	94.1	5.9	-	-	75.1	7.1	7.1	7.1	3.6	64.5	20.9	8.3	2.1	4.2	77.1	14.5	4.2	2.1	2.1
3. Talk/explain about AIDS	47.1	47.1	5.9	-	67.9	14.3	7.1	7.1	3.6	56.3	29.1	10.4	2.1	72.9	72.9	20.8	-	4.2	2.1
4. Participate in women's groups which restrict men's visits to CSWs	35.3	35.3	29.4	-	46.4	32.1	3.6	7.1	10.8	20.8	39.6	20.8	16.7	2.1	58.3	29.1	4.2	6.3	2.1
5. Have relatives and parents speak to husbands	35.3	11.8	41.8	11.8	50.0	21.4	17.9	7.1	3.6	27.1	27.1	31.2	12.5	2.1	62.5	20.8	4.2	10.4	2.1
6. Have sub-district officials or village headmen speak to husbands	11.8	17.6	47.1	23.5	42.9	32.1	14.3	7.1	3.6	20.8	31.3	31.3	14.5	2.1	50.0	31.3	10.4	6.2	2.1
7. Have a Buddhist monk speak to him	23.5	5.9	29.4	41.2	46.4	14.3	28.6	7.1	3.6	27.1	14.5	39.6	16.7	2.1	33.3	20.8	22.9	20.9	2.1

Table 2. Knowledge of AIDS prevention and treatment before and after intervention.

AIDS prevention and treatment	Control group		Trial group	
	Before (%)	After (%)	Before (%)	After (%)
1. AIDS prevention can be achieved by				
1.1 Having sex only with people who dress well and look clean				
Yes	44	54	55.6	22.2
No	48	38	35.5	73.3
Didn't know / Didn't answer	8	8	8.9	4.4
1.2 Using a condom every time you have sex				
Yes	88	84	88.9	91.0
No	4	14	7.8	7.9
Didn't know / Didn't answer	8	2	3.3	1.1
1.3 Taking antibiotics every time before having sex				
Yes	78	90	15.6	5.5
No	12	4	76.7	90.0
Didn't know / Didn't answer	10	6	7.6	4.5
1.4 Don't have sex with Prostitutes				
Yes	92	70	84.4	84.4
No	0	28	11.1	13.3
Didn't know / Didn't answer	8	2	4.4	2.2
2. What a person should do if they suspected that they had been infected with HIV				
2.1 Blood test				
Yes	96	98	100	100
No	0	2	0	0
Didn't know / Didn't answer	4	0	0	0
2.2 Have their urine tested				
Yes	70	64	71.1	27.8
No	22	32	24.4	67.8
Didn't know / Didn't answer	6	4	4.4	4.4
2.3 Having a stool examination				
Yes	60	58	64.4	22.2
No	34	36	28.9	72.2
Didn't know / Didn't answer	6	6	6.7	5.6
3. AIDS can be cured				
Yes	4	4	6.7	10
No	88	92	81.6	90
Didn't know / Didn't answer	8	4	7.8	0

family members not to have sex with a commercial sex worker (CSW). In terms of having sex with a brothel-based CSW, the percentage of the control group participating in commercial sex was 18.2 per cent in the Pre-test, but 0 per cent in the Post-test. This means that the members of the control group did not have sex with a brothel-based CSW in the 3 months prior to the Post-test. In comparison, the percentage of participation in commercial sex of the trial group also fell, from 5 per cent in the Pre-test to 2.5 per cent in the Post-test. Furthermore, more than 80 per cent of the control group and the trial group did not use condoms with their spouses and never had sex with anyone other than their spouses.

In terms of condom provision services, both the control group and the trial group answered that the most convenient way was, to get a condom free of charge from the health station.

6. Women's Empowerment

In the Pre-test, women in both the control group and the trial group indicated the best way to convince husbands not to visit sex workers was for the wives to instill a concern for their spouse and children 94.1 and 64.5, respectively, followed by talking to the husbands' about HIV/AIDS, 47.1 and 56.3 respectively. (Table 3). The margin between these "high impact" ways to influence their hus-

bands' behavior narrowed in the Post-test survey to 75.1/67.9 among the control group and 77.1/72.9 in the trial group. It is interesting to note that in comparing the results of the Pre-test and Post-test questionnaires, both the control group and trial group results indicated a greater willingness to have outside groups, relatives and public officials intervene in this generally guarded "family matter".

The interventions focusing on women's groups which were subsequently developed included the provision of alternative ways for housewives to talk to their husbands about their behavior, correction of misunderstandings about HIV/AIDS, and examples of how family members discuss HIV/AIDS, STDs, and risk behavior. The messages were given in the dramatic form of the traditional Northeastern community music theater.

7. Results : Group Discussions.

At the beginning of the intervention process, villagers were invited to either the temple pavillion or the community center to listen to talks, an "orientation lecture", from project field workers and the local community leaders on HIV/AIDS, risk behavior and community/family efforts. A video tape on AIDS and STDs was shown and the villagers raised questions and engaged in discussion. Married women were the primary target population.

After contacts were made, married women, husbands, and youth were separately invited and organized into small discussion groups of 8 to 10 persons. There were 2 discussion facilitators assigned to each group to stimulate interaction and group dynamics. Group participants discussed situations in their communities, i.e. risk behavior, socio-cultural factors which contribute to the spread of HIV, and discrimination. Emphasis was placed on sexual and reproductive health and on the mobilization of members of the family and community in prevention, support and care.

Most of the members of the women's group, family group, leadership group, and the youth group had correct knowledge of HIV transmission. Only a few did not understand whether sharing facilities and personal items, such as public toilets, clothes, and mosquito bites with HIV-infected people could transmit HIV. Also, in terms of testing for HIV, there was a misunderstanding that HIV could be detected by urinalysis, stool examination and X-ray. Furthermore, they could not distinguish between HIV-infected individuals and persons with AIDS. These results corresponded with those from interviews by questionnaires.

In terms of awareness of the AIDS problem, most of the sample population knew that the AIDS epidemic is real but that it did not concern them. When discussing about people with AIDS, they stated that neighbors and the community still discriminated against people with AIDS (PWA) and that AIDS brought difficulties to the family because a family would have to spend a lot of money for treatment and thereby lose opportunities for the future.

In terms of motivation and motivational strategies for AIDS prevention, most of the sample population emphasized condom use campaigns, AIDS information publications, training, warning family members not to have "AIDS-risk behaviors", teaching about AIDS in the family while the children are still young. The person who would be considered the most effective person to take the role of warning the children was the father. Furthermore, in the women's group it was also emphasized that the wives should behave well so that the husbands would be considerate and would chose not to have sex with CSWs, or, they should demand their husbands use condoms if they can not stop having sex with CSWs. The youth group emphasized that AIDS is dangerous and should be broadcast. Additionally, the leadership group emphasized that condoms be available to both men and women all the time.

The groups felt that it was possible for them to come together in a united AIDS campaign. Priority should be placed on an active campaign against women becoming commercial sex workers.

In terms of media and AIDS education, most of the sample population got AIDS information from television, newspapers, videos, brochures or posters. The youth group and family group preferred personalized media, e.g. trainers and other complementary media such as video and pictures which emphasized fear. The women's group preferred the media that depicted fear and was full of pictures. The leader group required the long drama about AIDS which emphasized fear, and the preferred content should be AIDS symptoms to be aired on television. These responses corresponded to the data from interviews by questionnaires.

In regard to the roles of the family, community and organizations, most of the sample population were of the opinion that families should take the role of preventing family members contacting

HIV/AIDS, by teaching the children about sex education. The family members should also give love and care to one another in the family, train family members about AIDS, not permit family members to participate in commercial sex, and insist that the father become a good model for his children. Communities and organizations should take the role of providing AIDS knowledge to the villages. The community leader should be the one who teaches the people about AIDS. Group discussions should be arranged, and a cooperative effort against AIDS in the villages and a campaign against sending daughters to become CSWs should be conducted.

New values should be instilled in the community deferring to monogamy. The youth group should emphasize that the new generation should not drink alcohol, or smoke, and that the person who does not participate in commercial sex is considered a good person. Adults should behave well and become good role-models for their offspring. The family group was of the opinion that the campaigns against multiple partner relationships and campaigns to promote monogamy should be conducted while encouraging men to be aware of and take responsibility for their wives and children.

In determining AIDS risk behavior, the discussion groups were of the opinion that the behavior consisted of drinking alcohol, treatment by illegal doctors in the village, drug addiction, (including marijuana), traveling to the cattle and buffalo market, homosexuality, sexually explicit movies, gambling, playing snooker in villages, and false ideas about condoms which lead to non-condom use.

8. Results : In-depth Interviews.

From the in-depth interviews, it was found that most men had sex with CSWs before marriage without using condoms. Some men had sex with women in the village and with their wives before marriage. Nearly all men refrained from having sex with CSWs after marriage. In addition, none of the men used condoms while having sex with their wives because of the "unnatural feeling".

Most of the sample population had a good knowledge of HIV transmission. Only some of the individuals were not clear about non-transmission modes. Eating together, public toilets, wounds and mosquito bites, for example, were thought to be modes of HIV transmission.

In terms of AIDS prevention, abstaining from commercial sex visits or if participating in commercial sex, the use of a condom during sexual intercourse could prevent HIV.

When questioned about HIV testing, most of the sample population had the correct understanding that HIV can be detected through a blood test. A few people, however, misunderstood and thought that HIV could be detected by urinalysis and stool examination. Therefore, the answers obtained from the in-depth interviews matched the results of the interviews by questionnaires.

In terms of AIDS awareness, most of the sample population knew that the AIDS epidemic is a reality, but that the disease did not concern them because they did not have any risk behavior. Moreover, the sample population was of the opinion that society discriminates against people with AIDS. However, if someone close to them was infected with HIV, they would take care of them. Others said that they would move away from those infected.

Appropriate strategies for AIDS prevention included teaching children to identify with their families and warn them not to participate in commercial sex, but if they can not follow this, use condoms. The values of monogamy and virginity should be cultivated and promoted. Both parents and teachers should teach children about AIDS while they are young. In addition, the police should not permit the opening and operation of brothels, both commercial sex workers and clients should have their blood tested, and they should be taught about AIDS, also.

In seeking suggestions for AIDS prevention through the media, it was recommended that AIDS information training should be conducted much more than it currently is. Moreover, a doctor and a trainer should teach about HIV/AIDS in ways to make villagers understand. A drama about AIDS should be aired on television, and cassette tapes about AIDS should be played over the public broadcast system.

In discussing the problems and obstacles, it was mentioned that villagers always drink alcohol and then participate in commercial sex afterwards, and no one is willing to prohibit this from happening. Alcohol sold freely without regulation, large numbers of youths who are addicted to drugs, gather in gangs at snooker clubs, and later participate in commercial sex were listed as other problems. Furthermore, the parents and adults are unaware of what these young people are doing and therefore, it has become difficult to control their behavior.

Appropriate strategies to accomplish the objectives of changing HIV-risk behavior, living together with HIV infected persons without discrimination, and supporting and caring for persons with AIDS, emerged from the analysis of the data collected from the interviews by questionnaires, group discussions and in-depth interviews. These appropriate strategies were, organization of training workshops for the different target groups; for example, the men's group, the women's group, and the youth group. The workshops would use a combination of lectures, slide shows and video formats about how HIV is transmitted and not transmitted, AIDS symptoms, treatment and prevention. Special emphasis should also be placed on the areas where the target groups have answered questions incorrectly.

9. Training workshops

Group activities were arranged which emphasized attitudinal, motivational and behavioral HIV/AIDS prevention, including correct condom usage. These were arranged in such a manner that questions were raised and it was up to the participants to find the answers which could then be put into practice. There were 50 women attended the training workshop, each woman was selected from every 10 households located in the same area. They were consequently considered AIDS volunteer leaders to provide AIDS training for family members and members of their community. They were also expected to be the leaders of the women's groups to empower the women to bargain with family members and community members to change their HIV risk behavior.

Organizing training workshops in 2 formats not only provided AIDS information, but also provided the opportunity for family members, youths, community leaders, district officers and health workers to cooperate, share ideas and to participate in an AIDS prevention campaign at the community level.

10. AIDS educational media

Both the control group and the trial group indicated that the AIDS educational media from which they usually got AIDS information most was the television in the Pre-test. In the Post-test, the control group still answered that they got AIDS information most often from television, but the trial group answered that they got AIDS information most often from the trainers, followed by television, in the Post-test.

The preferred media indicated by both the control group and the trial group in the Pre-test was that they would like to have trainers to come and talk to them in the villages. In the Post-test, the control group answered that they preferred television, followed by training workshop, but the trial group answered that they preferred channels of information most often from the trainers, followed by television, cartoons, traditional music, in declining order in the Post-test. (Table 4). To this end, the villagers seemed eager for interaction and in-

Table 4. Preferred channels of information.

Channels of information	Control group				Trial group			
	Pre-Test		Post-Test		Pre-Test		Post-Test	
	No	%	No	%	No	%	No	%
1. Television	16	32	29	58	22	24.4	31	34.5
2. Radio	-	-	1	2	-	-	2	2.2
3. Poster / Calendar	6	12	-	-	6	6.7	2	2.2
4. Brochure	-	-	-	-	1	1.1	1	1.1
5. Cartoon	-	-	-	-	-	-	5	5.6
6. Traditional Northeastern community music theater	-	-	-	-	2	2.2	3	3.3
7. To have trainers came to discuss in the villages	24	48	20	40	51	56.7	42	46.7
8. A doctor	-	-	-	-	3	3.3	2	2.2
9. Slides, movies, videos	2	4	-	-	5	5.6	2	2.2
10. Books about AIDS	2	4	-	-	5	-	-	-
Total	50	100	50	100	90	100	90	100

volvement and it was this eagerness which helped in the creation of a calendar produced in collaboration with the movie star magazine, Darapapayon. The calendar contained photographs of famous movie stars and motivational statements to evoke prevention behavior and compassion and care for those with HIV and AIDS in the community. Of perhaps greater significance is that the villagers took an active part in developing the calender, choosing the movie stars they preferred, writing the motivational statements, and in the pre-testing. In addition, a large poster which was very colorful and designed to attract attention, was produced containing the same photographs and motivational themes as those in the calender.

The suplementary media for increasing AIDS knowledge, understanding and awareness, the research team adapted the analyzed results to be used as guidelines in media production. Besides the production of radio cassettes which would be used both inside and outside of the home, (even though the main purpose of the tapes was community broadcasts) other media as mentioned above, included calendars, and posters with movie stars popular with the target population (from the data from in-depth interviews and discussion groups) and pictures of the villagers themselves (selected by the trial group). In addition, a motivational message about AIDS prevention accompanied each picture.

All media produced was distributed to all of the sample populations, in every household, in every village and to the person in charge of the public broadcast system and to everyone who participated in the training.

Conclusions and Recommendations

The project team concluded that the villagers were enthusiastic and actively participated through out the project implementation period. We also felt that project really captured the interest of married women. Moreover, the involvement of local authorities, approaching the target population especially the district hospital personnel and district officers was crucial to the success and institutionalization of these intervention strategies. The project team has since been informed that they will continue and expand this effort. Whatever the case, the following conclusions were given:

1. The people in the rural area have good knowledge about how HIV is transmitted but they still do not understand how HIV is not transmitted.

2. The people in the rural area can not distinguish the difference between HIV infected persons and persons with AIDS, and they also do not understand that asymptomatic HIV persons can spread HIV.

3. Rural people think that besides a blood test, HIV can be detected by urinalysis, stool examination, vaginal examination and X-ray.

4. Most of the people still discriminate against people with HIV/AIDS in the community, but if someone close to them is infected with HIV they would have them move out or take them to the hospital to have the hospital staff look after them.

5. Talking about condoms was embarrassing especially for women. Moreover, men usually refused to wear them or used them incorrectly when they did consent to wear them.

6. The rural women were too embarrassed to talk to their husbands about sexual behavior. Even though their husbands had extramarital sex and thought that their husbands did not tell the truth they remained quiet because they wanted to avoid quarrels.

7. Most men realize that they can get HIV if they have sex with commercial sex workers, but they do not realize that they can get infected through casual sexual encounters with non commercial-sex partners.

8. Training and group activities will increase the training participants' understanding, moreover, they can share ideas and opinions with one another.

9. Appropriate media should be produced in the form that the target groups will understand easily. They should be produced with the target group's needs in mind. In addition, it is beneficial to have the target group participate in the media production, and be represented in the media through pictures, sounds or linguistic dialect.

10. HIV educational programme for rural families should also keep in mind, time, place, climate, planting seasons, saling seasons for agricultural products and local dialects.

Although the incidence of HIV infection in Thailand is still increasing at present, the trend of new HIV infection has shown a decrease since 1994 in populations other than pregnant women and newborn children. The World Health Organization has estimated that the HIV prevalence in women will be equal to that of men by the year 2000. The reason for this is that the HIV epidemic was spread

by men who participated in commercial sex before marriage or as an extra-marital activity, resulting in the HIV epidemic spreading to families. Therefore, it seems clear that this project, AIDS Prevention Strategies for Rural Families in Northeastern Thailand, is an important project which can prevent AIDS from spreading to families. This is especially true for rural families which lack the opportunities to obtain information and education. Because of the depressed economic state of the rural areas, family members must leave the village to find work in the cities, resulting in changes in behavior, including risk behavior. The result of this study indicated the effectiveness of the training format mentioned and the development and use of appropriate media are the strategies which help the target population develop AIDS knowledge, a good attitude about risk behavior, HIV prevention methods, and the ability to live with people with HIV/AIDS without discrimination.

In addition, this effective training form should be implemented in other provinces and in other appropriate sectors through the cooperation of relevant agencies, then it may be possible to reduce the incidence of HIV throughout the country through the policy "Thai families against AIDS".

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กลวิธีป้องกันโรคเอดส์ สำหรับครอบครัวชนบท ในภาคตะวันออกเฉียงเหนือ

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โครงการวิจัยเรื่อง "กลวิธีป้องกันโรคเอดส์ สำหรับครอบครัวชนบท ในภาคตะวันออกเฉียงเหนือ" เป็นโครงการวิจัยเพื่อหารูปแบบและสื่อที่เหมาะสมในการรณรงค์ป้องกันโรคเอดส์ โดยใช้ข้อมูลที่ได้จากการศึกษาวิจัยเชิงปริมาณและการวิจัยเชิงคุณภาพ จากประชากรเป้าหมาย มาสร้างรูปแบบและจัดทำสื่อแล้วนำไปทดลองใช้กับประชากรตัวอย่างในกลุ่มทดลอง ประเมินผลด้วยการวัดระดับความรู้ ทัศนคติและแนวคิดในการป้องกันพฤติกรรมเสี่ยงต่อการติดเชื้อ เปรียบเทียบระหว่างก่อนและหลังการรณรงค์ฯ ในกลุ่มเดียวกัน และเปรียบเทียบกับกลุ่มควบคุม ใช้ระยะเวลาในการศึกษาวิจัย 1 ปี 6 เดือน โดยใช้พื้นที่และประชากรในจังหวัดขอนแก่น

ผลการวิจัยพบว่า รูปแบบในการให้ความรู้ที่ประชากรเป้าหมายต้องการ คือการจัดอบรมเป็นกลุ่ม โดยวิทยากรที่มีความรู้มาบรรยาย พร้อมกับมีภาพสไลด์ หรือวิดีทัศน์ ที่เกี่ยวกับเรื่องโรคเอดส์ให้ดูประกอบ สื่อที่ต้องการ ได้แก่ โทรทัศน์และเทปเสียง เปิดตามหอกระจายข่าว เมื่อนำรูปแบบและสื่อไปทดลอง พบว่าประชากรในกลุ่มทดลอง มีความรู้ทั่วไปเกี่ยวกับโรคเอดส์ ทัศนคติเกี่ยวกับพฤติกรรมการป้องกันโรคเอดส์ และการอยู่ร่วมกับผู้ติดเชื้อ/ผู้ป่วยเอดส์โดยไม่รังเกียจ แรงจูงใจเพื่อให้เกิดความตระหนักต่อปัญหาโรคเอดส์ ดีกว่าก่อนการรณรงค์ฯ และดีกว่าประชากรกลุ่มควบคุม ผู้วิจัยเสนอแนะให้ทำรูปแบบนี้ไปใช้กับประชากรทั่วภูมิภาคและทั่วประเทศ เพื่อลดปัญหาการแพร่ระบาดของโรคเอดส์สู่สถาบันครอบครัว

คำสำคัญ : เอ็ชไอวี/เอดส์, ครอบครัวชนบท, ประชากรเป้าหมาย

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