Sex Education and Women's Health: Attitudes of Thai People Toward Sex Education

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SEX EDUCATION AND WOMEN'S HEALTH: ATTITUDES OF THAI PEOPLE TOWARD SEX EDUCATION

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ABSTRACT

In the era of the worldwide HIV/AIDS epidemic, heterosexual women have become one of the groups most vulnerable to this disease, and women in Thailand are no exception. Sex education is one of the ways women can become both more knowledgeable about sex and more aware of the impacts of gender ideologies on their perceptions and sexual behavior patterns. Sex education can therefore empower women to assert control over their lives and their health. Teaching or publicly discussing certain aspects of sex and sexuality, however, is still unacceptable in Thai society, and many Thai women are not obtaining the information essential for redefining their relationships with their partners or negotiating for safer and healthier sex lives.

This study investigates the attitudes of Thai people toward sex education in terms of their readiness to accept information about sex and sexuality. The study finds that many of the respondents still lack accurate knowledge about biological, psychological and practical aspects of sex. Although the study's findings indicate that many Thai people have positive attitudes toward sex education, many hold misconceptions about gender and sexuality. Many respondents are reluctant to include topics such as homosexuality, abortion or sexual intercourse in sex education curricula.

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Chapter I

Introduction

My role in Thailand's Department of Non-Formal Education in the Ministry of Education is to develop curricula and learning/teaching materials for non-formal education[1] programs. These programs cover various areas of information and knowledge to serve the out-of-school population, or people who cannot access schooling services or lack opportunities to further their education in a formal schooling system. Health and AIDS education are among the Department's programs.

From my nearly four-year-long involvement in developing health and AIDS education activities, I have learned that realistic and accurate information concerning sex and sexuality is limited for many in the Thai population, particularly for young adults in rural areas. The education provided as a part of such courses as Health, Science, and Physical Education is very superficial. Moreover, these subjects are mostly taught at the secondary education level, grades 8 and 9. According to educational statistics of the Ministry of Education (1992), many students in rural areas do not continue on to secondary education. In order to reach more students, sex education in school must begin earlier, at the primary education level. At the same time, non-formal education should supplement information about sex education for out-of school population through its education programs as well.

Though many health promotion programs provide information concerning sex education — for example, family planning programs and AIDS prevention campaigns for the out-of-school population — the programs often target particular clients (e.g., married

persons, military conscripts). Sexual practices are rarely discussed between husbands and wives and even less between parents and children. Most people receive information concerning sex and sexuality from friends, direct experience and some mass media. This information may not be realistic or accurate.

I am confident that providing education on aspects of sex and sexuality for various groups at every level of the education programs will encourage positive health behaviors, particularly for reproductive health, among Thai people. It will also be one measure to reduce or eliminate women's ill health as caused by unsafe sex practices. Certain issues related to sexual conduct are generally treated as social taboos by the majority of the Thai people. Introducing issues such as abortion or homosexuality to Thai society, especially to children, may therefore be met with skepticism and resistance. Conveying realistic knowledge about sex to the target groups without offending the Thai public's views is, therefore, very crucial and needs careful consideration.

The purpose of this study

According to Weinstein (1989), different people will be at different stages of readiness for behavioral change and interventions to move people toward a desired behavior should vary according to these stages. It is necessary therefore, first, to assess the stage of clients' readiness for change, then tailor interventions or approaches for behavior change accordingly.

People's current attitudes and their degree of exposure to sex education put them at various stages of readiness to accept information and knowledge that will improve their sexual and reproductive health. It is very important that the content of sex education

should cover the current needs of the learners, and recognize socio-cultural attitudes. An examination of people's present level of knowledge about sex and sexuality as well as their attitudes toward the necessity for formal sex education is therefore crucial. Such an examination will inform program developers about ways to eliminate people's skepticism about the provision of sex education and to help them both accept the knowledge provided and modify their sexual attitudes and behaviors.

This study aims to assess the stages of the Thai people's readiness for sexual behavior change by examining their attitudes toward the necessity for sex education. The findings of this study will indicate the current needs for sex education and present levels of knowledge or information about it. The results of this study may also reflect people's willingness to adopt knowledge and change their sexual practices. It is hoped that these findings will be used as guidelines for Thai educators and curriculum developers to consider as they expand the scope of existing sex education in the future.

Organization of the study

This thesis consists of five chapters: *Introduction, Conceptual Framework, Overview of Thai Sexual Behaviors and Their Impacts on Health, Study Design and Methodology*, and *Results and Discussion*.

This chapter, *Introduction,* explains the background, purpose and scope of the study.

Chapter 2, *Conceptual Framework,* discusses the influence of cultural values and social norms related to sex and sexuality on people's perceptions, attitudes and behaviors related to their sexuality, and describes how such perceptions, attitudes and behaviors

affect their sexual and reproductive health. This chapter suggests that people have different degrees of consciousness about the impacts of sex and sexuality on their health. Such differences put people at various stages of readiness to change their sexual attitudes or to adopt healthier sexual behaviors.

The discussion in this chapter shows that exposure to accurate and realistic information about sex and sexuality helps people to become aware of the impacts of sex and sexuality on their behavior and can eventually change such behavior. It also shows that sex education can foster changes in negative sexual beliefs, attitudes and behaviors and promote the improvement of people's sexual and reproductive health.

Chapter 3, *Overview of Thai Sexual Behaviors and Their Impacts on Health,* surveys a number of issues concerning sexual knowledge, attitudes and practices of Thai people. It is a discussion of the way cultural values and norms related to sex and sexuality affect particularly Thai women's sexual practices and how such practices affect their health. The discussion in this chapter suggests what types of information about sex education are needed in present Thai society.

Chapter 4, *Study Design and Methodology,* describes the design and methodology of this study. It includes background information about the study setting, profiles of the study site, criteria for site selection, the sample population, instruments employed in the study, procedures of data collection, and the limitations of this study.

Chapter 5, *Results and Discussion,* presents the findings and my discussion of them. The results are divided into two parts: data gathered from a questionnaire survey and data from interviews and a small group discussion. Data from the questionnaire are presented in three parts — participants' characteristics, participants' attitudes toward and

need for sex education, and the level of their current knowledge about sex education and some safer sex practices. Data from the interviews and group discussion are presented in excerpt form to highlight the findings from questionnaires. Finally, I discuss how the results can be used and present other interesting aspects of the study.

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[1] **Non-Formal Education** in Thailand has originated from adult education programs launched in 1938, just prior to the Second World War. The Department of Non-Formal Education was set up in the Ministry of Education when the concept of lifelong education became prevalent. Non-formal education programs include literacy campaigns, functional literacy program, work-oriented functional literacy, primary and secondary school equivalent education -- as obtained from the conventional schooling system, and occupational skill training. Non-formal education activities also include the provision of village learning centers and district public libraries; and educational radio and television programs, regularly broadcast through national and local stations.

Chapter 2

Conceptual Framework

In *Women and Health* (1991), Smyke proposes that women's health is affected by economic, social status, demographic and political factors. She adds that most women in the world live in extreme poverty. Being poor, many of these women cannot afford the right kind of food or shelter or get health care when needed. Women are expected to perform several roles at one time, and trying to handle the conflicts arising from these roles exposes women to a great deal of stress. When there are imbalances between population growth and the availability of natural resources, women are subjected to control of their reproductive ability. Though I found Smyke's discussion useful to a certain extent, I also found that the impact of these factors was too broad to pinpoint their link to particular health problems of women.

Because I have focused this study on women's reproductive health, I have narrowed my investigation to the way sex and sexuality influence women's perceptions and health behavior patterns. I have taken a social constructionist approach and assume that cultural values and social norms regarding sex[1] and sexuality influence people's perceptions and attitudes related to their own sexuality. In turn, these perceptions and attitudes influence individuals' sexual behaviors and so affect their sexual and reproductive health. Therefore, I explore North American literature which discussed factors that influence people's perception and attitudes related to sexual behaviors, and show how

such perceptions, attitudes and behaviors affect the conditions of their sexual and reproductive health.

I also assume that people have different degrees of consciousness about the impact of sex and sexuality on their health. As a result, people are at different stages of readiness to change their sexual attitudes and adopt healthier sexual behaviors. I also assume that exposure to accurate and realistic information about sex and sexuality will help individuals be aware of the impact of sex and sexuality on their behaviors and eventually cause changes in their behavior. Sex education is one approach to inform people of such information.

This review of literature has also convinced me that sex education has the potential for changing people's sexual practices. It is an initial approach to prepare people for such change. I feel that being knowledgeable about sex and sexuality will encourage Thai women to make changes to achieve their well-being in the society. I will use the conceptual framework presented in this chapter to understand sexual matters in Thai contexts better, and to provide the groundwork for introducing sex education that is appropriate for the Thai people.

In addition, I will explain how sex education can encourage people to change their negative sexual beliefs, attitudes, behaviors and promote the improvement of people's sexual and reproductive health. The discussion in this chapter will also clarify the scope of what I mean by sex education.

The scope of sexuality: the definition

Generally, the term *sex* is used either to identify the human biological gender as female and male or to refer to physical activity involving the genitals (i.e., having sex). Irvine (1995) says that most people do not ask for clarification when a friend talks about "having sex." She also claims that many people in the United States perceive sex simply and narrowly as sexual intercourse.

In examining 25 sex education related texts published during 1975 to 1984 and commonly used either in health and sex education classes at college level or education methods texts and curricular guides in these areas, Whatley (1988) found that sex education in school curricular materials and teacher education texts revealed the often subtle misinterpretation of biology that can strongly affect both female and male students in terms of their psychological perceptions and attitudes about sex and sexuality. She explained that school sex education texts often stressed that sex hormones play a major role in physical and psychological changes in girls and boys during puberty. In other word, biological factors determine differences in female and male sexual development and in their sex roles. The implication here is that biological factors determine the norms and anything else is abnormal. Consequently, sex education teaches students that the norms are the biological sex roles of heterosexual relationships in terms of courting, dating and marriage.

This assumption is, however, slowly changing. Over the last two decades, educators in many parts of the world have begun to promote and encourage a view of sex not just as the capacity for certain physical acts but as an aspect of an individual's total personality (Irvine, 1995). Masters, Johnson and Kolodny (1992) also suggest that sex is

the center of such ancient institutions as marriage and the family. It dominates almost every aspect of many cultures and societies. In general, the word *sexuality* has come to have a broader meaning than sex. It refers to all aspects of being and feeling sexual. Sexuality includes emotions, beliefs, attitudes and values, as well as a physical dimension The expanded dimension of sexuality gives people a more comprehensive means to perceive and evaluate the consequences of sexual activity and knowledge about sex.

The construction of human sexuality can be projected by theoretical explanations of sexual meanings, the formation of sexual cultures and the organization of systems of sexuality and gender (Irvine, 1994).

Traditional theories of sexuality

Traditional work on sexuality has emphasized biological differences. Sigmund Freud (1856 - 1939) was one of the earliest theorists. His theory of human sexual development has been widely popularized and still influences current discourse on the nature of human sexuality. Freud saw the sexual development of girls and boys as fundamentally different and emphasized that these physical differences were bound to lead to differences in psychic development. According to Freud (1977), the different development of girls' and boys' sexuality begins with the Oedipus complex, and girls have three lines of development after they recognize that they do not have a penis. They may either have a general revulsion from sexuality, cling to threatened masculinity, or follow a roundabout path to femininity (Freud, 1977:336). Freud asserted that when a girl realizes that she does not have a penis, she perceives that she is inferior to boys.

More contemporary sex researchers (e.g., Kinsey, 1953 and Masters and Johnson, 1966) also projected a powerful belief in universal differences between female sexuality and male sexuality. They were convinced that sexuality is a natural force existing in every human being at birth. The differences are the result of biological factors that constitute the sex drive. Because sexuality is an internal, probably biological drive or instinct, it is universally expressed throughout different historical times and across different cultures.

Irvine (1995) argues that the traditional notion that sexuality is a deep and natural instinct has given powerful support to the idea that males are naturally sexually aggressive while females are naturally sexually passive. This myth also reinforces the idea that women have to be responsible for taming or controlling the powerful male sex drive. In many cases, such a myth is an excuse to force women to accept a double sexual standard and men's sexual promiscuity. It has taken decades for the contemporary women's movement to dislodge the idea that rape results from an uncontrollable explosion of male sexual drive.

The concept of sexuality as a social construction

Over the last two decades, researchers of sex, gender and sexuality have developed new perspectives on these subjects. Many researchers on human sexuality (for example, Basow, 1992; Brettell and Sargent, 1993; Jacobsen, 1994; and Lorber, 1994) have employed the social construction theory to investigate sexuality and individuals' sexual behavior and experience. These social constructionists reject the idea that gender is biologically innate. To them, the differences in female and male biological sexual functions do not control the development of physical and mental superiority/inferiority in women

and men. Rather such hierarchies have more to do with the social construction of gender than with genetic and hormonal factors related to sex (Adesso, Reddy and Flemming, 1994). In fact, to some, gender is a human invention like religions, language and technology (Lorber, 1994). Gender constructing processes begin the day a person is born — for example, new-born babies will be talked to or treated differently according to their sexes and baby girls will be dressed differently from baby boys.

Social construction researchers argue that sexuality is not a fixed foundation of human life that developed in a predictable manner because of certain biological functions. Instead, sexuality is a social product constructed by the social and cultural influences of specific historical times. It is not biologically innate. Each culture creates its own sexual ideology[2]. This ideology creates series of certain behavioral patterns and roles that women and men are expected to perform within their society. To understand individuals' sexuality and behaviors, one must understand the range of meanings they attach to particular behaviors, feeling, and fantasies (Irvine, 1995).

The social construction theory challenges popular ideas of human sexuality as a hormonally driven imperative by suggesting that culture is a key factor for understanding sexuality and human sexual behaviors. The theory proposes that what people consider to be sexual can vary greatly from culture to culture and that human sexual interests, behaviors, expectation, and perhaps even desire are arbitrated by the available set of cultural options rather than by a behavioral constant:

> Sexuality is not universal either throughout history or across cultures. It is doubtful that there is an internal, essential sex drive or force. Biology plays a small role, if any, in determining our sexuality. Sexuality is a deeply influenced and constructed by social, political, economic, and cultural

factors. We must examine the specific meanings attached to sexuality at particular historical moments in particular culture (Irvine 1995: 14).

According to this view, sexuality is a historically evolving set of ideas that evokes a range of responses and attempts at regulation. Hence, the development of human sexuality is not simply a developmental stage characterized by physiological surges. Every stage of sexuality development is given meaning by the culture in which people live. Sexuality therefore takes shape in interaction between the individual and the social world (Irvine, 1994 and 1995).

The elements of sexuality

The social construction theory also projects the ways cultural values and norms influence the composition of sexuality and how each element of sexuality affect people's sexual perceptions, attitudes and behaviors. While a common and widespread definition of sexuality refers to the functions of biological reproduction and sexual relations, what constitutes acceptable sexual practices varies depending upon the cultural, religious and economic conditions of a society. Cultures differ in the degree of importance they give to conceptions of sexuality relationships in day-to-day activities.

Stromquist (1992) comments that sexuality is often defined in ways that seriously constrain women's physical mobility and autonomy and consequently shapes individual and collective conceptions of what women should be. Herold (1989) agrees, saying that attitudes toward female sexuality differ from those toward male sexuality. For example, in most societies, sexual activity by men is more acceptable or encouraged than that by woman. In 1984, Bleir argued that sexuality is more a construct of ideology and culture

than a collection of information about biology and the body. By 1992, Stromquist described sexuality as a composition of the following elements:

- sexual characteristics (the physiology and anatomy of sexual organs);
- sexual beliefs (beliefs concerning women's virginity, men's sexual drives, impurity of menstruation, etc.);
- cultural norms (sexual double standard, women's virginity, etc.);
- sexual taboos (masturbation, abortion, knowledge of heterosexual and homosexual practices);
- physical and psychological violence (rape, sexual abuse, sexual harassment, etc.).

These elements of sexuality are used to create sexual ideologies and sexual standards, which are employed by various social institutions to control and guide human sexual behaviors and practices. Althusser (1971: quoted by Dwyer 1978: 227) suggests we must understand the structure and functioning of such ideological apparatus in order to comprehend how systems of domination are perpetuated from generation to generation. With respect to sexuality, power and control are axial to the modern understanding of humans as sexual beings (Bleir, 1984).

Sexual ideology and its influence on women's behavior

In the fields of psychology and social science, (e.g., Institute of Medicine, 1994; Beall and Sternberg, 1993; and Sprecher and McKinney, 1993), it is argued that human behaviors are conditioned and determined by multiple factors in the individual and in social environments. The individual factors include roles, attitude, experience, knowledge, self-

esteem and so on. Factors in the social environment range from cultural values, social norms, and levels of social arrangements, to social institutions.

Evidently, women's reproductive roles are often arbitrated by socio-cultural factors, especially factors that relate to sexual ideology and sex roles. These factors have prevented women from controlling and improving their reproductive health. Ruzek, Clarke and Olesen (1997) suggest that a health model for women should emphasize the ways sex roles as well as other social roles and rules affect women's health behaviors. They propose that paying attention to social and behavioral factors in health can enhance the development of risk reductions and expand physicians' perceptions of sources of women's ill health. In other words, to understand women's health problems, it is necessary to see the way sexual ideologies and standards influence women's behaviors and health practices.

Sears (1992) explains that ideology is a constellation of beliefs and values, embedded in a particular social and cultural context and often held unreflectively by individuals. Rinehart (1993) sees ideology as the reflection of people's values. According to Sears' and Rinehart's arguments, ideology originates from cultural traditions and social contexts. Social ideology and social contexts create and influence an individuals' personality or behavior pattern characteristics. According to social constructionists, socialization is usually regarded as an important process of creating and maintaining sexual ideology. McKinney defines the process:

> Socialization is the process of teaching and encouraging the development of an understanding of the appropriate ways to think and behave within a particular society. ... Socialization, then, is also a form of social control. Teaching particular value or norm guides and limits a person's beliefs and behavior ... The socializing agents in the area of sexuality are, primarily,

> parents, siblings, spouses, peers, media, church, school and legal system. The content of sexual socialization includes sexual attitudes, values, behavioral norms, and gender roles (1986: 105).

Dwyer (1978) states that sexual ideology has played a crucial role in forging certain perceptions, behaviors and consciousness in females interacting with males in their society. Sexual ideologies also restrict individual functioning and influence many negative relationships between women and men in a society. Usually, expectations about social behaviors often involve norms that affect sexuality and sexual ideology provides behavioral standards which guide or limit individuals' behaviors. Many forms and degrees of these ideologies or standards continue to place women in positions subordinate to men. From this point of view, sexual ideology is more than the observance of certain sexual mores or the expression of particular sexual beliefs. It reflects the hegemonic power of dominant social groups to control the body politic, and also reflects the limits of this power. These characteristics influence the way individuals perceive both the behavior of others and their own behavior.

Virginity is an example of a worldwide aspect of sexual ideology. Though certain aspects of this ideology also apply for some groups of men — celibacy for Catholic priests or abstention for Buddhist monks, Afshar (1985) argued that virginity appears to concentrate on women and holds women responsible for their family's honor. Concerns for women's virginity and safety — which at first appear to be measures to protect vulnerable women — result in establishing social controls or constraints on women's behaviors and provide justifications for denying women certain rights (Stromquist, 1992: 55). For instance, girls and young women are often forbidden to acquire information or

knowledge related to sex or sexuality for fear that it will encourage them to engage in premarital sex. In rural areas in Thailand, for example, girls are discouraged from participating in vigorous sports because people still believe that girls who do so may break their hymens.

The beliefs and standards about virginity in many Western societies may have changed. They are, however, still practiced by most Asian people, including Thai. Ward and Taylor (1994) studied six ethnic groups in America — Vietnamese, Portuguese, Black, White, Haitian and Hispanic. Their study shows that in all groups, boys were generally allowed more freedom and were assumed to be more sexually active than girls. Sexual activity for adolescent females was discouraged before marriage. Girls were always taught that sex is acceptable only within the framework of marriage or long-term relationship (Ward and Taylor, 1994: 63). The value placed on virginity not only prevents women from obtaining information or knowledge that would better their health and life, it also requires women to bear the burden of a double standard in sexual behavior and sex roles in society.

In their study, Thomson and Holland (1994) argue that young heterosexual women lack power, autonomy and control within sexual situations. They illustrate the way heterosexual standards shape and constrain women's practice of both unprotected and safer sex. Thomson and Holland explain that condoms are often associated with certain types of sex. For example, condoms are often used for a one-night stand or a sexual encounter outside an established relationship. When women feel that the relationship has moved to a steady stage, they often cease condom use and transfer to the pill as a method of contraception. This is because condom use in the steady relationship is often regarded

as the lack of mutual trust between partners. Many young women's objections to the use of condoms are also centered around fears of the partner's disapproval, which is related to male sexual pleasure and sexual disruption (Thomson and Holland,1994: 22-23). This situation is also similar to the Thai situation which I will discuss in the next chapter.

Morokoff and Calderone (1994) emphasize that awareness of the consequence of sexuality is an important aspect of the decision to engage in sexual behavior, especially with respect to safer sex practices. They also explain the effects of power on the sexual relationship where a traditional sexual norm is that it is a woman's duty to be sexually available to her husband. Conversely, the husband has the right and duty to have sex with his wife. This norm suggests that the man is supposed to initiate sex and the woman just goes along.

In their study, Morokoff and Calderone find that 51 percent of husbands and 48 percent of wives indicated that the husband is more likely to initiate sex, and 42 percent of male partners over age 40 indicate they would be bothered by their partner's initiating sex (1994: 255-256). Though the study does not report husbands' reactions to their wives' refusal to have sex, it concludes that the inability to initiate or refuse sex with their husbands causes stress in the wives and can result in their infertility as well.

Dwyer (1978) notes that many prominent social and political theorists, such as Marx and Engels, Lukacs and Sartre, have postulated the importance of ideology in promoting or hindering change at the socio-political level. Dwyer comments that:

> By providing its adherents with a radical perspective on existing social conditions, for example, a potent ideology can encourage shifts in consciousness, shifts that can lead a subjugated group to protest its own subjugation. Alternatively, a well-formulated ideology of dominance can

rationalize the existence of a system appear closed to the possibility of reform (1978: 227).

Rinehart (1993) sees ideology as the reflection of people's values and states that the ways women accept or challenge social ideology such as sexual ideologies reflect the values that shape women's very beliefs about what it means to be a woman. Dwyer suggests:

> If an ideology validates inequality in the eyes of its believers, and if variants from that ideology serve as indicators of discontent among certain segments of the populace as well as potential stimuli for protest and change, the distinction of female and male views on gender role ideology might lead to generalized insights about the structure of sexual ideology and might additionally lead to a regrouping of sexual ideologies in more meaningful political terms (1978: 228).

In summary, to understand the structure and function of such ideological mechanisms can enable me to see how systems of domination affect people's perceptions, behaviors and practices. It also helps me to determine what needs to be changed and how to encourage people to change it.

Raising consciousness on reproductive health

The attention of this study focuses on women's reproductive health and what influences women to engage sexual practices that put them at risk. From the literature review in the previous part of this chapter, I have come to understand that women's overall health has a strong linkage with their reproductive capacity, and that sexuality is an important factor that shapes or affects women's health perceptions, attitudes, and practices.

Health is often defined as soundness of body or mind and freedom from disease, defect or ailment. It is now accepted that individual ill-health is not the caused by disease alone, but also socio-cultural environments. This is because socio-cultural environments can influence people's perceptions, attitudes and behaviors. Consequently, certain behaviors can cause people's ill-health. For example, people who do not practice safer sex can be infected with sexually transmitted diseases.

Ruzek, Clarke and Olesen (1997) say that feminist conceptualizations of health typically emphasize the way in which working and living conditions as well as personal health practices create health. Tong (1989) also argues that cultural values, social norms and attitudes regarding sex and sexuality restrict women's identity and behaviors. Socially constructed roles make it exceedingly difficult for a woman to identify and develop her own sexual desires and needs. Cultural values, social norms and attitudes also cause women to be unable to control their lives and roles or negotiate for the betterment of their lives.

To promote women's health, there is a need to identify the areas of women's health and the factors that influence women's decisions to engage in healthy behaviors. At present, doctors and many other professionals have begun to treat sex and sexuality as a health concern (Irvine, 1995). The content areas of women's health often include reproductive health, diseases commonly found in women, gender and social influences on women's health (ideologies, roles and poverty), violence against women, and women's and health care policy (Allen and Phillips, 1997; Ruzek, Clarke and Olesen, 1997 and Adesso et al. 1994).

The World Health Organization's (WHO) Global Policy Council has recognized the crucial impacts of women's reproductive health as well as the diversity of women's particular health needs before, during and after child bearing age. The Council has approved and announced the following definition of reproductive health in 1994:

> *Reproductive health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when, and how to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*

The WHO also stresses that health promotion should not focus only on disease prevention. It should emphasize assisting people to recognize and understand the components of behaviors as well as factors that influence their health risk behaviors as well. On one hand, social environments may affect people's health behaviors and the condition of their health. On the other hand, the conditions of people's health can affect social environments. Individuals, groups and organizations should therefore be active agents in shaping health practices and policies to optimize both individual wellness and collective well-being (WHO, 1984).

If women are to achieve reproductive health in the context of this definition, LaGuardia (1991) suggests that they must not only have access to necessary health services. They must also have adequate knowledge, ability and right to control when, with whom, and under what conditions they have sexual relationships. To do so, there is a

need, officially and explicitly, to recognize that sex is not a distinction between female and male and that sexuality is not merely an activity for procreation. It is important that people realize the impacts of sexuality on their sexual health practices, especially practices that may seriously affect their reproductive and overall health. In addition, health promotion activities should be derived from the basic belief that sexual health is a part of the right to health in general and human rights in particular (WHO, 1992).

What motivates people to behave or not to behave in their best health interests has puzzled and inspired researchers from many disciplines for a long time (Parrott, 1995: 20). According to Terry, Gallois and McCamish (1993), a large number of variables affects people's willingness to engage in such behaviors, including age, gender and socio-economic status. Prochaska and DiClemente (1984) describe behavior change as a process in which an individual progresses through a series of different stages. The stages of behavior change they identify provide a description of when particular shifts in attitudes, intention, and behavior occur. These stages have been labeled Pre-contemplation, Contemplation, Preparation, Action, and Maintenance (Prochaska and DiClemente, 1984; Prochaska, DiClemente and Norcross, 1992).

Pre-contemplation is the stage in which people are unaware or under-aware of having problems. People in this stage have no intention of or do not think about changing their behavior in the foreseeable future. Contemplation is the stage in which people become aware that a problem exists and begin to think seriously about changing behavior but have not yet made a commitment to take action. Preparation is a stage that combines intention and behavioral criteria. Individuals in this stage plan to take action or change their behavior in the near future. Action is the stage in which individuals modify their

behavior, experience, or environment in order to overcome their problem. Maintenance is the stage in which people work to continue the gains attained during action.

Prochaska, DiClemente and Norcross (1992) suggest some techniques of behavior change that suit people in the different stages. These techniques are consciousness raising, dramatic relief, environment re-evaluation, self-re-evaluation, self-liberation, reinforcement management, helping relationships, counter-conditioning, and stimulus control. Stages of change in which particular techniques of change are emphasized are shown below.

Figure 2.1 Stages of Change in Which Particular Processes of Change Are Emphasized

Pre-contemplation	Contemplation	Preparation	Action	Maintenance
Consciousness raising Dramatic relief Environmental re-evaluation				
	Self-re-evaluation			
		Self-liberation		
				Reinforcement management Helping relationships Counter conditioning Stimulus control

Prochaska, DiClemente and Norcross (1992) state that people often remain in contemplation stage for a long period of time because of the difficulty in evaluating the benefits of changing behavior. Individuals in the contemplation stage are most open to consciousness raising techniques (Prochaska and DiClemente, 1984). Furthermore, it is believed that an individual will feel more comfortable practicing the least inhibited behavior. After experiencing positive reinforcement and a decline in inhibition caused by guilt, fear or embarrassment, the person will advance to the next behavior (DeLamater, and MacCorquodale, 1979).

Prochaska, DiClemente and Norcross's theory of stages of behavioral change has convinced me that assessing attitudes of Thai people toward sex education can reveal the degree of people's willingness and readiness to make their sexual behaviors change.

Hence, the assessment will enable me to determine the content of sex education program and the suitable way to convey such knowledge to those people accordingly.

Sex education for reproductive health promotion

I stated earlier that I consider sex education as a way to raise women's awareness about the impact of sexuality on their health and help women overcome fears or inhibitions about sex and sexuality. The literature reviews here affirm my assumption that socialization is an important way to create sexual ideologies and standards which conditioned people to practice certain sexual behaviors. Eventually, these behaviors affect their sexual and reproductive health, and sex education can be a way to re-socialize people about sex and sexuality.

On this subject of sex education, the WHO Conference on Education and Treatment in Human Sexuality in 1974 declared that:

> The development of positive attitudes toward sexuality as an integral component of health should be a primary goal of education ... activities, and that appropriate sex education to the general public has the highest priority of any approach to sexual health care, because of its importance as prevention and its potential for affecting the largest number of people.

The United Nations also urges every government to ensure that adolescents, both girls and boys, receive adequate education, including family life and sex education. Suitable family planning information and services should be made available to adolescents within the changing socio-cultural framework of each country.

Perry, Griffin and Murray argue that health behavior patterns "are learned in early life, are seen to consolidate in adolescence, and then persist into adulthood" (1985: 379).

These patterns also apply to sexual behaviors. The earlier people obtain accurate information about sex and sexuality, the quicker and easier they develop healthier sexual behavior patterns. There are many reasons to become more knowledgeable about sexual topics. For example, Masters, Johnson and Kolodny (1992) claim that acquiring accurate information about sexuality can help prevent sexual problems and can enable people to better educate their children about sex. According to Masters, Johnson and Kolodny (1992), becoming well informed about sex can also help individuals deal more effectively with certain types of sexual problems, e.g., sexually transmitted diseases, sexual abuse and harassment. Masters, Johnson and Kolodny (1992) also propose that studying sexuality is even more important in terms of helping learners become more sensitive and aware in their interpersonal relationships. In the light of the HIV/AIDS epidemic, being knowledgeable about sexuality can help people to understand the toll unsafe sex practices may take and how to make choices to avoid them.

Adamson, Briskin and McPhail (1988) note that when problems are identified, the solution is generally seen to be a change in attitude and values, often through the process of education. Education is frequently regarded as an ideal tool to raise individuals' consciousness and assist people to acquire knowledge that will encourage them to change their attitudes and values (Sleeter and Grant, 1991).

Knowledge is a source of power and it enables a person to exercise her/his potential. Knowledge helps a person to envision the contours and limits of existence, what is desirable and possible and what actions might bring about those possibilities. Knowledge widens a person's experience and provides analytical tools for thinking through questions, situations and problems. Rogers (1974) suggests the more educated a

person is, the better (s)he is able to make responsible and informed choices between possible courses of behavior. The more aware (s)he is of these possibilities, the more freedom (s)he has in the way (s)he conducts her/his life. Education is not just the informing of facts or the imparting of skills; it should also aims at the promotion of personal autonomy, which involves making choices, rationally and freely.

To improve health and the quality of their lives, it is important that women become aware of factors that put them in positions of powerless. At the same time, women must be encouraged to change or discard some socio-cultural values that have negative impacts on their lives and roles. Like education at its best, sex education, which aims at promoting women's reproductive health, cannot involve only the transferring of certain facts, or training in relevant skills (whatever those might be). Nor can it involve imposing a particular attitude toward sexual morality. Rather, sex education should encourage people to achieve the maximum possible degree of knowledge and understanding concerning sexual behaviors. At the same time, it should assist people to be aware of the full range of sexual behaviors and values, so that they can meaningfully choose how they themselves will behave (Rogers, 1974).

Although it has become clear that sex education is necessary for all people in the present day, the teaching of sex education for the public is still controversial in every society, even in Western societies where discussions about sex and sexuality are more acceptable. This tension is well demonstrated in the literature on sex education (see Avery and Lee 1970; Kinlander, 1970; Rogers, 1974; Szirom, 1988; Sears, 1992; Klein, 1992). Because of its controversial nature, sex education in many countries is provided as a subject under different names, such as family life education, sexuality education, family

and population education, and so on. The content of these courses also varies. Some cover a wide range of sexual issues, and some are rather narrow and limited. While curriculum developers and educators acknowledge the importance of this subject, they must provide sex education that is socially acceptable to the public.

As Wienstein and Sandman (1992: 180) say, "Knowing which factor one would like to change is not the same as knowing how to change it." Education may be regarded as an ideal tool to empower people for making change, but transferring knowledge requires more than the simple passing on of some superficial technical knowledge or information. Especially with sex education, the impact of the existing dominant culture and socio-political structure is likely to be as important as, if not more significant than, the impact of technical knowledge and skills.

For example, a woman may acquire good technical information about contraceptive methods. She technically knows how each method works and which method has less negative effects on her health, but socially and culturally she has no power or authority to decide to use contraceptives. The technical knowledge she has obtained then becomes useless. Education should be a process that enables her to integrate her personal, socio-cultural and technical knowledge to solve her everyday life problems.

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[1] **Sex** here is used to refer to biological gender as female and male. In some contexts of this study, it also means physical activity involving the genitals, such as having premarital sex..

[2] **Sexual ideology** is my interchangeable term with **gender ideology**.

Chapter 3

Overview of Thai Sexual Behaviors and Their Impacts on Health

Culture is created and recreated by people through their everyday interactions. Difference in cultural backgrounds produce different ideologies, perceptions, attitudes, visions, and actions (Asian Development Bank, 1994:8). To bring change into a particular society requires a culturally sensitive approach geared to the specific socio-cultural milieu of the society.

This chapter gives an overview of some issues concerning sexual knowledge, attitudes and practices of the Thai people. The discussions in the conceptual framework help me see the ways sex and sexuality affect Western women's sexual perceptions, attitudes and behaviors. Here, I use the concepts discussed in the previous chapter to compare and analyzed the way Thai cultural values and norms related to sex and sexuality affect the sexual behaviors and the reproductive health of Thai women.

Research on Thai sexual behavior

Sittitrai and Barry (1989) claim that there has been an explosion of research and publications on human sexuality and sexual behaviors as well as sex education and academic courses in Western educational institutions in the past two decades. In Thailand, Thai researchers began to become involved in these fields of study only after the 1970s, and outside funding from international organizations has played an important role in the

emergence of these studies. There are many factors that have brought the issues of sexuality and sexual attitudes to the attention of Thai people. One important factor that has contributed to this interest in sexual customs and beliefs is the overall effort to create a family planning program in Thailand. Another factor is the increase in cross-cultural interactions through the mass media and tourism, which has become intertwined with the increased sex trade and a sharp rise in sexually transmitted diseases and the human immunodeficiency virus (HIV) or the acquired immune deficiency syndrome (AIDS) infection.

Many studies about sex and sexuality in Thailand during the 1970s and 1980s (such as Prasatkul, Chamratrittirong, Bennett and Chittrawatanapaet, 1987; Sakondhavat, Kanato, Luengtongkam and Koochaisit, 1986; and Wuttiprasit 1983) focused on adolescents (15 to 24 years old), both in and out of school. Much attention was given in these studies to courting, dating, premarital sexual experiences, family planning and abortion because these issues reflect rejection or acceptance of the social norm and can produce other serious social and health problems. The results of those studies are often used to formulate educational or counseling programs on sex education and, especially, family planning and the prevention of sexual transmitted diseases for adolescents.

After the first case of HIV/AIDS was identified in Thailand in 1984 (Nopakesorn, 1995), researchers realize the limitation of their knowledge about Thai sexuality and its impacts on people's HIV-related risk and behavior. The later studies related to sex and sexuality in Thailand, therefore, focused on people's attitudes toward condom use for safer sex; patterns of unsafe sex practice; risk behaviors and high risk groups; knowledge

about HIV/AIDS as well as preventive measures; and attitudes toward and the care of HIV infected people (see National Commission on Women's Affairs, 1994).

Courting and dating

In Thailand, as in many other parts of the world, courting and dating mark a stage of sexual maturation which advances a person from childhood to adolescence. This stage is the early expression of an interest in having sexual interaction with another person. Traditionally, courting by young Thais was under the strict supervision of family members. The courting couple could not be out of guardian's sight together. They had to stay where anyone in the family could see them easily. A woman going out with her suitor would have a friend, a sister or a cousin accompanying her. In the Northeast of Thailand, a man who touched an unmarried woman would be fined by the woman's family. As a result of socio-cultural changes, such as the increase of sexually mixed interaction in school and workplaces and the loosening of family monitoring over young people's behaviors, these courting and dating customs are fading out (Kanato and Rujkorakarn, 1994).

Contemporary courting and dating in Thailand can involve petting, embracing, kissing and, in some cases, sexual intercourse. Chompootaweep, Yamarat, Pumsuwan and Dusitsin (1987) suggest that sexual interest among Thai teenagers begins early, as young as age 11. Studies (Bhothong, 1985; Wuttiprasit, 1983) indicate that first dating occurs among the majority of Thai adolescents between the ages of 13 to 18 years. A study by Wuttiprasit (1983) suggests that males tend to start dating earlier than females. The age of the first date is also related to the age of first masturbation (Sittitrai, Phanuphak, Barry and Brown, 1992). Sakondhavat et al. (1986) report that 30.9 percent of their sample

masturbated, and 16.1 percent had had sex with their dating partners. Studies also show that about 50 percent of both rural and urban male respondents reported having their first intercourse before age 18 (Rattanapaichit, 1990; Wajeepiwat, 1990). According to Sittitrai et al.(1992), by the age of 14 and 15, more than 40 percent of male respondents and about 30 percent of female respondents reported having first intercourse. The median ages of first intercourse of Thai men, both rural and urban, is 18 years. Urban female respondents reported first intercourse much later than the rural with the median ages of first intercourse being 23 and 19 years respectively.

Kanato and Rujkorakarn (1994) claim that Thai males were, and still are, socialized from a young age to value sexual experience and the knowledge gained from courting and dating their sexual partners. In Wuttiprasit's study (1983), most male respondents would decide to marry at least their third date, and usually preferred one who was younger; female respondents, on the other hand, are married to the man who was either their first or second lover or date. While most Thai adolescents reported feeling compelled to seek their parents' opinion on their dates (Chaowalit 1978), the female adolescents showed more reliance on their parents' opinions (Nitirach 1982).

Premarital sex

Sittitrai and Barry argue that researchers in most Southeast Asian countries often regard premarital sex primarily, if not exclusively, as genital intercourse:

> The distinction has been not just a matter of design but also a matter of conceptualization. To understand premarital sexual behaviors and attitudes, one must examine all sex acts and expressions, considering the individuals' physical and emotional development, socio-cultural socialization and

> adaptation, related aspects of social institutions ... Societal or group cultures prescribing or prohibiting premarital sex need to be studied in detail over generation, between genders, and by demographic and socio-economic characteristics (1989: 177).

The definition of virginity employed in studies of Thai researchers primarily refers to having never engaged in genital intercourse. It is sometimes extended to mean never having engaged in any type of sexual contacts, even in kissing and petting (see Nopakesorn, Sweat, Kaensing and Teppa 1993; Sittitrai and Barry, 1992; Wuttiprasit, 1983). Surveys on premarital sex or virginity therefore yield only vague accounts of sexual behavior before marriage, and have not produced a clear picture of individuals' perceptions of virginity.

Despite the ambiguity about its definition, female virginity is still highly valued, particularly among Thai females. A study by Porapakkam, Vorapongsathorn and Pramanpol (1985) shows that about half of the male respondents set virginity as a priority for their mate selection and that females who engaged in premarital sex would not have good reputations. In contrast, Sakondhavat et al. (1986) found that 45 percent of the student population of both sexes in the Northeast perceived premarital sex as acceptable and believed such acts should be forgiven. In the same study, 48 percent of male students did not view non-virgin females as stigmatized, and about 40 percent were willing to marry a non-virgin female. In 1991, a study on Knowledge, Attitudes and Practice on Contraception and AIDS Prevention Among the Youth Residing in the Dormitories in Bangkok (Population Development Association, 1991) found that 66 percent of the

female sample said premarital sex was not acceptable, while only 33 percent of the male sample said so.

Traditionally, Thai women were not expected to be sexually active before or outside marriage. Female teenagers in Thai society were often discouraged from seeking knowledge or information about sex. For Thai males, it was the opposite. They were allowed to be sexually active and could engage in casual sex for an extended period prior to marriage. It was presumed that the levels of sexual activity by Thai women were extremely low, especially sexual activity outside committed relationships (Sittitrai and Brown, 1995; Weniger et al., 1991). A study by Wongboonsin and Porapakkam (1989) shows that 30.1 percent of male respondents and only 3.1 percent of female respondents reported having premarital sex. The majority of Thai females had their first intercourse with their spouse after marriage. Both female and male adolescents felt that men could be sexually promiscuous without affecting their marriageable status (Kanato and Rujkorakarn 1994). The average age of Thai females at first sexual intercourse was reported to be 21, and 95 percent married their first sexual partners (Weniger et al., 1991). More recent data from Chiangmai University (1995) shows Thai men had their first sexual experience when they were about 16 to 17 years old, and women at about 18 years old. About 44 percent of the men said that their first sexual experience was with a commercial sex worker, and 48 percent of the women had their first sexual intercourse with men in their community.

Although premarital sex is not the socio-cultural norm for Thai women, it is no longer regarded as unusual. At the same time, data show that sexually transmitted disease (STD) prevalence among Thai youth — mostly males — aged between 15 to 19 years was 23 percent in 1995 and that the percentage increased to 36 percent in the 20 to 24 year

age group (Ministry of Public Health, 1995). Another recent study shows an increase in casual sex by young Thai people. Sittitrai and Brown (1995) point out that the initial round of sentinel surveillance on AIDS conducted in Bangkok reveals that approximately 20 percent of the single people surveyed admitted to having had sex in their lifetimes, while 10 percent had done so within the last year. This is part of a worldwide trend toward earlier sexual initiation of adolescents and later age of marriage. The fear of HIV has caused many young Thai men to shift away from commercial sex to non-commercial casual sex. The high sexually transmitted diseases infection levels among Thai males may therefore place a great number of previously unexposed single Thai females at risk. A study by Rattanapaichit (1990) indicates that 38 percent of the total 164 sexually experienced respondents reported having sex with commercial sex workers, 34 percent with their flirtatious female friends and 24 percent with their girlfriends.

Many Thai have learned to believe (from all sorts of media and HIV/AIDS prevention campaigns) that HIV/AIDS infection is restricted to particular persons, such as homosexuals and commercial sex workers. The sexual double standard which emphasizes that young women are not sexually active leads many men to assume these young women are likely to be free of HIV/AIDS, and so are safe sources for their sexual affairs. A study by Havanon, Knodel and Bennett (1992) also shows that single males display a remarkable double standard in thinking that their partners did not have sex in the past and are not having sex with other men in the present.

In fact, Soonthorndhada (1992) affirms that many Thai female adolescents prefer to engage in sexual relationships with partners of a higher socio-economic class, especially with persons with whom they are not familiar or who are not from their neighboring areas.

These women may prefer strangers because they do not want their peers to know of their sexual activities, which might lead to their being ostracized or being labeled as 'flirtatious' or 'loose.' These women may also feel that their personal and/or household resources are inadequate, and that sexual relationships with upper class men will provide them with additional material and economic support. They may feel that they can best achieve their goals by having sexual relationships with persons outside their friendship and family circles.

The belief that young women will not engage in sexual activity before marriage affects not only the people studied, but also the activities of researchers and planners. I noticed that while most studies heavily focus their investigation on Thai sexual behaviors of both single and married males, studies of female sexual behaviors focus mostly on married women or female commercial sex workers. Very few researchers include single women. As a result, young single women are often left out of sexual health promotion programs and therefore do not acquire knowledge about sex education, health risks and skills for negotiating safer sex. This makes them very vulnerable in their reproductive and overall health.

Marriage

According to Kanato and Rujkorakarn (1994), marriage in Thailand is viewed as an institution that legitimizes culturally appropriate sexual relationships between a woman and a man, and sexual relations are a product of marriage and the starting of a family. The majority of Thai people choose their spouses themselves, but often seek their family's approval for marriage. Marriage through arrangement by the family or introduction by

someone else is also practiced and seems to be more frequent in urban than rural areas (Sittitrai and Barry, 1989; Kanato and Rujkorakarn, 1994).

The age of first marriage among Thai people has changed over time. In earlier times, women had less sexual freedom. They were less mobile and had less chance to travel away from their families. Many women saw marriage as a path for social mobility or as a vehicle for escaping their family's supervision or obligations (Kanato and Rujkorakarn, 1994), and married very young. The present trend is toward delaying marriage. For example, the average age of first marriage among Thai women between 1964 and 1968 was 19.3 years, while the average age in 1979 to 1984 was 20.1 years (Knodel et al., 1987), and in 1992 was between 22.5 to 23 years (Sittitrai, Phanuphak, Barry and Brown, 1992). This trend may also be influenced by socio-economic pressures, such as the decline of the agricultural sectors, which required much female labor, and the expansion of new labor markets in the industrial sectors.

A sexual double standard is still accepted to a substantial degree in Thai society. As previously discussed, Thai women are expected to be virgins until they marry. Women who have sex before marriage or have extramarital affairs often face bringing disgrace to their family members and suffering personal discrimination. Thai men are not subject to the same sanctions, although it is considered disrespectful for men to discuss their non-marital sexual activity with others, and Thai law is consistent with a pro-monogamous stance. In practice, however, there is considerable acceptance for married men to have more than one sexual partner (Havanon et al., 1992). Thai men's extramarital affairs are not necessarily considered shameful acts and are more acceptable in cases where the men meet the financial needs of their families. Even in instances where the men do not take

financial responsibility for their families, most women tolerate their husbands' extramarital activities.

In many cases, when husbands have extramarital affairs, their wives are blamed for lacking techniques to bind their husbands to the family. In the wife's case, an extramarital affair is judged differently. Havanon et al. (1992) remarks that this double standard is clearly reflected in Thai divorce law. A Thai man can obtain an immediate divorce if his wife is unfaithful. The Thai wife, on the other hand, can obtain a divorce only if she has conclusive proof that her husband has taken another woman as his de facto wife.

One explanation of why Thai wives tolerate the promiscuous behavior of their husbands lies in differences in women's and men's sexual values. Komin, for example, (1990) argues that Thai women have been socialized more differently than Thai men and have internalized different life goals. A comfortable life and family happiness/security are major parts of women's lives. Thai men are more oriented toward power, achievement, and material wealth. They place significantly higher value on social recognition as part of their drive for success in life. In general, Thai men are not as concerned with family as are women. Matters concerning the home usually rest with women (Komin 1990).

Such social values and laws accentuate the tolerant attitude towards multiple partners for Thai men and condition women to do whatever necessary to keep the family happy and secure, even allowing their husbands to have extramarital sex. Heterosexual behavior is the main route of sexually transmitted diseases for 90 percent of women, and over 70 percent of patients with AIDS/HIV related cases were infected through sexual contact with their spouse or partner (Chiang Mai University, 1995).

Premarital sex, extramarital sex and commercial sex service

Dunn (1995) and Poopat (1993) find that the gender belief held among rural and traditional Thai is that women are not supposed to know or learn many things related to sex and sexuality, in contrast to men. In social terms, proper males are expected to be sexually virile, while proper females should be docile and repressed in their sexuality. It is accepted in Thai society that men have an insatiable sexual drive and that it is a part of male's natural identity. A large number of Thai women believe that men, by nature, need an outlet for their excess sexual drive and that commercial sex workers are a necessary channel. For example, one study found that more than 50 percent of women thought it is common and acceptable that men have sex with commercial sex workers both before marriage and after marriage (Damrongkittikul et al., 1993), a belief that encourages and perpetuates sexual promiscuity among Thai men.

Many studies on sexual behaviors of male students in Thailand (e.g., Dhevadithep et al., 1992; Wanichasenee and Choopanya, 1990; Wajeepiwat, 1990; Rattanapaichit, 1990) found that males reported having their first intercourse between 9 and 18 years of age. These studies also indicated that between 34 and 38 percent of Thai men had their first intercourse with commercial sex workers. Although these studies found that most men had adequate knowledge about HIV/AIDS and preventive measures against it, few used condoms.

There are many factors that influence men not to use condom. As explained in the previous chapter that condom use is often associated with certain sexual practices and beliefs. For example, condom use in the steady relationship is often regarded as the lack of mutual trust between partners; it can cause sexual disruption and reduce sexual pleasure.

Many Thai people see the use of condom merely as a means of family planning rather than a way to avoid sexual health risk or safer sex practices (Sittitrai et al., 1992; and Havanon et al., 1992). In addition, roles for Thai women dictate that male contraceptive methods, such as using condoms, are within the male domain — women are not expected to be involved in such contraceptive decision-making (National Commission on Women's Affairs, 1995a). Hence, it becomes difficult for women to demand or encourage men to use condom.

Studies (Poopat, 1993; Kowsupat et al., 1992; Saweangdee and Isarapakdee, 1991) indicate that most Thai men had their first sex experience with commercial sex workers and that many Thai men first visit commercial sex services because of peer pressure during high school or their first year in a university. They were often under the influence of alcohol when they visited commercial sex services. In 1992, a quarter of Thai men between the ages of 20 and 24 reported visiting commercial sex services in the last year (Sittitrai et al., 1992). Data from these studies also suggest that some Thai men might have their first sexually transmitted disease before leaving primary school and that a number of young Thai men become infected with sexually transmitted diseases before they married.

A study by Heavaroengchai (1994) notes that even though extramarital affairs are socially inhibited for both women and men, a great number of Thai men still practice extramarital sex. Kanato and Rujkorakarn (1994) also suggest that the extramarital relationships with commercial sex workers which are common among Thai men are often perceived as having fewer moral implications and less likely to involve emotional obligation or responsibility. Many Thai wives accept or tolerate husbands' extramarital

sex, as long as their husbands do not have a mistress. Most wives also see mistresses as long term emotional and financial responsibility for their husbands, which may lead to the husband seeking a divorce. The wide acceptance of men's extramarital affairs with commercial sex workers is found equally among women who are well educated and those who are not (Poopat, 1993).

A study by Damrongkittikul, Attamate, Chaikuna, Dhevadithep and Poochareon (1993) finds 61 percent of female and 62 percent of male respondents agree that wives who cannot fully satisfy their husbands' sexual demands should allow them to seek sexual services outside the home. Most extramarital relationships occur with commercial sex workers. This study also finds that 87 percent of husbands and 82 percent of wives in the same sample group would fully approve of husbands' extramarital affairs as long as the husbands know how to avoid later complications, such as being contaminated by a sexual transmitted disease.

A report on Women, Family and AIDS Prevention (Chiangmai University, 1995) recounts that 73 percent of urban men, married and single, had sex with commercial sex workers while 81 percent of men in rural areas did so. Sittitrai et al.(1992) report that about 27 percent (44 out of 163) of married men in the sample group in urban areas and 12 percent (59 out of 509) of those in rural areas usually had sex outside their marriage. The frequency of all sample groups visiting commercial sex services within the past 12 month ranged from one to twenty visits. More than 60 percent of those sampled had visited commercial sex services between 2 and 10 times in a year.

The ideology that women should keep their virginity or 'remain pure' until marriage also makes it difficult for a properly brought up single woman to discuss

anything related to sex with her spouse-to-be. The discussion of personal sexual history is viewed by many men as evidence of mistrust or as undermining their dignity. For fear that their boyfriends might feel humiliated and refuse to marry them, many women dare not request their spouses-to-be to have a blood test for sexually transmitted diseases before they marry.

Homosexuality

Evidence surfacing in novels, poetry, works of arts and biographies also indicates that homosexual and bisexual relationships in Asian countries other than Korea are socially tolerated (Sittitrai and Barry, 1989). Although homosexuality is neither sanctioned nor encouraged, many Thai still view it as an unconventional practice because heterosexuality is regarded as a common norm for most Thai people.

Many homosexuals and transvestites have become famous by engaging in television acting and the fashion business in Thailand. As far as I know, one professor in a renowned university in Thailand is a gay advocate. I am also acquainted with some homosexuals who are in administrative positions and are well accepted by their staff. However, my association with homosexual friends may cause my personal bias of thinking that homosexuality is generally usual in Thai society.

Few thorough studies on homosexuality have been done in Thailand. In a study by Muangman (1988), about 4 percent of female and 12 percent of male students who participated in the study admit practicing homosexual relations. A later survey by Sittitrai et al. (1992) suggested that over 96 percent of the Thai people were heterosexual, as summarized by Table 3.1.

Table 3.1: Reported gender choice in sexual experiences among sexually experienced respondents.

	Gender of respondents			
	Male		Female	
	Number	Percent	Number	Percent
Female only	923	96.6	11	0.9
Mostly female, some male	27	2.8	0	0
Equally male and female	2	0.2	1	0.1
Mostly male, some female	1	0.1	2	0.2
Male only	2	0.2	1233	98.9
Total	955	100	1247	100

In another study, Sittitrai, Sakondhavat and Brown (1992) commented that there appear to be some regional variations in reported orientation, with half of the men reporting homosexual or bisexual orientation coming from the Northeast (North 6.3 percent, Northeast 50.0 percent, Central 18.8 percent, South 12.5 percent, Bangkok 12.5 percent, Total N=32). Among the women in the same study, those reporting same-sex behavior were more widely distributed among the provinces (North 7.1 percent, Northeast 28.6 percent, Central 0.0 percent, South 35.7 percent, Bangkok 28.6 percent, Total N=14).

I believe the percentage of actual homosexual practice may be higher than the studies show. For example, Sittitrai et al. (1989) explain that studies have shown that many of the male sex workers in Bangkok bars providing for homosexuals describe themselves as heterosexual in orientation but perform sex with men to obtain income. The early HIV/AIDS prevention campaigns have conditioned a great number of people to perceive such practices as shameful. As a result, many homosexuals hesitate to admit their preferred sexual identity.

Abortion

To date, there had been very little research on abortion in Thailand. Riley and Sermsri (1974) explain that there were two methods of the traditional induced abortion. The first method was the taking of "hot medicine" to bring on menstruation which appeared to be delayed, to aid the labor and to clean out the uterus after the abortion is done. If the first method failed, the second method was massaging to "press out the fetus." Riley and Sermsri emphasized that though these traditional methods were common, they were, however, painful and dangerous, and the extent of their use has never been measured.

Knodel, Chamratrithirong and Debavalya (1987) suggest that results from a number of sources other than direct survey questions show the substantial prevalence of induced abortion in Thailand. In 1979, study by Research and Evaluation Unit of National Family Planning Program indicated that abortion was widely practiced and a minimum of about 300,000 illegal abortions occurred per year in Thailand. Narkavonnakit and Bennett (1981) found a considerably high incidence of abortion: an abortion rate of 107 per 1,000 women aged between 15 to 44.

Though induced abortion used to be a common method of birth control in Thai society, it has become a crime under Article 301-305 of the Criminal Code of Thailand promulgated in 1956. The reasons for the restriction of abortion is to deter single young women from being promiscuity, and to comply with the religious teaching that killing is sinful (National Commission on Women's Affairs, 1995a). Reports of the Committee on the Elimination of Discrimination against Women submitted to the National Commission on Women's Affairs (National Commission on Women's Affairs, 1996) emphasizes that

abortion under Thai law (Article 305) is allowed only if the pregnancy shows evidence of fetal abnormalities or a risk to the mother's life or it is the result of rape or forced prostitution. Medically supervised abortions are also available for pregnant women who are infected with HIV/AIDS, mostly in urban areas. Non-medically-supervised abortions remain a health risk for Thai women in isolated or rural areas.

According to the Committee on the Elimination of Discrimination against Women (National Commission on Women's Affairs, 1996), an amendment to allow abortion — in the case where the fetus was believed to suffer from serious disease or disability, or when the mother was suffering psychological health threat — was proposed in 1983. This amendment was passed by the House of Representatives by 70 votes to 2. Nevertheless, after a campaign based on religious considerations the Senate voted against the proposal and it failed. The rate of maternal death from abortion per 1000 live births has fallen from 206 in 1989 to 120 in 1993 (National Commission on Women's Affairs, 1996 and 1995b). The movement by Thai feminists to change the abortion law in Thailand is still ongoing.

Sex education in Thailand

In the midst of the threat to Thai people's health by the AIDS epidemic, data presented so far shows that many Thai, particularly adolescents, tend to engage in casual unplanned sex and in unsafe sexual relations. Although education to raise the Thai consciousness about the relationship of negative sexual attitudes and sexual risk and safer sex practices is crucial. At present, sex education occupies an ambivalent position in Thailand. According to a sex survey carried out in Thailand by the UK-based condom maker, Durex, most Thai people are still conservative when it comes to sex education and

felt that sex education should start late, at 15 years. This survey also stated that Thailand was rated near the bottom end of scale in the important area of sex education (*Bangkok Post* on October 29, 1997). On reason is that, in Thai society, sex and sexuality are largely perceived as a personal intimacy and secrecy. Though the sexual behaviors of Thai people, particularly men, reported in the previous discussion may appear permissive, they do not imply that Thai people are generally open-minded toward or accept certain trends in sex and sexuality. For example, females do not often have premarital sex without censure, and education of girls about sex and sexuality is restricted.

When cultural values and norms prevent an open discussion of sex, the idea of promoting sexual and reproductive health and enhancing individuals' sexual autonomy through sex education raises several serious questions for curriculum developers. For example, whether current sex education is adequate; who should decide the adequacy of the program's content; when sex education should be introduced to children, at what age; what topics students and parents need to be included in the programs; who should teach it and how to teach it without public resistance. Examining the current sex education in Thailand, in both formal and informal situations, may answer some of these questions.

Sex education from parents

In 1973, Schiller found that the home was the source of sex education for most people and other sources such as school, media or peers merely supplemented the messages an individual learned daily in the family. Graves (1974) too discovered that, again and again, parents were named as ideal sex educators; equally often, it was admitted that parents largely failed in this responsibility. Some contemporary researchers (e.g., Basow, 1992; Greenglass, 1982) still viewed the family as the primary educator of young

people regarding their sexuality and sex roles from the time they are born. Szirom (1988) concluded that very little explicit or positive sex education actually occurred at home. This statement is still true in many Thai homes today, in my view.

As I stated earlier, open discussions about sex are rather unusual for most Thai people. Many Thai parents feel awkward about discussing any issues related to sex with their children. In contemporary Thai society, some Thai parents may talk about hygienic practice during menstruation with their daughters or how to avoid premarital encounter with their sons. They, however, are not likely to discuss contraception for the purpose of planned premarital sex with their children. Consequently, Thai adolescents who exhibit sexual permissiveness or interest will receive negative signals and messages from their parents, such as strong disapproval, a disappointed look, and, sometimes, a scornful comment. This also makes it difficult for Thai children to communicate with their parents about sex.

Sex education from friends and media

Since sex education at home is not available for teenagers, many seek information about sex from friends and media. Some studies point out that friends are the major source of sex information (Basow, 1992; Greenglass, 1982). Although friends are frequently used as a source of sex information, Szirom also claims that friends cause the most misinformation among young people and teenagers who initially learn about sex from peers are more likely to express dissatisfaction with the way they learned about sex (1988: 88).

Szirom (1988) also says it has been difficult to obtain empirical evidence as to the influence of the media in the area of sex education. My opinion is that the media, such as

books, newspapers, magazines and so on, do, however, play an important role in conveying information about sex. The following are examples from two sex counseling columns. These questions reflect some of the need for knowledge and information about sex and sexuality by the Thai people.

> *Q 1: Dear Doctor, I had an intercourse with a commercial sex woman, only for two minutes. I went to urinate right after that. I know that she has AIDS. Two days after this intercourse, I had my blood test at a clinic. The doctor told me to come back for another test in the next three months. Will I get infected if a woman with AIDS gave me an oral sex? Can I get infected from kissing her mouth? (Daily News, Feb 2, 1997)*

> *Q 2: Dear Doctor, my boy friend told me that I will not be pregnant if we make love without using condom the day my period just stops. Is that true? I am not sure about it myself (Daily News, Feb 9, 1997).*

> *Q 3: Dear Doctor, I can say that I am a gay by birth, because I've felt that way since I was at kindergarten age. The feeling became stronger when I reached my adolescent age. I felt frustrated about myself. Why I am not the same as other people. I frequently thought of committing suicide. Do you think I need or can get a treatment to become normal? (Daily News, Feb. 23, 1997)*

> *Q 4: Dear Mr. (name of the columnist), My husband is addicted to visiting prostitutes. How should I take this? Please do not suggest me to let it goes for the reason that it a natural habit of men. I am sick and tired when my husband gives me this line. If I become promiscuous and people in our community look down on me, what do you think a man like my husband will feel? Please help me with a good advice (Khunying Magazine, issue 12, Nov. 1995).*

Sex education in school

Though sex education is not prohibited in Thai schools, the information about sex being taught is still limited. Sex education in Thai schools includes human physical

development, human reproduction system, artificial insemination, child birth, family planning, contraception and sexually transmitted diseases. These subjects are often confused with and usually taught as a sketchy part of Science, Health, Physical Education or Social and Life Experiences. Aspects related to positive sexual practices, e.g., skills to negotiate for safer sex, understanding of homosexuality, masturbation, sexual harassment, and so forth, are not provided in any curriculum outline. All the subjects about sex mentioned above are commonly taught at grade 8 and 9 (Curriculum Outline of General Education: Secondary level, 1987, Ministry of Education, Thailand).

Several studies on sex education and family planning, e.g. Bhodhisarn (1981); Boa-gnam (1985); and Pitanon (1985), have shown that Thai adolescent students generally have positive attitudes toward sex education and that boys tend to be more open to sex education than girls. Level of knowledge, particularly about sexually transmitted diseases, in some areas of Thailand is low (Grasaekulrat 1988). Moreover, *Population Reports* (1982) also indicates that knowledge of human reproduction and sexuality among teachers is also limited and that teaching about sex is still considered an uncomfortable task. Usually, teachers agree that sex education should begin at higher secondary level or grades 9 to12 (Sangthaitaweeporn 1987).

The accessibility of formal sex education

It was mentioned earlier that the number of primary level students who go on to higher levels of education is very low. The 1997 Report on Educational Statistics of the Ministry of Education reports the total students enrolled in primary schools (grade 1-6) all over the country is 6,246,380. The number of students in lower secondary school (grade

8-10) is 3,795,353, while the total number of upper secondary (grade 11-12) is 2,377,232. According to the 1994 Report on Educational Statistics of Ministry of Education, the percentage distribution of students by sex in all educational levels, academic year 1993, are almost equal between females and males. This report shows that there are 49 percent of girls and 51 percent of boys graduated from primary education and 49 percent of females and 51 males graduated from lower secondary education. In upper secondary education, there are 49 percent of female and 51 of male graduates.

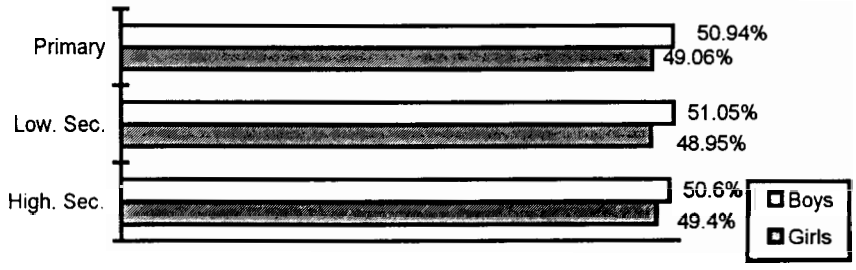

Figure 3.1 Participation in Formal Education by Sex, Academic Year 1993

Despite the fact that Thai girls and boys have an equal opportunity for compulsory education at present, education beyond upper secondary level is still limited for girls and women. Some Thai parents, especially rural parents whose family resources to support their children are very limited, do not see the value of higher education for their daughters. The view is that since women spend much of their time engaging with household chores, they will not have much chance to utilize acquired academic skills. Sons, on the other hand, will represent the name of the family and influence in others' lives. Consequently, education for men usually emphasizes gaining position, prestige and power for their family, while education for women emphasizes preparing to be good daughters, pleasing wives and beloved mothers.

Furthermore, the report on '1993 Labor Force Survey' projects that the percentage of labor force participation of girls and boys from rural areas is much higher than that of girls and boys from urban areas. Twenty-four percent of 13 to 14 year old rural girls and 23.6 percent of 13-to-14-year-old rural boys are in the labor force, while only 13 percent of urban girls and 8.8 percent of urban boys of the same age participate in the labor market. Based on these statistics, a great number of rural girls and boys participate in the labor market soon after they finish their primary education. They are therefore likely to lack the formal knowledge on reproduction and issues related to sex practice, which is available at the secondary level only.

Although many sex education programs, such as family planning, and AIDS education programs, are provided outside school settings in Thai society, these types of educational programs are often provided only for specific target groups — e.g., married people, commercial sex workers and commercial sex clients, whom intervention planners view as a high risk in sexual practices. Such programs are rather limited for or sometimes inaccessible to most teenagers. The lack of realistic knowledge about sex, together with a number of interrelated factors, such as a general loosening of family monitoring and control over young people's behaviors, peer group pressure, and increased access to sexually stimulating materials (Soonthorndhada, 1992), leads to unwanted pregnancies and induced abortions among girls and young women. Illegal abortions are a major cause of death and health problems among female teenagers.

Since research has shown that sex education curricula for the purpose of health promotion should cover a broader areas of sexual and reproductive information and knowledge, I find the existing sex education program in Thailand inadequate. I believe that

a careful investigation of the needs, the attitudes and current level of knowledge about sex is not only crucial but necessary for the initiation for health promotion programs in Thailand.

In summary, some aspects of sex education are made available to the Thai people. Many aspects related to sex and sexuality were left out of the existing curriculum, however, and are inaccessible for young and unmarried persons. I am convinced that sex education with a content that promotes positive attitudes toward sex and sexuality can provide a strong basis for the formulation and promotion of sexual health. I hope the findings presented in this thesis can yield useful information for the future development of sex education courses and other sexual health promotion programs in Thailand.

Chapter 4

Study Design and Methodology

This chapter provides background information about the study setting, profiles of the study site, criteria for the selection of the study site, the sample population, the research methodology and instruments employed for the study, as well as study procedures and limitations.

The setting

Thailand is located in Southeast Asia. The overall area of the country is 512,820 square kilometers or 51.3 million hectares, about the size of France. In 1987, Thailand was ranked eighteenth among the most populous nations in the world (Pongsapich, 1987). According to the 1996 census of the National Statistical Office, Thailand has 59,460,382 people. Although it is regarded as a 'newly industrialized country' in the region of Southeast Asia (World Bank, 1993), it is still predominantly an agricultural country. Eighty percent of the population live in rural areas and participate in the agricultural sector. In 1993, eighty-five percent of these farmers earned less than US$ 700 per year (National Statistical Office, 1993).

Thailand is a relatively homogeneous country. Although each region exhibits distinctive subcultures and dialects, certain national characteristics are shared. Approximately 85 percent of Thai people practice Buddhism, and the Central Thai dialect is taught and understood throughout the kingdom (National Statistical Office, Report on

Population Census, 1996). Free compulsory primary education (grade 1-6) is provided by the government. More than 85 percent of the Thai people are literate, about 50 percent continue their education beyond the primary level, and less than half of high school graduates go on to universities and other post-secondary learning institutes (Ministry of Education, 1997).

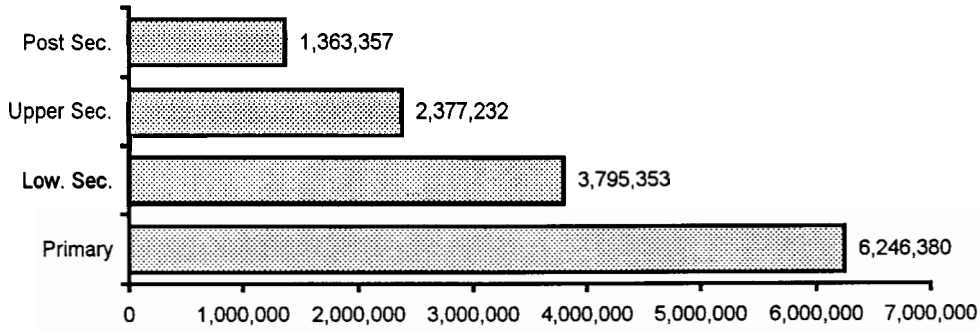

Figure 4.1 Student Enrollment by Educational Levels, Academic Year 1996

Thailand is divided into four geographic administrative regions, which are further divided into 76 provinces. From the largest to the smallest in terms of population size, the four regions are the Northeast, the Central, the North, and the South. Bangkok is the capital of the country. The sites used for this study are located in three provinces of the Upper North region. I will give an overview on the profiles of these sites in the following section.

Profiles of the study site and sample population

The North covers one third of the country's area. It is a mountainous region with numerous plain areas between the valleys. It is administratively divided into the Upper and the Lower North. There are 16 provinces in this region.

According to the 1996 annual report of the Department of Local Administration, Ministry of the Interior, the overall population of the North is 11,896,331. Of this population, 5,949,685 are females and 5,946,646 are males. Eighty percent live in rural areas, and more than 95 percent are Buddhists. Although most people speak the northern dialect in their everyday life, the Central Thai dialect is taught in school and is well understood in this region.

The population of the North shares certain characteristics with populations in other regions of the country. For example, most people acquire only a low level of education (see Table 4.1). A large part of the labor force engages in agriculture (see Table 4.2), many as hired labor in private enterprises or as free family labor (see Table 4.3).

Table 4.1 Distribution of labor force (13 years old and up) by level of education

North	Overall Labor Force	no Education	lower than Grade 4	Lower Primary (Grade 4)	Upper Primary (Grade 6)	Lower Secondary (Grade 9)	Upper Secondary (Grade 12)	Vocational College	University		Teachers Training College	Short Course Vocational Training	Other
									academic	professional			
Total	5,780,276	509,146	226,315	2,961,911	1,059,359	446,022	156,223	93,198	108,787	86,383	129,982	360	2,589
Female	2,428,306	269,907	87,448	1,249,632	443,185	147,654	51,304	30,956	53,998	29,133	74,346	323	429
Male	3,351,970	239,239	138,867	1,712,288	626,175	298,368	104,919	62,244	54,789	57,250	55,636	37	2,160

Table 4.2 Distribution of employed labor force (13 years old and up) by profession

North	Overall labor force	professional	administrative	clerical	sales	farmers	transport	craftsman	service
Total	5,780,276	235,561	119,430	113,333	667,620	2,740,308	170,826	1,491,299	221,948
Female	2,428,306	129,354	14,473	63,431	315,903	1,164,844	7,588	538,510	114,202
Male	3,351,970	106,207	104,957	69,902	271,716	1,575,464	163,238	952,740	107,746

Table 4.3 Distribution of labor force (13 years old and up) by employed status

North	Overall labor force	Employer	Govt.' employee	private employee	own-account worker	unpaid family worker
Total	5,780,276	240,726	434,993	1,987,612	1,873,756	1,243,188
Female	2,428,306	30,252	152,643	753,340	593,176	898,896
Male	3,351,970	210,474	282,351	1,234,272	1,280,580	334,292

Source: National Statistical Office, Labor Force Survey, Round 1 (Feb.) 1996

As the country's socio-economic development proceeds toward industrialization, many provinces in every region, including the three in this study, have experienced rapid urbanization, rapid expansion of the tourist industry, increasing industrialization in agriculture and manufacturing, and migration from rural to urban areas. The rapid socio-economic changes have also influenced and accelerated the expansion of the commercial sex industry within these three provinces. One of the results is an increasing rate of HIV/AIDS infection among the population in these areas.

Thai women's health and the AIDS epidemic

As Murphy and Kelly point out (1994), many people still view AIDS as primarily affecting homosexual males and intravenous drug addicts. Though it is true that the epidemic has for the most part affected men, HIV infection is increasingly becoming a major threat to women around the world. Chin (1990; 1995) suggests that AIDS has become the leading cause of death for women aged 20-40 in some areas of the world. The Surveillance Unit of Global Program on AIDS of the World Health Organization (GPA/WHO) has estimated that during the 1980s, there were approximately 500,000 cases of AIDS in women and children worldwide (quoted in LaGuardia, 1991: 17).

Nopakesorn (1995) projects the progression of the AIDS epidemic in Thailand as a series of waves. He explains that this progression is classified according to the types of people that were infected most. The first wave started in 1984 with a single case of AIDS in a homosexual man. The infection of AIDS at this time was found spreading through the gay male community. The second wave occurred among intravenous drug users in 1988 and was shortly followed by the third wave which swept through commercial sex workers' community. This eventually lead to the fourth wave in 1991 when more male customers of commercial sex workers began to get infected. These men have brought AIDS into their families, creating the fifth wave of AIDS infection among their wives and the upcoming sixth wave as more and more children are either infected with or affected by HIV/AIDS.

During these waves, HIV/AIDS interventions changed greatly. In the early waves, intervention efforts concentrated on describing *the risk groups*, namely homosexuals, intravenous drug users, and commercial sex workers. Threats and fear tactics and mass approaches were heavily used. The HIV virus was portrayed in graphic illustrations as a devilish monster or a demon. Ugly photographs of full-blown AIDS symptoms were likewise shown in all AIDS brochures, posters and spot campaigns on television. Although these campaigning materials were seen by people of all ages, the number of HIV-infected people still increased. One consequent of the early wave interventions was to create misconceptions and about people with AIDS.

As Thailand moved on to the fourth and fifth waves, which saw HIV/AIDS passed on to heterosexual men and women, intervention efforts shifted to attacking *risk behaviors* and focused on the three routes of HIV transmission: i.e. sharing needles, having multiple sex partners, and unsafe sex practices between commercial sex workers and their

customers (e.g., not using condoms). During these interventions, women and children were regarded as the group at the lowest risk of AIDS infection. Thus, they were overlooked and excluded from the attention of AIDS prevention workers. Women in general, wives and children especially, were the groups who were educated least about AIDS preventive measures, but were becoming increasingly affected by AIDS.

Around 1991, AIDS spreads into families and puts the general public at a risk, as women and children or the future population of the country were becoming infected with HIV. Current intervention efforts have started to refer to *risk situations,* connecting HIV/AIDS to other factors related to promoting, both directly and indirectly, risk behaviors, such as urban migration among young rural women, weakened family and community ties, eroded social and cultural values, and availability of alcohol, pornographic materials, drugs, and commercial sex places (Chiang Mai University, 1995).

Individuals and organizations whose work was dealing with HIV/AIDS issues started to realize that each population sub-group was different in its social and cultural background. Therefore, it seemed important to utilize different strategies to reach each group. As a result, the delivered message was gradually shifted from the risk group to the risk behavior to the risk situation. The delivery approach has moved from AIDS as a medical problem to AIDS as a social problem.

At present, government and non-government organizations continue to aim AIDS education programs at the whole population. Most programs aim at informing people about AIDS preventive measures and eliminating discrimination against HIV/AIDS patients. To my knowledge, these programs still emphasize factual knowledge about the disease, how it is transmitted and how to prevent or protect against it. The preventive

measures still emphasize safer sex practices for men rather than women — for example, encouraging men to use condoms and avoid promiscuous acts such as having multiple partners or visiting commercial sex services (see self-learning texts on AIDS education of Ministry of Education as example). Skills for women to negotiate sexual safety are missing from almost all programs — for example, how to refuse sex with a partner who does not wear a condom during intercourse.

In 1996, the overall number of HIV/AIDS patients in Thailand was 51,495, and 22,053 of them lived in the six upper northern provinces (Ministry of Public Health, 1996; and NAPAC, 1996). According to an annual report on public health (Ministry of Public Health, 1995), 42 percent and 24 percent of people infected with HIV/AIDS were laborers and agriculturists respectively. Of all those infected with HIV/AIDS, 14 percent were in the 20 to 24 age range, and 30 percent were 25 to 29 years old, while 22 percent and 14 percent were among the age groups of 30 to 34 and 35 to 39 respectively.

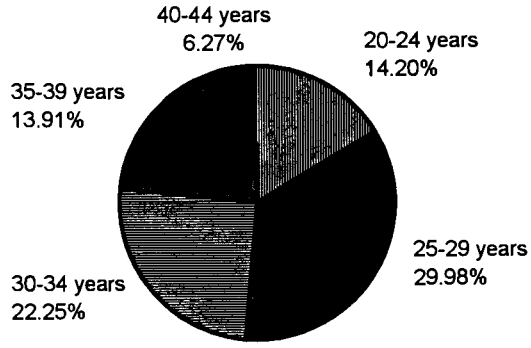

Figure 4.2 Age range of people infected with HIV/AIDS in 1996

To date, most females afflicted with HIV/AIDS and AIDS Related Complications (ARC) are between the ages of 20 and 24 years, while their male counterparts are between

25 and 29 years old. Both of these groups represent a large proportion of Thailand's workforce. Furthermore, recent studies of the Thai population indicate that the incidence of risk behaviors related to HIV/AIDS infection are very high, especially in the upper northern provinces — for example, condom use among Thai people is very low; multiple sexual partners are common; and unplanned sex and intercourse under the influence of alcohol are prevalent among teenagers (Mohpadungkul, 1994; Nopakesorn, Sweat, Kaensing and Teppa, 1993; Sittitrai, Phanuphak, Barry and Brown, 1992).

The selection of the study site

Three provinces in the North region were selected as the study site. They were chosen by probability and cluster sampling techniques. Two sub-districts in each province were chosen in terms of rural and urban strata. Within each chosen sub-district population, two villages were picked by random sampling to represent the overall province population. For each village, between 25 to 65 participants were selected to represent the overall population of its province. On the basis of my knowledge, I can confirm the following:

1. These participants probably were representatives of the overall population in terms of the shared characteristics. These shared characteristics include cultural beliefs and practices in terms of being conservative[1] or liberal[2]. They also refer to present socio-economic status, such as educational background, patterns of labor force participation, and residential and working locations — rural and urban.
2. According to data presented earlier in this chapter, the total HIV/AIDS patients of the country were 51,495 and 22,053 of them lived in the six upper northern provinces. The highest rate of HIV/AIDS infection in this region makes it apparent

that sex education and information concerning safer sex practices are crucial and urgently needed for people in this area.

3. I have worked in the Upper North region for more than 15 years, since May 1979. My experience helps me understand various issues concerning the target population. For example, I speak the northern dialect very well, I am familiar with most of the local customs and culture, and I can follow the way of northern people's life easily. Moreover, I have made good and strong connections with many local organizations, to which I can turn when I need assistance.
4. I will continue to work in this area after my graduation. Therefore, I will be able to use the findings of this study immediately and apply them in the development of my future work.

Definition and selection of participants

The primary target population for this study was single and married Thais between the ages of 18 and 40 years. Members of the target population have different occupations, and they are registered as residents of the selected provinces. The names of participants were randomly selected from the list of participants enrolled in non-formal education centers within the study sites from 1992 to 1996.

Research methodology

> *Choosing a method for a piece of research is a political choice. When you choose a certain method you adopt a particular way of seeing and constructing the world which may prevent you from knowing it another way.* (Kirby and McKenna, 1989:64)

Each research methodology bears its own distinctive nature and merit. For this study, I chose a combination of quantitative and qualitative research methods. The major advantage of quantitative method is that the statistical tools and sampling techniques necessary for effective confirmation and generalization are known and widely used (Zeller, 1989). In comparison with qualitative study, quantitative study permits an extensive amount of information on a larger number of sampling, and the information can be quickly interpreted and analyzed. Ultimately, it increases a researcher's ability to generalize findings.

Statistical information, however, is not free from biases and distortions caused either by an investigator or respondents. Possible biases include the representativeness of the selected sample, and the participants' willingness to reveal the answer. Data obtained might therefore fail to illustrate the actual diversity of participants within a sub-sample group. Qualitative data add an in-depth view of the context surrounding people's behaviors which help increase the accuracy of quantitative research.

I found it feasible to use a questionnaire survey because I could quickly gather data on a large scale, in terms of number of informants and their geographical range. I will present the data in numbers and percentages. According to Reinharz (1992), such statistics are powerful because they are concise, easy to remember and understand. Their brevity makes them easily communicated to people who seek information. In addition, the statistical information from the questionnaire helped me identify the specific topics that I should investigate further by interviews.

Interviewing is a useful instrument for collecting qualitative data. It can yield more detailed information than the questionnaire survey. The interview allows participants to

identify or express their thoughts and experiences more clearly and extensively than in a mailed questionnaire. Participants have the chance to recall information or experiences which are difficult to express in a questionnaire survey. In addition, interviewer and interviewee can clarify ambiguous issues occurring during the interview. Important or crucial issues which may arise during the interview help increase qualitative information gathered by the questionnaire survey. To me, the combination of research methods ensures the reliability of the research product.

Instruments

The questionnaire and the semi-structured interview used in this study were in the central Thai language. It is the dialect which is taught and understood throughout the country. The questionnaire and the interview guide, both Thai and English versions, are provided as Appendix I and Appendix II. The two instruments each have three parts. The first part is on the participant's personal data, in terms of age, sex, marital status, education, occupation, income, and residential and working locations. The second part contains questions concerning the participant's attitudes toward and need for sex education. The third part deals with the participant's current level of knowledge about safer sex and sex education in relation to biological, psychological, and technical aspects. The last section of the third part is about gender issues, which partially reflect the participants' present attitude toward the provision of a formal sex education program in Thailand.

The questionnaire and the interview guide were prepared in Thai and pre-tested on a number of Thai people who are students, restaurant employees and homemakers who

live within Burnaby and Vancouver, British Columbia. The pre-test particularly emphasized making the questions clear and easy to understand for actual participants. After the pre-test and revision of the instruments, 345 questionnaires were prepared for distribution to participants in Thailand by mail and by direct contacts. Volunteer participants were interviewed later.

This study was conducted on a voluntary basis, and participants' identities are protected. They were informed about the terms and conditions of their participation in the study through a cover letter for the questionnaire and a letter of informed consent for the interview. Both the cover letter and the consent letter were translated into the Thai language (see Appendix III a and III b).

Data gathering and potential bias

After defining the target population, I contacted the Provincial Non-Formal Education Centers within the selected provinces to obtain a list of participants' names and addresses. Using the defined characteristics, I randomly selected participants who enrolled in non-formal education programs during 1992 - 1996 and resided within the study site.

The time for my research in Thailand was only three months, February 18 to May 10, 1997.[3] I chose to use the quickest way of contacting participants and mailed out 100 questionnaires to the participants selected from the list. Only 48 questionnaires were returned within three weeks. Fourteen questionnaires were returned because participants no longer lived at the mailing addresses. Five were returned blank and four were partly filled out.

Using the lists of non-formal education participants may limit the representation of the target population, but I was well aware of this potential bias. In order to obtain more information and to avoid any bias in survey sampling, I looked for another way to contact participants from other sources. I began by visiting agencies that work within the selected study site, such as agricultural extension units, community development centers, public schools, family planning centers and some non-government organizations. During my previous years of working in the North region, I had established good connections and strong working relationships with several people who work in these organizations and received a great deal of support and assistance from them.

During these visits, I was sometimes given a chance to talk to participants in the programs and to distribute my remaining questionnaires to interested participants who seemed to fit the defined target population. I also had opportunities to interview 11 participants and discussed my research subject with a group of 30 high school students and 4 science teachers. Some participants were introduced to me by friends, which established trust for the interview and yielded more complete results. The assistance and support from these friends not only helped shorten my research time and reduced the expense of my research process, but also helped me feel less stress.

Limitations

One limitation of this study is that the representativeness and reliability of the findings are affected by various constraints. For example, the sample size is rather small and represents only the Upper North population. Although the Thai population is considered homogenous in many aspects, there are still several sub-cultural differences

among the populations of different regions.[4] Thus, the results of this study should not be cited as if they apply to the population of other regions of the country. Furthermore, owing to the limited research on homosexuality in Thailand, some information presented in this study come from my personal observations. Personal opinions can be biased and inaccurate, and they should not be cited as if they reflect the opinion of an overall population of the country.

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[1] Being conservative here refers to holding attitudes influenced by traditional and socio-cultural beliefs or customs toward sex and sexuality which assume that women and men are biologically assigned to perform certain roles and acted accordingly to their biological sex.

[2] Being liberal implies to being open-mindedness toward or accepting of certain trends in sex and sexuality — for example, education of girls about sex and sexuality, or a talk or discussion about sex between children and parents.

[3] I also participated in a field school program organized by Simon Fraser University and carried out in Thailand during January 12 to May 10, 1996. During this time, I conducted studies on women and development and prostitution in Thailand as the fulfillment of the program. These studies are the foundations for my thesis.

[4] Sub-cultural differences here refer to particular cultural norms and beliefs practiced by a population in one certain region, but not in the others. For example, the belief in an ancestral spirit (*Phid Phi)* is a form of traditional social control practiced in several northern Thai villages. *Phid Phi* is the belief that any sexual transgression initiated by a man is an offense to the woman's maternal ancestral spirits. The custom of *Pai Len Saow* in the Northeast is similar to *Pai Aew Saow* in the North. *Pai Len Saow* and *Pai Aew Saow* are customs which encourage young men to visit and court young women, within or outside their villages, at the women's houses, but, any young man who touches the woman he visited must pay a fine to the woman's guardians. This fine is called *Prub Mai* in the Northeast and *Kah Sia Phi* in the North. These customs and beliefs are not applied to people in other regions.

Chapter 5

Results and Discussion

The findings presented in this chapter are the combination of data from a questionnaire survey, interviews, and a group discussion I conducted in 1996 and 1997. Data from the questionnaire survey are divided into three parts: participants' characteristics, participants' attitudes toward and need for sex education, and their current level of knowledge about sex education and some safer sex practices. Data from an interview and a discussion are excerpted to highlight each part of the questionnaire findings.

Summary of questionnaire data

A total of 345 questionnaires were distributed to the target participants both by mail and by direct contact as explained in the chapter *Study Design and Methodology*. A total of 225 questionnaires were returned. Among these, 184 were completely filled in, 41 had some individual items not completed, and 19 were blank. In total, 225 returned questionnaires were processed for the analysis.

Part I: Participants' characteristics

This part describes the participants' personal data according to sex, age, marital status, educational attainment, occupation, income, residence and workplace location.

The total of 225 respondents consists of 126 (56 percent) females, 87 (39 percent) males, and 12 (5 percent) who did not indicate their sex. The ratio of female to male respondents deviates from the actual population distribution of the selected provinces.

According to the 1996 census by the National Statistical Office, the population distribution in the three selected provinces was 49.8 percent females and 50.2 percent males in Chiangmai, while Payao had 50.3 percent females and 49.7 percent males, and Lamphun had 49.9 percent females and 50.1 percent males. This deviation may result from my method of distributing the questionnaires by direct contact. With this method, I could not control the ratio of female and male respondents as I could do with a mailing list because I met more women than men through the direct contact. This study, however, does not emphasize comparing attitudinal differences between sexes, and the deviation should not significantly affect the analysis.

For analytical purposes, it should be noted that urban participants are defined as people living in municipal areas of the selected provinces, while individuals living outside these areas are defined as rural people. By this definition, Thailand was estimated in 1994 as having 75-80 percent of its population living in rural areas (National Statistical Office, 1994). The ratio of rural to urban respondents in this study appears to be close to the national estimate.

As Table 5.1 shows, the age of the respondents ranges from under 20 years to over 40 years. The number of respondents aged under twenty is equal to the number of those who are between 20 and 30 years of age (36 percent in each group). These two groups constitute 71 percent of the overall sample. The rest are 19 percent in the 31-40 years age group and 20 persons (10 percent) whose ages are over 40 years. The majority of respondents, 83 percent, live in rural areas. Respondents' characteristics here are useful for analyzing whether most young rural Thai are less knowledgeable about sex and sexuality as I have assumed.

Table 5.1 Distribution of respondents by sex, age and residence

Residence	Female					Male					No Answer (N/A)			
location	<20	20-30	31-40	>40	Total	<20	20-30	31-40	>40	Total	20-30	31-40	>40	Total
Rural (n)	49	42	11	4	106	28	14	12	10	64	8	1	1	10
%	38.9	33.3	8.7	3.2	84.1	32.2	16.1	13.8	11.5	73.6	66.7	8.3	8.3	83.3
Urban (n)	1	9	6	4	20	2	6	11	3	22	1	1	0	2
%	0.8	7.1	4.8	3.2	15.9	2.3	6.9	12.6	3.4	25.3	8.3	8.3		16.7
N/A (n)	0	0	0	0	0	0	0	0	1	1	0	0	0	0
%									1.1	1.1				
Total (n)	50	51	17	8	126	30	20	23	14	87	9	2	1	12
%	39.7	40.5	13.5	6.3	100%	34.5	23.0	26.4	16.1	100%				

The data in Table 5.2 show that most respondents are single (62 percent). Thirty-two percent of the respondents are married, 4 percent are divorced, 1.3 percent are widowed and another 1.3 percent did not indicate their marital status. As discussed in chapter 3, this corresponds to current trend toward late marriage among Thai people. The respondents characteristic here also benefit to the study's analysis. When cross tabulated with the respondents' knowledge of sex education and safer sex, the data support my assumption that single Thai women have limited knowledge about sex and sexuality.

Table 5.2 Distribution of respondents by sex, marital status and residence

Resident	Single				Married				Widowed			Divorced				N/A
location	female	male	N/A	Total	female	male	N/A	Total	female	N/A	Total	female	male	N/A	Total	female
Rural	73	40	6	119	28	24	2	54	1	1	2	2	0	1	3	2
Urban	10	9	1	20	7	10	0	17	0	0	1	2	3	0	5	1
N/A	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
n	83	49	7	139	35	35	2	72	1	2	3	4	3	1	8	3
%	36.9	21.8	3.1	61.8	15.6	15.6	0.9	32	0.4	0.9	1.3	1.8	1.3	0.4	3.6	1.3

As Table 5.3 shows, most rural respondents, 67 percent of females and 53 percent of males, work outside their residential village. Data in Table 5.3 also respond to the situations discussed in chapter 3 that more young rural Thai people work outside their home village and are not under their family's supervision. These young rural people,

therefore, have more freedom than when they were at home. This increases their tendency to engage in several risk behaviors, especially under peer pressure or alcohol influence.

Table 5.3 Residential and work location by sex

Working location	Female			Male		
	Rural	Urban	Total	Rural	Urban	Total
At home	9.5%	1.6%	11.1%	8.0%	1.1%	10.3%
in village	7.9%	2.4%	10.3%	9.2%	6.9%	16.1%
out of village	56.3%	9.5%	65.9%	39.1%	14.9%	54.0%
N/A	10.3%	2.4%	12.7%	17.2%	2.3%	19.5%
Total %	84.0%	15.9%	100.0%	73.5%	25.2%	99.9%
Total no.	106	20	126	64	22	86

As shown in Table 5.4, respondents' educational attainments are as follows: 8 percent to the primary level, 20 percent to the lower secondary level, 35 percent to the higher secondary level, and 36 percent to the post secondary level. These data appear to contradict the projection in Chapter 3 which suggested that many Thai do not continue their education beyond the primary level. This contradiction may result from selecting participants through a random sampling method. Nevertheless, these data give another benefit for the study analysis. When cross tabulated with the respondents' knowledge of sex education and safer sex, the data support my contention that the existing sex education programs do not provide adequate knowledge about sex and related topics, and it can be assumed that both in-school and out-of-school populations do not have sufficient information about sex.

Table 5.4 Distribution of respondents' educational attainment by sex

Education	Female		Male		N/A		Total	
Primary	9	4.0 %	6	2.7 %	3	1.3 %	18	8.0 %
Lower sec.	32	14.8 %	11	4.9 %	1	0.4 %	44	19.6 %
Higher sec.	41	18.2 %	34	15.1 %	4	1.8 %	79	35.1 %
Post sec.	43	19.1 %	36	16.0 %	3	1.3 %	82	36.4 %
N/A	1	0.4 %	0	0 %	1	0.4 %	2	0.9 %
Total	126	56.5 %	87	38.7 %	12	5.2 %	225	100 %

The data in Table 5.5 shows that a large number of the sample are laborers (32.9 percent) while the rest are approximately comprised of 21 percent students, 16 percent government service personnel, 6 percent agriculturists, 2 percent self-employed, and 22 percent respondents who did not indicate their occupation. One reason for a high percentage of laborers in the sample population is that the Northern Industrial Development Zone is located in one of the selected provinces and is in close proximity to the other two provinces. Thus, a large number of the population in these three provinces work as laborers in this industrial zone. Most factories located in this industrialized zone require that their workers have finished at least lower secondary education. Most manufacturing laborers in the Upper North of Thailand obtain their education through distance education programs of the Non-Formal Education (NFE) Centers located within each province. I also selected respondents from the student lists of these NFE Centers. However, the analysis shows that occupations do not seem to impact the differences of respondents attitudes toward sex and sexuality as do other characteristics, e.g., education attainment or marital status.

Table 5.5 Distribution of respondents' occupation by sex

Occupation	Female		Male		Not Answer (N/A)		Total	
Student	19	8.44 %	29	12.89 %	0	0.0 %	48	21.33 %
Laborer	60	26.67 %	8	3.56 %	6	2.67 %	74	32.89 %
Agriculturist	8	3.56 %	4	1.78 %	2	0.89 %	14	6.22 %
Gov. Service	11	4.89 %	24	10.67 %	1	0.44 %	36	16 %
Self-employed	3	1.33 %	1	0.44 %	0	0.0 %	4	1.78 %
N/A	25	11.11 %	21	9.33 %	3	1.33 %	49	21.78 %
Total	126	56 %	87	38.67 %	12	5.33 %	225	100 %

The data in Table 5.6 also indicate that most female sample, 48 percent, engage in the labor sector, while 28 percent of the male sample work in government service and 33

percent are students. According to traditional Thai value system and beliefs (see Komin, 1991), working in the government service could bring individuals certain social prestige such as leadership, power and wealth. In the past, most positions in government service were occupied by men and it was the ultimate goal of Thai parents to have their children working in the government sector. Even now, some Thai parents still carry such an idea, and some still favor higher education for sons in order that sons can enter the careers in the governmental sector.

Table 5.6 Distribution of respondents' income and occupation by sex

	Female								Male							
Income	Student	Laborer	Agricul-turist	Gov. service	Self-employed	N/A	Total n	%	Student	Laborer	Agricul-turist	Gov. service	Self-employed	N/A	Total n	%
<2000	11.1%	2.4%	1.6%	0	0	4.0%	24	19.0	19.1%	1.1%	1.1%	0	0	2.3%	21	24.1
2000-3599	0.8%	5.6%	0.8%	0	0.8%	3.2%	14	11.1	2.3%	1.1%	1.1%	1.1%	0	3.4%	8	9.2
3600-4599	0.8%	14.3%	1.6%	0	0	2.4%	24	19.0	1.1%	0	1.1%	0	0	0	2	2.3
4600-5599	0.8%	16.7%	0.8%	0	0	3.2%	27	21.4	0	1.1%	1.1%	0	0	2.3%	4	4.6
5600-6000	0	7.1%	0	0	0	0.8%	10	7.9	0	1.1%	0	0	0	2.3%	3	3.4
>6000	0	0.8%	1.6%	8.7%	1.6%	4.0%	21	16.7	0	4.6%	0	26.4%	1.1%	9.2%	36	41.4
N/A	1.6%	0.8%	0	0	0	2.4%	6	4.8	10.3%	0	0	0	0	4.6%	13	14.9
n	19	60	8	11	3	25	126		29	8	4	24	1	21	87	
%	15.1	47.6	6.3	8.7	2.4	19.8		100	33.3	9.2	4.6	27.6	1.1	24.1		100

Looking at the distribution of income in correlation with occupation and the purpose of income earning in Tables 5.7, the data suggest that many male respondents regard themselves as the sole or main income earners, while fewer female respondents see themselves as such. Many women often see themselves as additional income earners, even when their husband earns less. This view may be the influence of the traditional gender ideology about the role of a husband and a wife.

Yoddumnern-Attig et al. (1992) explain that, traditionally in Thailand, men have been the main economic providers of the household. While men left the house to work during the day, women often handled household chores and earned additional income at home. The authority to decide economic and politic matters often rested with the husbands and decisions concerning household matter with the wives. Though this division of female and male roles has changed, due to advanced education and the increase of women's participation in the labor force and the political arena, it is likely that many women still regard men as the main economic providers for the family and this may affect women's ability or power in redefining and negotiating for the safer sex with their partners. An in-depth investigation of whether this is true is, however, beyond the scope of this thesis.

Table 5.7 Distribution of respondents' income and the purpose of earning income

	Female							Male						
Income	Sole earner	Main earner	Additional earner	Self support	N/A	n	%	Sole earner	Main earner	Additional earner	Self support	N/A	n	%
<2000	0	0.8%	10.3%	0.8%	7.1%	24	19.0%	1.1%	2.3%	13.8%	0	6.9%	21	24.1%
2000-3599	0	0	7.9%	2.4%	0.8%	14	11.1%	0	4.6%	3.4%	1.1%	0	8	9.2%
3600-4599	0.8%	0.8%	14.3%	2.4%	0.8%	24	19.0%	0	1.1%	1.1%	0	0	2	2.3%
4600-5599	4.0%	4.8%	7.1%	4.8%	0.8%	27	21.4%	1.1%	0	2.3%	1.1%	0	4	4.6%
5600-6000	0.8%	0	5.6%	1.6%	0	10	7.9%	0	0	2.3%	1.1%	0	3	3.4%
>6000	0	2.4%	11.1%	2.4%	0.8%	21	16.7%	5.7%	28.7%	5.7%	1.1%	0	36	41.4%
N/A	0	0	0.8%	0	4.0%	6	4.8%	0	0	0	0	14.9%	13	14.9%
n	7	11	72	18	18	126		7	32	25	4	19	87	
%	5.6%	8.7%	57.1%	14.3%	14.3%		100%	8.0%	36.8%	28.7%	4.6%	21.8%		100%

Part II: Attitudes toward sex education and safer sex

This part of the questionnaire asked respondents to express their opinion toward the necessity for sex education and list the topics that they would include in a sex education program. Here too, respondents suggested at which levels of education sex education should be taught and by whom. At the end of this part, respondents were asked to indicate their best sources of information about sex. The results of the questionnaire are as follows.

Table 5.8 displays the findings about respondents' attitudes toward the necessity for and the impacts of sex education.

Table 5.8 Distribution of responses to the question, "I think formal sex education is ..."
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	Agree		Undecided		Disagree	
1. a prime way to promote the betterment of women's health.	75.4	75.9	18.3	19.5	6.4	4.6
	170	75.6%	43	19.1%	12	5.3%
2. a prime way to prevent unwanted pregnancy.	91.3	87.4	5.6	11.5	3.2	1.2
	202	89.8%	17	7.6%	6	2.6%
3. a prime way to prevent or reduce unplanned sex among teenagers.	90.4	85.0	7.1	14.9	2.4	0.0
	197	87.6%	25	11.1%	3	1.3%
4. a prime way to slow down the spread of sexually transmitted diseases.	93.6	89.7	5.6	10.3	0.8	0.0
	206	91.6%	18	8.0%	1	0.4%
5. a prime way to slow down the spread of AIDS.	92.1	90.8	5.6	9.2	2.4	0.0
	207	92.0%	15	6.7%	3	1.3%
6. a prime way to eliminate gender inequality.	69.8	64.4	23.0	28.7	7.2	6.8
	150	66.6%	60	26.7%	15	6.7%
7. necessary for accurate knowledge about safer sex.	89.7	93.1	7.9	3.5	2.3	3.5
	205	91.1%	14	6.2%	6	2.7%
8. necessary to overcome myths about sexuality.	84.9	89.7	13.5	5.8	1.6	4.6
	195	86.7%	24	10.7%	6	2.7%
9. necessary to overcome myths about sexually transmitted diseases.	88.9	93.1	8.7	4.6	2.4	2.3
	204	90.6%	16	7.1%	5	2.2%
10. needed because parents cannot talk about sex with their children.	62.7	78.2	23.8	17.2	13.5	4.6
	155	68.9%	47	20.9%	23	10.2%

11. a cause of premarital sexual conduct among teenagers.	19.8	19.5	27.0	34.5	53.2	46.0
	47	20.9%	66	29.3%	112	49.7%
12. not necessary because children will eventually find out about sex.	17.5	13.8	27.0	19.5	55.6	66.7
	37	16.5%	52	23.1%	136	60.4%
13. inappropriate because sex is not a subject to be formally taught.	14.3	12.7	18.3	15.0	67.5	72.4
	33	14.6%	37	16.4%	155	68.9%

In general, the data in Table 5.8 indicate that the majority of respondents have positive attitudes toward sex education. For example, over 92 percent agree that sex education is the prime way to help slow down the spread of sexually transmitted diseases (94 percent females and 90 percent males), especially HIV/AIDS (92 percent females and 91 percent males). About 90 percent of this sample (90 percent of the females and 93 percent of the males) agree that sex education can offer them accurate knowledge regarding safer sexual practices such as to prevent unwanted pregnancy (92 percent females and 87 percent males); and to reduce/prevent unplanned sex among teenagers (90 percent females and 85 percent males).

In addition, the majority of the respondents agree that sex education can offer them many other benefits. For example, Close to 86 percent agree that sex education is a way to help people overcome myths about sexuality and about sexually transmitted diseases(89 percent of the female and 93 percent of the males). Three quarters also agree that sex education is a way to promote women's health. The percentage who agree that sex education will have positive impacts on women's health and gender issues is almost equal between females and males (75 percent females and 76 percent males on health, and 70 percent females and 64 percent males on gender equality). About 70 percent do not agree that teaching sex education formally is inappropriate (67 percent of female and 72 percent males). In contrast, only 21 percent fear that sex education will cause premarital

sex among teenagers. This kinds of positive attitudes toward sex education strongly suggest that sex education will be well accepted by most Thai people.

A closer look at the figures in Table 5.8 also reflects some attitudinal differences between female and male respondents. For example, female respondents list items 1, 2, 3, 4 and 5, about 3 to 6 percent, more often than the males. Questionnaire items 1 to 5 suggest that sex education is a prime way to promote women's health, to prevent or reduce unplanned sex and unwanted pregnancy as well as to help slow down STD and AIDS infections. According to the data, the women may realize that unplanned sex, unwanted pregnancy, and STD and AIDS are more likely to affect their health through their reproductive role. They expect, therefore, that sex education can and will yield them benefits.

On the other hand, male respondents listed items 7, 8, 9 and 10 about 4 to 5 percent more often than the females. Questionnaire items 7-10 in the same table state that sex education is necessary in that it would provide accurate information about safer sex practices, knowledge to overcome myths about sexuality and sexually transmitted diseases, and provide a substitute for parents' roles in providing information about sex. The males appear more concerned about these aspects of sex education than the females. As discussed in chapter 3, many Thai men often practice unsafe casual sex before and after marriage, and many see that sex education is necessary to help them avoid the risks of casual sex.

In addition, more men than women (78 percent and 63 percent respectively) agree that sex education is necessary because parents cannot talk about sex with their children. This suggests that fewer male respondents seek information about sex from their parents

and may obtain information about sex from other sources. A formal sex education program could be one of those sources.

Table 5.9 projects the results of the questionnaire which asked respondents to list the topics that they would include in a sex education program.

Table 5.9 Distribution of responses to questions about topics to be included in sex education.
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	agree		undecided		disagree	
1. girls' physical changes as they reach puberty	96.0	87.7	3.2	6.9	0.8	3.4
	210	93.3%	11	4.9%	4	1.7%
2. boys' physical changes as they reach puberty	95.2	94.3	3.7	3.5	0.8	2.3
	212	94.2%	10	4.4%	3	1.2%
3. emotional conditions of children as they reach puberty	92.9	88.5	4.0	5.8	3.2	5.7
	205	91.1%	11	4.9%	9	4.0%
4. how to deal with children's interest and curiosity about sex	79.4	88.5	9.3	5.8	11.1	5.7
	187	83.1%	18	8..0%	20	8.9%
5. the female and male human reproductive system	85.7	82.8	11.9	9.2	2.4	8.0
	189	83.9%	25	11.1%	11	4.8%
6. sexual intercourse	49.2	54.0	27.8	24.1	23.0	21.8
	113	50.1%	62	27.6%	50	22.2%
7. pregnancy and childbirth	87.3	82.8	9.5	9.2	3.2	8.0
	190	84.4%	23	10.2%	12	5.5%
8. family and parenthood	93.7	92.0	3.2	5.8	3.2	2.3
	209	92.9%	10	4.4%	6	2.7%
9. dating and personal relationships	77.8	82.8	17.5	9.2	4.8	8.0
	179	79.5%	33	14.7%	13	5.7%
10. precautions about dating	94.4	92.0	4.0	3.5	1.6	4.6
	209	92.9%	10	4.4%	6	2.7%
11. the proper roles of women and men in marriage	89.7	92.0	7.9	5.8	2.4	2.3
	204	91.1%	15	6.7%	5	2.1%
12. family planning	95..2	92.0	2.4	4.6	2.4	3.4
	212	94.2%	7	3.1%	6	2.7%
13. contraception	92.9	94.3	3.8	4.6	4.0	1.1
	210	93.3%	9	4.0%	6	2.7%
14. induced abortion	52.4	56.3	16.3	11.5	37.3	32.2
	121	53.8%	23	10.2%	81	35.9%
15. masturbation	33.3	55.2	34.9	33.3	31.7	11.5
	94	41.8%	77	34.2%	54	24.0%
16. impotence and frigidity	39.7	60.9	42.1	23.0	18.3	16.1
	108	48.0%	79	35.1%	38	16.9%
17. sexual practices (homosexual, heterosexual and bisexual)	31.7	36.8	19.8	21.8	48.4	41.4
	75	33.3%	46	20.4%	104	46.2%
18. menstruation and its biological / psychological aspects	89.7	78.2	7.1	13.8	3.2	8.0
	192	85.3%	21	9.3%	12	5.3%

19. menopause and its biological / psychological aspects	83.3	79.3	15.9	11.5	0.8	9.2
	184	81.8%	32	14.2%	9	3.9%
20. male aging and its biological / psychological aspects	84.1	87.4	14.3	8.0	1.6	4.6
	191	84.9%	28	12.4%	6	2.7%
21. sexually transmitted diseases	96.0	96.6	1.6	2.3	2.4	1.1
	215	95.5%	5	2.2%	5	2.1%
22. preventive measures against sexually transmitted diseases	96.0	96.6	3.8	2.3	0	1.1
	215	95.6%	9	4.0%	1	0.4%
23. sex counseling and resources of sex counseling	85.7	93.1	11.9	3.5	2.4	3.4
	199	88.4%	20	8.9%	6	2.7%
24. how to teach sexual morals to children	84.1	94.3	10.3	3.5	5.6	2.3
	199	88.4%	16	7.1%	10	4.4%
25. sexual abuse and sexual harassment	97.6	93.1	0.8	6.9	1.6	0
	214	95.1%	9	4.0%	2	0.8%
26. the harmful effects of sexual abuse, harassment and pornography	88.1	85.1	7.1	9.2	4.8	5.7
	195	86.7%	19	8.4%	11	4.9%

According to Table 5.9, there are 11 topics which more than 90 percent of the respondents thought important to be included in sex education:

1. preventive measures against sexually transmitted diseases (95.6 percent)
2. information about sexually transmitted diseases (95.5 percent)
3. sexual abuse and sexual harassment (95.1 percent)
4. family planning (94.2 percent)
5. boys' physical changes as they reach puberty (94.2 percent)
6. girls' physical changes as they reach puberty (93.3 percent)
7. contraception (93.3 percent)
8. precautions about dating (92.9 percent)
9. family and parenthood (92.2 percent)
10. emotional conditions of children as they reach puberty (91.1 percent)
11. proper roles of women and men in marriage (91.1 percent)

The data in Table 5.9 correlate with the data in Table 5.8 which suggests that most respondents see sex education as a way to reduce the problems of sexually transmitted diseases and unsafe sex practices such as unplanned sex. The extensive activities on family

planning and HIV/AIDS prevention by various agencies in the country can be one important factor that makes people recognize the crucial role of sex education for this purpose.

Less than 50 percent support sexual practices whether heterosexual, homosexual or bisexual (33 percent), masturbation (42 percent), and impotence and frigidity (48 percent). About half of all respondents support the inclusion of information about sexual intercourse (50 percent) and induced abortion (54 percent). The data in this section also suggest gender preferences. Controversial topics such as masturbation, impotence and frigidity, and sexual intercourse are more often selected by male respondents to be included in sex education programs. About 55 percent of the male respondents select information about masturbation, while only 33 percent of the females do so, perhaps because masturbation is a common sexual release for young men who cannot afford or are reluctant to have sex with commercial sex workers (Rattanapaichit, 1990).

Again, 61 percent males want impotence and frigidity included in sex education programs, but only 40 percent of females request this topic. The request to include induced abortion is from men more often than from women — 52 percent of females and 56 percent of males support including information about induced abortion in the curriculum. According to the interview data, almost all participants, especially females, also feel hesitant about the inclusion of abortion. The concerns they express are often based on religious beliefs as well as possible consequences:

> *It is a great sin to kill. Abortion is killing. (36 year old female)*
>
> *The content of this topic should not urge people to see abortion as the first but the very last option. (A female teacher)*

This subject should enable learner to rationalize their sexual act as well as mental and social consequences that abortion will bring. (42 year old female)

If it will not encourage teenagers to think abortion is as common as having a tooth pulled, I think it should be all right to teach this subject. (A man in the government service)

Slightly more males than females support including information about sexual intercourse — 54 percent and 49 percent respectively. Although not surprisingly, menstruation and menopause are topics more often listed by females than by males (almost 90 percent of the women requested knowledge about menstruation), still almost 80 percent of the men indicate their interest in these topics.

In the questionnaire, one female respondent made a striking suggestion to include the ways to cope with stress caused by sexual abuse and harassment. I believe many young women experience sexual abuse or harassment, but they dare not ask for help. This issue is crucial to the mental health of these women and should be given more attention. Another interesting suggestion came from a married male respondent who works in a government service sector. He suggested including a topic concerning laws about rights and protection for each sex. More programs to assist people with these two important issues would be wise for educators and other concerned parties to seriously consider these topics and include them soon in sex education programs.

Other comments which emerged from the interview were:

To include or exclude any topic is not so crucial as to make a complex topic simple for children to understand, more important, appropriate for their needs at each certain age and circumstance. (A 44-years-old female staff of a non government organization)

The most important issue is how sex education can assist learners to realize the consequences of their sexual acts. For example, what consequences unplanned sex will bring them. (A mother with two teenage children)

It is important to note that the requested topics are not only factual. Respondents also suggested topics related to emotions, relationships and communication, for instance, family and parenthood, precautions during dating, and the proper roles of women and men in marriage. In my opinion, these respondents are showing that they support sex education which would not only provide them with factual biological and medical information, but also help them obtain practical knowledge and skills to reinforce the factual messages.

Regarding the question of when sex education should be taught and who should teach it, Table 5.10 shows that 94 percent of the respondents support formal sex education in upper secondary school (grades 10 to 12). The percentage of respondents who supported formal sex education in lower secondary school (grades 7 to 9) and university or college is slightly lower, 89 percent and 84 percent respectively.

Table 5.10 Distribution of responses to the question, "I think that most Thai people would support sex education..."

Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	agree		undecided		disagree	
1. in primary school	46.0	32.2	19.8	25.3	34.1	42.6
	92	40.9%	49	21.8%	84	37.4%
2. in lower secondary school	92.0	85.1	6.4	9.2	1.6	5.7
	201	89.4%	17	7.6%	7	3.1%
3. in upper secondary school	94.4	94.0	4.0	2.3	1.6	3.5
	212	94.3%	8	3.6%	5	2.2%
4. in post secondary school	83.3	86.2	7.1	8.0	9.5	5.7
	189	84.0%	19	8.4%	17	7.5%
5. from school only	24.6	26.5	26.2	26.4	49.2	47.3
	57	25.3%	59	26.2%	109	45.4%
6. from parents only	23.0	24.1	24.6	26.4	52.4	49.4
	52	23.1%	57	25.3%	116	51.6%

7. from medical personnel only	38.1	39.0	15.9	18.4	46.0	42.5
	87	38.6%	37	16.4%	101	44.9%
8. from parents, school and medical personnel.	92.8	93.1	2.4	2.3	4.8	4.7
	210	93.3%	5	2.2%	10	4.4%

Sex education in primary school (grades 1 to 6) receives the least support. Only 41 percent of the sample agree that sex education should be taught at this level, while 37 percent oppose the idea and 22 percent cannot make up their minds. When probed about their response during the interview, it appeared that half of the interviewees (7 out of 11) thought children at primary education age were too young to learn about sex and might not yet be interested in sex, and some thought that sex education might even encourage children to try sex before the appropriate age. In contrast, participants who supported sex education in primary education level thought that topics concerning puberty and menstruation were important for children at this age, and that it would be too late to teach them in high school.

According to Table 5.10, about 93 percent of the respondents agree that all concerned parties, e.g., parents, school, and medical personnel, should be involved in teaching sex education. About a quarter of the respondents accept that medical personnel should teach sex education. Data here also show that parents are listed least, with only 23 percent of respondents preferring that parents teach sex education, and 52 percent oppose (53 percent of the female and 49 percent of the male respondents).

During the interview, respondents were asked to suggest suitable ways to organize and teach sex education. Their answers are wide-ranging:

> *Girls and boys should be taught separately. Girls should be taught by a female teacher and boys by a male. (A married male in government service, age 38)*

The teacher should ask students in the class how they prefer to be taught. Some topics they (girls and boys) can learn together and learn separately in some topics. (A married female laborer, age 34)

Sex education should not be taught only in school. The provision (of sex education) should cover various occupation groups such as factory workers. (A female laborer, age 21)

If we help students to overcome their embarrassment in discussion about sex by teaching as a single sex group or as a girl's topic and a boy's topic, when will they learn to understand each other? (A father of three children)

I think it depends on the topic. For example, my six-years-old son learned from somewhere that men should wear condoms while their penis is hard on. He asked me how a hard on penis was like. I couldn't explain but my husband just said it was like when you need to pee badly. If our boy asks how a menstrual cramp is, I believe my husband couldn't explain it either. (A female director of one non government organization)

The variety of suggestions for organizing sex education class makes it difficult to give a conclusive analysis here. Nevertheless, almost all interview participants (9 out of 11) agreed that multimedia is well suited for the presentation of sex education programs. Some topics — e.g., dating, menstruation, sexually transmitted diseases or contraception — might be taught by a teacher, a medical specialist or other health personnel. Other topics such as puberty or childbirth can be presented as films, self-instruction texts, or as a combination of text books, films, lectures, and group discussion. More importantly, sex education providers, e.g., school teachers, health program organizers, and non-formal education facilitators — should be trained in the use of multimedia and be aware of effective strategies to facilitate teaching-learning activities.

As Table 5.11 shows, 71 percent of the respondents choose a teacher as their best source of learning about sex, a mother was second (68 percent), and books third (63 percent), with experience ranking as their last choice (13 percent). In general, the data shows that the number of respondents who identified the mother as the best source of information about sex is about 9 percent higher than those who identified the father. More females preferred to seek information about sex from their mother and more males from their father.

Table 5.11 Distribution of responses to the question, "My best source for learning about sex is ..."
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	agree		undecided		disagree	
1. my mother	81.8	62.0	8.7	18.4	9.5	19.5
	168	68.0	27	12.0	30	13.3
2. my father	54.8	64.4	24.6	18.4	20.6	17.3
	133	59.1	49	21.8	43	19.1
3. siblings	65.0	54.0	22.2	27.6	12.7	18.4
	135	60.0	55	24.4	35	15.6
4. other relatives	47.6	41.4	34.9	34.5	17.5	14.2
	102	45.3	78	34.7	44	20.0
5. teacher	70.7	71.3	21.4	19.5	8.0	9.3
	159	70.7	48	21.3	18	8.0
6. medical personnel	59.5	54.0	44.4	35.6	0.8	1.2
	126	56.0	93	41.3	5	2.2
7. friends	58.7	62.1	29.4	18.4	11.9	19.5
	135	60.0	58	25.8	34	15.1
8. experience	6.4	22.9	25.4	33.3	68.2	43.7
	29	12.9	66	29.3	130	57.7
9. books	55.5	69.0	23.8	17.2	20.6	13.8
	140	62.2	46	20.4	39	17.3
10. TV and films	41.1	47.1	24.6	26.4	33.3	26.4
	100	44.4	60	26.7	65	28.9

In the interview, most female participants said they often consulted their mothers about menstruation and dating. Males often asked their parents about certain sexual behaviors, such as their interest in the opposite sex. When asked whether parents have

ever offered advice or discussed protected sex with them, no interviewees gave an affirmative answer. Five participants admitted that they could not ask their parents direct questions about sex. Both females and males said that parents were their first source of information, but in fact, parents became the last persons with whom they consulted. Here are some participants' comments:

> *I confided in my parents on several things. But when it comes to something about sex, I had no guts. Why? Being with my parents every day, I can imagine what will happen if I ask about sex. (A high school female student)*
>
> *It takes a strong courage. I once did. (laugh) My parents gave me half an hour preaching instead of an advice. (22-year- old male student)*
>
> *It is an uneasy feeling to ask them. I often expect the worst from my parents. I have never heard they talk about sex, so I assume my question might shock them. (18-year-old male student)*

Participants' views expressed here are similar to what Chan (1994) found in her studies. Chan states that within traditional Asian families, parents play the dominant role in an adolescent's understanding of what would be considered appropriate expressions of sexuality. An open discussion of sexual issues with parents may not be unusual in many families. Parents often give a strong and direct message of disapproval, however, if the children are too overtly sexual. Chan also emphasizes that the cultural expectation of most Asian parents is that sexual activity should be pursued within the context of emotional intimacy and a long-term relationship. Any deviation from this range would not only result in punishment, but also be accompanied by expressions of disappointment and a strong sense of shame from family members (Chan, 1994: 92-93). As a result, young people become discouraged about seeking information about sex from their parents.

When asked why they confided in their teacher more than their parents, participants often said that teachers were more open than their parents and that it was therefore easier to talk about sex with teachers. One teacher commented that a classroom atmosphere and classmates helped students feel more comfortable about asking questions about sex. Another teacher added that teachers' characters and experiences could affect their teaching performance in sex education class. She explained that she was single when she taught sex education the first time. There were several issues she did not know about and she felt uncomfortable answering some of her students' questions. After she married and also received some in-service training on teaching sex education, she found it easier and more comfortable discussing information about sex with her students. These two teachers, however, agreed that teaching sex education, in general, was still an uncomfortable task. One of the teachers stated, "Sometimes, I don't know how much I should teach them. Usually, students want to know more than what is there in the curriculum."

The data in Table 5.11 also indicate that women sought information about sex from their siblings more often than men did, while men sought this information from friends and books more often than women did. The questionnaire did not specifically ask if their siblings and friends were of the same sex as the respondents. The result from the interview was also inconclusive. Interviewees often gave the answer 'it depends'. Other interviewees said:

> *If I have a good relationship and feel confident in the person, a man or a woman, I ask. (A female laborer)*

It depends on the character of the person you are going to ask. If that woman is open-minded and takes my question seriously, I will ask her (A 22 years old male student).

If it is too personal, I would rather talk with a person of the same sex. If it is a general topic, such as why men like pornography, I can talk to either men or women (A male staff in a government service).

It depends on the topic. If I want to know how men react to their partners' infidelity, I will surely ask male friends. I absolutely won't talk about how a woman should initiate sex with any male friends (A female teacher).

Concerning the influences of friends and media as sources of sex information, six interviewees (2 females and 4 males) revealed that friends' advice often affected their initial sex experience. Their confidence in seeking advice from friends often decreased if it caused a mistake or failure in actual practice. Media, on the other hand, had a stronger impact on their sexual beliefs and practices. Two interview participants agreed that the media is good because it often suggests that readers or viewers verify or obtain more information from other reliable sources such as specialist agencies.

Information from media must be checked again and again before the information is released to the public. So, I think media should be more reliable than friends. (Male student)

Usually, information about sex or health in the media is given by reliable sources such as doctors, teachers or government personnel. I believe they cannot afford to misinform the public. (Female laborer)

I had sexual problems with my husband. Many times I found good solutions for my problems from a column in the newspapers. (36-year-old widow)

A total of 126 respondents (56 percent) identified medical personnel as the best source of information about sex. Of these respondents, 48 percent had post secondary

education, 39 percent had higher secondary education and 13 percent had lower secondary education. This finding correlates with the information I received from talking to the director of the Family Planning Association of the Northern Province (FPNP). She said that most clients who came to seek information concerning sex or sexual problems at the FPNP clinic were educated persons. The FPNP reaches people with lower levels of education, especially in rural areas, through its medical mobile units or FPNP training programs on reproductive health and AIDS prevention.

Part III: Knowledge of sex education and safer sex

The questionnaire in this part requested respondents to express their current knowledge about sex education and safer sex practices on four issues, biological, psychological, technical and gender-related.

Table 5.12 displays respondents' knowledge of sex education on biological aspects.

Table 5.12 Distribution of responses to questions about sex education on biological aspects
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	correct		incorrect		undecided	
1. Puberty is a set of physical transforming processes, which starts when children are at the age of 9-10 and stops at the age of 18-19	54.0	59.9	25.4	16.7	16.7	21.8
	128	56.9%	50	22.6%	43	19.1%
2. Children who reach puberty are able to reproduce.	87.3	87.4	2.4	4.6	7.9	8.0
	197	87.6%	7	3.1%	18	8.0%
3. Girls usually reach puberty earlier than boys.	86.5	87.4	1.6	4.6	8.7	10.3
	193	85.8%	7	3.1%	21	9.3%
4. Men's sperm can live within a woman's uterus longer than three days.	15.9	12.6	33.3	41.4	47.6	46.0
	35	15.6%	83	36.9%	103	45.8%
5. A woman is not likely to get pregnant if she forgets to take a contraceptive pill the day after she had intercourse with her partner.	12.7	16.9	40.5	34.5	43.7	49.4
	32	14.2%	83	36.9%	106	47.1%

6. Missing a menstrual period for more than 45 days is a sign of pregnancy.	35.7	34.5	23.8	14.9	37.3	50.6
	81	36.0%	45	20.0%	95	42.2%
7. The ovaries of a woman who is taking contraceptive pills still produce eggs but do not release them.	53.2	46.0	15.1	18.4	28.6	35.6
	114	50.7%	35	15.6%	72	32.0%
8. Breast feeding can prevent pregnancy.	10.3	10.3	50.0	48.3	36.5	41.4
	24	10.7%	111	49.3%	86	38.2%
9. Pap tests are necessary for married women only.	26.7	23.0	56.3	57.5	14.3	19.5
	56	24.9%	128	56.9%	37	16.4%
10. It is necessary for everyone to have a blood test before getting married.	92.9	92.0	2.4	2.3	1.6	5.7
	208	92.4%	6	2.7%	7	3.1%
11. Rh factor is a blood characteristic that can complicate pregnancy.	25.4	31.0	3.2	3.4	68.3	65.5
	63	28.0%	7	3.1%	151	67.1%
12. A blood test is needed to reveal the Rh factor.	55.6	47.1	4.0	3.4	37.3	49.4
	118	52.4%	8	3.6%	95	42.2%
13. A blood test is needed to reveal genetic abnormality.	51.6	59.8	11.9	6.9	33.3	33.3
	119	52.9%	25	11.1%	77	34.2%
14. A blood test is needed to reveal sexually transmitted diseases.	88.1	82.8	1.6	3.4	7.1	13.8
	191	84.9%	6	2.7%	24	10.7%

The data in this table show that most respondents have accurate knowledge only about puberty, certain topics about contraception and some health benefits of a blood test. Nevertheless, the data here also indicate that the respondents do not have adequate knowledge about biological aspects of sex. For example, I have learned from a doctor that sperm of a healthy man can live in a woman's uterus longer than 76 hours. A partner of such a man is more likely to get pregnant if she forgets to take a contraceptive pill the day after she had intercourse with him. Data in Table 5.12 show that only 15.6 percent of the respondents know that men's sperm can live in the woman's uterus longer than three days and about 37 percent (40.5 percent of females and 34.5 percent of males) know that a woman is likely to get pregnant if she forgets to take a contraceptive pill the day after she had intercourse. Less than 36 percent (35.7 percent of females and 34.5 percent of males) correctly answer that missing menstrual period for more than 45 days is a sign of pregnancy.

Although the findings in Table 5.12 may suggest that this sample population has accurate knowledge about puberty, it should not be generalized as being true for all other groups. From my interview with one science teacher, I learned about an unfortunate situation of one girl in her school. This teacher told me about a grade 7 student who did not know she was pregnant until after her sixth month of pregnancy. This teacher said:

> *"She came running to the school counseling room and told us that something was moving in her stomach and she looked very frightened. We looked and examined her abdomen and found that the girl was pregnant. We interviewed her and learned that she had intercourse with a sixth grade boy next door once but* ***did not think the boy was old enough to make her pregnant."***

This situation is not only an admonition for people who assume that the existing sex education is already adequate. The findings here are also a warning sign for curriculum planners, educators and all concerned parties to reconsider the coverage of the present sex education program in terms of its content and application so that it suitably responds to the actual needs of learners in each age group.

Table 5.13 outlines the respondents' knowledge of sex education on psychological aspects. Respondents' knowledge of sex education on these aspects vary, but can be arranged into three categories. The first group are topics toward which the respondents exhibit a strong conservative attitude — an attitude influence by traditional socio-cultural norms about sex and sexuality, assuming that women and men are biologically assigned to perform certain roles and practices and should act accordingly. For example, women should be docile and keep their virginity until married, while men should be sexually virile and can have casual sex before or after marriage. The second group are topics which

respondents view with a more liberal attitude — an openmindedness toward or an acceptance of certain trends in sex and sexuality, for example, female's premarital sex is not stigma. The third group are topics with inconclusive results.

Table 5.13 Distribution of responses to questions about sex education on psychological aspects.
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	Correct		Incorrect		Undecided	
1 Children under 10 years have no interest in or curiosity about sex.	34.1	46.0	34.1	27.6	28.6	26.4
	88	39.1%	72	32.0%	61	27.1%
2 Taking contraceptive pills for a long period of time makes women sterile.	22.2	17.2	31.7	33.3	42.9	49.4
	45	20.0%	74	32.9%	102	45.3%
3 Hysterectomies increase the degree of sexual desire in women.	8.7	10.3	44.4	47.1	43.7	42.5
	23	10.2%	103	45.8%	95	42.2%
4 Vasectomies reduce the degree of sexual desire in men.	9.5	10.3	39.7	49.4	47.6	40.2
	22	9.8%	99	44.0%	100	44.4%
5 Promiscuous people usually are infected with AIDS/HIV.	81.7	81.6	5.6	4.6	9.5	13.8
	186	82.7%	11	4.9%	24	10.7%
6 Prostitutes are the source of sexually transmitted diseases.	86.5	75.9	3.2	8.0	7.1	16.1
	186	82.7%	11	4.9%	24	10.7%
7 Homosexuality spreads sexually transmitted diseases.	49.2	51.7	11.9	11.5	35.7	36.8
	113	50.2%	28	12.4%	80	35.6%
8 Girls who participate in vigorous sports will break their hymen.	50.8	66.7	14.3	5.7	31.7	27.6
	129	57.3%	26	11.6%	66	29.3%
9 Men need sex more than women.	48.4	42.5	5.6	5.7	42.9	51.7
	103	45.8%	13	5.8%	105	46.7%
10 Menstrual blood is dirty.	33.3	39.1	38.9	26.4	24.6	34.5
	82	36.4%	75	33.3%	64	28.4%
11 Masturbation is a deviant behavior.	20.6	12.6	38.1	59.8	38.1	27.6
	39	17.3%	104	46.2%	78	34.7%
13 Homosexuality among women is a deviant behavior.	69.8	79.3	12.7	9.2	14.3	11.5
	165	73.3%	25	11.1%	31	13.8%
14 Homosexuality among men is a deviant behavior.	65.9	75.9	13.5	11.5	17.5	12.6
	157	69.8%	29	12.9%	35	15.6%
15 For children, learning about sex is like playing with fire.	33.3	26.4	29.4	41.4	34.1	32.2
	71	31.6%	76	33.8%	74	32.9%

The more conservative or unconventional issues on psychological aspects of sex education include the following beliefs:

- promiscuity, prostitution and homosexuality have a strong linkage with the infection and the spread of STD and HIV

- homosexuality is a deviant behavior
- girls who participate in vigorous sports will break their hymen
- men need sex more than women

About 84 percent of the sample agree that commercial sex workers are the main source of STD and that promiscuous people are usually infected with HIV/AIDS. Almost 60 percent agree that homosexuality spreads sexually transmitted diseases and over 70 percent view homosexuality as a deviant behavior. More than 50 percent agree that homosexuality spreads sexually transmitted diseases. The percentage of men who hold these misconceptions is about 10 percent higher than the percentage of women. This suggests that Thai males are more homophobic than Thai females.

The fact that the country's first AIDS case was found in a homosexual person in 1984 coupled with the rising number of HIV/AIDS cases among commercial sex workers and their clients in later years (Nopakesorn, 1995) are reasons why many people view promiscuity, prostitution and homosexuality as the major source of HIV/AIDS and other sexually transmitted diseases. Furthermore, several AIDS prevention programs launched from 1984 to 1990 also carried a message that confirmed this view.

The percentage of male respondents who agree that homosexuality and promiscuity spreads sexually transmitted diseases is almost equal to the percentage of females, but the percentage of female respondents who agree that prostitution spreads sexually transmitted diseases is about 10 percent higher than the percentage of male respondents. A study by Havanon, Knodel and Bennett (1992) also found that respondents, when asked "What persons are at risk for AIDS?", often identified commercial sex workers as the highest risk group. Other groups they identified were

promiscuous women, commercial sex clients who do not use condoms, homosexuals and IV drug addicts. The study emphasized that rarely did any respondent perceive that men who have multiple non-commercial sex partners and who do not use condoms are an important risk group. These misconceptions about promiscuity, homosexuality, prostitution and sexually transmitted diseases can influence people to overlook the actual risk of their sexual behavior.

About half of all respondents uphold traditional views on the issues of men's sexual needs and women's virginity. Almost half of all the respondents (46 percent which includes 48 percent of all females and 43 percent of all males) agree that men need sex more than women. While 6 percent of the respondents refused to agree, 47 percent are undecided. On the issue of virginity, women are less likely than men to agree that girls who participate in vigorous sports can lose their hymen; 51 percent of all female respondents and 67 percent of all male respondents support that traditional viewpoint.

Respondents show a more liberal view toward masturbation. Table 5.13 shows that 104 out of 221 respondents (38 percent of females and 60 percent of males) do not agree that masturbation is a deviant behavior. Five interviewed participants (three men and two women) agreed that masturbation was less risky than having sex with commercial sex workers. However, they also thought frequent masturbation was embarrassing and not a healthy behavior. Both female and male interviewees thought the number of men who masturbated was much higher than the number of women.

Sterilization also received a more positive view from respondents. About 45 percent do not agree that hysterectomy or vasectomy affects sexual desire in women or men, while 10 percent agree that it can increase sexual desire in women and decrease

sexual desire in men, the number of respondents who are uncertain about the effects of masturbation or sterilization on human sexual desire is high.

Respondents' views on children's interest in sex, the effect of contraceptive pills and menstruation seem inconclusive. The number of respondents who agree that children under 10 years of age have no interest or curiosity about sex is almost the same as those who disagree with this statement. Respondents' answers on the issue that learning about sex is for children like playing with fire also show similar results. This finding responds to the finding in Table 5.10 which displays that less respondents support sex education for children at the primary education level with the same reason.

In Table 5.14, respondents are asked to express their technical knowledge of sex. Questions are mainly related to safer sex practices such as condom use, preventive measures against sexually transmitted diseases and HIV/AIDS, and contraceptive measures.

Table 5. 14 Distribution of responses to questions about sex education on technical/practical aspects
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	correct		incorrect		undecided	
1. Condoms should be put on before sexual entry.	69.0	73.6	7.1	11.5	20.6	14.9
	160	71.1%	20	8.9%	41	18.2%
2. Using condoms during all sexual intercourse can protect against sexually transmitted diseases.	88.9	93.1	0.8	2.3	7.1	4.6
	203	90.2%	3	1.3%	15	6.7%
3. Blood tests cannot detect HIV during the first 6 months of the contamination.	35.7	36.8	23.0	29.9	38.1	33.3
	82	36.4%	59	26.2%	80	35.6%
4. Condoms are an effective method to prevent sexually transmitted diseases.	83.3	90.8	3.2	2.3	10.3	6.9
	194	86.2%	6	2.7%	21	9.3%
5. Latex condoms offer the best protection against AIDS.	45.2	39.1	22.2	33.3	29.4	27.6
	101	44.9%	58	25.8%	62	27.6%
6. A man who has had a vasectomy can still transmit the AIDS virus.	73.0	83.9	5.6	3.4	18.3	12.6
	176	78.2%	10	4.4%	35	15.6%

7. Douching the vagina before and after sex can protect against sexually transmitted diseases.	15.1 37	17.2 16.4%	30.2 71	33.3 31.6%	51.6 113	49.4 50.2%
8. Venereal diseases are transmitted only through sexual intercourse.	54.0 113	41.4 50.2%	12.7 37	23.0 16.4%	30.2 71	35.6 31.6%
9. The IUD is the least effective method for pregnancy prevention.	16.7 34	11.5 15.1%	22.2 51	21.8 22.7%	57.9 136	66.7 60.4%
10. A woman should take the birth control pill after the first day of her menstruation.	27.0 59	23.0 26.2%	29.4 60	23.0 26.7%	40.5 102	54.0 45.3%
11. Sterilization is 100% effective in pregnancy prevention.	61.9 156	78.2 69.3%	4.0 8	3.4 3.6%	31.0 57	18.4 25.3%

Table 5.14 suggests that the many of respondents have an adequate knowledge about the use of condoms and its effectiveness in protecting against sexually transmitted diseases. It is interesting to find the different degree of respondents' confidence in the effectiveness of condom use for protection against sexually transmitted diseases in general and HIV/AIDS in particular. While approximately 90 percent of the respondents (89 percent of females and 93 percent of males) agree that using condoms during sexual intercourse can protect against sexually transmitted diseases, only 45 percent (45 percent of females and 39 percent of males) were sure about the effectiveness of condoms against HIV/AIDS. Although 78 percent (73 percent of females and 90 percent of males) agree that men who have had vasectomy can still spread HIV/AIDS, some studies suggest the possibility that many sterilized men may not use condoms as protection against sexually transmitted diseases. For example, studies by Sittitrai et al. (1992) and Havanon et al. (1992), found that most people thought of condoms use, especially with their spouse or regular partner, as a contraceptive means rather than a protection against sexually transmitted diseases.

The findings here raise the question of why people are not confident in the effectiveness of condoms as protective measures against infection with the AIDS virus. It

is also possible, in my opinion, that this lack of confidence has been obtained from media and/or friends. After the explosion of the AIDS epidemic in 1984, the media have given the Thai public information — for example, that the size of AIDS virus is extremely microscopic, or that some people who use condoms are still infected with HIV/AIDS because they either do not use condoms properly or they were previously infected before using condoms. With such information, many people assume that the AIDS virus can pass through the pores of latex fiber. Despite the efforts of medical researchers and the media since then, this misconception still lingers in many peoples' minds.

Two male students with whom I talked during a group discussion also showed concern about the effectiveness of condoms against HIV/AIDS infection. They asked whether wearing three condoms at a time could prevent the virus from leaking through. I told them that, as far as I know, the AIDS virus could not pass through latex condoms. I also said people who used condoms and were still infected with HIV/AIDS might have used expired condoms, or removed it improperly, or might have already been infected before they started to use condoms. I recommended that these students consult with medical personnel about this.

The respondents' technical or practical knowledge about safer sex practices seems to be low. Most do not know when a woman should take a birth control pill. When cross tabulated, the highest percentage of respondents who do not know about contraception falls in the groups of young, single and rural. Many women do not know when birth control pills should be taken — 62 percent of single and 46 percent of married women. Most of the female respondents who do not have this knowledge are under 20 (66 percent) or aged 20 to 30 (55 percent); 60 percent are rural and 45 percent are urban.

About half agree that venereal diseases are transmitted only through sexual intercourse, but only 26 percent of all respondents agree that a blood test cannot detect an HIV infection with the first six months of contamination. Several respondents also mistakenly believe that HIV symptoms will show right after an individual receives the virus. This finding is consistent with the kinds of issues raised in Thai sex columns. For example, one man told a sex counseling columnist that:

> *I had an intercourse with a commercial sex woman, only for two minutes. I know that she has AIDS. Two days after this intercourse, I had my blood test at a clinic. The doctor told me to come back for another test in the next three months. (Daily News, Feb 2, 1997)*

This finding is similar to other studies such as Havanon et al. (1992) and Sittitrai et al. (1992) which suggest that one third of Thai people they studied were unaware that HIV carriers could not be detected through symptomatology. Just over 20 percent of their researched population thought a person who was HIV infected would always show symptoms and 11.6 percent said they did not know. According to Havanon et al. (1992) and Sittitrai et al. (1992), this misunderstanding gave people unrealistic opinions of their ability to recognize HIV infected individuals and to determine their risk in sexual situations. Consequently, several people preferred screening a potential partner for risk to practicing safer sex.

The last section of the questionnaire allowed respondents to record their attitudes towards some traditional gender standards and ideologies practiced among Thai people. In general, Table 5.15 indicates that the majority of respondents disagree with all the traditional standards, ideologies and beliefs about gender roles and practices asked in this

section of the questionnaire. For example, it is traditionally believed that sex is not a subject that children, especially girls, should learn until they are mature, which implies after they are married. About 74 percent of the respondents disagree with this statement.

Table 5.15 Distribution of responses to questions about sex education on gender aspects
Note: Figures in the first line of each item show the percentage of females and males, and the second line show the total number and the percentage of both sexes.

	Agree		disagree		no answer	
1. Children, especially girls, should not learn about sex.	22.2	20.7	70.6	73.6	7.1	5.7
	48	21.3%	163	72.4%	14	6.2%
2. Men should have casual sex experience before they are married.	24.6	35.6	65.9	58.6	9.5	5.7
	64	28.4%	144	64.0%	17	7.6%
3. Women should divorce their promiscuous husbands.	80.2	71.3	10.3	20.7	9.5	8.0
	174	77.3%	32	14.2%	19	8.4%
4. Chaste women will be better wives and mothers.	32.5	31.0	58.7	62.1	8.7	6.9
	73	32.4%	135	60.0%	17	7.6%
5. Men should consider virginity as a measure of a woman's goodness and virtue.	19.8	28.7	70.6	63.2	9.5	8.0
	52	23.1%	154	68.4%	19	8.4%
6. Men are superior to women.	14.3	27.6	76.2	62.1	9.5	10.3
	43	19.1%	161	71.6%	21	9.3%
7. Men are like the front legs of an elephant while women are like the hind ones.	22.2	32.2	69.8	58.6	7.9	9.2
	57	25.3%	150	66.7%	18	8.0%
8. Man is like paddy. Woman is like rice.	48.4	39.1	31.7	43.7	19.8	17.2
	99	44.0%	85	37.8%	41	18.2%
9. Having a daughter is like having a toilet in front of the house	32.5	28.7	57.1	62.1	10.3	9.2
	68	30.2%	136	60.4%	21	9.3%

Respondents give a variety of reasons for supporting sex education for children:

- The more sex is hidden, the more curious and anxious children want to find out. Let them learn about sex according to their needs at each age.
- Being ignorant about sex can put children at risk of unhealthy sexual encounters such as unprotected or unplanned sex which can jeopardize children's physical and psychological health.
- Sooner or later, children will encounter sexual problems or engage in sexual activities such as dating. Sex education at an early age can prepare children to understand and deal with those problems or handle their sexual encounters safely and properly.

- Having accurate and realistic knowledge about sex at an early age is a good ground for children to develop positive attitudes toward their gender roles and sexuality, as well as the formulation of safer sexual behavior patterns.

The 22 percent of respondents who oppose sex education for children, especially girls, also have various reasons. Many respondents explain that learning about sex may encourage children to experience sex before their appropriate age. Some clarify that they only object to sex education for children under 14 years old and emphasize that children in this age group are too young to be interested in or understand the complications of sex. To them, children at this age are better learning proper manners in interacting with other people rather than learning about sex. The percentage of respondents who agree that children should not learn about sex here is close to the percentage of respondents who do not support sex education in primary school (37 percent) and do not agree that children under 10 years old are interested in sex (39 percent).

Regarding the question of whether men should have casual sex experience before they are married, 64 percent of the respondents disagree with this traditional practice. This figure constitutes 66 percent of females and 64 percent of males. When looked at by rural - urban strata, the percentage distributes to 65 percent rural and 70 percent urban females, 58 percent rural and 64 percent urban males. About 25 percent of females (26 percent rural and 20.0 percent urban) and 28 percent of males (39.1 percent rural and 27.0 urban) agree that men should experience casual sex before becoming married. The data indicate that more rural people still support this practice, especially men with primary education (50 percent) and post high school education (36 percent). Most of the respondents who do not agree with this practice say that casual sex can create several problems — directly,

these men may be infected with sexually transmitted diseases and spread them to their wives or partners and indirectly they promote and perpetuate the commercial sex business. A few respondents who agree with men's casual sex experiences before marriage offer as reasons that sexually experienced men can make their wives enjoy sex much better than inexperienced men.

When asked if women should divorce their promiscuous husbands, over three quarters of the respondents (77 percent) agree, giving the reason that promiscuity shows the husbands' disrespect and irresponsibility to the family and in particular to their wives. Only 14 percent of the respondents do not agree with the divorce, saying that it might cause psychological problems for the children. The percentage of rural and urban women who approve of divorcing promiscuous husbands differs significantly. The data implies that more urban than rural respondents support divorce — 85 percent of the urban women support it, but only 69 percent of the rural women. The same dichotomy is apparent in the rural and urban male samples; 67 percent of rural and 86 percent of urban men agree that women should divorce their promiscuous husbands. Several respondents, however, in giving reasons, support this case only in a situation when no other solutions to stop the husband from being promiscuous can be found.

Most of the respondents seem to disagree with the traditional beliefs and standards concerning virginity. About 60 percent (59 percent of females and 60 percent of males) do not agree that chaste women will be better wives and mothers, and 68 percent (71 percent of females and 68 percent of males) disagree with the idea that men should take virginity as a measure of a woman's goodness and virtue. Some of these respondents comment that a woman might have lost her virginity through several causes other than sexual

intercourse, or that it is socialization but not virginity that creates good qualities in a woman.

Twenty-three percent of the respondents (20 percent of the females and 29 percent of the males) agree that men should take virginity as a measure of a woman's goodness and virtue. About 33 percent of the respondents (36 percent of females and 31 percent of males) agree that chaste women will be better wives and mothers. As reasons, these respondents argue that a woman who keeps her chastity shows that she is taking proper responsibility for maintaining the good reputation of herself and of her family. If she shows such responsibility, it can be assumed that she will keep being responsible in any other task she has as a wife or a mother.

Cross tabulation suggests that the change in ideology about virginity may be more apparent in urban areas. The percentage who still uphold this traditional belief about virginity is comprised of 15 percent urban and 21 percent rural females, 18 percent urban and 33 percent rural males. Fifty-eight percent of the rural women and 59 percent of the rural men and 65 percent of the urban females and 73 percent of the urban males disagree with the idea that chaste women will be better wives and mothers. When looked at the percentage of respondents who agree with this idea, it appears that 33 percent of the rural women and 38 percent rural men and 30 percent of urban females and 14 percent of urban males hold this view.

When comparing the respondents' educational attainments, the data show that approximately 65 percent of females and 64 percent of males with post high school education disagree that chaste women make better wives and mothers and that virginity proves a woman's goodness and virtue. Very few of the respondents with primary

education disagree with these beliefs but 45 percent of the females and 33 percent of the males with primary education agree. The data at this point suggests that people with high level of education may discard these traditional beliefs faster than people with lower level of education.

According to the data, it can be concluded that more men than women and more rural than urban respondents uphold this traditional belief about the quality of chaste women, and many rural males still believe in the significance of virginity while very few urban men do. In addition, educational levels also influence the tendency of the respondents' disagreement or agreement with the traditional beliefs about virginity.

When asked whether men are superior to women, about 71 percent of the sample (76 percent of women, 62 percent of men) disagree. The number of women who do not agree with this statement is about 10 percent higher than the number of men. However, the percentage of the single men who disagree that men are superior to women is about 16 percent higher than that of the married men, while the percentage of the single women is only 1.2 percent lower than that of the married women. The rural-urban stratum, however, does not significantly affect respondents' attitudinal differences. There is only 1 percent difference between rural and urban women as well as between rural and urban men.

There is a Thai saying, "Men are like the front legs of an elephant while women are like the hind ones," which implies that in family life men lead and women follow. Regarding this adage, about 70 percent of the female and 59 percent of the male respondents disagree. With the variables of marital status and rural-urban strata, about 86 percent of the married women and 63 percent of the single women do not agree with the

adage. Of the minority who support this belief, 26 percent are rural and 5 percent are urban females; 34 percent are rural and 27 percent are urban males.

At this point the data suggest that more men than women and more rural than urban people still agree with the idea that men lead and women follow. Respondents who agree with the adage are mostly in the groups with primary and lower secondary education and a few are in the post high school education group (22 percent of females and 33 percent of males with primary education, and only 14 percent of females and 28 percent of males with post high school education).

Two more adages were used in the questionnaire: "Man is like paddy. Woman is like rice" and "Having a daughter is like having a toilet in front of the house." The first adage reflects norms for gender valuation. It means that men have a high quality of paddy. No matter where it drops, the paddy will not rot but will grow and yield some day. Women and rice, if placed or dropped in an improper place or condition, will rot and no longer be valued. In other words, women are prone to sexual stigma and are devalued more easily than men; women should be careful about what they do and where they are. The second adage, "Having a daughter is like having a toilet in front of your house," says that a toilet in front of a house is an easy accessible releasing place for everyone. Therefore, it is rather difficult for the owner to keep this toilet clean and free of a bad smell. The smell of the toilet usually bothers the owner who lives in the house more than the person who made the toilet dirty and smelly. It is similar to the reputation of a daughter in one's family. Very often, a woman involved in a sexual misconduct is looked down upon and, consequently, her family will be blamed by others for not properly

looking after the daughter. At the same time, the man who polluted her and his family are less likely to be condemned.

Forty-four percent of the sample (48 percent of the females and 39 percent of the males) agree with the saying, "Man is like paddy. Woman is like rice." From the cross tabulation with other variables such as rural-urban, marital status and so on, it appears that these variables do not significantly differentiate respondents' attitudes. For example, the percentage of rural females here is only about 4 percent higher than that of urban females, while the distribution of rural to urban male differs only by 2 percent. Also about 49 percent of rural compared to 45 percent of urban women agree with the adage, while 39 percent of rural and 41 percent urban of men agree. Equally, the difference between single and married women and men who agree with this adage is a marginal 2 percent. The highest number of females who agreed with this saying is in the age group of 31-40 (59 percent), while males concentrate in the age group of 21-30 (55 percent). In some areas, particularly rural areas, the family and the community networks are still tight and strong. Women's involvement with sexual misconduct (such as premarital sex and adultery) is strongly sanctioned. This data also suggest that the women feel the impact of this sexist adage more than men, especially rural women.

About 32 percent of the women and 38 percent of the men disagree with the saying, "Man is like paddy. Woman is like rice". In this group, the highest number of females who disagree is in the age groups of under 20 and 21 to 30 (equally 14 percent). The number of men who disagree is rather high in the age groups under 20 and 31 to 40 (22 percent and 14 percent respectively). The percentage of respondents who disagree with this adage is also concentrated in the more educated groups — about 13 percent of

the females with post secondary education and 10 percent with higher secondary education disagree with this saying, and about 3 percent males with primary education and 6 percent with lower secondary education. This data suggest that young and educated respondents tend to disagree with traditional beliefs about female and male valuation.

Just over 60 percent of the respondents (57 percent of females and 62 percent of males) disagree with the saying, "Having a daughter is like having a toilet in front of your house." Among the respondents who disagree, 57 percent are rural and 60 percent are urban women, together with 61 percent of rural and 68 percent of urban men. These figures here indicate that more men than women and more urban than rural do not agree with the adage.

When looked at in terms of the age variable, 69 percent of the females who do not agree with this adage are between 21 and 30; 52 percent under 20; 47 percent 31-40; and 38 percent over 40. As for males, 74 percent are 31-40 years, 63 percent under 20; 60 percent 21-30 years, and 43 percent over 40. From a cross section of the respondents' sex and their educational attainments, 65 percent of the women and 69 percent of the men with post high school education disagreed with the adage, while in other education groupings ranges from 44 to 61 percent. The data, therefore, suggest that the young and the more educated respondents will reject the traditional belief associated with this adage — that a daughter is more likely to jeopardize a family's reputation than a son. Thirty percent of the women and 29 percent of the men agree with this adage. Of these, 32 percent are rural and 35 percent are urban females; 33 percent are rural and 18 percent are urban males.

Conclusion and discussion

The findings of this study reveal the following key points:

- Most of the respondents have positive attitudes toward sex education, especially on the topics that are already in the conventional sex education and AIDS education programs. These topics include biological knowledge about puberty, pregnancy, contraception, sexually transmitted diseases and certain measures to protect against sexually transmitted diseases.
- The respondents lack accurate knowledge about sex education in some biological aspects and in several psychological, technical and practical aspects, particularly topics related to gender beliefs and standards, and sexuality. This may cause by an inadequacy of information in the content of the existing sex education programs. Many respondents, therefore, express their needs to include more practical as well as factual information in sex education programs.
- Many respondents still uphold and follow certain traditional sexual beliefs and standards about gender and sexuality. Many hold misconceptions about biological, psychological and, consequently, practical aspects of sex education. For example, some respondents agree with the statement that children aged under 10 are not yet interested in sex and sexuality and do not agree that sex education is necessary for children at this age. Fewer respondents support sex education in primary education level.
- The data indirectly indicate that the respondents look at sex education through the lens of traditional norms about sex and sexuality. For instance, some still request

more information necessary for heterosexual practices and ignore homosexual and bisexual practices. A great number of the respondents also express their skepticism about including some unconventional topics such as intercourse, homosexuality, and abortion in sex education programs. Respondents' hesitation to include these topics often seems to be affected by their traditional beliefs, norms and standards toward gender and sexuality.

- The data suggest that people are more confident in learning about sex from teachers, but that teachers are expressing ambivalence about teaching sex education. In addition, many parents and teachers also feel uncertain about the content areas of sex education and feel uncomfortable teaching children about sex and sexuality.
- The data suggest that respondents' gender roles, opportunities for education, age, marital status and residential strata have a significant influence on the respondents' acceptance or doubt about the impacts of sex education.
- The respondents' readiness for accepting information about sex and their intention to make behavioral changes can be categorized into three groups — a pre-contemplation, contemplation, and preparation stage. The pre-contemplation group in this study consists of individuals who are young females, who live in rural areas, and who have a low level of education. Individuals who fit into the contemplation and preparation groups are mostly urban and some rural as well as ones who have high educational attainments.

Very often respondents' written comments contradict the attitudes they express in the listed items. For example, fewer respondents list 'agree' in the item "men are superior to women", but in the space provided in the questionnaire, they write:

- Men are superior because they are strong. (But they are not smarter.)
- Men are superior because no matter how wrongly they behave, they face no stigma, which is the opposite for women.
- Men should lead because they have to take responsibility for the mistakes which occur. (Then, women are free from a blame because they just follow the men.)
- Men are not superior to women. They only make decisions quicker.
- Men can lead but under women's supervision.
- Men are superior because society allows more opportunities for them than for women.
- Men are physically superior to women but women are mentally superior to men.
- Men are not superior to women. But women should consult men in certain conditions.
- Undecided, because men are stronger and more determined, but they are less gentle, less thoughtful and less careful than women.

To a certain extent, the respondents' comments project the degree and the limitation of power and control that Thai females have over their bodies and their sexuality. For example, while the respondents accept men's physical superiority, they do not accept that men are intellectually superior to women. Some respondents also see that, in contrast to women, society provides men with more opportunities to exercise their ability and forgives or ignores men's mistakes. The comments of many respondents, particularly women, indicate that they are aware of an existing inequality between females and males.

These comments also reflect the respondents' mixed feelings of wanting to reject but having to accept those gender beliefs and norms. The reason for these mixed feelings is that respondents realize that it is almost impossible for them to avoid sexual encounters in the present socio-economic conditions, and it is also very difficult for them to ignore the socio-cultural consequences of trying to break those sexual norms and standards. At present, socio-economic changes within the country have provide more opportunities of sexually mixed interactions for young Thai females and males. Young females are no longer under the supervision of parents and the family but have more chances for education or work in cities that are far from home and probably surrounded by sexually arousing environment such as night-clubs, discos and brothels. In contrast to the socio-economic conditions, cultural norms and standards of sexual behaviors and conducts of Thai people have changed very slightly and several social sanctions related to certain sexual conducts are still as rigid as they used to be.

As discussed in chapters 2 and 3, socially constructed gender stereotypes and standards allow men more freedom in their sexuality and give them the right to control women's sexuality and body but force women to accept a passive role which puts them in a subordinate position in society resulting in their inability to control their sexuality and their bodies. The data also confirm that although many Thai women are aware of the impacts of gender and sexuality on their lives and roles, some are not yet conscious of these as the actual source of their sexual health problems. Sex education can be a way to raise the consciousness of this group. These women may be ready to take action to achieve sexual equality if they receive support or encouragement from concerned institutions and society.

As mentioned earlier in this thesis, women's health conditions are very much related to their reproductive roles and their power to exert control over their sexuality and their bodies. As long as society still attaches female sexuality to the domains of emotional relationships and reproduction, women becoming knowledgeable about sex and having control over their sexuality can be a threat to both society and men. This will make it more difficult for women to get support from men and society. In this situation, women will be confronted with the conflicts between fulfilling their traditional relationships with men and struggling to achieve the betterment of their health and social equality. The question here is whether the concerned institutions are ready and willing to support women to make changes for the improvement of their health and position within society. In my opinion, the enforcement of government policies and plans to integrate women's issues into every institutions' schemes is the only way to make all institutions recognize women's particular needs, the problems they are confronting, and the supports that are necessary. An investigation of institutions' readiness and willingness to support women in making changes is also necessary.

Although I personally think a formal sex education can be one good way to counter traditional beliefs about sex and sexuality such as sexual double standard and homophobia, several issues need further investigation for more conclusive evidence. For instance, whether sex education at the primary education level is too soon or too late for the children, at which educational levels that topics such as sexual practices, contraception, abortion or sexual harassment should be introduced, how much children at each level should know or learn about sex and sexuality, whether psychological aspects,

legal issues and human rights issues should be included in the abortion and sexual harassment topics.

Another challenge for educators and curriculum developers is how to integrate unconventional topics into the school curriculum or programs appropriately. Findings in this study have already suggested topics or area content that should be included in sex education curriculum. These findings do not suggest the scope or detailed outline of each topic that will be suitable for the targets' readiness to change their attitudes and behaviors. As earlier discussed, despite people are more confident in learning about sex from teachers, teachers express feeling uncomfortable teaching children about sex and sexuality, as well as their ambivalence about the content areas of sex education. A training program for teachers in teaching sex education is, therefore crucial and must not be overlooked by educators and planners.

As a health analogy, gender inequality is an extremely complicated syndrome because it is caused by several socio-cultural diseases. It is not easy to diagnose and very difficult to cure. Ignorance of sexuality is one noticeable symptom of gender inequality. Sex education is also one of many ways to make people conscious of their misconceptions about gender and sexuality, and to foster positive sexual attitudes and behaviors. In this respect, sex education is a vaccine to introduce positive sexual perceptions and attitudes in people's minds. These positive sexual attitudes and behaviors will eventually encourage them to practice healthier behaviors. Therefore, sex education is a good cure for ignorance about sexuality and its consequences.

This thesis is not aimed at finding a miracle cure for gender inequality. It is only an attempt to find new ingredients to produce a stronger vaccine for preventing ignorance

about sexuality. These ingredients, however, require experienced specialists to mix them into a stronger formula that will help people feel healthier to fight the illness of gender inequality. I hope specialists will consider trying my proposed ingredients soon. I am sure that sex education is not the only basis for the improvement of women's health, but it is one of the best to begin with.

The best lesson I have learned from this study can be explained with a Thai saying: "The more you learn, the more ignorant you find you are." Doing this study helps me learn that knowledge about sex and sexuality is, in facts, endless and far more complicated than I expected. Based on the findings of this study, I still see several related issues that needed a thorough study and investigation:

- The assessment of particular needs for information about sex and sexuality of people in pre-contemplation, contemplation, and preparation for behavior change stage.
- A comparative study on the current perceptions or concepts of sex and sexuality of Thai people in pre-contemplation, contemplation, and preparation for behavior change stage.
- A study on specific gender preferences in the area contents of sex education.
- The study on the current needs and knowledge of children at primary education level about sex and sexuality.
- An in-depth study on the content of current sex education curricular, learning texts and teacher's guide for teaching sex education.
- The assessment of teachers' needs for training in teaching about sex and sexuality.

- An investigation on the influences of the media and friends as the sources of information about sex and sexuality.
- The study on the impacts of sex and sexuality on women's lives and behaviors other than health issues.
- A study on people's knowledge and attitudes towards conventional issues about sex and sexuality, e.g., homosexuality and abortion in medical, religious and human rights perspectives.
- A study on the influence of media on people perceptions and attitudes toward sex and sexuality as well as its accuracy in informing Thai people about sex education.

Appendix I

Questionnaire

Attitudes of Thai people toward safer sex and sex education

Part I: Respondent's personal data

Instruction Please mark ✓ in the appropriate boxes, and write your response in the provided space as necessary.

Age: ☐ under 20 ☐ 20-30 ☐ 31-40 ☐ over 40

Sex: ☐ Female ☐ Male ☐ Other.....

Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced ☐ Other.....

Education: ☐ Primary level ☐ Lower secondary level ☐ Higher secondary level ☐ Post secondary level

Occupation: .....

Income (in Thai Baht): ☐ Less than 2,000/month ☐ 2,000-3,599/month ☐ 3,600-4,599/month ☐ 4,600-5,599/month ☐ 5,600-6,000/month ☐ More than 6,000/ month

You are: ☐ the sole income earner in the family. ☐ the main income earner in the family. ☐ the additional income earner in the family. ☐ earning income to support yourself only.

Residential location: ☐ Rural area ☐ Urban area

Working location: ☐ Home ☐ Within the residing village ☐ Outside the residing village

Part II: Attitudes...

Part II: Attitudes toward safer sex and sex education.

Instruction Read the following statements and check ✓ in the box that you think most appropriate

box 5: strongly agree
box 4: agree
box 3: undecided
box 2: disagree
box 1: strongly disagree

A. I would be supportive of a sex education course which has information on:	5	4	3	2	1
girls' physical changes as they reach puberty					
boys' physical changes as they reach puberty					
emotional conditions of children as they reach puberty					
how to deal with children's interest and curiosity about sex					
the female and male human reproductive system					
sexual intercourse					
pregnancy and childbirth					
family and parenthood					
dating and personal relationships					
precautions about dating					
the proper roles of women and men in marriage					
family planning					
contraception					
induced abortion					
masturbation					
impotence and frigidity					
sexual practices (homosexual, heterosexual and bisexual)					
menstruation and its biological / psychological aspects					
menopause and its biological / psychological aspects					
male aging and its biological / psychological aspects					
sexually transmitted diseases					
preventive measures against sexually transmitted diseases					
sex counseling and resources of sex counseling					
how to teach sexual morals to children					
sexual abuse and sexual harassment					
the harmful effects of sexual abuse, harassment and pornography					

B. I would...

B. I would think that most Thai people would support sex education	5	4	3	2	1
in primary school					
in lower secondary school					
in upper secondary school					
in post secondary school					
from school only					
from parents only					
from medical personnel only					
from parents, school and medical personnel.					
from (please indicate)					

C. I think formal sex education is	5	4	3	2	1
a prime way to promote the betterment of women's health.					
a prime way to prevent unwanted pregnancy.					
a prime way to prevent or reduce unplanned sex among teenagers.					
a prime way to slow down the spread of sexually transmitted diseases.					
a prime way to slow down the spread of AIDS.					
a prime way to eliminate gender inequality.					
necessary for accurate knowledge about safer sex.					
necessary to overcome myths about sexuality.					
necessary to overcome myths about sexually transmitted diseases.					
needed because parents cannot talk about sex with their children.					
a cause of premarital sexual conduct among teenagers.					
not necessary because children will eventually find out about sex.					
inappropriate because sex is not a subject to be formally taught.					

D. My best source for learning about sex is/was:	5	4	3	2	1
my mother					
my father					
siblings					
other relatives					
teacher					
medical personnel					
friends					
experience					
books					
TV and films					
other					

Part III: Knowledge...

Part III: Knowledge of sex education and safer sex.

Instruction Check ✓ in the box you think the most appropriate for each statement.

A. Biological Aspects	correct	incorrect	undecided
Puberty is a set of physical transforming processes, which starts when children are at the age of 9-10 and stops at the age of 18-19.			
Children who reach puberty are able to reproduce.			
Girls usually reach puberty earlier than boys.			
Men's sperm can live within a woman's uterus longer than 3 days.			
A woman is not likely to get pregnant if she forgets to take a contraceptive pill the day after she had intercourse with her partner.			
Missing a menstrual period for more than 45 days is a sign of pregnancy.			
The ovaries of a woman who is taking contraceptive pills still produce eggs but do not release them.			
Breast feeding can prevent pregnancy.			
Pap tests are necessary for married women only.			
It is necessary for everyone to have a blood test before getting married.			
Rh factor is a blood characteristic that can complicate pregnancy.			
A blood test is needed to reveal the Rh factor.			
A blood test is needed to reveal genetic abnormality.			
A blood test is needed to reveal sexually transmitted diseases.			

B. Psychological Aspects	correct	incorrect	undecided
Children under 10 years old have no interest in or curiosity about sex.			
Taking contraceptive pills for a long period of time makes women sterile.			
Hysterectomies increase the degree of sexual desire in women.			
Vasectomies reduce the degree of sexual desire in men.			
Promiscuous people usually are infected with AIDS/HIV.			
Prostitutes are the source of sexually transmitted diseases.			
Homosexuality spreads sexually transmitted diseases.			
Girls who participate in vigorous sports will break their hymen.			
Men need sex more than women.			
Menstrual blood is dirty.			
Masturbation is a deviant behavior.			
Homosexuality among women is a deviant behavior.			
Homosexuality among men is a deviant behavior.			
For children, learning about sex is like playing with fire.			

C. Technical...

C. Technical Aspects	correct	incorrect	undecided
Condoms should be put on before sexual entry.			
Using condoms during all sexual intercourse can protect against sexually transmitted diseases.			
Blood tests cannot detect HIV during the first 6 months of the contamination.			
Condoms are an effective method to prevent sexually transmitted diseases.			
Latex condoms offer the best protection against AIDS.			
A man who has had a vasectomy can still transmit the AIDS virus.			
Douching the vagina before and after sex can protect against sexually transmitted diseases.			
Venereal diseases are transmitted only through sexual intercourse.			
The IUD is the least effective method for pregnancy prevention.			
A woman should take the birth control pill after the first day of her menstruation.			
Sterilization is 100% effective in pregnancy prevention.			

D. Gender Aspects

Instruction: Underline the words in the bracket you think expresses your opinion and give a reason for your choice in the space provided .

1). I (agree / disagree) with the belief that children, especially girls, should not learn about sex because .....
.....

2). I (agree / disagree) that men should have casual sex experience before they are married because .....
.....

3). I (agree / disagree) with the belief that chaste women will be better wives and mothers because .....
.....

4). I (support / reject) men who consider virginity as a measure a woman's goodness and virtue because
.....

5). I (agree / disagree) with the belief that men are superior to women because .....
.....

6). I (agree / disagree) that women should divorce their promiscuous husbands because .....
.....

7). I (agree / disagree) with the saying, "Man is like paddy. Woman is like rice" because .....
.....

8). I (agree / disagree) with the saying, "Men are like the front legs of an elephant while women are the hind ones" because .....

9). I (agree / disagree) with the saying, "Having a daughter is like having a toilet in front of the house" because .....

Thai Translation of Appendix I

แบบสอบถาม

เกี่ยวกับทัศนคติ, ความต้องการ และความรู้ความเข้าใจเรื่องเพศศึกษา

ตอนที่ 1: ข้อมูลส่วนตัวของผู้ตอบแบบสอบถาม:

คำแนะนำ ขีดเครื่องหมาย ✓ ใน ☐ ที่ตรงกับข้อมูลส่วนตัวของท่าน และเขียนคำตอบในช่องว่างที่กำหนดให้

อายุ: ☐ ต่ำกว่า 20 ปี ☐ 20-30 ปี
☐ 31-40 ปี ☐ เกิน 40 ปี

เพศ: ☐ หญิง ☐ ชาย
☐ อื่นๆ.....

สถานภาพสมรส: ☐ โสด ☐ สมรส
☐ หม้าย ☐ หย่า
☐ อื่นๆ.....

การศึกษา: ☐ ประถมศึกษา ☐ มัธยมศึกษาตอนต้น
☐ มัธยมศึกษาตอนปลาย ☐ สูงกว่ามัธยมศึกษาตอนปลาย

อาชีพ: .....

รายได้(บาท): ☐ ต่ำกว่า 2,000 ต่อเดือน ☐ 2,000-3,599 ต่อเดือน
☐ 3,600-4,599 ต่อเดือน ☐ 4,600-5,599 ต่อเดือน
☐ 5,600-6,000 ต่อเดือน ☐ สูงกว่า 6,000 ต่อเดือน

ท่านเป็น: ☐ คนเดียวที่หารายได้เลี้ยงสมาชิกทุกคนในครอบครัว
☐ คนหารายได้หลักของครอบครัวโดยมีคนช่วยหารายได้เสริม
☐ คนหารายได้เสริมของครอบครัวโดยมีคนหารายได้หลัก
☐ คนหารายได้เลี้ยงตนเองโดยไม่ต้องรับผิดชอบใครอื่น

ที่ตั้งของบ้านพัก: ☐ ชนบท หรือ ชานเมือง ☐ ในตัวเมือง

สถานที่ที่ท่านทำงาน: ☐ ทำในบ้าน ☐ ตั้งอยู่ในเขตบ้านที่อาศัยอยู่
☐ อยู่ห่างหรือต่างเขตจากบ้านที่อาศัยอยู่

ตอนที่ 2: ทัศนคติเกี่ยวกับเพศศึกษาและพฤติกรรมทางเพศที่ปลอดภัย

<u>คำแนะนำ</u> โปรดขีดเครื่องหมาย ✓ ในช่องที่ท่านเห็นว่าเหมาะสม

ช่อง 1: เห็นด้วยอย่างยิ่ง
ช่อง 2: เห็นด้วย
ช่อง 3: ไม่แน่ใจ
ช่อง 4: ไม่เห็นด้วย
ช่อง 5: ไม่เห็นด้วยอย่างยิ่ง

1. ข้าพเจ้าสนับสนุนการสอนวิชาเพศศึกษาที่มีเนื้อหาเกี่ยวกับเรื่องต่อไปนี้	1	2	3	4	5
การเปลี่ยนแปลงสภาพทางร่างกายของเด็กหญิงที่ย่างเข้าวัยเจริญพันธ์					
การเปลี่ยนแปลงทางสภาพร่างกายของเด็กชายที่ย่างเข้าวัยเจริญพันธ์					
การเปลี่ยนแปลงสภาพทางอารมณ์ของเด็กที่ย่างเข้าวัยเจริญพันธ์					
การให้ความรู้ทางเพศที่เหมาะสมแก่เด็กที่มีข้อสงสัยหรือความสนใจเรื่องเพศ					
ระบบสืบพันธ์ของเพศหญิงและเพศชาย					
การร่วมเพศ/การมีเพศสัมพันธ์					
การตั้งครรภ์และการให้กำเนิดทารก					
ครอบครัวและหน้าที่ของเป็นพ่อแม่					
การเลือกคบและสร้างความสัมพันธ์ส่วนตัวกับเพศตรงข้าม					
ข้อควรระวังในการคบและสร้างความสัมพันธ์ส่วนตัวกับเพศตรงข้าม					
บทบาทหน้าที่อันดีงามที่คู่สมรสพึงปฏิบัติต่อกัน					
การวางแผนครอบครัว					
วิธีคุมกำเนิด					
การทำแท้งและปัญหาการทำแท้ง					
ปัญหา / สาเหตุการสำเร็จความใคร่ด้วยตนเอง					
การหมดสมรรถภาพและหมดความต้องการทางเพศในหญิงและชาย					
การมีเพศสัมพันธ์กับเพศเดียวกัน (เกย์ เลสเบี้ยน)					
การมีรอบเดือนและปัญหาที่เกี่ยวข้องกับการมีรอบเดือน					
การหมดรอบเดือนและปัญหาที่เกี่ยวข้องกับการหมดรอบเดือน					
การเปลี่ยนแปลงสภาพทางกายและจิตใจของผู้ชายที่เริ่มสูงอายุ					
โรคติดต่อทางเพศสัมพันธ์					

1. ข้าพเจ้าสนับสนุนการสอนวิชาเพศศึกษาที่มีเนื้อหาเกี่ยวกับเรื่องต่อไปนี้ (ต่อ)	1	2	3	4	5
ข้อปฏิบัติเพื่อหลีกเลี่ยงการติดโรคติดต่อทางเพศสัมพันธ์					
การให้คำปรึกษาปัญหาเรื่องเพศ / แหล่งบริการข้อมูลหรือคำปรึกษาทางเพศ					
คุณธรรมทางเพศสำหรับเด็กและวัยรุ่น					
ข้อปฏิบัติเพื่อหลีกเลี่ยงหรือรับมือเมื่อถูกคุกคามหรือลวนลามทางเพศ					
ผลกระทบร้ายแรงของการถูกลวนลามทางเพศ และจากสื่อลามกทางเพศ					

2. ข้าพเจ้าคิดว่าคนไทยส่วนใหญ่จะสนับสนุนการสอนวิชาเพศศึกษาที่	1	2	3	4	5
จัดสอนในระดับประถม					
จัดสอนในระดับมัธยมศึกษาตอนต้น					
จัดสอนในระดับมัธยมศึกษาตอนปลาย					
จัดสอนในระดับที่สูงกว่ามัธยมศึกษาตอนปลาย					
สอนโดยครูในโรงเรียนเท่านั้น					
สอนโดยพ่อแม่เท่านั้น					
สอนโดยเจ้าหน้าที่สาธารสุขหรือแพทย์เท่านั้น					
ทุกฝ่ายที่เกี่ยวข้อง คือ พ่อแม่ โรงเรียน และผู้เชี่ยวชาญ ดำเนินงานนี้ร่วมกัน					
อื่นๆ (โปรดระบุ)					

3. ข้าพเจ้าคิดว่าการสอนเพศศึกษาในโรงเรียน	1	2	3	4	5
เป็นวิธีหนึ่งที่จะช่วยส่งเสริมสุขภาพของผู้หญิงให้ดีขึ้น					
เป็นวิธีหนึ่งที่จะช่วยป้องกันการมีครรภ์ที่ไม่พึงประสงค์หรือก่อนวัยที่สมควร					
เป็นวิธีที่จะช่วยลดปัญหาการมีเพศสัมพันธ์โดยไม่คิดหน้าคิดหลังของวัยรุ่น					
เป็นวิธีหนึ่งที่จะช่วยลดปัญหาการติดโรคติดต่อทางเพศสัมพันธ์					
เป็นวิธีหนึ่งที่จะช่วยชลอการระบาดของโรคเอดส์					
เป็นทางหนึ่งที่จะลดความเชื่อที่ทำให้เกิดความไม่เท่าเทียมทางเพศ					
เป็นเรื่องจำเป็นเพราะช่วยให้วัยรุ่นได้ความรู้เกี่ยวกับเพศที่ถูกต้องเหมาะสม					
เป็นวิธีหนึ่งที่จะช่วยแก้ความเข้าใจผิดๆในเรื่องความประพฤติทางเพศ					
เป็นวิธีหนึ่งที่จะช่วยแก้ความเข้าใจผิดๆในเรื่องโรคติดต่อทางเพศสัมพันธ์					
เป็นเรื่องจำเป็นเพราะผู้ปกครองมักรู้สึกอึดอัดที่จะสอนลูกเกี่ยวกับเรื่องนี้เอง					

3. ข้าพเจ้าคิดว่าการสอนเพศศึกษาในโรงเรียน (ต่อ)	1	2	3	4	5
จะกระตุ้นให้วัยรุ่นมีเพศสัมพันธ์ก่อนเวลาอันควรมากขึ้น					
ไม่จำเป็นเพราะในที่สุดเด็กจะเรียนรู้เรื่องนี้ไปได้เอง					
ไม่เหมาะสมเพราะเพศศึกษาไม่ใช่เรื่องที่จะนำมาสอนอย่างโจ่งแจ้ง					

4. แหล่งที่ให้ความรู้หรือคำปรึกษาทางเพศศึกษาที่ดีที่สุดของข้าพเจ้าคือ	1	2	3	4	5
แม่					
พ่อ					
พี่น้อง					
ญาติสนิท เช่น น้า อา					
ครู อาจารย์					
เพื่อนฝูง					
ลองทำเอง					
อ่านจากหนังสือ ตำรา					
รายการโทรทัศน์หรือภาพยนตร์					
แหล่งอื่นๆ(โปรดระบุ)					

ตอนที่ 3: ความรู้ความเข้าใจเรื่องเพศศึกษา

<u>คำแนะนำ</u> โปรดขีดเครื่องหมาย ✓ ในช่องที่ท่านเห็นว่าเหมาะสม

1. ด้านชีววิทยา	ถูก	ผิด	ไม่แน่ใจ
วัยเจริญพันธ์คือวัยที่เด็กเกิดการเปลี่ยนแปลงทางร่างกายตอนอายุย่าง 8-9 ปีไปจนถึงอายุ 18- 19 ปี			
ในวัยเจริญพันธ์ เด็กหญิงจะเริ่มมีประจำเดือน, เด็กชายเริ่มผลิตเชื้ออสุจิ			
โดยปกติ เด็กหญิงจะย่างเข้าวัยเจริญพันธ์เร็วกว่าเด็กชาย			
เชื้ออสุจิสามารถมีชีวิตอยู่ในมดลูกของผู้หญิงได้เกิน 3 วัน			
ผู้หญิงจะไม่ตั้งครรภ์หากลืมกินยาคุมกำเนิดในวันที่ถัดจากมีเพศสัมพันธ์ไปแล้วหนึ่งวัน			
ผู้หญิงต้องรอให้ประจำเดือนขาดเกิน 45 วันก่อน จึงจะแน่ใจได้ว่าตนตั้งครรภ์จริง			
ยาคุมกำเนิดไม่ได้ทำให้มดลูกหยุดผลิตไข่ แต่ทำให้ไข่ไม่ตกเท่านั้น			
ผู้หญิงจะไม่ตั้งครรภ์หากมีเพศสัมพันธ์ในระยะที่ยังให้ลูกกินนมตนเอง			

1. ด้านชีววิทยา (ต่อ)	ถูก	ผิด	ไม่แน่ใจ
การตรวจมะเร็งปากมดลูกเป็นเรื่องจำเป็นสำหรับผู้หญิงที่แต่งงานแล้วเท่านั้น			
การตรวจเลือดก่อนแต่งงานเป็นเรื่องที่ควรทำสำหรับคู่สมรสทุกคู่ในปัจจุบัน			
ค่า Rh เป็นองค์ประกอบในเลือดที่จะทำให้เกิดความผิดปกติในการมีครรภ์และทารกในครรภ์			
การตรวจเลือดจะช่วยให้เราทราบความผิดปกติของค่า Rh ในเลือด			
การตรวจเลือดจะช่วยให้เราทราบความผิดปกติทางกรรมพันธ์ได้			
การตรวจเลือดช่วยให้ทราบว่าเราติดโรคหรือไม่ติดโรคทางเพศสัมพันธ์			

2. ด้านจิตวิทยา	ถูก	ผิด	ไม่แน่ใจ
เด็กที่อายุต่ำกว่า 10 ขวบยังไม่มีความสนใจ หรืออยากรู้อยากเห็นเกี่ยวกับเพศ			
การกินยาคุมกำเนิดนานๆจะทำให้ผู้หญิงเป็นหมัน			
การทำหมันทำให้ความต้องการทางเพศของผู้หญิงผิดปกติ			
การทำหมันทำให้สมรรถภาพทางเพศของผู้ชายลดลง			
คนที่มีพฤติกรรมสำส่อนทางเพศมักจะติดโรคเอดส์			
โสเภณีเป็นแหล่งสำคัญที่ทำให้เกิดโรคติดต่อทางเพศ			
การมีเพศสัมพันธ์กับเพศเดียวกันเป็นสาเหตุของการระบาดของโรคติดต่อทางเพศ			
การเล่นกีฬาที่ผาดโผนทำให้เยื่อพรมจารีของเด็กสาวฉีกขาดได้			
ผู้ชายมีความต้องการทางเพศบ่อยกว่าผู้หญิง			
เลือดประจำเดือนเป็นเลือดสกปรก			
การสำเร็จความใคร่ให้ตนเองเป็นพฤติกรรมทางเพศที่ผิดปกติ			
ผู้ชายมีเพศสัมพันธ์กับผู้ชายเป็นพฤติกรรมทางเพศที่ผิดปกติ			
ผู้หญิงมีเพศสัมพันธ์กับผู้หญิงเป็นพฤติกรรมทางเพศที่ผิดปกติ			
การเรียนรู้เกี่ยวกับเพศเปรียบเหมือนการเล่นกับไฟสำหรับเด็ก			

3. ด้านเทคนิค	ถูก	ผิด	ไม่แน่ใจ
ผู้ชายต้องสวมถุงยางอนามัยก่อนเริ่มการร่วมเพศ			
การใช้ถุงยางอนามัยช่วยป้องกันการติดโรคติดต่อทางเพศ			
เราจะยังไม่ทราบว่าเราติดเอดส์ หากเราไปตรวจเลือดในช่วง 6 เดือนแรกที่ติดเอดส์			
การใช้ถุงยางอนามัยเป็นวิธีป้องกันการติดโรคเอดส์ที่ดีที่สุด			

3. ด้านเทคนิค (ต่อ)	ถูก	ผิด	ไม่แน่ใจ
การใช้ถุงยางอนามัยเป็นวิธีที่ลดการระบาดของโรคติดต่อทางเพศ			
ผู้ชายที่ทำหมันถาวรแล้วก็ยังต้องใช้ถุงยางอนามัยเพื่อป้องกันการติดโรคติดต่อทางเพศ			
การล้างช่องคลอดด้วยน้ำยาล้างช่องคลอด ช่วยป้องกันการติดโรคติดต่อทางเพศได้			
กามโรคติดต่อทางเพศสัมพันธ์เท่านั้น			
ผู้หญิงต้องกินยาคุมกำเนิดหลังมีประจำเดือนแล้วหนึ่งวัน			
การใส่ห่วงเป็นวิธีคุมกำเนิดที่มีประสิทธิภาพต่ำที่สุด			
การทำหมันถาวรเป็นการคุมกำเนิดที่ได้ผล 100 %			

4. มาตรฐานและความเชื่อทางเพศ

<u>คำแนะนำ</u> ขีดเส้นใต้คำในวงเล็บที่ตรงกับความเห็นของท่าน และเขียนอธิบายเหตุผลประกอบความเห็นในช่องว่าง

1. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับความคิดที่ว่าเด็ก โดยเฉพาะเด็กหญิง ไม่สมควรเรียนเรื่องที่เกี่ยวกับเพศศึกษา เพราะ _____

_____

2. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) ที่ผู้ชายควรมีหรือหาประสบการณ์เรื่องเพศก่อนแต่งงาน เพราะ_____

_____

3. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับความคิดที่ว่าผู้หญิงที่บริสุทธิ์ผุดผ่องทางเพศมักเป็นเมียและแม่ที่ดีในอนาคต เพราะ _____

_____

4. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับผู้ชายที่ใช้พรมจารีเป็นมาตรฐานในการเลือกผู้หญิงที่ตนจะแต่งงานด้วย เพราะ _____

_____

5. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) ความเชื่อที่ว่าเพศชายเป็นเพศที่มีข้อดีเหนือกว่าเพศหญิง เพราะ _____

_____

6. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับผู้หญิงที่ขอแยกทางกับสามีที่เจ้าชู้หรือขาดความรับผิดชอบต่อครอบครัว เพราะ _____

_____

7. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับคำพูดที่ว่า "ผู้ชายเปรียบเหมือนข้าวเปลือก ผู้หญิงเปรียบเหมือนข้าวสาร" เพราะ _____

_____

8. ข้าพเจ้า (เห็นด้วย/ไม่เห็นด้วย) กับคำพูดที่ว่า "ผู้ชายเปรียบเหมือนช้างเท้าหน้า ผู้หญิงเปรียบเหมือนเท้าหลัง" เพราะ _____

_____

9. ข้าพเจ้า (เห็นด้วย / ไม่เห็นด้วย) กับคำพูดที่ว่า "มีลูกสาวเหมือนมีส้วมสาธารณะไว้หน้าบ้าน" เพราะ _____

_____

Appendix II

Interview Guide

Attitudes of Thai people toward safer sex and sex education

Part I: **I will ask participant's personal data and check in this sheet.**

Sex: ☐ Female ☐ Male
☐ Other.....

Please tell me about your:

Age: ☐ under 20 ☐ 20-30
☐ 31-40 ☐ over 40

Marital Status: ☐ Single ☐ Married
☐ Widow/Widower ☐ Divorced
☐ Other.....

Education: ☐ Primary level ☐ Lower secondary level
☐ Higher secondary level ☐ Post secondary level

Occupation: .....

Income (in Thai Baht): ☐ Less than 2,000/month ☐ 2,000-3,599/month
☐ 3,600-4,599/month ☐ 4,600-5,599/month
☐ 5,600-6,000/month ☐ More than 6,000/ month

You are: ☐ the sole income earner in the family.
☐ the main income earner in the family.
☐ the additional income earner in the family.
☐ earning income to support yourself only.

Residential location: ☐ Rural area ☐ Urban area

Working location: ☐ Home ☐ Within the residing village
☐ Outside the residing village

Part II: Interview Questions

1. Did you ever have any sex education courses during school? from your parents? from friends? from medical personnel?
2. Have you taken or do you known anyone who has taken sex education courses? What is good or bad about them?
3. Do you have children or friends with whom you have given or received sex education information, help?
4. What problems have you had in obtaining such information? In what ways would you feel comfortable or enjoy getting such information?
5. What do you think about the government's plan to introduce a compulsory course on sex education?
6. If formal sex education is given as a compulsory course in all schools, what changes in Thai society might happen?
7. Could you elaborate on your opinion of sex education courses in terms of
   - content of the courses,
   - age range of students who will take the courses,
   - whether students of both sexes should be taught together or separately,
   - advantages and disadvantages of the courses,
   - who would be best to teach sex education.
8. Based on your knowledge, please tell me whether you think the following statements are correct or incorrect.

A. Biological Aspects	correct	incorrect	undecided
Puberty is a set of physical transforming processes, which starts when children are at the age of 9-10 and stops at the age of 18-19.			
Children who reach puberty are able to reproduce.			
Girls usually reach puberty earlier than boys.			
Men's sperm can live within a woman's uterus longer than 3 days.			
A woman is not likely to get pregnant if she forgets to take a contraceptive pill the day after she had intercourse with her partner.			
Missing a menstrual period for more than 45 days is a sign of pregnancy.			
The ovaries of a woman who is taking contraceptive pills still produce eggs but do not release them.			
Breast feeding can prevent pregnancy.			
Pap tests are necessary for married women only.			
It is necessary for everyone to have a blood test before getting married.			
Rh factor is a blood characteristic that can complicate pregnancy.			
A blood test is needed to reveal the Rh factor.			
A blood test is needed to reveal genetic abnormality.			
A blood test is needed to reveal sexually transmitted diseases.			

B. Psychological Aspects	correct	incorrect	undecided
Children under 10 years old have no interest in or curiosity about sex.			
Taking contraceptive pills for a long period of time makes women sterile.			
Hysterectomies increase the degree of sexual desire in women.			

Vasectomies reduce the degree of sexual desire in men.			
Promiscuous people usually are infected with AIDS/HIV.			
Prostitutes are the source of sexually transmitted diseases.			
Homosexuality spreads sexually transmitted diseases.			
Girls who participate in vigorous sports will break their hymen.			
Men need sex more than women.			
Menstrual blood is dirty.			
Masturbation is a deviant behavior.			
Homosexuality among women is a deviant behavior.			
Homosexuality among men is a deviant behavior.			
For children, learning about sex is like playing with fire.			

C. Technical Aspects	correct	incorrect	undecided
Condoms should be put on before sexual entry.			
Using condoms during all sexual intercourse can protect against sexually transmitted diseases.			
Blood tests cannot detect HIV during the first 6 months of the contamination.			
Condoms are an effective method to prevent sexually transmitted diseases.			
Latex condoms offer the best protection against AIDS.			
A man who has had a vasectomy can still transmit the AIDS virus.			
Douching the vagina before and after sex can protect against sexually transmitted diseases.			
Venereal diseases are transmitted only through sexual intercourse.			
The IUD is the least effective method for pregnancy prevention.			
A woman should take the birth control pill after the first day of her menstruation.			
Sterilization is 100% effective in pregnancy prevention.			

9. Please tell me your reason for agreeing or disagreeing with the following statements:
   - Only parents should learn about sex.
   - Only married couples should learn about sex.
   - Children, especially girls, should not learn about sex.
   - Men should have casual sex experience before they get married.
   - Men should take virginity as a measure of a woman's goodness and virtue.
   - Chaste women will be better wives and mothers.
   - Chaste men will be better husbands and fathers.
   - Men are like the front legs of an elephant while women are like the hind ones.
   - Having a daughter is like having a toilet in front of the house.
   - Man is like paddy. Woman is like rice.
   - Women should divorce their promiscuous husbands.
   - Men are superior to women

Thai Translation of Appendix II

แบบสัมภาษณ์

เกี่ยวกับทัศนคติ ความต้องการ และความรู้ความเข้าใจเรื่องเพศศึกษา

ตอนที่ 1: ข้าพเจ้าจะถามข้อมูลส่วนตัวของผู้ให้สัมภาษณ์ในเรื่องต่อไปนี้:

อายุ: ☐ ต่ำกว่า 20 ปี ☐ 20-30 ปี
☐ 31-40 ปี ☐ เกิน 40 ปี

เพศ: ☐ หญิง ☐ ชาย
☐ อื่นๆ.....

สถานภาพสมรส: ☐ โสด ☐ สมรส
☐ หม้าย ☐ หย่า
☐ อื่นๆ.....

การศึกษา: ☐ ประถมศึกษา ☐ มัธยมศึกษาตอนต้น
☐ มัธยมศึกษาตอนปลาย ☐ สูงกว่ามัธยมศึกษาตอนปลาย

อาชีพ: .....

รายได้(บาท): ☐ ต่ำกว่า 2,000 ต่อเดือน ☐ 2,000-3,599 ต่อเดือน
☐ 3,600-4,599 ต่อเดือน ☐ 4,600-5,599 ต่อเดือน
☐ 5,600-6,000 ต่อเดือน ☐ สูงกว่า 6,000 ต่อเดือน

ท่านเป็น: ☐ ผู้เดียวที่หารายได้เลี้ยงดูครอบครัว
☐ ผู้หารายได้หลักของครอบครัวโดยมีคนหารายได้มาเสริม
☐ ผู้หารายได้เสริมของครอบครัวโดยมีคนหารายได้หลัก
☐ ผู้หารายได้สำหรับตัวเองโดยไม่ต้องรับผิดชอบใครอื่น

ท่านมีที่อยู่ในเขต: ☐ ชนบท หรือ ชานเมือง ☐ ในตัวเมือง

สถานที่ที่ท่านทำงาน: ☐ ทำในบ้าน ☐ ตั้งอยู่ในเขตบ้านที่อาศัยอยู่
☐ อยู่ห่างหรือต่างเขตจากบ้านที่อาศัยอยู่

ตอนที่ 2: คำถามในการสัมภาษณ์

1. ท่านเคยได้รับความรู้เรื่องเพศศึกษาจากโรงเรียน ผู้ปกครอง เพื่อน หรือแพทย์บ้างหรือไม่
2. ตัวท่าน หรือคนที่ท่านรู้จักที่เคยเรียนเกี่ยวกับเพศศึกษา เห็นว่าวิชานี้มีข้อดีหรือข้อเสียอย่างไรบ้าง
3. ท่านเคยให้คำปรึกษา หรือ ขอคำปรึกษา/ความช่วยเหลือด้านเพศศึกษาจากบุตรหลานหรือเพื่อนบ้างหรือไม่
4. ท่านประสบปัญหาใดบ้างในการหาความรู้เกี่ยวกับเพศศึกษา แหล่งข้อมูลใดบ้างที่ท่านรู้สึกสบายใจในการไปขอ หรือสอบถามข้อมูลเกี่ยวกับเรื่องดังกล่าว
6. ท่านมีความเห็นอย่างไรหากรัฐบาลจะให้มีการสอนเกี่ยวกับเพศศึกษาเป็นวิชาบังคับในโรงเรียน? ท่านคิดว่าการสอนเพศศึกษาในโรงเรียนมีข้อดี/ ข้อเสีย หรือมีปัญหาในการเรียนการสอน หรือจะทำให้เกิดการเปลี่ยนแปลงทางสังคมอย่างไรบ้าง ?
7. กรุณาให้ความเห็นเกี่ยวกับเพศศึกษาในเรื่องต่อไปนี้
    - เนื้อหาที่สำคัญของหลักสูตรควรจะเป็นเรื่องใดบ้าง
    - เด็กในกลุ่มอายุใดบ้างที่ควรเรียน
    - ควรให้เด็กหญิงและชายเรียนเรื่องนี้ด้วยกันหรือแยกกลุ่มกันเรียน
    - ท่านเห็นว่าการเรียนวิชานี้จะเกิดผลดีหรือเสียอย่างไรบ้าง
    - ท่านเห็นว่าใครที่จะเป็นผู้สอนเพศศึกษาได้ดีที่สุด
8. โปรดตอบว่าคำถามต่อไปนี้ถูกหรือผิด ตามที่ท่านรู้หรือเข้าใจ

1. ด้านชีววิทยา	ถูก	ผิด	ไม่แน่ใจ
วัยเจริญพันธ์คือวัยที่เด็กเกิดการเปลี่ยนแปลงทางร่างกายตอนอายุย่าง 8-9 ปีไปจนถึงอายุ 18- 19 ปี			
ในวัยเจริญพันธ์ เด็กหญิงจะเริ่มมีประจำเดือน, เด็กชายเริ่มผลิตเชื้ออสุจิ			
โดยปกติ เด็กหญิงจะย่างเข้าวัยเจริญพันธ์เร็วกว่าเด็กชาย			
เชื้ออสุจิสามารถมีชีวิตอยู่ในมดลูกของผู้หญิงได้เกิน 3 วัน			
ผู้หญิงจะไม่ตั้งครรภ์หากลืมกินยาคุมกำเนิดในวันถัดจากวันที่มีเพศสัมพันธ์ไปแล้วหนึ่งวัน			
ผู้หญิงต้องรอให้ประจำเดือนขาดเกิน 45 วันก่อน จึงจะแน่ใจได้ว่าตนตั้งครรภ์จริง			
ยาคุมกำเนิดไม่ได้ทำให้มดลูกหยุดผลิตไข่ แต่ทำให้ไข่ไม่ตกเท่านั้น			
ผู้หญิงจะไม่ตั้งครรภ์หากมีเพศสัมพันธ์ในระยะที่ยังให้ลูกกินนมตนเอง			
การตรวจมะเร็งปากมดลูกเป็นเรื่องจำเป็นสำหรับผู้หญิงที่แต่งงานแล้วเท่านั้น			
การตรวจเลือดก่อนแต่งงานเป็นเรื่องที่ควรทำสำหรับคู่สมรสทุกคู่ในปัจจุบัน			
ค่า Rh เป็นองค์ประกอบในเลือดที่จะทำให้เกิดความผิดปกติในการมีครรภ์และทารกในครรภ์			
การตรวจเลือดจะช่วยให้เราทราบความผิดปกติของค่า Rh ในเลือด			
การตรวจเลือดจะช่วยให้เราทราบความผิดปกติทางกรรมพันธ์ได้			
การตรวจเลือดช่วยให้ทราบว่าเราติดโรคหรือไม่ติดโรคทางเพศสัมพันธ์			

2. ด้านจิตวิทยา	ถูก	ผิด	ไม่แน่ใจ
เด็กที่อายุต่ำกว่า 10 ขวบยังไม่มีความสนใจ หรืออยากรู้อยากเห็นเกี่ยวกับเพศ			
การกินยาคุมกำเนิดนานๆจะทำให้ผู้หญิงเป็นหมัน			
การทำหมันทำให้ความต้องการทางเพศของผู้หญิงผิดปกติ			
การทำหมันทำให้สมรรถภาพทางเพศของผู้ชายลดลง			
คนที่มีพฤติกรรมสำส่อนทางเพศมักจะติดโรคเอดส์			
โสเภณีเป็นแหล่งสำคัญที่ทำให้เกิดโรคติดต่อทางเพศ			
การมีเพศสัมพันธ์กับเพศเดียวกันเป็นสาเหตุของการระบาดของโรคติดต่อทางเพศ			
การเล่นกีฬาที่ผาดโผนทำให้เยื่อพรมจารีของเด็กสาวฉีกขาดได้			
ผู้ชายมีความต้องการทางเพศบ่อยกว่าผู้หญิง			
เลือดประจำเดือนเป็นเลือดสกปรก			
การสำเร็จความใคร่ให้ตนเองเป็นพฤติกรรมทางเพศที่ผิดปกติ			
ผู้ชายมีเพศสัมพันธ์กับผู้ชายเป็นพฤติกรรมทางเพศที่ผิดปกติ			
ผู้หญิงมีเพศสัมพันธ์กับผู้หญิงเป็นพฤติกรรมทางเพศที่ผิดปกติ			
การเรียนรู้เกี่ยวกับเพศเปรียบเหมือนการเล่นกับไฟสำหรับเด็ก			

3. ด้านเทคนิค	ถูก	ผิด	ไม่แน่ใจ
ผู้ชายต้องสวมถุงยางอนามัยก่อนเริ่มการร่วมเพศ			
การใช้ถุงยางอนามัยช่วยป้องกันการติดโรคติดต่อทางเพศ			
เราจะยังไม่ทราบว่าเราติดเอดส์ หากเราไปตรวจเลือดในช่วง 6 เดือนแรกที่ติดเอดส์			
การใช้ถุงยางอนามัยเป็นวิธีป้องกันการติดโรคเอดส์ที่ดีที่สุด			
การใช้ถุงยางอนามัยเป็นวิธีที่ลดการระบาดของโรคติดต่อทางเพศ			
ผู้ชายที่ทำหมันถาวรแล้วก็ยังต้องใช้ถุงยางอนามัยเพื่อป้องกันการติดโรคติดต่อทางเพศ			
การล้างช่องคลอดด้วยน้ำยาล้างช่องคลอด ช่วยป้องกันการติดโรคติดต่อทางเพศได้			
กามโรคติดต่อทางเพศสัมพันธ์เท่านั้น			
ผู้หญิงต้องกินยาคุมกำเนิดหลังมีประจำเดือนแล้วหนึ่งวัน			
การใส่ห่วงเป็นวิธีคุมกำเนิดที่มีประสิทธิภาพต่ำที่สุด			
การทำหมันถาวรเป็นการคุมกำเนิดที่ได้ผล 100 %			

9. โปรดบอกเหตุผลประกอบว่าทำไมท่านจึงเห็นด้วยหรือไม่เห็นด้วยในเรื่องต่อไปนี้

- พ่อแม่ ผู้ปกครองเท่านั้นที่ควรเรียนเกี่ยวกับเพศศึกษา
- คนที่แต่งงานแล้วเท่านั้นที่ควรเรียนเกี่ยวกับเพศศึกษา
- เด็กๆ โดยเฉพาะเด็กหญิง ไม่สมควรเรียนเรื่องเกี่ยวกับเพศศึกษา
- ที่ผู้ชายควรมีหรือหาประสบการณ์เรื่องเพศก่อนแต่งงาน
- ผู้หญิงที่บริสุทธิ์ผุดผ่องทางเพศมักเป็นเมียและแม่ที่ดีในอนาคต
- ผู้ชายที่ใช้พรมจารีเป็นมาตรฐานในการเลือกผู้หญิงที่ตนจะแต่งงานด้วย
- ผู้หญิงควรขอแยกทางกับสามีที่เจ้าชู้หรือขาดความรับผิดชอบต่อครอบครัว
- "ผู้ชายเปรียบเหมือนข้าวเปลือก ผู้หญิงเปรียบเหมือนข้าวสาร"
- "ผู้ชายเปรียบเหมือนช้างเท้าหน้า ผู้หญิงเปรียบเหมือนเท้าหลัง"
- "มีลูกสาวเหมือนมีส้วมไว้หน้าบ้าน"
- เพศชายเป็นเพศที่มีข้อดีเหนือกว่าเพศหญิง

Appendix III (a)

Tossaporn Sariyant
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Moo Baan Kurusapha
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Tel 054 490374

February 20, 1997

Dear Participant,

I am a civil servant in the Department of Non-formal Education, of the Ministry of Education. I am conducting research for my Master of Arts Degree in Women's Studies at Simon Fraser University in British Columbia, Canada.

My research is aimed at assessing the attitudes of Thai people toward the necessity for and emphasis in sex education. Besides submitting this research as a part of the degree fulfillment, I intend to develop from my research a guideline for the preparation of sex education curricula for the non-formal education program. This development will be proposed to the Department of Non-formal Education.

Please note that your co-operation in this research is on a voluntary basis. Your identity will be kept anonymous. All questionnaires will be destroyed after the completion of my research. I agree to the best of my capacity and knowledge to keep participant's confidentiality throughout and not to misrepresent the participant's information in any way. Under the stated condition, I would like to ask for your co-operation in filling in the questionnaire. Please use the enclosed envelope to return this questionnaire to me.

In case you have any concerns or questions about this research, please contact me at the address given above or write to

Dr. Marjorie Cohen
Chair, Department of Women's Studies
Simon Fraser University, Burnaby
British Columbia, Canada V5A 1S6
Tel. (604) 291-5526.

In addition, I will also interview people on the same topic. If you are interested in participating in the interview, please sign the attached statement of informed consent and return it together with the questionnaire.

Thank you for taking the time to read this and for considering participation in my research.

Sincerely yours,

Tossaporn Sariyant

Thai Translation of Appendix III (a)

น.ส. ทศพร สาริยันต์
๑๘๘/๑๑๖ ซอย ๓ หมู่บ้านคุรุสภา
อ. สันทราย จ. เชียงใหม่ ๕๐๒๑๐
โทร. (๐๕๔) ๔๘๐-๓๗๔

๒๐ กุมภาพันธ์ ๒๕๔๐

ถึง ผู้ตอบแบบสอบถามที่นับถือทุกท่าน

ข้าพเจ้าเป็นข้าราชการกรมการศึกษานอกโรงเรียน จะทำการวิจัยเพื่อใช้เขียนวิยานิพนธ์สำหรับการเรียนระดับมหาบัณฑิต สาขา Women's Studies ณ มหาวิทยาลัย Simon Fraser ในหัวข้อเรื่อง "ทัศนคติ ความต้องการและความรู้ความเข้าใจเรื่องเพศศึกษา" การวิจัยครั้งนี้จะทำโดยใช้แบบสอบถามประกอบกับการสัมภาษณ์แบบตัวต่อตัว ผลการวิจัยในครั้งนี้ นอกจากจะนำไปเป็นข้อมูลในการทำวิทยานิพนธ์แล้ว ข้าพเจ้าอาจนำผลการวิจัยไปใช้ในการพัฒนาหลักสูตรเพศศึกษาในอนาคตอีกด้วย

ข้าพเจ้าขอเรียน ณ ที่นี้ว่า การกรอกแบบสอบถามครั้งนี้ไม่มีมีการบังคับใดๆ ท่านจะกรอกหรือไม่กรอกแบบสอบถามได้ตามความสมัครใจของตัวท่านเอง ประการสำคัญคือข้าพเจ้าจะเก็บชื่อและที่อยู่ของท่านรวมทั้งข้อมูลที่กรอกในแบบสอบถามไว้เป็นความลับตลอดไป

หากท่านมีข้อข้องใจหรือข้อสงสัยในรายละเอียดของการวิจัยนี้ โปรดอย่าลังเลที่จะสอบถามข้าพเจ้าตามที่อยู่ หรืออาจติดต่อสอบถามได้ที่

Dr. Marjorie Cohen
Chair, Department of Women's Studies
Simon Fraser University, Burnaby
British Columbia, Canada V5A 1S6
Tel. (604) 291-5526.

ขอขอบคุณที่ให้ความสนใจ และให้ความร่วมมือในครั้งนี้เป็นอย่างดี

ขอแสดงความนับถือ

(น.ส. ทศพร สาริยันต์)

หมายเหตุ นอกจากจะเก็บข้อมูลด้วยแบบสอบถามแล้ว ข้าพเจ้ายังเก็บข้อมูลโดยการสัมภาษณ์แบบตัวต่อตัวอีกด้วย หากท่านมีความประสงค์จะให้สัมภาษณ์ด้วย โปรดกรอกแบบอนุญาตให้สัมภาษณ์ที่แนบมาพร้อมนี้ โดยส่งคืนมาถึงข้าพเจ้าพร้อมกับแบบสอบถามที่ท่านกรอกแล้ว ข้าพเจ้าขอขอบคุณในความร่วมมือของท่านมา ณ โอกาสนี้ด้วย

Appendix III (b)

Tossaporn Sariyant
188/116 Soi 3
Moo Baan Kurusapha
San Sai, Chiangmai 50210
Tel 054 490374

February 20, 1997

Dear Participant,

I am a civil servant in the Department of Non-formal Education, Ministry of Education. I am conducting research for my Master of Arts Degree in Women's Studies at Simon Fraser University in British Columbia, Canada.

My research is aimed at assessing the attitudes of Thai people towards the necessity for and emphasis in sex education. Besides submitting this research as a part of the degree fulfillment, I intend to develop from my research a guideline for the preparation of sex education curricula for the non-formal education program. This development will be proposed to the Department of Non-formal Education. Therefore, I will be interviewing women and men who are interested in sharing their ideas and attitudes on this research topic.

This interview will be on one-on-one basis. With the permission of participants, the interview will be audio-taped and partially transcribed. Materials from the transcripts will be used in my research to investigate in detail Thai attitudes and will not be used in any way which identifies any particular interviewee. They will be destroyed after all research is completed. I will keep participants' confidentiality throughout. Participants also have the right to withdraw from my research process at any time.

If you are interested in participating this interview, please sign the attached statement of informed consent. This is to insure and indicate that you clearly understand the terms and conditions of this study.

If there are any concerns or questions about this research, participants can contact me at (604) 473-5027 or to

Dr. Marjorie Cohen
Chair, Department of Women's Studies
Simon Fraser University, Burnaby
British Columbia, Canada V5A 1S6
Tel. (604) 291-5526.

Thank you for taking the time to read this and for consenting to participate in my research.

Sincerely yours,
Tossaporn Sariyant

Statement of Informed Consent to Interview

Having been asked by Tossaporn Sariyant of the Women's Studies Department, Simon Fraser University to participate in an interview, under the terms and conditions stated in the consent letter attached, I_____, agree to so participate.

Name (please print) _____

Address _____

Signature _____

Date _____

As the principal researcher I, Tossaporn Sariyant, agree to respect the confidentiality of the above named participant with regards to all information revealed in the interview session, including any information which is not audio-taped or transcribed. I agree, to the best of my capacity and knowledge, to accurately represent the information from the participant and will not present my results in any way which either misrepresents the participant's information or violates confidentiality. I will destroy all transcripts after all research is completed.

Signature _____

Date _____

If you have any complaints please contact

Dr. Marjorie Cohen
Chair, Department of Women's Studies
Simon Fraser University, Burnaby
British Columbia, Canada V5A 1S6
Tel. (604) 291-5526.

Once signed, a copy of this consent form will be provided to you. If you would like a copy of the summary report of this research upon completion, please contact me at the address given above.

Thai Translation of Appendix III (b)

น.ส. ทศพร สาริยันต์
๑๘๘/๑๑๖ ซอย ๓ หมู่บ้านคุรุสภา
อ. สันทราย จ. เชียงใหม่ ๕๐๒๑๐
โทร. (๐๕๔) ๔๘๐-๓๗๔

๒๐ กุมภาพันธ์ ๒๕๔๐

ถึง ผู้มีความประสงค์ให้ข้อมูลในการวิจัยทุกท่าน

ข้าพเจ้าเป็นข้าราชการกรมการศึกษานอกโรงเรียน จะทำการวิจัยเพื่อใช้เขียนวิยานิพนธ์สำหรับการเรียนระดับมหาบัณฑิต สาขา Women's Studies ณ มหาวิทยาลัย Simon Fraser ในหัวข้อเรื่อง "ทัศนคติ ความต้องการและความรู้ความเข้าใจเรื่องเพศศึกษา" การวิจัยครั้งนี้จะทำโดยใช้แบบสอบถามประกอบกับการสัมภาษณ์แบบตัวต่อตัว ซึ่งจะมีการบันทึกเทประหว่างสัมภาษณ์ และถอดเทปสัมภาษณ์นี้ด้วย หากผู้ให้สัมภาษณ์อนุญาต ข้าพเจ้าจะนำคำพูดที่ถอดจากเทปบางส่วนไปประกอบการเขียนวิทยานิพนธ์ ประการสำคัญคือข้าพเจ้าจะเก็บชื่อและที่อยู่ของผู้ให้สัมภาษณ์รวมทั้งข้อมูลที่ให้สัมภาษณ์ไว้เป็นความลับตลอดไป ข้าพเจ้าจะทำลายเทปสัมภาษณ์และคำพูดที่ถอดจากเทปทันทีที่ข้าพเจ้าทำวิทยานิพนธ์เสร็จเรียบร้อยแล้ว

หากท่านสนใจจะให้ข้าพเจ้าสัมภาษณ์ท่าน โปรดลงนามในแบบอนุญาตให้สัมภาษณ์ซึ่งแนบมาพร้อมจดหมายนี้ การลงนามในแบบอนุญาตให้สัมภาษณ์นี้ เป็นการแสดงว่าท่านเข้าใจขบวนการของการสัมภาษณ์ครั้งนี้ดีแล้ว และเต็มใจให้ข้าพเจ้าสัมภาษณ์ท่านได้ อนึ่ง ท่านสามารถยกเลิกหรือเพิกถอนการยินยอมที่จะให้ข้าพเจ้าทำการสำภาษณ์ท่านได้ทุกเมื่อ

หากท่านมีข้อข้องใจหรือข้อสงสัยในรายละเอียดของการวิจัยนี้ โปรดอย่าลังเลที่จะสอบถามข้าพเจ้าตามที่อยู่ หรืออาจติดต่อสอบถามได้จาก

Dr. Marjorie Cohen
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Simon Fraser University, Burnaby
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ขอขอบคุณที่ให้ความสนใจ และให้ความร่วมมือในครั้งนี้เป็นอย่างดี

ขอแสดงความนับถือ

(น.ส. ทศพร สาริยันต์)

แบบแสดงความยินยอมให้สัมภาษณ์

ข้าพเจ้า _____ ได้รับการขอความร่วมมือในการให้คำสัมภาษณ์ จาก น.ส. ทศพร สาริยันต์ นักศึกษาจากคณะสตรีศึกษา ของมหาวิทยาลัย Simon Fraser ตามข้อตกลงที่กล่าวใน จดหมายข้างต้น ข้าพเจ้าเข้าใจข้อตกลงต่าง ๆ ดีแล้ว จึงได้ลงนามแสดงการยินยอมให้ความร่วมมือในการนี้

ชื่อ(โปรดเขียนตัวบรรจง)_____

ที่อยู่ _____

ลายเซ็น _____

พยาน _____

ว.ด.ป. _____

ข้าพเจ้า น.ส. ทศพร สาริยันต์ ในฐานะผู้ทำการวิจัย ข้าพเจ้าจะเคารพความคิดเห็นและข้อมูลที่ไครับจากผู้ให้ข้อมูลที่มีชื่อปรากฏในข้างต้นนี้ ทั้งในส่วนที่มีการบันทึกไว้ด้วยเทปเสียงหรือมิได้บันทึกไว้โดยวิธีใดก็ตาม ข้าพเจ้าสัญญาที่จะไม่ใช้ข้อมูลที่ได้รับมาในทางผิดโดยเด็ดขาด และข้าพเจ้าจะเก็บข้อมูลส่วนตัวของผู้ให้สัมภาษณ์ไว้เป็นความลับตลอดไป

ลายเซ็น _____

ว.ด.ป._____

หากท่านมีข้อร้องเรียนใด ๆ เกี่ยวกับการวิจัยของข้าพเจ้า ท่านสามารถส่งคำร้องเรียนไปยัง

Dr. Marjorie Cohen
Chair, Department of Women's Studies
Simon Fraser University, Burnaby
British Columbia, Canada V5A 1S6
Tel. (604) 291-5526.

ข้าพเจ้าจะมอบสำเนาเอกสารที่ท่านลงนามแล้วให้ท่านเก็บไว้เป็นหลักฐานหนึ่งฉบับด้วย หากท่านมีความสนใจผลงานวิทยานิพนธ์ที่สมบูรณ์แล้วของข้าพเจ้า โปรดติดต่อข้าพเจ้าได้ตามที่อยู่ในจดหมายนี้

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