1998

Thai Red Cross HIV/AIDS public information campaigns in Bangkok

Pim Pisalsarakit
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

Recommended Citation

Pisalsarakit, Pim, "Thai Red Cross HIV/AIDS public information campaigns in Bangkok" (1998). *Master's Theses*. 1715.

DOI: <https://doi.org/10.31979/etd.ev4v-etx6>

https://scholarworks.sjsu.edu/etd_theses/1715

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

**A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600**

**THAI RED CROSS
HIV/AIDS PUBLIC INFORMATION CAMPAIGNS
IN BANGKOK**

A Thesis

Presented to

**The Faculty of the School of Journalism and Mass Communications
San Jose State University**

**In Partial Fulfillment
of the Requirements for the Degree
Master of Science**

by

Pim Pisalsarakit

August 1998

UMI Number: 1391538

**Copyright 1998 by
Pisalsarakit, Pim**

All rights reserved.

**UMI Microform 1391538
Copyright 1998, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

© 1998

Pim Pisalsarakit

ALL RIGHTS RESERVED

APPROVED FOR THE SCHOOL OF JOURNALISM
AND MASS COMMUNICATIONS

A handwritten signature in cursive script, reading "Diana Stover".

Dr. Diana Stover

A handwritten signature in cursive script, reading "Wm. A. Tillinghast".

Dr. William A. Tillinghast

A handwritten signature in cursive script, reading "WGBriggs".

Dr. William G. Briggs

APPROVED FOR THE UNIVERSITY

A handwritten signature in cursive script, reading "William Fiske".

ABSTRACT

THAI RED CROSS HIV/AIDS PUBLIC INFORMATION CAMPAIGNS IN BANGKOK

by Pim Pisalsarakit

This thesis is a case study of the effectiveness of three community-based HIV/AIDS prevention campaigns conducted in Thailand by the Thai Red Cross Society. Field work in Bangkok included documentary analysis, direct observation, and in-depth interviews. The study examined the campaigns' target audiences, messages, sources, channels, and the use of interpersonal communication to reinforce mass media messages that were disseminated from 1987-1990 (health education and social campaigns) to 1991-1995 (multisectorial collaboration campaigns). Thailand began its third stage, community mobilization campaigns, in 1996. The study, which examined all three stages, found that the complementary combination of mass media, interpersonal communication, and community interventions appeared to be effective in the fight against AIDS. Since 1995, the number of new HIV infections in Thailand has begun to drop significantly. This is a success story in a country where sex is still a taboo subject.

Acknowledgements

First, I would like to thank Dr. Diana Stover, my primary thesis advisor. Without her patience and encouragement, I could not have finished this thesis. I would like to extend my gratitude to Dr. William Tillinghast and Dr. William Briggs, who gave me helpful feedback on my thesis drafts.

Many thanks go to Dr. Praphan Phanuphak and all the people at the Program on AIDS, Thai Red Cross Society, especially Sasathorn Chaiyapet, Greg Carl, and Uemporn Navy. I truly appreciated their tremendous cooperation.

It would have been impossible for me to conduct this case study without the great dedication of the interviewees, especially Dr. Yooth Bodharamik, who was always ready to help. Thanks to all of you. I would also like to thank the teachers and faculty members who allowed me to conduct direct observations in their classes.

In Thailand, I was warmly welcomed everywhere I went. People were very nice and cooperative. Therefore, my appreciation goes to all Thais I met during the field work period.

I would also like to thank all my friends in the United States, as well as those in Thailand, who never hesitated to lend me a hand whenever I needed help. A special appreciation is extended to my dearest friend, Kritini Prachabarn, who was my backup in Bangkok.

My parents are the most important people in my life. With all my heart, I would like to thank my father, Pongpun Pisalsarakit, and my mother, Benjamas Pisalsarakit.

They have always had faith in me. Their love and understanding led me through all the darkest moments when I ran out of hope.

Finally, I would like to express my gratitude to my guardian angel, Thanicha Niyomwan, whose love and support have been very important throughout the years. I cannot thank him enough for all his unconditional help.

Dedication

To Pongpun and Benjamas Pisalsarakit and Thanicha Niyomwan.

Table of Contents

Chapter I – Introduction	1
Chapter II – Literature Review	4
Chapter III – Method	49
Chapter IV – Findings	59
Chapter V – Conclusion	112
References	123
Appendix A – Table of Acronyms	130
Appendix B – Letter of Approval from the Thai Red Cross Society	131
Appendix C – Letter of Approval from the Human Subjects-Institutional Review Board	132

List of Figures

Figure 1 – Distribution of Reported AIDS Cases by Year of Diagnosis in Thailand, September, 1984 to December, 1995	25
Figure 2 – Distribution of Reported AIDS Cases in Thailand by Type of Transmission, 1984-1996 (Data as of March 31, 1996)	27
Figure 3 – HIV Prevalence Among Selected Group in Thailand	29

CHAPTER I

Introduction

Public communication campaigns are conducted to deliver specific information to people in general as well as those in specified target groups. Most of the campaigns are designed to achieve the goal of behavioral modification. According to Paisley (1981), the unifying principle of public communication campaigns is reform. The campaigns may affect the structure of society or only the lifestyles of individuals. Significantly, reform is the action that makes society or the lives of individuals better.

Most public communication campaigns aim to change behaviors among the target audience, but many campaigns can only reinforce the existing attitudes of the audience (Alcalay, 1983; Singer, Rogers, & Glassman, 1991). Some shortcomings in the campaign processes, such as dissemination of complicated messages or the inappropriate use of media, cause the designed messages to miss the target audience (Alcalay, 1983; Bush & Boller, 1991; Cameron & Yang, 1991; de Vroome, Paalman, Dingelstad, Kolker, & Sandfort, 1994). Moreover, regarding the role of the media, Alcalay pointed out that mass communication could be effective in an attempt to increase the level of information about a particular subject, but it might not have an effect on attitude or behavior change. As a result, media could only be a reminder of the existence of a particular issue in some cases.

Health professionals and researchers have attempted for many decades to educate and guide the general public as well as specific groups of people on how to have a healthier life. They have conducted public health campaigns using mass media as well as

interpersonal communication to present health information and to stimulate awareness, attitudinal change, and change of behavior among their target audience (Backer, Rogers, & Sopory, 1992).

Among many health problems and diseases that campaign practitioners have to deal with, there is one disease with no way to cure: acquired immune deficiency syndrome (AIDS). This disease, which is caused by the human immunodeficiency virus (HIV), has become the world's pandemic within only one decade. The first cases of AIDS in the United States were reported in 1981 (Centers for Disease Control and Prevention, 1994). By 1991, the United States had the largest number of documented AIDS cases in the world, with the report of more than 80,000 cases of full-blown AIDS (Bush & Boller, 1991). Bush and Boller pointed that "[s]ince there is no medical cure or vaccine for the virus, the primary weapons available for prevention are public information and education" (p. 28).

People in developed countries like the United States or the European Community are well-informed in general because of the pervasiveness of HIV/AIDS educational campaigns during the past decade (Brown, 1991; CDC, 1994; de Vroome et al., 1994; Hausser & Michaud, 1994; Moatti et al., 1992; Ratzan, Payne, & Massett, 1994; Træen, 1990). However, other parts of the world are not as well-informed. Both Africa and Asia are hit severely by the disease ("AIDS moves on," 1995). Although three quarters of the AIDS cases have been found in Africa, health researchers have predicted that Asia would replace sub-Saharan Africa as the region with the most number of AIDS and AIDS-related cases in the world ("AIDS moves on," 1995, p. 31).

In Thailand, the spread of AIDS is accelerated by the booming prostitution industry (Ford & Koetsawang, 1991; Limanonda, van Griensven, & Nokyoongthong, 1995; Muecke, 1992). The Thai tradition of prostitution patronage among Thai men at every level of the society as well as the high tolerance for male polygamy are among the factors that make the efforts to stop AIDS unsuccessful (Muecke, 1992). More educational campaigns are needed at the community level to fight the people's misunderstanding about HIV/AIDS and to create changes in sexual behaviors.

A case study of three community-based campaigns of the Program on AIDS, Thai Red Cross Society (i.e., the Wednesday Friends Club, the HIV/AIDS Prevention for Slum Communities Project, and Facts for Life: Curriculum for Youth, Red Cross Youth Division) provides in-depth information and analysis on how to conduct HIV/AIDS educational campaigns effectively and on what techniques should be performed. The method of the study includes triangulation of documentary analysis, direct observation, and in-depth interviews. The research questions are about the target audience, messages, sources, channels, and interpersonal communication techniques of each of the three projects based on the seven-step framework composed by Flay and Burton (1990).

Since almost all the literature is on HIV/AIDS prevention campaigns in Western societies, this case study will broaden the research activity to include Thailand. The knowledge obtained from the case study will lead to a better understanding of how to conduct a future campaign to fight AIDS, not only in Bangkok, Thailand, but also in other places in the world.

CHAPTER II

Literature Review

Public Communication Campaigns

There is no precise definition of a public communication campaign. In Paisley's (1981) viewpoint, a public communication campaign represents "someone's intention to influence someone else's beliefs or behavior, using communicated appeals" (p. 23). He stated that the unifying principle of such campaigns was reform that would definitely lead to a better life as well as to a better society.

Many public communication campaigns attempt to discourage people from doing something undesirable (Centers for Disease Control and Prevention, 1994; de Vroome et al., 1994; Hausser & Michaud, 1994; Maccoby & Solomon, 1981; McAlister, 1981; Mendelsohn, 1973; Moatti et al., 1992; Ratzan et al., 1994; Træen, 1990). The goal of many public communication campaigns is to change the attitudes or behaviors of the target audience (Paisley, 1981). However, in the past, the usefulness and effectiveness of information campaigns had long been doubted by many scholars (Atkin, 1981). Hyman and Sheatsley's (1947) attack on the process of information campaigns obviously indicated the influence of the low-effect theory on public information campaigns. The researchers found the group of chronic "know-nothings," or the people who, regardless of how much information was disseminated concerning a mass communication effort, were never reached by the designed message. Consequently, this negative viewpoint led to questions about the effectiveness of public information campaigns.

However, campaign researchers became more optimistic when some social scientists reported positive findings on campaign effectiveness. Mendelsohn (1973) found that the findings from his study were opposite of those of Hyman and Sheatsley (1947) as he launched an information campaign called “The National Drivers Test.” The results suggested that his innovative information format together with strong prior promotion could overcome public apathy. Mendelsohn contended that campaign practitioners should strive for practical and realistic goals, such as trying to educate people about their weak driving skills rather than trying to eliminate all freeway auto accidents. Moreover, the author also created “A Short History” campaign to educate the public on alcohol abuse. The six-minute non-verbal film featured both live action and animation, demonstrating induction of false optimistic behavior caused by alcohol in the case of drunk driving. The content appeared to be effective in increasing viewers’ knowledge and in having an impact on the attitudes on the dangers of drinking and driving. Therefore, Mendelsohn stated that public communication campaigns should be conceptually approached in a manner similar to traditional product advertising by first defining target markets and then focusing in on a direct benefit, and a novel and creative presentation. He also argued that information presented in an engaging manner could not only increase awareness about the issue, but could also lead to attitude and behavior modification.

Many information campaigns in the past were considered unsuccessful because they failed to elicit a sustained behavioral change (Alcalay, 1983; Hyman & Sheatsley, 1947; Singer et al., 1991). However, the learning of information disseminated appears to

be a necessary but not sufficient condition to induce change, whether it be on a cognitive, affective, or behavioral level.

Public Health Campaigns

Public health campaigns, which are the major part of public information campaigns, have been conducted all over the world (e.g., Brown, 1991; CDC, 1994; de Vroome et al., 1994; Hausser & Michaud, 1994; Maccoby & Solomon, 1981; McAlister, 1981; Moatti et al., 1992; Ratzan et al., 1994; Træen, 1990). There are several definitions of health communication campaigns. Backer and Rogers (1993) cited the 1988 work of Rogers and Storey that the concept of a health communication campaign follows from the following definition:

1. A campaign is purposive and seeks to influence individuals.
2. A campaign is aimed at a large audience.
3. A campaign has a more or less specifically defined time limit.
4. A campaign involves an organized set of communication activities. (pp. 1-2)

Public health campaigns, in the viewpoint of Flay and Burton (1990), are “an integrated series of [1] communication activities, [2] using multiple operations and channels, [3] aimed at populations or large target audiences, usually [4] of long duration, [5] with a clear purpose” (p. 130). The authors suggested that public communication campaigns should be preplanned and well organized, consist of the use of mass media and other communication activities, target not only the general public but also specific sub-groups, require a long period of time to achieve maximum effects, and have a clear purpose.

Backer, Rogers, and Sopory (1992) stated that “[h]ealth communication campaigns typically have interpersonal (training, counseling) and community

(neighborhood group, advocacy) components as well, and in the more sophisticated campaigns these various elements are carefully interwoven through an overall strategic design” (pp. 3-4).

Among the theories used in health campaigns, Alcalay (1983) noted that the theory of cognitive dissonance, social learning theory, and the theory of diffusion of innovations “have been of critical import to the field of mass communication as shown by the fact that they have provided the theoretical basis for the design of innumerable campaigns . . . through mass media, as much in the area of health as in other areas of education” (p. 88). Regarding the cognitive dissonance theory, “people are made uncomfortable when various elements of their perceptual fields are inconsistent with each other. . . . Because dissonance is a source of discomfort, the individual handles it by changing his mind about the topic . . . by thinking less of the public-figure said . . .” (p. 88).

Alcalay also found that the social learning theory proposes essential techniques to stimulate behavioral changes and to maintain those changes without previously having modified attitudes. Moreover, the theory states that a change of behavior through concrete action may cause a change in attitude; therefore, it provides a mode of desirable behavior, which is presented by means of “modeling”—seeing, hearing, or reading about the process of such behavior—that could lead to behavioral change.

Another theory, diffusion of innovations, “focuses on identifying certain characteristics of both the sender and the receiver that are necessary to maximize communication innovations” (p. 88). An innovation is “an exchange of an idea, a

practice or an object perceived as new by the individual or by the community” (p. 88).

Alcalay stated that such communication would be much more effective “when there is a high degree of empathy and similarity between sender and receiver” (p. 88). The opinion leaders in the community play an important role in this communication chain. The last theory the author mentioned, social inoculation, “is concerned with resistance to social pressure for harmful behavior” (p. 89). The individual needs to know how to defend the healthy attitudes or behavior to be able to get rid of unhealthy ones. As Alcalay noted: “The process . . . consists of presenting the arguments that support the desired behavior, followed by a presentation of arguments used to promote the undesired behavior, followed in turn by answers refuting such arguments” (p. 88).

Some researchers recommended the use of social marketing in campaign design (Atkin & Arkin, 1990; Manoff, 1985; Solomon, 1981; Wallack, 1990). The knowledge of social marketing planning can be applied to the planning process of campaigns, according to Manoff. The author also suggested that the target audience should be analyzed for segmentation before setting practical and probable objectives. In the formulation of the campaign’s concepts and message design, Manoff wrote that a formulative evaluation approach and community-based participation are needed: “The modern health educator needs to understand social marketing’s appreciation for media diversity and the special advantages of each medium in terms of target audience and message” (p. 153). The author also emphasized the significance of message designs that are the major concern of social marketing. However, the content of any particular message and its relevance to local problems differed from case to case. Finally, Manoff

(1985) pointed out that continuing health education in the public was required to maintain a strong result.

Public information campaign practitioners have suggested that mass media, such as television and radio, could play an important role in disseminating information during health crises. Atkin and Arkin (1990) as well as Bush and Boller (1991) pointed out the significance of the use of television advertising concerning health issues. Generally, television advertising came in the form of public service announcements (PSAs). They were used to convey essential information to the public to generate awareness, heighten the public's sensitivity to particular health issues, and change or reinforce the public's attitudes toward specific behaviors related to the problem. Bush and Boller stated that PSAs were more advantageous than other forms of mass media, such as broadcast news or news articles in a magazine, because the messages in PSAs were shorter in length, easier to understand, and more intrusive.

However, PSAs also have problems which limit their effectiveness. The authors stated that "most PSAs are still regarded by broadcasters as filler for unsold air time" (Bush & Boller, 1991, p. 30). Moreover, the authors cited studies by O'Keefe, Schmeling and Wotring, and Udry et al., concluding that, unlike commercial ads, PSAs did not have strong personal-relevance characteristic. The audience could not identify with conflicting messages since they were hard to understand and not related to the lifestyle of the audience. Because of these shortcomings of PSAs, the authors urged campaign practitioners to reconsider the function of health-related television advertising.

It appears that not every public health campaign can successfully reach its goal despite the design and efforts. Alcala (1983) found that the role of mass communication in campaigns is not the changing of attitudes and behaviors but reinforcement of existing ones. Moreover, people who tend to change their attitudes or behaviors because of public health campaigns are not always the target audience. Alcala wrote about the weak point of mass communication: “[a]n important limitation of the mass media as an instrument of change comes from the very nature of media: there is no opportunity for active audience participation or immediate feedback” (p. 92). A change in these weak points would enable scientists to reach the maximum effectiveness of public communication campaigns.

Interpersonal Communication

To overcome such weak points, health researchers have introduced another strategy to be included in public health campaigns, that is interpersonal communication. To define the term, Roloff (1981) suggested the following: “Interpersonal communication is a symbolic process by which two people, bound together in a relationship, provide each other with resources or negotiate the exchange of resources” (p. 30). Interpersonal communication has been widely used in public campaigns because of its most notable feature: influence (Chaffee, 1981; McAlister, 1981). Cappella (1987) noted that “if interpersonal communication has any essential feature, it is that persons influence one another’s behavior over and above that attributed to normal baselines of action” (p. 228).

People engage in conversations either to find the information they need to make up their minds or to persuade others to agree with them (Chaffee, 1981). This

interpersonal persuasion, if added in a campaign, may contribute to behavioral and attitudinal change when mass media may be able to achieve only the awareness of campaign's messages and knowledge of the audience (Alcalay, 1983; Solomon, 1981). The use of media alone appears to be overemphasized since it is not a mere solution to many public health issues (Flay & Burton, 1990; McAlister, 1981; Robinson, 1981; Williams, 1984). Some researchers have suggested a complementary approach of mass media, interpersonal communication, and community interventions to achieve desirable behavioral changes among members of a target audience (Backer et al., 1992; Catford, Dillow, Nutbeam, Waters, & Woolaway, 1984; Flay & Burton, 1990; Maccoby & Solomon, 1981; McAlister, 1981). Many public health campaigns have included interpersonal communication as one of the techniques for disseminating campaign messages to the audience (Engelberg, Flora, & Nass, 1995; Maccoby & Solomon, 1981; McAlister, 1981; Robinson, 1981; Sheer & Cline, 1995).

McAlister (1981) noted that public health campaigns needed the interpersonal approach to train the audience in skills necessary to translate the intention into action. The author stated that "[m]ass communication media may effectively inform, persuade, and train their audiences, but lasting change will not be achieved in the absence of a supportive social environment" (p. 92). McAlister contended that using different approaches together would help campaign practitioners to achieve their goals:

Because it is easier to distribute printed or audiovisual messages to mass audiences than it is to organize supportive interpersonal communications on a large scale, campaigns have tended to rely solely on mass communication. This narrow approach to the problem has yielded relatively poor results. But researchers now realize that campaign effectiveness may depend upon the creation of opportunities for interpersonal communication, participation, and

social reinforcement. This has led to attempts to efficiently integrate mediated and interpersonal communications . . . (p. 92)

Maccoby and Solomon (1981), who reported on the Stanford Heart Disease Prevention Program's success, wrote that "behavior change for better health can be accomplished through sustained community-based education . . ." (p. 115). Since the authors conducted their media-only campaign at the same time as the campaign with media plus intensive instruction, they found that the face-to-face instruction and counseling were crucial in the stimulation of desirable changes in the target audience. Although the media-only campaign was quite successful, the authors contended that adding interpersonal communication into a health campaign would be a fail-proof attempt for campaign practitioners:

However, we believe that the power of the media can be enhanced if we can find ways to use them to stimulate and coordinate programs of interpersonal instruction in natural community groups, such as facets of the existing health care system or employee groups, and to deliver some forms of specialized training and counseling (e.g., training in improved eating habits to achieve weight loss or skills for avoiding smoking). (p. 115)

The effectiveness of campaign messages depends upon the social environment in which they are received; therefore, if the messages are supported by interpersonal communication and community interventions, they will be much more likely to be effective (Catford et al., 1984; Flay & Burton, 1990; McAlister, 1981; Robinson, 1981; Solomon, 1981).

Regarding all the effort put into the design and conduct of public health campaigns, campaign practitioners should not be discouraged by the results since their

campaigns at least help create awareness in particular health issues and disseminate new information to the public (Alcalay, 1983; Solomon, 1981).

Public HIV/AIDS Prevention Campaigns

One of the serious health issues is the spread of the acquired immune deficiency syndrome (AIDS), which is caused by the human immunodeficiency virus (HIV) (Gould, 1993; Merson, 1992; Sills, 1994; Wiel, 1992). Many campaign practitioners have conducted public HIV/AIDS prevention campaigns all over the world using different messages, media, and approaches (Brown, 1991; CDC, 1994; de Vroome et al., 1994; Engelberg et al., 1995; Hausser & Michaud, 1994; Limanonda, Posayachinda, Danthamrongkool, & Nokyoongthong, 1996; Limanonda, van Griensven, & Nokyoongthong, 1995; Lyttleton, 1994; Moatti et al., 1992; Perloff, 1991; Ratzan et al., 1994; Sheer & Cline, 1995; Stroman & Seltzer, 1989; Træen, 1990). One strategy researchers have found effective in achieving behavioral change is interpersonal communication. This approach appeared to be quite effective in the campaigns that targeted teenagers or young adults (Brown, 1991; Sheer & Cline, 1995). Other researchers suggested that future HIV/AIDS education campaigns should include the use of interpersonal interventions for maximum results (de Vroome et al., 1994; Shah et al., 1991; Træen, 1990).

In addition, regarding public HIV/AIDS prevention campaigns, Maibach, Kreps, and Bonaguro (1993) found that the best available public health strategy for limiting the spread of HIV transmission and AIDS was “strategic health communication campaigns” (p. 15). The authors introduced a Strategic Health Communication Campaign model that

included five stages: planning, use of theory, communication analysis, implementation, and evaluation and reorientation. Although the major concerns appeared to be like those of public health communication planning in general, Maibach et al. emphasized that HIV/AIDS prevention campaigns “should be implemented with awareness of macrosocial and cultural constraints; be designed to influence an audience’s motivation to engage in behavior change; be evaluated to refine campaign process and strategies; and be sustained for a sufficient amount of time to promote long-term behavior change” (pp. 31-32).

In the United States, among plans and public health campaigns regarding AIDS designed during the late 1980s, the “America Responds to AIDS” campaign by the U.S. Department of Health and Human Services, through the Centers for Disease Control and Prevention (CDC), was one of the most extensive governmental health campaigns ever. The campaign was conducted from July, 1987 to February, 1991 (Ratzan et al., 1994), with the goal of increasing awareness of AIDS issues.

While the America Responds to AIDS campaign’s target was, mostly, the general public, the AIDS prevention campaign Brown (1991) studied was aimed at college students. The author pointed out that college students, though having a high degree of AIDS knowledge, did not always practice safe sex because they underestimated their personal risk. The author studied the 1987 campaign launched at an American university in the Pacific region, which consisted of interpersonal communication and the use of an educational videotape. The author found that the students exposed to the AIDS educational videotape increased the accuracy of their AIDS-related beliefs by almost 8%

from the time of the pretest to the time of the posttest. However, the author noted that the weak link between beliefs about AIDS and personal concern about the risk of AIDS among the students demonstrated that increasing AIDS knowledge might not necessarily promote AIDS prevention.

Although interpersonal communication appeared to be unable to change sexual behavior directly in Brown's study, it might have indirect effects on the adoption of preventive practices. The author pointed out that students who had more knowledge about AIDS engaged in more communication concerning the problem and that this communication could contribute indirectly to behavioral change. Therefore, Brown urged researchers to pay more attention to the link between interpersonal communication and AIDS prevention.

AIDS has struck not only the United States but also many countries in Europe, Asia, and Africa. In Europe, various campaigns against AIDS and HIV infection have been actively launched since the 1980s. For example, safe sex campaigns in The Netherlands were started by the Dutch Foundation for Sexually Transmitted Diseases Control (STD Foundation) in 1987, five years after the first AIDS diagnosis in the country (de Vroome et al., 1994). The researchers analyzed changes in knowledge, attitudes, and behavior of the general population, including two specific target groups, people from 15 to 20 years of age, called "the young," and the people who were non-monogamous.

The first safe sex campaign's purpose was to make condom use a socially acceptable topic. Then, campaigns targeted at the young were launched to emphasize

both condom use and skills to postpone sexual activities and to communicate about safe sex. Since the young had excuses for not practicing safe sex, the “Excuses campaign” was started in 1989 to inform the young that they were at risk as well. In 1992, the “Cupid campaign” was targeted at the young with low education since “[r]esearch revealed that knowledge about AIDS and [sexually transmitted diseases] was less among those with lower educational levels” (de Vroome et al., 1994, p. 280). Finally, in 1993 the campaign “Have safe sex or no sex” was started to emphasize self-efficacy. According to the study, the campaigns were successful in reaching the specific target groups. However, de Vroome et al. pointed out that mass media were effective only in the early stages of the behavioral change process; therefore, interpersonal interventions should be added to cause actual adoption of safe sex behavior.

Another outstanding safe sex campaign was started in Norway in 1988. The campaign, called “Interrail” after the name of a train ticket for persons under 26 to travel all over Europe, was launched to promote condom use as a protection against HIV transmission (Træen, 1990). The campaign was based on the cooperation between the government and private sectors. Media channels used were a poster displayed in railway stations and schools, a TV program, a TV spot, a pop song, and a music cassette given for free when buying an “Interrail” ticket.

Træen studied the public awareness of the campaign among adolescents and found that the pop song called “the Rubber Song,” the TV spot, and the poster were the elements that could reach the target audience effectively. The pop song, with humorous lyrics encouraging the listener to use condoms, was heard by 50% of the respondents.

The author found that “the high awareness of the campaign elements may be accounted for by the way the message was presented: in a simple, humoristic, and straightforward manner” (p. 39). The author noted that people tended to seek out information that had high personal relevance. In the study, the reason why more young women than young men reported awareness of the campaign might be the fear of pregnancy. In addition, Træen wrote that, since sexual issues were “traditionally taboo restricted areas” (p. 40), adolescents should be encouraged to communicate about such issues, especially AIDS and sexually transmitted disease topics, to create more awareness among themselves.

In France, Moatti et al. (1992) conducted research on French national media campaigns concerning the impact of AIDS and condom promotion on the population 18 years of age and over. The goals of the campaigns were to maintain public awareness of the risks of HIV/AIDS, to achieve behavioral change, and to prepare the public to live with people who were HIV positive as well as AIDS victims.

The researchers found that the campaigns could reach a very large proportion of the population. More than 90% of the respondents reported that they had seen TV ads about condoms, and 71% reported seeing TV ads about AIDS. However, the campaign did not appear to be effective in changing people’s attitudes because almost half of the respondents reported that they had not felt personally influenced by the campaigns. The authors found that socio-demographic characteristics played an important role in the change of attitude and behavior since young, highly educated, and single respondents were exposed to messages and reported a positive impact on their personal attitudes and behaviors more than other groups of respondents.

Although the study showed high awareness and knowledge increase in terms of HIV/AIDS as well as an increase in condom use, Moatti et al. still doubted the causal effect of campaign messages on the public's actual adoption of preventive behavior. At least, media campaigns had reinforced existing attitudes and behaviors of the French population. The authors stated that public information should make condom use a social norm to more effectively promote the adoption of this behavior.

In Switzerland, Hausser and Michaud (1994) studied the effectiveness of the Swiss STOP-AIDS campaign among adolescents. The study was conducted after the campaign had been launched for five years. The goal of the campaign was to increase condom use, especially with new or casual partners. Hausser and Michaud paid attention to a task force on teenage AIDS prevention set up by the cantonal (state) government of Vaud in 1987. Many educational programs were conducted both inside classrooms and outside. The authors found that the number of teenagers who decided to purchase and use condoms and those who discussed condom use with their partners had increased. The authors suggested that the teenagers might accept condom use as a desirable option in sexual relationships.

However, Hausser and Michaud noted the nature of adolescence, adding that because the young liked taking risks, many of them might not use condoms. The use of condoms as a new social norm or a tool to prevent pregnancy should be the focus of campaigns. Since campaign messages for teenagers were different from those for the general population, the involvement of the young in the campaign design process should benefit the efforts to reach this specific target group.

Thailand: An Example of the AIDS Situation in Asia

Asia has more than half of the world's population. Although HIV/AIDS became an alarming issue in the Western Hemisphere and in Africa in the early 1980s, this deadly disease received little attention in most of Asia before the early 1990s (Gould, 1993; Merson, 1992; Sills, 1994; Wiel, 1992). From statistics of the World Health Organization (WHO), Africa has about 71% of the world's AIDS cases, whereas approximately 10% are in Asia ("AIDS moves on," 1995).

Although Asia appears to be in the early phases of an explosive HIV/AIDS epidemic, WHO estimates that there are more than 1.5 million HIV infections in Asia (Brown & Xenos, 1994, August). Brown and Xenos stated that, although Asia has only 10% of the total 15 million HIV infections estimated for the world as a whole, WHO projected that, by the turn of the century, more new HIV infections would occur in Asia than in all the rest of the world combined. According to Dr. John Dwyer, president of the AIDS Society for Asia and the Pacific Region, "the rate of increase of new infections is greater in Asia than anywhere else in the world" and Asia is projected to replace Africa as the region with the most number of AIDS cases in the next decade ("AIDS moves on," 1995, p. 31). However, only a few AIDS cases have been reported as a result of an inadequate HIV surveillance systems in most Asian countries. The severe situation is yet to come. An early example is Thailand.

Thailand has a population of about 60 million people and covers a total land size of 198,456 square miles (Limanonda et al., 1996). The country has 76 provinces and its capital is Bangkok. Located in the central area of Southeast Asia, Thailand is bordered

by Laos in the northeast, Cambodia in the east, Myanma in the west, and Malaysia in the south. In the early 1990s, Thailand had one of the fastest growing economies in the world. Since 1987, the Thai economy achieved an impressive 9-13% annual growth in terms of Gross Domestic Product (GDP) (Limanonda et al., 1996). Although about two-thirds of the nation's labor force still work in agriculture, the nation's industrial, construction, and service sectors have greatly expanded in recent years and now hold the predominant share of Thailand's Gross Domestic Product.

Thailand has documented the earliest and most explosive growth of HIV/AIDS in the region. Brown and Xenos (1994, August) pointed out that the AIDS situation in this country had received the most coverage worldwide "due to the country's openness in admitting the problem, its success in monitoring it, and its willingness to address it" (p.

3). The authors also stated the importance of HIV surveillance system as follows:

Every Asian country has an HIV/AIDS problem to one degree or another, but until systematic testing is conducted throughout the region, it will be difficult to compare the relative magnitudes of the national epidemics. Because Thailand has monitored extensively for HIV since 1985, a clear picture of the spread of HIV there has been obtained, and concrete efforts to slow the epidemic have been implemented. (p. 3)

The epidemic in Thailand began in September, 1984, with the first documented AIDS case in Bangkok: a homosexual man who had spent many years studying in the United States came back home and fell ill (Gould, 1993; Sills, 1994; Brown & Xenos, 1994, August). The man died a few months later. During the next two years, the majority of early AIDS cases detected were among homosexual and bisexual men. Many of them had been abroad or had had sexual relationship with foreigners (Brown & Xenos, 1994, August). Since then, progressive numbers of AIDS cases as well as people with

HIV were reported throughout the country. The infection rate in Thailand has accelerated: now about 1-2% of the 60 million population is HIV-infected—twice the U.S. rate.

In a few years after the first AIDS case was reported in Thailand, many HIV/AIDS studies aimed at female commercial sex workers were conducted, but at that time little HIV infection was found in that group. Then, in late 1987, drug rehabilitation clinics in Bangkok noted a rapid rise in the presence of HIV in blood serum samples taken from their clients (Brown & Xenos, 1994, August). The authors found that infection among intravenous drug users “skyrocketed” from zero to 30% between November, 1987 and August, 1988 (p. 3). HIV infection levels continued to rise, finally stabilizing at 35% in 1988 (p. 3). The virus then spread to male and female sex workers and their clients with the result that heterosexual transmission became increasingly prevalent. By 1991, many provinces in Thailand started reporting cases of perinatal transmission. However, since 1985, the country has initiated blood screening and since 1989, every unit of donated blood has been screened for HIV. The HIV/AIDS epidemic is more advanced in the north of Thailand and the largest number of AIDS cases are reported from that part of the country. It is expected that the HIV/AIDS epidemic in Thailand will continue to expand, with heterosexual intercourse being the most important mode of transmission.

The factors contributing to the rapid spread of HIV infections in Thailand may also be explained by the Thai gender-related culture and the prostitution industry in the country. Muecke (1992) noted that “[b]eliefs that boys are mischievous and men

irresponsible, whereas girls are dutiful and women loyal, run deep in Thai society” (p. 898). In the past, Thai women were “owned” by their parents or husbands. Until the late 19th century, the author stated that Thai women could be traded legally:

... it was legal for a man to sell or give away his wife or daughter without her consent, as a present to his superior or in payment of his debts; men could also purchase slave women as their lesser wives, and gain Buddhist merit for their generosity in doing so ... (p. 892)

The author found that the prostitutes in Thailand from the 15th century to the late 19th century were women who had been sold into prostitution by their parents or husbands. However, the Thai media wrote that prostitution began in Thailand as the result of “the massive presence of American G.I.s in the 1960s when they were stationed in several large military bases [in Thailand] ... and flocked to Thailand for ‘rest and recreation’ from the Vietnam War” (pp. 894-895). The author noted that the Thai media blamed foreigners, instead of Thai people, on the prevalence of prostitution in the country. Although prostitution became illegal in 1960, Muecke also noted that massage parlors were legalized in 1966 and became “one of the major cover-ups for prostitution” in Thailand (p. 892).

Although prostitution is illegal in Thailand, the tradition of prostitution patronage among Thai men makes it impossible to eliminate, or even control, the expanding sex industry (Ford & Koetsawang, 1991; Limanonda et al., 1995; Lyttleton, 1994; Muecke, 1992). Muecke pointed out that Thai children have been raised with the expectation that “real men need sex, and good girls control their sexuality so as not to overcome men with temptation” (p. 898). Therefore, Thai society appears to accept polygamy and

prostitution as normal. The author stated the highly prevalent indigenous use of prostitution by Thai men as follows:

It is widely accepted as normal for Thai men to visit prostitutes, and for the most masculine of men, police, military, and government officials, to patronize the sex service industry. The higher need for men than women to demonstrate sexual prowess may be associated with Thai tolerance of both prostitution and polygamy. (p. 895)

Since 1985, when the Thai economic boom started, the sex industry expanded rapidly. Foreign investment poured into big cities, especially Bangkok, causing an increase in income differentials between Bangkok and the rest of the country (Muecke, 1992). The increasing poverty of rural areas relative to urban areas resulted in the migration of young women from villages to work in the service and industrial sectors in the cities (De Jong, Richter, & Isarabhakdi, 1996; Muecke, 1992). Those women also became workers in the prostitution industry (Muecke, 1992).

At first, when the Thai people were informed about a few AIDS cases in Thailand, they considered AIDS to be a homosexual or a Westerner's disease (Ford & Koetsawang, 1991). According to Ford and Koetsawang, the Thai government "was accused by the press of not providing sufficient information about HIV/AIDS to the public, partly . . . to protect Thailand's burgeoning tourist industry" (p. 406). Later the government linked the rapid transmission of HIV to female commercial sex workers (Muecke, 1992). It has been estimated that about 70% of female sex workers in Thailand have sexually transmitted diseases; thus, the absence of medical check-ups for low-income sex workers may contribute to the acceleration of HIV transmission (Ford & Koetsawang, 1991).

Unfortunately, other groups of people have also become the victims of the disease: the wives and girlfriends of the men who visit sex workers as well as infants of HIV-infected mothers. Brown and Xenos (1994, August) reported that about 2% of women going to prenatal care clinics in June, 1993 tested HIV positive, and at several maternity hospitals where infection levels are monitored, the percentage of infected mothers has been doubling every year (p. 3).

According to a 1996 report from the AIDS Division, Ministry of Public Health of Thailand, many studies and surveys have been conducted in Thailand by different institutes to document the extent of the HIV/AIDS epidemic. There are two major sources of statistics on HIV infections and AIDS cases: the AIDS Voluntary Reporting System and the Semi-annual Sentinel Seroprevalence Surveillance System.

The AIDS Voluntary Reporting System provides information on the number of persons affected with AIDS as well as other symptomatic HIV infections. This information is used primarily for the planning of community and hospital care. Meanwhile, the Sentinel Seroprevalence Surveillance System monitors the trends of the HIV/AIDS epidemic. This system is used to estimate the HIV situation among the general population and to project the extent of the HIV/AIDS epidemic in the future.

Since 1991, the Thai government has relied on the AIDS Voluntary Reporting System for the national overall AIDS cases. Health institutions and physicians have been encouraged to report the specific details of the cases anonymously to public health authority (AIDS Division, 1996). As in most countries in Asia, under-reporting of AIDS cases remain problematic ("AIDS moves on," 1995; Brown & Xenos, 1994, August).

Figure 1. Distribution of reported AIDS Cases by year of diagnosis in Thailand, September, 1984 to December, 1995.

Source: Division of Epidemiology, Ministry of Public Health.

Figure 1 (AIDS Division, 1996) shows the distribution of reported cases of AIDS by year of diagnosis from September, 1984, when the first AIDS cases were reported in Thailand, to the end of 1995. The cumulative number of reported AIDS cases (not the number of HIV-infected persons) from September, 1984 to December, 1995 is 36,500.

Figure 2 (AIDS Division, 1996) demonstrates the reported AIDS cases by type of transmission. The figure shows the numbers of different groups of people who got AIDS. The groups were categorized according to methods of HIV transmission. The data were collected from 1984 to March 31, 1996. Sexual intercourse (i.e., heterosexual male, heterosexual female, and homosexual/bisexual) accounts for about 79% of AIDS cases, while infection among intravenous drug users (IDUs) accounts for about 7% of the reported cases. The proportion of vertical transmission, or HIV transmission from infected mothers to their infants (vertical transmission), is almost 6%. Reports from the AIDS Division also indicated that more than 89% of the cases were in the age range of 15-49 years. A ratio of male to female was 5.4:1.

Another system to obtain data is the Sentinel Seroprevalence Surveillance System, a cross-sectional HIV serosurvey among specific population groups. Started in June, 1989, the survey has been carried out twice a year in June and December.

According to WHO (1991), the first survey covered 14 selected provinces throughout Thailand. Among the 14 provinces, five of them were considered the most popular tourist attractions: Bangkok, Chiang Mai, Chon Buri, Phuket, and Songkla. The second survey was expanded to include 31 provinces and later subsequent surveys covered all 76 provinces in the country. All surveys covered seven population groups:

Figure 2. Distribution of reported AIDS cases in Thailand by type of transmission, 1984-1986 (Data as of March 31, 1996).

Source: Division of Epidemiology, Ministry of Public Health.

intravenous drug users (IDUs), low-charge (low-income) and high-charge (high-income) female prostitutes, male prostitutes, male outpatients at sexually transmitted disease (STD) clinics, donated blood, and pregnant women in antenatal care clinics.

The HIV prevalence rates have increased among all groups since 1989. The groups with significantly high rates are low-charge and high-charge prostitutes, male outpatients at sexually transmitted disease clinics, and, recently, pregnant women. However, the trend of HIV infection among drug users has decreased since 1989. Figure 3 (AIDS Division, 1996) shows the HIV prevalence trends among selected groups from June, 1989 to June, 1994.

In 1991, the “Thai Working Group,” comprised of representatives from the Ministry of Public Health, Ministry of University Affairs, other governmental organizations (GOs), non-governmental organizations (NGOs), and WHO, developed estimates and projections on the number of people with HIV/AIDS in Thailand (AIDS Division, 1996). The group estimated that as of September, 1991, the cumulative number of HIV-infected persons in Thailand was 200,000 to 400,000. At the end of 1993, the number was updated to 700,000.

Based on the AIDS Division’s estimation, it was projected that, in Thailand, there might have been 6,000 to 30,000 HIV-infected persons developing AIDS annually from 1993 to 1997. The Thai Working Group also made long-term projections on the future number of Thai people with HIV/AIDS by the next decade. Assuming no significant changes in behavior since 1991, the group projected 2 to 4 million cumulative HIV infections and 350,000 to 650,000 cumulative cases of AIDS in Thailand by the end of

Figure 3. HIV prevalence among selected groups in Thailand.

Source: Data from HIV sentinel surveillance, Division of Epidemiology, Ministry of Public Health.

this century. However, in 1993, the National Economic and Social Development Board (NESDB) working group revised this figure, using more updated sexual behavior data, predicting that the estimated cumulative figure of HIV infections in Thailand in the year 2000 may be 1.3 million (p. 6).

Lyttleton (1994) noted that “[f]or most people in Thailand, AIDS remains a distant threat defined and described by the media” (p. 135). However, the author found that the AIDS situation in Thailand is severe, resulting from many factors:

There is a broad consensus that Thailand has all the prerequisites for rapid escalation of HIV transmission: a large number of heroin addicts, a large and heavily patronized commercial sex industry, an active gay population, many seasonally migrating workers and added to this, some 200,000 truck drivers many of whom ply the length and breadth of the country, stopping at the many truck-stop brothels. (p. 135)

Although the government has tried to fight against the spread of HIV infections and AIDS, it found that the AIDS campaign could present an obstacle to Thailand’s economic growth. According to Muecke (1992), the Thai government “benefits economically from the contributions of sex entertainment to tourism income . . .” (p. 896). When the tourism industry became Thailand’s major revenue, the government tried to attract as many tourists as possible. Muecke wrote that “[t]he role of foreigners in developing prostitution into a sex industry has been openly acknowledged by government officials. Government policy [in 1980] to promote tourism has included development of the sex trade” (p. 896).

Clement (1992) commented that “[a] much praised AIDS awareness campaign, which was launched in Thailand [in 1991] by an interim government, will be greatly toned down because it is undermining the country’s . . . tourist industry . . . [Public

Health] Ministry officials also claimed that a projection by the United Nations of the possible prevalence of HIV infection in Thailand by the year 2000—one in four adults—was “overblown” and that the spread of AIDS in the country had slowed considerably” (p. 1264).

The Thai government’s policy related to HIV/AIDS prevention focuses upon penalizing sex workers, to the neglect of other risk factors of HIV transmission (Muecke, 1992). The factors include high population mobility (De Jong et al., 1996), sexual tradition that endorses male sexual freedom (Ford & Koetsawang, 1991; Limanonda et al., 1995; Lyttleton, 1994; Muecke, 1992), and rare use of condoms (Shah et al., 1991). Despite the Thai government’s denial of the seriousness of the AIDS epidemic in the country (Clement, 1992), the government later realized that AIDS would affect the entire population unless it started conducting education and prevention campaigns nationwide. The government’s action has resulted in an increase in the AIDS prevention budget (Limanonda et al., 1995) and the cooperation between governmental organizations and non-governmental organizations in the fight against the spread of the disease (Limanonda et al., 1996; *The Program on AIDS*, n.d.).

At present, there is an increasing number of people with AIDS and other symptomatic HIV infection cases seeking medical and hospital care. By the end of the century, mortality resulting from AIDS could become the leading cause of death in Thailand. AIDS-related mortality among infants and young children will increase and may reverse many of the important gains made by effective national child health programs, such as the “Control of Diarrhoeal Disease and Expanded Program on

Immunization.” In addition, the number of orphans will become an increasingly larger problem since most parents who are HIV positive will not live long (Brown & Xenos, 1994, August).

HIV/AIDS Campaigns in Thailand

During the decade since the first AIDS case was reported, the Thai government together with governmental and non-governmental organizations have been implementing massive campaigns on HIV/AIDS prevention. The vigorous effort of individuals and organizations to fight AIDS has been recognized internationally. Such implementation has provided lessons that could help other countries to learn or to follow in Thailand’s footsteps to stop AIDS.

Because of the country’s need to control the AIDS epidemic, many programs and measures were introduced. They included the appointment of the Permanent Secretary of the Ministry of Public Health as chairperson of the National AIDS Committee (NAC), while later on the Prime Minister took on this role when AIDS became the serious health issue of the country (AIDS Division, 1996). Activities on AIDS prevention are integrated into the existing national health systems. Many HIV/AIDS prevention programs are also conducted by provincial health authorities as well as national and international non-governmental organizations.

Limanonda et al. (1995) found that the budget for HIV/AIDS prevention programs in Thailand had increased from 4.6 million Baht (U.S. \$200,000) in 1988 to 1.6 billion Baht (U.S. \$62 million). Mass communication campaigns on HIV/AIDS prevention and health education have been conducted by various groups (Limanonda et

al., 1996; *The Program on AIDS*, n.d.). Limanonda et al. noted that training programs for health personnel have been organized to enable those people to monitor the AIDS situation in the country. Moreover, condoms have been distributed on a free-of-charge basis and the first 100%-condom-use program in brothels was established in 1989 (Limanonda et al., 1995). Later the program became the official policy of the National AIDS Committee in 1991. The authors also found that policies regarding confidentiality in case reporting and non-discriminative care for AIDS patients were issued by the government. Medical care, counseling services, and free antiviral drugs to all full-blown AIDS patients who are unable to afford those needed services are provided in all provincial government hospitals (p. 4).

From 1984 to 1994, sex workers of both sexes were considered a primary high-risk group; therefore, the group received high attention from both governmental and non-governmental organizations working on AIDS. This group had a higher chance of both receiving and transmitting HIV through commercial and non-paying sexual partners. Findings from various studies showed high rates of HIV infection among commercial sex workers. Limanonda et al. (1995) also noted that “[t]he rapid transmission of HIV in Thailand is also facilitated by the fact that ‘visiting a prostitute’ among Thai men is still widely practiced while the practice of condom use is at relatively low rate” (p. 5). By using the services of commercial sex workers, Thai men have accelerated the spread of HIV into the general population, including their partners or spouses and their infants.

To combat and stop the spread of HIV/AIDS in Thailand, many education and information campaigns have been launched to promote knowledge concerning the

disease, build desirable HIV/AIDS perceptions (i.e., it is possible to live in the same house or work with an HIV-infected person), eliminate misunderstandings, and promote the practice of safe sex (Asian Red Cross and Red Crescent AIDS Task Force, 1997; Chaiyapet, Carl, & Jaiprayoon, 1996; Limanonda et al., 1996; Limanonda et al., 1995; Lyttleton, 1994; *The Program on AIDS*, n.d.; Shah et al., 1991).

At present, the AIDS pandemic in Thailand calls for outreach efforts that are based upon more effective theories of behavioral change that target and influence individuals at high risk for HIV/AIDS, especially secondary school and college students who are sexually active but have been overlooked (B. Kunachindaporn, personal communication, November 24, 1996; Chaiyapet et al., 1996). These sexually active people can contribute to a more severe situation unless they are educated to realize the seriousness of HIV/AIDS prevention (Limanonda et al., 1995).

The Program on AIDS, Thai Red Cross Society

In Thailand, there are many governmental and non-governmental organizations conducting HIV/AIDS prevention campaigns and research. The Thai Red Cross Society is one of them. The Society's Program on AIDS officially began in December, 1989. Before that time, between 1987 and 1989, the Society had carried out many HIV/AIDS activities as the Center for AIDS Research and Education of the Thai Red Cross Society. The Thai Red Cross also owns and operates Chulalongkorn Hospital, which has been providing care and support to people with HIV/AIDS since 1985 when the AIDS epidemic was in its earliest stage. The Society has published a booklet, *The Program on AIDS* (n.d.), which stated its role in HIV/AIDS prevention that the Society "has played a

leading role in defending the human rights of HIV-infected people, in educating the general public about HIV and AIDS and especially taking part in making progressive national policies and plans on AIDS” (p. 1). In addition, the booklet also provided information about the overall projects conducted by the Society:

The Society has also provided training in peer education skills and non-formal counseling to members of socially and economically disadvantaged groups such as slum dwellers, hilltribes, young people working in factories and sex workers. It has contributed significantly to the development of health promotion and life skills approach in AIDS education not only in Thailand but also in neighboring countries such as Myanmar [Burma]. It is also known for the first anonymous HIV counseling and testing center in Asia. The Thai Red Cross has also pioneered new ways of providing HIV-infected people and their families with information, medical care and psycho-social support. Through its AIDS program, the Red Cross works with people infected with HIV and families to conquer their fears and anxieties, to regain their sense of self-worth and self-confidence, and to face the future with a new sense of hope. (p. 1)

An out-patient clinic, the Immune Clinic, was set up at Chulalongkorn Hospital in late 1985 to follow-up patients with AIDS after they were discharged from the hospital. The clinic is divided into three main parts. The first part is the medical service together with preliminary counseling. The second part consists of the counseling service, which is staffed by specially trained nurses and a social worker. The role of the counselors is to provide information, help patients understand their situation, and come up with solutions to their problems.

The third part of the clinic is a support service provided by volunteers from the Wednesday Friends Club, an organization of HIV-positive people supported by the Society. The club also provides a hot line telephone counseling service for HIV-infected people, patients with AIDS, and their family. The people working for the hot line service

are volunteers who have received HIV counseling training from the Thai Red Cross Society.

The Wednesday Friends Club. In 1991, the Thai Red Cross Society's Program on AIDS assisted HIV-infected people and AIDS patients who had received the Society's treatment or counseling services to establish a club for people with HIV/AIDS (*The Program on AIDS*, n.d.). The name of the club is "Wednesday Friends Club" since the club members met every Wednesday in the past. According to the Society's booklet, the club's membership has grown to more than 1,000 members throughout the country. Its members help one another by providing psycho-socioeconomic support. The Wednesday Friends Club is the first of its kind in the country. The club is located at the headquarters of the Thai Red Cross Society in Bangkok.

The objectives of the club are as follows (B. Kunachindaporn, personal communication, June 26, 1996):

1. To be the center of communication among the HIV-infected people and AIDS patients.
2. To prepare newly infected people to face the upcoming situation and to educate them about AIDS facts and how to take care of themselves.
3. To boost morale among HIV-infected people and AIDS patients as well as their families.
4. To help provide members with cheap medication and donated medicine.
5. To disseminate updated news about HIV/AIDS information, new treatments, vaccines, and health tips.

6. To provide the general public with knowledge and a better understanding regarding HIV/AIDS and the infected people through the club's public outreach program.
7. To prevent people with HIV/AIDS from committing crimes.
8. To cooperate with other governmental and non-governmental organizations.

The club is working in cooperation with the "Bodang (Red Ribbon)" Drop-in Center for People Living with HIV/AIDS, which is another project of the Program on AIDS. Both organizations co-publish a newsletter called "Jodmaikao Soon Bodang (Red Ribbon Center Newsletter)." The newsletter's publication is funded by the Australian Agency for International Development (AUSAID).

Another activity of the Wednesday Friends Club is the public outreach program intended to create a better understanding of the general public toward HIV/AIDS and the HIV-infected people. It is an educational program consisted of a presentation by an HIV-infected volunteer, interactive games, and distribution of AIDS fact pamphlets. The speakers who are willing to reveal their HIV-positive status play a significant role in the program since their presentation is the heart of this educational campaign.

The public outreach program, which is funded directly by the Thai Red Cross Society, was first aimed at students in secondary schools, vocational schools, and colleges because students from 15 to 22 years old are sexually active (B. Kunachindaporn, personal communication, November 24, 1996). Now the program has been expanded to cover workers in the industrial and service sectors. This group is a growing segment of young people who have not continued their education; therefore, they may not be able to have access to adequate information on HIV/AIDS prevention.

Crowds of up to 1,000 people have been reported attending each presentation. The size of the audience depends on the size of the institution or the factory. The date and venue of each presentation is decided by the people who made a request or by the staff. Usually the public makes a request for the program's presentation. However, the club also promotes its outreach program by occasionally sending press releases to newspapers and magazines.

Some of the more than 10 people who run the club are HIV positive and willing to reveal their secrets to the general public. Most of them work voluntarily. Only a few of the permanent staff receive small monthly payments. According to the staff, the use of interpersonal communication techniques in their outreach program has been effective; however, no survey or study has been conducted to measure the effectiveness of the message (B. Kunachindaporn, personal communication, June 26, 1996).

The HIV AIDS Prevention for Slum Communities Project. Another public outreach campaign of the Thai Red Cross Society's Program on AIDS is a community-based educational campaign called "the HIV/AIDS Prevention for Slum Communities Project." The campaign started in May, 1993 with financial support from a Norwegian non-governmental organization. At present, the campaign is funded by the Ministry of Public Health of Thailand. The project, which targets slum dwellers in the Bangkok metropolitan area, is now run by five team members together with the help of Thai Red Cross officials and health volunteers (T. Suthikiri, personal communication, November 17, 1997).

The objectives of the project are to educate Bangkok slum dwellers, who live in all 50 districts of the Bangkok metropolitan area, about sexually transmitted diseases and HIV/AIDS and to help them develop skills in HIV/AIDS prevention. The skills being taught include those in common health care and how to survive in the big city economically and socially. The project aims at poor and uneducated people at the family and community levels. After four years, the project has covered 13 districts in Bangkok. There were 54 slum communities reached by this project by the end of 1996; each community has a population of at least 5,000. Currently, the staff members and volunteers have been working in 10 communities in the Ratchathewi District (T. Suthikiri, personal communication, November 17, 1997).

The five staff members train Red Cross health volunteers to help them conduct educational activities on the sites. The media used in the activities are slides, videotapes, posters, flip charts, brochures, books, and comic books with HIV/AIDS prevention themes. They play educational games with the slum dwellers, have conversations with them, and give advice on HIV/AIDS and other problems. Interpersonal communication is the major approach used in this project.

The project publishes a newsletter called “Jodmaikao Chumchon Sampan (Community Relations Newsletter)” every three months to provide updated news about the community, project activities, special events, and HIV/AIDS information (T. Suthikiri, personal communication, November 17, 1997).

Facts for Life: Curriculum for Youth, Red Cross Youth Division. Another project of the Program on AIDS, Thai Red Cross Society, is a peer-based HIV/AIDS educational

campaign called “Facts for Life: Curriculum for Youth,” which is conducted by the Red Cross Youth Division. The project started in 1996 with financial support from the Asian Red Cross and Red Crescent AIDS Task Force (ART). This organization, established in 1994, “is a regional working group of professionals and volunteers nominated by 12 Red Cross and Red Crescent Societies in Asia to promote HIV/AIDS activities at the grass roots level” (ART, 1997, p. 1).

The objectives of the project are as follows (Chaiyapet, 1996; S. Chaiyapet, personal communication, June 19, 1997; Chaiyapet, Carl, & Jaiprayoon, 1996):

1. To educate youths about sexually transmitted diseases (STDs) and AIDS, prevention from infection, and care for persons with HIV/AIDS.
2. To provide training in counseling skills for peer educators to help others overcome irrational fears and misconceptions regarding HIV/AIDS and HIV-infected people.
3. To support peer educators in their group activities regarding sexually transmitted disease and AIDS prevention.
4. To help participants develop and practice skills in rational thinking, good decision making, problem solving, and interpersonal communication.
5. To develop participants’ confidence in their abilities to educate their peers so that they contribute to the reduction of the risks of HIV infection among their friends.

The Facts for Life project begins with training of peer educators (or facilitators) in how to use the curriculum and facts about sexually transmitted diseases and HIV/AIDS, family planning, counseling techniques, narcotics, and activities of the Red Cross Youth.

The trainees are school and college students in the Red Cross Youth program. Each facilitator and an assistant then lead a group discussion in school or college. The size of the group is 10-15 people, including peer leaders. The project's staff may observe the discussions and help the facilitators if they have problems. Currently, about 30 peer facilitators have been trained (S. Chaiyapet, personal communication, June 19, 1997).

In school, the discussion begins in an introductory meeting after all the group members and facilitators introduce themselves to one another. After that, they meet again—probably every week—and continue their discussion about life, their goals in life, how to reach the goals, their future obstacles (e.g., diseases, sexually transmitted diseases, HIV/AIDS, and narcotics), and how to prevent them. Another format of the Facts for Life meetings is to complete all activities within two days following the same manual used in the first format.

By the time the group members reach the seventh session, which is the last, they should obtain the knowledge to take care of their own health as well as that of family members, develop positive attitudes towards HIV-infected people, and be able to provide basic care for persons with HIV/AIDS (Chaiyapet, 1996; S. Chaiyapet, personal communication, June 19, 1997).

In conclusion, the three public outreach campaigns of the Program on AIDS, Thai Red Cross Society, (i.e., the Wednesday Friends Club, the Slum Communities project, and Facts for Life) share significant similarities which are the characteristics of the projects and their approaches. The three projects are being conducted at the community level, use mixed media to disseminate the messages, and, most importantly, use

interpersonal communication as the major approach to reaching the target audience (B. Kunachindaporn, personal communication, November 24, 1996; Chaiyapet, Carl, & Jaiprayoon, 1996; S. Chaiyapet, personal communication, June 19, 1997; T. Suthikiri, personal communication, November 17, 1997).

Interpersonal communication appears to contribute to the increase in awareness, knowledge, and behavioral changes among Thai people regarding HIV/AIDS. Shah et al. (1991) found that, in addition to mass media, relatives, friends, and health personnel played an important role as the source of HIV/AIDS information for low-educated women living in Bangkok. Moreover, the authors noted that “business and professional women heard about AIDS from friends and relatives more than those who had no occupation or who worked in the service sector” (p. 1289). HIV/AIDS-related topics appear to have been discussed widely in Thai society already. Therefore, the use of interpersonal communication in the three Red Cross projects is suitable for their Bangkok participants.

Overview of Literature and Framework for Study

The framework that will be used to study the three AIDS campaigns conducted by the Thai Red Cross Society was outlined by Flay and Burton (1990) as “necessary conditions for effective campaigns” (p. 132). These conditions were condensed into a short sequence of seven steps. The authors suggested that public communication campaigns, especially health-related ones, should follow these seven steps to be maximally effective:

1. [D]evelop and use high quality messages, sources, and channels;

2. [D]isseminate to the target audience;
3. [G]ain and keep the attention of the audience;
4. [E]ncourage favorable interpersonal communication about the issue;
5. [C]ause changes in behaviors of individuals, along with awareness, knowledge, opinions, attitudes, feelings, normative beliefs, intentions, or skills;
6. [C]ause broader societal changes;
7. [O]btain knowledge of effects through summative evaluation. (Flay & Burton, 1990, p. 132)

The literature can be related to the aforementioned framework step by step. The first step, which concerns the development and use of messages, sources, and channels, is firmly supported by research by Atkin and Arkin (1990), Manoff (1985), Solomon (1981), and Wallack (1990). The researchers noted the importance of message development as well as the right choice of sources and channels in their studies of the use of social marketing in public health campaigns. Mendelsohn (1973) suggested that campaign practitioners, using an approach similar to advertising, should come up with messages and media that are suitable for the audience to overcome public apathy. Bush and Boller (1991) discussed the benefits of the use of television and PSAs in public health campaigns.

The second step of disseminating the messages to the target audience, a key factor in campaign design, is related to almost all the studies in the literature review, particularly the studies of Backer et al. (1992), Brown (1991), Flay and Burton (1990), and those of social marketing (Atkin & Arkin, 1990; Manoff, 1985; Solomon, 1981;

Wallack, 1990). Flay and Burton wrote that public health campaigns should target not only the general public but also specific sub-groups or high-risk groups. Manoff even wrote that the first thing to do in campaign design is to analyze the target audience for segmentation because the audience's characteristics will determine the campaign's design (Flay & Burton, 1990).

The third step of gaining and keeping the attention of the target audience is described in the studies of Brown (1991), de Vroome et al. (1994), and Træen (1990). The researchers conducted HIV/AIDS prevention and education campaigns aimed at teenagers or young adults. They found that the use of media and approaches that could be related to the target audience produced desirable results. Educational videotapes or television programs presented by the audience's peers, pop songs, and other peer-related media used in the campaigns could gain the attention of the audience as well as improve the awareness and knowledge about HIV/AIDS and safe-sex activities.

The fourth step, encouraging favorable interpersonal communication about the issue, is consistent with studies by Backer et al. (1992), Brown (1991), Catford et al. (1984), Chaffee (1981), de Vroome et al. (1994), Engelberg et al. (1995), Flay and Burton (1990), Maccoby and Solomon (1981), McAlister (1981), Robinson (1981), Shah et al. (1991), Sheer and Cline (1995), and Solomon (1981). Maccoby and Solomon found that the success of their campaign, the Stanford Heart Disease Prevention Program, resulted from "the quality of the media campaign and . . . the synergistic interaction of multiple educational inputs and . . . interpersonal communication stimulated by application of these inputs in a community setting" (p. 115). The integration of mass and

interpersonal communications has been proven to be the most effective approach for public health campaigns by the aforementioned researchers.

The fifth step, which suggests that campaigns need to result in changes in awareness, knowledge, attitudes, and behaviors of the target audience, is criticized by some authors. Hyman and Sheatsley (1947) and Alcalay (1983) argued that public information campaigns usually do not result in attitudinal or behavioral changes in the audience. However, other researchers, such as Flay and Burton (1990), McAlister (1981), and Robinson (1981), contend that a complementary approach of mass media and community-based interpersonal interventions will help campaign practitioners to achieve not only changes in awareness and knowledge, but also changes in attitudes, beliefs, and behaviors; moreover, with sustained educational interventions at the community level, the audience appeared to be able to maintain the changes for a long period of time (Maccoby & Solomon, 1981).

The sixth step concerns the effect of campaigns on the society. This step is consistent with the study of Maccoby and Solomon (1981) as well as that of Flay and Burton (1990). Flay and Burton found that to achieve societal changes, it had to begin with “the accumulation of individuals who have changed” because of the campaign (p. 143). These individuals will lead to a change in social norms which, in turn, will lead to changes in the society. The authors noted the relationship between individual effects and interpersonal communication as follows:

Whether the target of change is health behavior or voting behavior, ultimately the level of societal change depends on both the kind and amount of individual change and the degree of interpersonal communication. . . . A campaign targeted to individuals can lead to social changes if enough of those individuals discuss it

with others—especially with politicians and other opinion leaders in a position to bring about changes. (p. 142-143)

Thus, the distinctive quality of interpersonal communication can contribute to the range of campaign effects, which is from the individual level to the societal level (Backer et al., 1992; Flay & Burton, 1990).

Finally, the seventh step, which concerns accumulating knowledge about the conditions of impact through summative evaluation, is discussed by Alcalay (1983), Bush and Boller (1991), Flay and Burton (1990), Limanonda et al. (1996), Limanonda et al. (1995), Robinson (1981), Singer et al. (1991), and Stroman and Seltzer (1989). The researchers who studied or conducted HIV/AIDS prevention campaigns concluded from the evaluation of their campaigns and other campaigns in the past that interpersonal communication would contribute to the effectiveness and long-term impact of their campaigns and they suggested this approach be conducted in future campaigns (Brown, 1991; de Vroome et al., 1994; Engelberg et al., 1995; Limanonda et al., 1996; Limanonda et al., 1995; Sheer & Cline, 1995; Træen, 1990). Flay and Burton noted that, although the knowledge about effects and impact might not influence the success of the already implemented campaigns, it would influence the design and effectiveness of other campaigns in the future. Therefore, such knowledge would prevent other campaign practitioners from repeating old mistakes.

This concise seven-step framework covers every significant issue that contributes to campaign effectiveness (Flay & Burton, 1990); therefore, it can be applied to the study of HIV/AIDS education and prevention campaigns in Thailand. The framework was practical when it was adapted for use with a case study of three outreach campaigns of

the Thai Red Cross Society's Program on AIDS: (1) the Wednesday Friends Club, (2) the HIV/AIDS Prevention for Slum Communities Projects, and (3) Facts for Life: Curriculum for Youth, Red Cross Youth Division.

Research Questions

The research questions were developed in parallel with the seven steps of Flay and Burton (1990), but the case study put its emphasis on the first four steps:

1. The development and use of high-quality messages, sources, and channels.
2. Disseminating to the target audience.
3. Attracting and keeping the attention of the audience.
4. Encouraging interpersonal communication about the issue.
5. Causing changes in awareness, knowledge, attitudes, beliefs, and behaviors of individuals.
6. Causing changes in the society.
7. Accumulating knowledge of campaign effects through summative evaluation.

Five research questions were developed from the first four steps of Flay and Burton (1990). According to Manoff (1985), audience segmentation should be the first priority of campaign design; therefore, the research questions deal with the target audience first. The research questions of this case study are as follows:

1. What is the target audience of each of the three projects?
2. What does each of the three projects do to attract the target audience?
3. In each of the three projects, what messages are being disseminated, by what sources, through which channels?

4. What is the role of mass media in the dissemination of HIV/AIDS information?
5. How does interpersonal communication supplement mass communication in the dissemination of HIV/AIDS information?

CHAPTER III

Method

This thesis is a case study on the three Thai Red Cross public outreach campaigns (i.e., the Wednesday Friends Club, the HIV/AIDS Prevention for Slum Communities Project, and Facts for Life: Curriculum for Youth, Red Cross Youth Division). The researcher made three trips to Thailand. Field work was conducted in Bangkok during the third trip, from December, 1997 to February, 1998. Dr. Praphan Phanuphak, director of Program on AIDS, Thai Red Cross Society, granted permission to conduct the case study on June 26, 1997 (see Appendix B). The Society provided assistance and cooperation in the course of the case study. However, there was no financial support for this study. Serena W. Stanford, associate vice president, Graduate Studies and Research, San Jose State University, granted permission to conduct the case study on December 12, 1997, after the request to use human subjects in the study was approved by the Human Subjects-Institutional Review Board (see Appendix C).

Data Gathering Techniques

According to Yin (1994), data gathering for case studies could rely on many sources of evidence. The author suggested the use of as many as six sources, which are documentary analysis, archival records, interviews, direct observation, participant-observation, and physical artifacts. The more sources used in a case study, the more complementary they would be. Because a major strength of case study data collection is the opportunity to use different sources of evidence (Yin, 1994), the method of this case

study includes triangulation of documentary analysis, direct observation, and in-depth interviews.

Documentary Analysis

Yin (1994) stated that “documentary information is likely to be relevant to every case study topic” (p. 81). For this case study, documentary analysis will be conducted.

The following information and documents were collected and analyzed:

1. Studies and evaluations of each campaign.
2. Information on the internal communication process (e.g., management and staff relations).
3. Internal documents and additional information regarding each campaign.
4. The funding process for each campaign (i.e., how much it receives, from whom, by what method).
5. External communication (e.g., published pamphlets, newsletters, recruiting system, press releases, connections to the governmental and non-governmental organizations).

The documentary analysis has contributed to a better understanding of each campaign. The results help identify strong points as well as weak ones that need improvement. The analysis has provided a closer look at the program’s formation and point out what to be reinforced or what to be changed, leading to a more effective outreach campaign in the future.

Direct Observation

Stake (1995) and Yin (1994) pointed out that observation would be useful in providing additional information and better understanding of the topic being studied. Yin noted that relevant behaviors or environmental conditions would be available for direct observation, whether it be formal or casual data collection.

For this case study, another method is conducting direct observations of the meetings in which the HIV/AIDS educational activities of each project took place. In each project, educational presentations and interactive activities, such as HIV/AIDS knowledge testing games, were observed to determine what messages were being disseminated, to what kind of audience, by what sources, and through which channels. The activities, interpersonal communication, and the media used in the projects were observed and analyzed to determine whether they are suitable to increase HIV/AIDS knowledge and preventive skills and to determine whether they are relevant to the target audience.

Each of the three outreach campaigns was observed at least twice, depending on the times when the campaigns' meetings were held during the field work period. Every direct observation of each project was conducted in the presence of the project's staff member. The results from the observations have given an overall picture of how the project works and how interpersonal communication is presented.

In-depth Interviews

The last method used in the case study is conducting in-depth interviews. According to Yin (1994), the interview is one of the most important sources of case study

information. Personal in-depth interviews were conducted with primary sources, which include the people who are working on the three campaigns as well as others who are involved in HIV/AIDS education and prevention campaigns, such as government officials, social workers, and researchers. Most of the prospective interviewees were previously contacted. Many had expressed their willingness to cooperate with the study before they were to be interviewed. Every effort was made to conduct personal interviews. However, the interviews were conducted depending on the availability of the primary sources during the field work period. Despite the effort, the Director of the AIDS Division, Ministry of Public Health, Dr. Wiput Phoolcharoen, was not available for a face-to-face interview; therefore, the subject was interviewed by phone. Since the interviewees were to be used as primary sources, all the interviews were tape recorded. Permission to tape record was asked prior to the interview.

Most of the information needed was obtained from the interviews that were conducted with staff members who work on each of the three campaigns. Most of the staff members work on the projects voluntarily. Many of them work without salary and some receive only a small monthly payment, although their incomes are very low. Their opinions about the campaigns and what they are doing are very useful data. The interviews have offered these people a chance to talk about their experiences on the projects, their expectations, the problems they have seen, and their suggestions.

Staff members on the three campaigns were asked the following questions:

1. What kind of training did you receive to be able to work in the project? How long was the training?

2. What group of people are you trying to reach in terms of (a) gender, (b) age, (c) education, (d) income level, and (e) occupation?

3. According to your observations, what kind of people, in terms of (a) gender, (b) age, (c) education, (d) income level, and (e) occupation, are most likely to attend the meetings and to be interested in the subjects discussed there?

4. In this project, what is your role in disseminating the AIDS messages to the audience? How do you do this? Who designed the messages?

5. What are the themes of the messages that are being addressed in your project? What are the contents of the messages? What are the key points you are trying to emphasize?

6. Is the language in the messages the one spoken by the participants? What is the language spoken? What kind of techniques is used to enable the participants to relate themselves to the contents of the messages?

7. According to your observations, what kind of messages have the participants found most receptive?

8. I know that sex is still a taboo subject in Thai society. Do you think the Thai culture affects the way you talk to the audience about AIDS and how to practice safe sex? How does it affect the way you are trying to get these messages across? In what way?

9. What has been more effective to get the messages across: distribution of handouts, media presentations of AIDS-related topics, interpersonal communication, or a larger AIDS campaign?

10. Which sources have the participants found the most credible: (a) printed materials, such as handouts and brochures; (b) mass media presentations, such as videotapes; or (c) interpersonal communication?

11. To what extent do you think the participants listen to the activity or project leaders? Do they appear to believe in what the leaders have said? How can you tell?

12. In this project, what type of media are used to generate the AIDS information: handouts, brochures, billboards, or mass media? What kind of media are the most popular among the participants? Is it because the messages that are conveyed through the particular media can be easily related to the participants? What media do they find less interesting? Why?

13. Outside the meetings, what type of media do the participants have access to? What kind of messages have they got from those media?

14. According to your experiences, what is the most effective way to teach the AIDS preventive skills: (a) having participants look at AIDS posters, (b) having them read books or brochures about AIDS, (c) having them watch videotapes about AIDS, (d) playing games with them, or (e) having conversations about AIDS with them? What is the least effective?

15. According to your experiences, what kind of techniques can reach the audience better: mass media, group discussions, face-to-face conversations, or all the mentioned techniques conducted at the same time? Why?

16. What are the most effective interpersonal communication techniques, such as group discussions, formal conversations, and informal conversations? Why are the particular techniques more effective than the others?

17. What are the problems in the project? Is funding one of the problems? How do the problems occur and how can they be solved?

Government officials, researchers, and social workers were asked the following questions:

1. When did Thailand start launching HIV/AIDS education and prevention campaigns? What kind of campaigns have been conducted? What are the stages of AIDS campaigns that have been conducted in the country? What is the current stage?

2. What kind of audience has been reached by those campaigns in terms of (a) gender, (b) age, (c) education, (d) income level, and (e) occupation?

3. What kind of media have been used? Are mass media still being used in current campaigns? If yes, what are the mass media used—in what campaigns?

4. What kind of media can reach the largest group of audience? What kind of media is the least effective?

5. What are the overall results of the AIDS campaigns that have been already conducted?

6. Have you ever conducted any HIV/AIDS prevention campaign? What is it about? What is the target audience? What are the messages, media, and techniques you have used to disseminate the messages? What is the result? Are you satisfied with the result? Why or why not?

7. According to your experiences, what is the most effective communication technique to convey HIV/AIDS educational messages?

8. What is your opinion about the use of interpersonal communication in HIV/AIDS educational campaigns? What is more effective: the use of interpersonal communication, the use of mass media, or both when they are conducted at the same time?

9. What kinds of campaigns are most needed to be launched regarding the current AIDS situation in Thailand? What kind of target audiences are yet to be reached? What kind of AIDS prevention messages are yet to be disseminated?

10. In school, should the subject of sexual education emphasize on condom use, sexually transmitted diseases, and AIDS? Why or why not? What age group should this subject be taught? What kind of campaigns should be conducted to support the effectiveness of sexual education in school?

11. What are the problems you have found when conducting campaigns/research on AIDS? Is funding one of the problems?

12. Has the Thai government provided enough funds to conduct HIV/AIDS prevention campaigns? How much money has been spent approximately? What are the other sources of funds?

The following list consists of the people who were interviewed and the manner in which each interview was conducted:

1. Paisal Suwannawong, project manager, Wednesday Friends Club, Program on AIDS, Thai Red Cross Society, personal interview conducted in Thai.

2. Malee Suphonphak, counseling officer, Wednesday Friends Club, Program on AIDS, Thai Red Cross Society, personal interview conducted in Thai.
3. Manop Pasuk, project manager, HIV/AIDS Prevention for Slum Communities Project, Program on AIDS, Thai Red Cross Society, personal interview conducted in Thai.
4. Uemporn Navy, project coordinator, Facts for Life: Curriculum for Youth, Red Cross Youth Division, Thai Red Cross Society, personal interview conducted in Thai.
5. Praphan Phanuphak, director, Program on AIDS, Thai Red Cross Society, personal interview conducted in Thai.
6. Greg Carl, researcher, Program on AIDS, Thai Red Cross Society, personal interview conducted in English.
7. Nimit Tienudom, social worker, Northern AIDS Prevention Project, ACCESS, personal interview conducted in Thai.
8. Yooth Bodharamik, Director-General, Department of Communicable Disease Control, Ministry of Public Health, personal interview conducted in Thai.
9. Wiput Phoolcharoen, director, AIDS Division, Department of Communicable Disease control, Ministry of Public Health, telephone interview conducted in Thai.
10. Nuntawun Yuntadilok, chief, Preventive Behavior and Social Development Section, AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, personal interview conducted in Thai.

11. Patanapong Chatiketu, researcher and Ph.D. candidate, Bangkok University, personal interview conducted in English.

The integrated data obtained from the triangulation of documentary analysis, direct observation, and in-depth interviews not only answer the research questions in this case study, but also provide suggestions useful for the development of a more effective HIV/AIDS educational campaign in the future.

CHAPTER IV

Findings

Overview of the AIDS Campaigns in Thailand

In 1983, the Division of Epidemiology, Ministry of Public Health, first reported the news of the HIV/AIDS outbreak in the United States (Kunanuson, 1998). Therefore, Thai physicians were able to follow the first AIDS case when the first Thai patient, who was in the full-blown stage of AIDS, returned from the United States after having been diagnosed as having AIDS and, in 1984, was hospitalized in one of the government hospitals in Bangkok and died in the same year (Population and Community Development Association, n.d.). However, during the first few years in the mid-1980s when AIDS first entered Thailand, AIDS was viewed as one of many issues of public health (Ungphakorn & Sittitrai, 1994). Therefore, the government had not yet launched any campaigns to inform the general public about the danger of this deadly disease (Kunanuson, 1998). From 1986 to 1987, the government sector that was in charge of the HIV/AIDS surveillance and contact tracing was the Venereal Disease Division, Department of Communicable Disease Control, Ministry of Public Health. The Ministry of Public Health “was the key player in determining and implementing national AIDS policies and strategies” during that time (Ungphakorn & Sittitrai, 1994, p. 155).

Regarding the media, Lyttleton (1996), citing the research of Serii Wangpaichit et al., found that “[i]n the mid to late 1980s, as the epidemic was slowly being recognized in Thailand, it was primarily print media that relayed warning information about

HIV/AIDS” (p. 363). Therefore, only a small group of the Thai population, mostly in big cities, was informed about the disease and its consequences.

Yuntadilok (1997) noted that, from 1984 to 1987, infections occurred primarily among homosexuals. Then, in 1987, there was a sharp increase of the HIV infection rate among intravenous drug users (IDUs). Soon after the infections among the first two groups, the HIV infections were detected in commercial sex workers. Yuntadilok found that the first cases of heterosexual HIV epidemic occurred in the late 1980s. The Minister of Public Health of Thailand informed the general public in 1989 that there was an AIDS epidemic among heterosexuals, in addition to that among intravenous drug users. In 1990, the Prime Minister announced that the HIV/AIDS prevention and control had become a national priority (Yuntadilok, 1997).

Currently, Thailand has had at least 10 years of HIV/AIDS prevention campaigns. Kunanuson (1998) divided the development process of the HIV/AIDS prevention campaigns conducted by the government from 1987 to the present into three phases as follows:

1. Health education and social campaigns (1987-1990).
2. Multisectorial collaboration campaigns (1991-1995).
3. Community mobilization campaigns (1996-present).

Health education and social campaigns (1987-1990). The goal was to create awareness about AIDS among the Thai people in general. The public was informed about the danger of the disease and the risk behaviors. Because AIDS was first seen as a health issue, the primary responses and health education messages from Thai health

authorities were formed on the basis of “the imported ideas of *risk groups*, [as] applied from the conventional communicable disease perspective” (Yuntadilok, 1997). The Ministry of Public Health declared that AIDS was a serious infectious disease; therefore, the Ministry required detailed notification of all cases of HIV infection and AIDS found in Thailand (Ungphakorn & Sittitrai, 1994). Kunanuson (1998) as well as Ungphakorn and Sittitrai also noted that, in 1985, the government started to ban foreign nationals infected with HIV from entering the country.

Since AIDS was declared a “serious infectious disease,” the groups considered to be “risk groups,” such as intravenous drug users and commercial sex workers, were tested for the HIV antibody. Ungphakorn and Sittitrai (1994) found that the widespread HIV testing was not done properly:

These tests were generally carried out without pre-test counseling, informed consent, or proper post-test counseling. All known sex workers were required to carry pink health cards detailing the results of quarterly HIV-antibody tests. Those who tested positive had their health cards taken away and were supposed to be sent home to their families, although this rarely happened. (p. s155)

The Ministry of Public Health and other governmental health sectors were in charge of campaigning in this phase. All kinds of media were heavily used, including mass media (e.g., the press, television, and radio), printed materials (e.g., handouts, brochures, posters, and booklets), and billboards. The government tried to use everything in its hands to disseminate HIV/AIDS information.

HIV/AIDS education and mass media campaigns were launched by the government in collaboration with some other non-governmental organizations. Those campaigns put an emphasis on the HIV infections transmitted by groups perceived to be

at risk (Ungphakorn & Sittitrai, 1994; Yuntadilok, 1997). Ungphakorn and Sittitrai pointed out that “[f]or many years this created a misleading perception that people were at risk because they were members of a group rather than because they [practiced] risk [behaviors]” (p. 155).

Regarding the broadcast campaigns, Lyttleton (1996) found that, since 1989 the government has been disseminating prevention and education information “with the amount of material appearing on television and radio far exceeding that found in many Western countries” (p. 364). HIV/AIDS campaigns have been broadcast in many forms, as categorized by Lyttleton as short spots, minidramas, full-length docudramas, and documentaries. The author found that the short spots not only received more airtime, but were also more likely to be watched since they did not require high viewing time. All of the spots had dramatizations and verbal educational messages.

The messages disseminated from the mass media in this period often linked the HIV infection and AIDS to death. The language used in the messages was judgmental when it mentioned the behaviors and lifestyles that were considered at risk (Ungphakorn & Sittitrai, 1994). The television spots that were geared to educate people about HIV/AIDS often blamed, although sometimes indirectly, the people who supposedly belonged to the risk groups for the spread of AIDS. Therefore, this style of campaign has resulted in a social stigmatization that is very difficult to change—the one that puts the blame on the so-called risk groups: intravenous drug users, homosexuals, and commercial sex workers (Ungphakorn & Sittitrai, 1994; Lyttleton, 1996; Yuntadilok, 1997).

Multisectorial collaboration campaigns (1991-1995). The goal was to put an emphasis on collaboration among the government, non-government sectors, and business sectors to fight against AIDS. The campaigns in this period carried the message that AIDS had not only become a serious public health problem, but also a major socioeconomic issue. Yuntadilok (1997) stated that studies conducted in Thailand showed that the use of *risk group* labeling had resulted in negative attitudes toward people who supposedly belonged to the groups of intravenous drug users, homosexuals, and commercial sex workers as well as people with HIV and AIDS. The author wrote that such a paradigm was “too narrow to address the . . . social, cultural, and economic forces which created the epidemic in Thailand” (p. 3). Therefore, the campaign approach in this period was broadened by the Thai government to include the greater influence: the social environment.

One of the accomplishments in this phase was the founding of the National AIDS Prevention and Control Committee in 1991. The Prime Minister then became the chair of the committee. Later it was called the National AIDS Committee (NAC) and every Prime Minister must be appointed as chairperson of this committee. Its responsibility is to oversee all the campaign work and to initiate national policies on HIV/AIDS. According to Yuntadilok (1997), it was during this phase that the first 5-year national AIDS prevention and control plan was drafted. Regarding the plan for 1992-1996, Ungphakorn and Sittitrai (1994) wrote that “[t]his was the first AIDS plan in the world to be developed within the framework of a National Plan for Social and Economic Development” (p. s156).

The media used in this period were quite the same as those used in the first phase. In addition to the media, national HIV/AIDS seminars and forums were held to generate the much needed cooperation among campaign practitioners and the governmental and non-governmental organizations involving in the HIV/AIDS prevention and education campaigns. Ungphakorn and Sittitrai (1994) summarized the campaign work in this period as follows:

Public education [programs] on AIDS became the joint responsibility of several ministries and government departments, responsible for different target groups. AIDS campaigns through government radio and television stations intensified, with more diverse messages, including appeals for understanding of people living with HIV/AIDS. AIDS education was gradually introduced into the primary and secondary school curriculum, adult education, institutes of higher education, and factories and companies. (p. s157)

However, both researchers stated that the Thai government appeared to have used a top-down approach when it was conducting campaigns to promote HIV/AIDS prevention. The researchers studied campaigns that were launched by the Ministry of Public Health, the Bangkok Metropolitan Administration (BMA), and other governmental organizations and found that those agencies had started using messages that emphasized traditional family values and morals (e.g., refraining from premarital sexual relationship, keeping sexual abstinence, and tightening family ties). Meanwhile, condoms (which suggest promiscuity) were still being distributed by the agencies. Therefore, the promotion of morals and family values might contradict that of condom use. The researchers wrote that “[t]his type of . . . campaign message, representing official wishful thinking, may be suitable for certain target groups [that carry the values promoted] . . . , but may also alienate large sections of society whose . . . values and

lifestyles clash with the values promoted” (p. s159). Because of the differences in the target groups, they noted that solutions to HIV/AIDS problems used in the campaigns should be based on the values and characteristics of each group.

Community mobilization campaigns (1996-present). The goal is to expand the campaign network from the national, regional, and provincial levels to reach the community level. The government found that the nation’s social and economic development had caused the rapid growth of materialism that resulted in the erosion of family values and morals in Thai society. Therefore, collaboration at the community level—among governmental and non-governmental organizations, local community leaders, and the people in the communities—would help stimulate the desired improvement of AIDS knowledge and life skills of the people. A crucial instrument that would help the government achieve its goal of reaching the community level was the new national AIDS plan, which was drafted during the transitional period between the last two phases of AIDS campaigns in Thailand.

The new 5-year (1997-2001) National Plan for Prevention and Alleviation of HIV/AIDS has been enforced since 1997 (National AIDS Committee, 1997). During the planning process, various governmental and non-governmental organizations as well as representatives from groups of people living with HIV/AIDS participated in the drafting of the plan (Yuntadilok, 1997). The plan consists of strategies to create a social environment that is conducive to HIV/AIDS prevention and education in the country. According to the plan, which was written by the Nation AIDS Committee (NAC, 1997), the strategies are as follows:

1. Developing the ability of individuals, their families, and communities in HIV/AIDS prevention and in coping with the consequences of AIDS.
2. Developing a socioeconomic environment that is conducive to HIV/AIDS prevention and supportive for HIV-positive as well as AIDS patients.
3. Developing a psycho-social environment that enables people living with HIV/AIDS to lead a normal life within the society.
4. Improving basic services existing in the socioeconomic system to assist in managing the problems caused by HIV/AIDS.
5. Expanding health promotions and medical services for HIV-infected people and AIDS patients.
6. Utilizing AIDS-related knowledge and research more effectively to help the process of HIV/AIDS prevention and control.
7. Enhancing international cooperation in the regional level as well as technological and technical transfer.
8. Revising and strengthening management structures and mechanisms for dealing with HIV/AIDS.

In this last phase, the Thai government no longer pursues its mass media “blanket” campaign. The use of media has been shifted to another level: the use of medical and health personnel, trained peer leaders, and local volunteers as the major source to reinforce the media’s messages and to educate people at grass-roots level.

According to Kunanuson (1998), government funding for HIV/AIDS prevention and control in Thailand was first given to the Venereal Disease Division, Department of

Communicable Disease Control, Ministry of Public Health, in 1989 as part of the budget for sexually transmitted disease control. In the same year the AIDS Division was founded (Yuntadilok, 1998). Then, in 1991, the government started dedicating a certain amount of the national budget to solve the AIDS problems. The money goes to all ministries involving in the national HIV/AIDS campaigns.

Regarding the national budget for HIV/AIDS, Kunanuson (1998) noted that the budget had increased over the years, from 180.7 million Baht (U.S. \$7.4 million) in fiscal 1991, to 637.5 million Baht (U.S. \$26.5 million) in 1992, to 1,121.5 million Baht (U.S. \$46.7 million) in 1993, to 1,142.5 million Baht (U.S. \$47.6 million) in 1994, to 1,558.3 million Baht (U.S. \$62.3 million) in 1995, and to 2,057.1 million Baht (U.S. \$82.3 million) in 1996. Since 1993, all the government's 14 ministries have submitted requests for funding to the Budget Bureau to support their HIV/AIDS prevention and education activities conducted at the central, regional, and provincial levels (Ungphakorn & Sittitrai, 1994). The budget each of the ministries received also increased from time to time. The Ministry of Public Health usually receives the highest proportion of the budget for HIV/AIDS. However, the national economic crisis that began in July, 1997, has resulted in the decrease of the national HIV/AIDS budget, from about U.S. \$67 million in 1997 to probably as low as about U.S. \$26 million in 1998, according to information Dr. Wiput Phoolcharoen, director of the AIDS Division, Ministry of Public Health, provided during an interview on February 9, 1998.

Overall, the HIV/AIDS campaigns conducted in Thailand from the mid-1980s to the present have yielded some desirable results. Dr. Phoolcharoen (1998) noted that "at

the present time, about 99% of the Thai people know about AIDS.” Moreover, in a study recently conducted among 21-year-old men from the northern part of Thailand who were conscripted into the Thai army by a lottery in 1991, 1993, and 1995, there was a significant decrease of the prevalence of HIV infection, from about 10-12% in 1991 to less than 7% in 1995 (Nelson et al., 1996). The researchers found that the number of men who reported using the services of commercial sex workers also dropped from about 81% in 1991 to about 64% in 1995. They also noted that the men in their study increased the use of condoms during their most recent sexual relations with commercial sex workers from 61% in 1991 to about 93% in 1995.

These findings are definitely a good sign of the multisectorial effort to fight against AIDS in Thailand. The decreasing trend of new HIV infection cases in the country shows that the continuous collaboration of the Thai government and many non-governmental organizations, both local and international, has resulted in some significant change in the Thai people’s awareness, attitudes, and behaviors. One of the non-governmental organizations that have conducted many HIV/AIDS information campaigns is the Thai Red Cross Society. Its campaign work under the Program on AIDS also contributes to the change in Thai society regarding the better understanding of HIV/AIDS.

Overview of the Thai Red Cross Campaigns

The Thai Red Cross Society started its effort to educate people about HIV/AIDS in March, 1985. Dr. Praphan Phanuphak (1998), director of the Program on AIDS, Thai Red Cross Society, said in an interview that, when the Chulalongkorn Hospital (which

belongs to the Society) was able to diagnose the first Thai patient as having AIDS in February, 1985, the public relations office of the Faculty of Medicine, Chulalongkorn University, informed the press about the case. That was the first time Thai physicians could document that AIDS was the cause of illness. Many newspapers, therefore, interviewed Dr. Phanuphak not long after the diagnosis. The public was informed about AIDS by the Thai Red Cross Society for the first time.

The Society started launching campaigns on HIV/AIDS prevention soon afterwards. Dr. Phanuphak (1998) noted that the first campaigns were aimed at homosexuals, male bisexuals, and female partners of male bisexuals because the first wave of HIV infection in Thailand occurred among this group of individuals. Then, the Society moved to the group of intravenous drug users, which was considered the second wave of HIV infection. In 1989, there was an outbreak of HIV infection among commercial sex workers of both sexes. The Society started launching campaigns aiming at sex workers as well as the general public. Dr. Phanuphak commented that "it was too late" to try to educate people and change their lifestyles since HIV/AIDS had already reached every segment of the Thai population.

When asked for an example of the HIV/AIDS campaigns being conducted by the Society, Greg Carl (1998), researcher for the Program on AIDS, Thai Red Cross Society, said that the outreach campaigns he conducted were life skills education campaigns. The campaigns used a comprehensive approach. Instead of simply providing information on AIDS to the target audience and hoping for a change in risk behaviors that may lead to the building of life skills, the comprehensive approach utilizes different techniques. It

starts by looking at the life skills the target audience already possesses, and then, adapts those skills for use as the tools to create the audience's life goals. When audience members have set their goals, they then learn negotiation skills, which help them to make decisions, to get away from troubles, and, finally, to be able to solve the problems in their lives. By accumulating these life skills, target audience members will be able to achieve their goals and to stop themselves from engaging in risk activities. Carl said that the campaign that uses this approach is called "Facts for Life." It has been conducted among male sex workers, out-of-school youth in rural and urban areas, and through Red Cross Youth in schools and colleges. The campaign favors the use of interpersonal communication, or two-way conversation, as it is the most effective way to change people's attitudes and behaviors.

Overall, the Thai Red Cross Society has reached many segments in Thai society not only in Bangkok, but also in other provinces. Its targets are usually youth in and out of school as well as adults in the work force. The Society uses all kinds of media, except broadcast media because it does not have enough funds either to create television or radio spots, or to purchase airtime. When he was asked whether the Thai Red Cross Society would conduct mass media campaigns in case it had sufficient funding to do so, Dr. Phanuphak (1998) replied that he did not think the Society would include such campaigns in its policy. He also added:

The Thai Red Cross Society will not request for funding [for mass media campaigns] because [such campaigns] are not the first priority of the Society. . . . [However,] if there are other organizations, such as the office of the Prime Minister or the Ministry of Public Health, that can handle such campaigns better [than the Society], we will let them continue their work. We will not compete

with them. . . . I am willing [to work with them as] a presenter or educator [in their mass media projects]. (recorded interview, January 5, 1998)

In response to questions about the Society's budget for HIV/AIDS campaigns, Dr. Phanuphak (1998) replied that the Society "has spent some 200,000 to 300,000 Baht (U.S. \$5,000-7,000) a year on booklet publication." Moreover, the Thai Red Cross Society has also received funds from the Ministry of Public Health to use in AIDS treatment services, but the Society has not received campaign funds from the Ministry.

The funds used in HIV/AIDS prevention and education campaigns for the Program on AIDS, Thai Red Cross Society, are provided mostly by international health organizations, such as the United Nations Children's Fund (UNICEF) and other international non-government organizations. However, the Ministry of Public Health also provides funding for a few projects, such as the HIV/AIDS Prevention for Slum Communities Project. Dr. Phanuphak (1998) noted in the interview that "UNICEF has made the most contributions" to the Society for campaign funding. To obtain the financial support from international health organizations, the Program on AIDS has to submit grant proposals to those organizations. HIV/AIDS funds are granted to the Program project by project. Each project has a different timeline. Therefore, Dr. Phanuphak said that it is difficult to estimate the overall funds the Thai Red Cross Society has received each year. The other source of funds is from public donations.

The Three Thai Red Cross Campaigns

The following data related to the three Thai Red Cross campaigns were obtained from documentary analysis, direct observations, and in-depth interviews.

The Wednesday Friends Club. The campaign has two main activities: The Wednesday Friends Club and the Bodang (Red Ribbon) Center. The Wednesday Friends Club is the administrative hub of the program, which includes an AIDS hotline telephone service and a place where the general public has access to the program. The Bodang Center is the drop-in center for HIV-infected people and AIDS patients. For some who come from the rural provinces to receive treatments at Chulalongkorn Hospital, it is a place to spend a night before or after going to the hospital. The Bodang Center is located just across the street from the Wednesday Friends Club, the Anonymous Clinic, and the headquarters of the Thai Red Cross Society. It is just a 5-minute walk from the Center to Chulalongkorn Hospital.

The Wednesday Friends Club is run by two sets of staff: the working group staff and the administrative committee. The working group consists of eight employees and a project manager. They are the people who actually manage the Club, publish newsletters, and conduct all the activities. Their performance is overseen by the administrative committee. The committee consists of six members of the Club who are elected every two years by all the 3,000 members.

The HIV/AIDS Prevention for Slum Communities Project. The Slum Communities project was initiated by Manop Pasuk in 1993. He has been working as project manager since then. Pasuk (1998) said that, during the first three years of the project, it was funded by a Norwegian international organization called “Reddbarna.” In the second year, the project was also funded by the Ministry of Public Health to run a campaign called “Maebaan Chumchon Sampan (Housewives for Community Relations)”

in parallel with the project's prevention and education activities. The second campaign required the staff to go back to the slum communities in which they had already conducted activities during the first prevention campaign to create an AIDS volunteer network among housewives in each community. Since these people had already been reached and trained for HIV/AIDS life skills from the first campaign, they were able to create AIDS educational and health care activities by themselves, with field support as well as financial support from the project's staff.

Pasuk (1998) noted in the interview that the second half of 1996 was a transition period for the project. Reddbarna had already stopped funding the project's AIDS prevention activities by the end of 1995; therefore, the project had to rely solely on funds from the Ministry of Public Health for the housewives network campaign. The network campaign ended in June, 1996, and the staff fully resumed its work in the primary prevention project under the funding of the AIDS Division, Ministry of Public Health. Although the concept was the same as that of the pioneer project started in 1993 with funds from Reddbarna, the funds were not as much as those given by Reddbarna. Therefore, the staff had to reduce the size of the areas the campaign planned to reach, from 18 slum communities to 10 communities a year. They plan to continue their work until there is no one left to support them (M. Pasuk, personal communication, January 17, 1998).

The HIV/AIDS Prevention for Slum Communities Project has three levels of administration. The top level is the Board of Director, including representatives from the Thai Red Cross Society, funding agencies, and the Bangkok Metropolitan Administration

(the City of Bangkok). The second level consists of two field project coordinators who are the officials of the Health in the Home Section, Thai Red Cross Society. The third level is the field staff. There are four staff members and a project manager.

Facts for Life: Curriculum for Youth, Red Cross Youth Division. In the past, the program on AIDS, Thai Red Cross Society, had conducted several HIV/AIDS educational campaigns using the concept, “Facts for Life.” Those campaigns were conducted among labor groups in the Eastern Seaboard industry area of the eastern region of Thailand as well as among out-of-school youth in urban and rural areas. Later, a researcher for the Program on AIDS submitted a proposal to the Asian Red Cross and Red Crescent AIDS Task Force (ART) regarding the use of the Facts for Life concept in the campaigns targeting youth that were planned to be launched by all Asian Red Cross and Red Crescent organizations. The proposal asked for the use of one universal manual that could be adapted to different situations in any country. The proposal was accepted by ART. The creation of Facts for Life: Curriculum for Youth began in 1995.

According to the information obtained during an interview with Uemporn Navy (1998), project coordinator, Facts for Life: Curriculum for Youth, Red Cross Youth Division, the Thai Red Cross Society assigned the Program on AIDS to find youth representatives who would join the Asian Red Cross and Red Crescent AIDS Task Force Conference in Indonesia in 1995. The Program on AIDS asked the Red Cross Youth Division to send two officials, a male and a female, as youth representatives to the conference.

At the conference in Indonesia, Navy, an official of the Red Cross Youth Division, and a researcher who had the experience of conducting labor group education campaigns, presented information on how to do group discussions and how to create educational activities to be used in the group discussions. The techniques were adapted to be suitable for youth in secondary schools and those in college.

In 1996, the campaign moved to the next step: the development of the project's manual and training of the Red Cross Youth Division staff. The manual was for use by the staff and peer leaders. After the manual, which was adapted from the one used in the labor groups campaigns, was developed and the staff training was completed, the staff conducted pilot projects among three youth groups. The staff also conducted pre-campaign and post-campaign surveys. The data obtained from the pilot project were used to improve the quality of the project's manual. At the end of 1996, the Red Cross Youth Division staff held the first peer leader training session for about 30 peer leaders, who came from secondary schools and the higher education institutes, such as vocational schools, and physical education colleges. Some of the schools and colleges had Red Cross Youth programs in the curriculum or school activities. The actual Facts for Life project has been conducted since the beginning of 1997.

The project is run by the Red Cross Youth Division under the supervision of the Program on AIDS, Thai Red Cross Society. Sasathorn Chaiyapet, researcher for the Program on AIDS, is the project manager. Navy, project coordinator, is in charge of the manual's development, training sessions, and other Facts for Life activities. She also

supervises peer leaders when they conduct their own HIV/AIDS education activities in school.

Identifying and Attracting Target Audiences for the Three Campaigns

The three Thai Red Cross campaigns are aimed at slightly different target groups. Although they all target both genders, the age groups, educational levels, income levels, and occupations are quite different.

The Wednesday Friends Club. The public outreach activities of this campaign target both men and women. According to Malee Suphonphak (1998), counseling officer, Wednesday Friends Club, the HIV/AIDS educational activities can be divided into two approaches. The first approach is that the Club sends its officers or volunteer speakers to conduct lectures and activities at schools, colleges, companies, or factories upon request. The staff members are not supposed to ask for the opportunities to speak. They have to wait until someone makes contact with them, asking them to send speakers to a particular event. Therefore, they cannot specify the demography of the target audience when they use this approach. The age of the audience can be between 12 to 35 years old. The audience ranges from secondary school students to college students, to blue- and white-collar workers; therefore, the education level ranges from low to high. The income level occupation of the audience varies considerably.

However, in some cases, the Club staff may use the second approach: the community outreach activities. They go to several communities to talk to slum dwellers and homeless people about AIDS. Using this approach, the staff inevitably targets people of all genders and age groups who have low education and low income. Most of the

people who live in the areas the staff can reach are daily wage-earners, street vendors, and produce sellers.

In response to the question about the kind of audience that appeared to be the most interested in outreach activities, Suphonphak (1998) as well as Paisal Suwannawong (1998), the Club's project manager, agreed that women appeared to be obviously involved in the campaign's lectures and activities. Adults, between 20 to 35 years old, who had middle to low educational levels (lower than high school) were also interested in the activities. Suphonphak said that "salaried officials, such as company employees," showed good participation (Suphonphak, 1998). However, Suwannawong noticed that the people who showed the most interest in the activities were "the ones having risk behaviors or knowing someone at risk" (Suwannawong, 1998).

The HIV/AIDS Prevention for Slum Communities Project. The campaign's general target is slum communities in the Bangkok metropolitan area. It aims at all the people living in slums. The age group has a wide range. Pasuk (1998), project manager of the campaign said that "children from nine years old to husbands and wives in their sixties have to be part [of the campaign] without gender discrimination." The campaign does not target any educational level in particular. However, it can be assumed that people living in such a poor environment have received a middle to low level of education (lower than high school). The income level of the target audience ranges from very low to moderate since there are wage-earners, street vendors, daily laborers, as well as people who own small businesses living in the same communities, according to the interview with Pasuk. He also noted that housewives in slum communities were very

willing to be involved in the project's activities and in building the HIV/AIDS network in their communities.

Facts for Life: Curriculum for Youth, Red Cross Youth Division. The target audience of this campaign is not only the youth involved in Red Cross Youth activities, but also those who have never experienced such activities before. The campaign staff tries equally hard to reach male and female audience members. According to Navy (1998), the campaign targets two age groups—those 15 to 20 years old and those 21 to 25 years old. The first age group consists of secondary school (junior-high and high school) students, Red Cross Youth members both in and out of school, and teenagers who have left school to work in factories or agricultural industries. The second age group consists of students in higher-education institutes, Red Cross Youth Volunteers in those institutes, and factory workers. The income level of the audience varies. Most of the participants are students; however, the staff has also reached youth who have blue-collar jobs and those who work with plant growers.

When she was asked about which audience group appeared to be the most interested in Facts for Life activities, Navy (1998) replied that male audience members obviously joined the sessions more than females because “men tend to show their sense of leadership [in a group setting]. Besides, the staff also targets physical education colleges where, generally, there are more male than female students.”

Direct Observations of the Meetings of the Three Campaigns

The following direct observations of the HIV/AIDS educational meetings of the three Thai Red Cross campaigns were conducted during the field work period in

Bangkok, Thailand. The Wednesday Friends Club's participants were 292 secondary school and university students aged between 13 and 22. The Slum Communities project could reach more than 1,000 slum dwellers of all ages. There were more females attending both projects' meetings than males. The Facts for Life campaign's participants were 13 men and 10 women aged between 18 to 20. The three campaigns' overall participation and attention was considerably high, about 80-100%. The Facts for Life project's participants had the highest attention. However, the Wednesday Friends Club's participants' response to question-and-answer parts was low.

The Wednesday Friends Club. The first direct observation of the public outreach program of the Wednesday Friends Club was conducted on Monday, January 12, 1998, at Satit Patumwan Demonstration School, a secondary school in Bangkok. There were three sessions in this observation since the meetings were held separately for 50 students in the 9th grade, 54 students in the 11th grade, and 122 students in the 12th grade. Each session lasted 35-40 minutes. The speakers from the Wednesday Friends Club were two HIV-infected volunteers, a 35-year-old former salesman and a 24-year-old former prostitute. Before each of the three sessions, the teacher in charge of the period briefed the students on the HIV status of the speakers and the topic to be discussed while the two volunteers waited outside. The speakers used microphones and loudspeakers to amplify their voices.

The former prostitute told the story about her life and how she became infected with HIV. When she was 14, she got married and had a child. One day, her husband left her and took their only child with him. He never came back. She moved to Bangkok and

became a prostitute. Although she asked her clients to use condoms every time she had sex, she did not know how to use condoms correctly. She got infected when a condom broke. In the brothel where she worked, all sex workers had biannual blood tests for HIV. When the brothel's owner found that she was infected, she was fired. The speaker was very emotional during her presentation.

The male speaker also told his life story. Many years ago before AIDS was detected in Thailand, he was a salesman who visited many prostitutes during his business trips. First, he got some sexually transmitted diseases although he used condoms several times. One day, he became very sick. After he received medical treatment at a hospital, a doctor told him that the result of his blood test was HIV-positive. He thought that he would certainly die in a few years. When he told his best friend about his HIV status, his friend told him to commit suicide because he would not live long. Afterwards, he told his mother, but she took him to see a psychic instead of a doctor. He spent a lot of money on herbal medicines that were said to cure AIDS. Finally, he did research on HIV/AIDS and found out about the Wednesday Friends Club.

The male volunteer captured the audience's attention because he had a sense of humor. He often mocked himself and told some jokes while talking about his sad life. In contrast, the female volunteer looked more serious as she described the difficulties she had been through.

The speakers then took turns talking about HIV/AIDS: how the virus is transmitted, how it is not transmitted, and AIDS prevention techniques. They also told the audience about the Wednesday Friends Club and its activities. After the discussion,

they allowed the students to ask questions, but audience members did not respond. Some students asked the teacher to ask questions for them.

During the second session, the teacher left the room. Suddenly, many students lost attention; they began to talk to one another, not listening to the speaker. After the former prostitute finished her story, the male volunteer helped his teammate to regain attention by asking the students to close their eyes and think that if they or their relatives were infected with HIV, what would they do with their future? He told the students that the female speaker was very brave to reveal to them that she used to be a prostitute. By doing so, she gave herself a bad reputation. Therefore, the students should have listened to her carefully.

The second direct observation of the public outreach activity that was organized by the Wednesday Friends Club was on Tuesday, January 13, 1998, at “Matayom Satit Prasanmitr (Prasanmitr Demonstration Secondary School),” a school under supervision of Srinakharinrajwiroj University in Bangkok. A 10th-grade class of 45 students attended the Club’s HIV/AIDS presentation. The speaker from the Club was a man aged between 30 to 35 who became a heroin addict when he was a teenager. He got HIV because he shared needles with his friends, but said he did not know exactly when he was infected. One day, he became ill and went to a hospital with his elder sister. His blood was tested for HIV. His sister was told that he was infected. When she went to hug him and cried, he realized that he must have gotten HIV.

The information the speaker gave to the students was similar to that of the first observation. As in the previous sessions, many students appeared to be afraid of

speaking out loud; therefore, the teacher told them to write down their questions and give them to her. The speaker answered every question enthusiastically. He was very friendly and approachable. However, he could not answer the questions about whether HIV can be transmitted from animals (e.g., dogs and cats) to humans and how effective the current HIV/AIDS medicines are.

The last direct observation of the Wednesday Friends Club's activity was on Friday, January 23, 1998, at Srinakarintrawiroj University, Prasanmitr Campus, Bangkok. The volunteer from the Club was a woman aged between 22 to 25. The meeting took place in a class of 21 juniors majoring in education.

When the young speaker began to tell her life story, the students in the back rows moved closer to her because she spoke quite softly. The speaker was raped many years ago, but the man who raped her came to apologize. She married him when she was 14. Four years later, her husband became sick with what he said was tuberculosis. The doctor was suspicious about his symptoms and wanted to have his blood tested, but he did not agree. He became sick again and the doctor found that he was HIV-infected. When the speaker got the news, she told her mother right away. Her parents took her to the hospital to have her blood tested. The result was positive. The speaker's husband went back to his home in the countryside, but his family did not allow the couple to stay with them. They had to live in a small house and her husband passed away soon after that.

The speaker moved back to live with her family. Everyone in the family was very supportive. After she called the hot line number of the Wednesday Friends Club, a

volunteer from the Club went to her house to talk to the whole family about HIV/AIDS and home care techniques. The volunteer later told her family that he had been infected for 13 years. The presence of the Club's volunteer inspired her to become an AIDS counselor at the Bodang Center, a section of the Wednesday Friends Club.

When she finished her story, she told the audience about the Club's activities. The speaker then asked the students to ask questions, but no one responded. After the presentation, a student went to talk to the speaker in person about her acquaintance who had HIV. The speaker had brought with her "Red Ribbon" pins and T-shirts printed with colorful illustrations and AIDS mottos. [A red ribbon is known as the symbol of the fight against HIV/AIDS.] She sold some of them to the audience. A pin costs about U.S. \$0.75 and a T-shirt costs about U.S. \$2.50. The money goes to the Wednesday Friends Club's volunteer program.

The HIV/AIDS Prevention for Slum Communities Project. The first direct observation of the HIV/AIDS meetings organized by the staff of the HIV/AIDS Prevention for Slum Communities Project was conducted on Friday, January 9, 1998, at the Roang Jay Community, Ratchathewi District, Bangkok. During the meeting, only health and related issues, such as common diseases and nutrition, were discussed. The field personnel of the project did not present any information about HIV/AIDS to the audience. Although the staff would like to talk about AIDS, the HIV/AIDS slides could not be shown there because of the lack of space to set up the screen. Therefore, the field staff members would have to find a new venue for the project's slide presentation when they visited this community the next time.

The second direct observation of HIV/AIDS prevention activities of the Slum Community project was conducted on Wednesday, January 14, 1998, at the Petrarat Community, Ratchathewi District, Bangkok. This community consisted of more than 100 families living in about 20 small houses. The head, or president, of the community estimated that there were at least 500 people who lived in this small, crowded place. There were three generations in most families. Most of the residents had low socioeconomic status, except a few including the head of the community who appeared to be better off than other community members.

The meeting had two parts, the afternoon health discussion and the evening HIV/AIDS activities. The field trip personnel consisted of three male members from the project's field staff, a female health volunteer who lived in the community, and three female officials from the Health in the Home Section of the Thai Red Cross Society. Two of the three officials had been to the meeting that the researcher first observed. The Thai Red Cross officials led the first part of the meeting and left the community several hours before the second part began. The project's staff and the community's health volunteer conducted the rest of the activities in the evening.

The meeting took place at a small makeshift soccer field the size of a basketball court, in front of an apartment building. The community is located behind this building. Microphones, loudspeakers, and the community's intercom system were used to transmit the message to the residents. The first part of the meeting was similar to the first observation. The field personnel did not present any HIV/AIDS information to the audience. The community's health volunteer told the researcher that there was a family

in this community suffering from AIDS and that the young mother and her infected baby also attended the meeting (M. Nissaiboon, personal communication, January 14, 1998).

The Slum Communities project's staff solely organized the second session. They had to set up a projector screen for their HIV/AIDS educational slide presentation. Microphones, loudspeakers, and intercom system were used to transmit the message. The activities in this part were games (for children, teenagers, and adults) and the slide presentation, which was the highlight of this session. There were more than 50 residents, about 30 children and 20 adults, participating in the second session. The project's staff led the children and adults through four games before they presented the HIV/AIDS slides.

About 17 children participated in all of the games. The first game was the condom blowing competition. When they touched condoms for the first time, they giggled and complained about the condom's slipperiness. However, they appeared to have fun. The next three games were not about AIDS. Later, adults also joined in. After each game, the winners were awarded notebooks. The rest of the game participants received pens. Both kinds of awards were printed with AIDS prevention mottos. Each adult received a booklet about HIV/AIDS. The booklet, "Rok AIDS Lae Tua Taan (AIDS and you)," written by Dr. Praphan Phanuphak, director of Program on AIDS, Thai Red Cross Society, was about AIDS facts, prevention, and home care.

At 7 p.m., the head of the community officially announced the opening of the 20-minute slide presentation. The activity was organized in collaboration with the Bangkok Metropolitan Administration, the Office of the Ratchathewi District, and the Program on

AIDS, Thai Red Cross Society. To encourage the audience to pay attention, the staff told audience members that after the presentation, awards would be given to any participants who could answer HIV/AIDS questions correctly. At that time, more adult males were present.

The slides were narrated by a male narrator whose clear, authoritative voice had been recorded with music in the background. The first slide was a picture of a woman's breasts. The nipples were censored. The voice said that AIDS in Thailand was found in male homosexuals first. It then spread to the mainstream population. After members of the gay community were infected, the next group that contracted HIV/AIDS was intravenous drug users, followed by female commercial sex workers. The narrator used the jargon "commercial sex workers," instead of more commonly known terms, such as "prostitutes" or "women who sell their bodies." The writer of the script perhaps wanted to use a euphemism, instead of a more direct word.

When several graphic, disgusting pictures of full-blown AIDS patients were shown, the music changed to a frightening tone. The presentation obviously emphasized the symptoms of the full-blown stage by showing many pictures of AIDS patients. The narrator said, with a strong voice, "Finally, everyone [who has AIDS] has to die." In the middle of the presentation, a female participant shouted out, "I'm not afraid of AIDS. I'm afraid of starvation." Other people asked her to be quiet.

Information on HIV/AIDS (e.g., transmission, blood testing for HIV, and risk behaviors), and prevention were the major concern in the presentation. The narrator advised the audience not to wait for the AIDS vaccine. Condom use and abstinence were

promoted with regard to sexual behavior. At the end of the slides, the narrator asked the audience to talk about what they had learned.

The last activity came after the slide presentation. The staff asked the children about 10 HIV/AIDS questions, such as “Can AIDS be cured?” and “How can people get the virus that causes AIDS?” The awards were notebooks, pens, and rulers—all printed with AIDS prevention mottos. When participants could answer open-ended questions, they would receive higher-valued awards, such as stuffed animals. A T-shirt with the Slum Communities project’s logo was given to the head of the community.

Facts for Life: Curriculum for Youth, Red Cross Youth Division. The first direct observation of the peer education activities organized by the staff of the Facts for Life: Curriculum for Youth, Red Cross Youth Division, was on Saturday, January 10, 1998, at Rajabhat Institute, Bansomdejchaopraya Campus, Bangkok. The researcher was told that the activity was a shorter version of the actual peer education program (U. Navy, personal communication, January 10, 1998). Some participants could not join the meeting on both Saturday and Sunday; therefore, the staff opted for the shorter version over the full one. The full version of the Facts for Life activity would take two days to complete. The short program, in this case, took only one day.

The staff consisted of three male peer leaders and the project coordinator. At the time the meeting occurred, the peer leaders were students of the college’s Faculty of Science and Technology, Department of Health Education, Safety Science Program. All of the 11 participants were freshmen from the peer leaders’ program. Before the

participants signed up for the meeting, the peer leaders who knew some of these freshmen personally had informed them about the Facts for Life activity.

The meeting took place in an activity room for “The Bansomdej Preventive Drug Education Center,” a project run by faculty members of the Institute. First, all participants and peer leaders introduced themselves by their nicknames. The leaders stated that everything said during the meeting was to be confidential. One leader distributed pieces of paper for the participants to write down their dreams or goals in life. When they finished writing, the pieces were collected. The leaders, following the program’s manual, used flip charts with illustrations to lead discussions on six different stages, or ages, in life: infancy, childhood, adolescence, adulthood, marriage, and old age.

After that, they talked about goals in life and how to achieve them. The peer leaders suggested the use of a goal formula: steps to help each participant to come up with a plausible, realistic goal. First, the participants were asked to think carefully about their real goals, to see the possibility of goal achievement. Then, they had to figure out how to reach their goals. Finally, they were told to be proud of themselves whenever they became successful in achieving what they wanted. However, whenever they failed, they should not give up. Instead, they should repeat the formula to see whether they aimed too high and whether they had made every effort to reach the goals. A peer leader randomly picked one participant’s goal from the written pieces of paper for discussion in this topic. It was about the person’s dream to be able to graduate from the Institute and find a decent job. The leaders asked the group to analyze the possibility of this goal and to come up with ways to achieve it. Then, they talked about possible obstacles that could

cause the participants to fail. In the flip charts, pictures of possible obstacles, including drugs and people with HIV, were shown. The leaders then discussed how to solve problems in life, pros and cons of the solutions, and how to avoid these problems.

A leader brought up a situation in which a husband had patronized a prostitute and asked the participants to help the man's wife think about any possible solutions to end the husband's conduct. One of the solutions was that the wife should encourage her husband to use condoms with prostitutes so that he would not become infected with HIV or other sexually transmitted diseases. However, the group also argued that condoms could break and the man could be infected anyway; therefore, the couple should talk about the possible outcomes and try to find the best solution for both [that is abstinence].

The project coordinator asked whether any participant would like to join the peer leader training program of the Red Cross Youth Division. Some participants were interested in the training session. The peer leaders then discussed two problematic situations that could occur in any student's life. Both cases were based on true stories. One case was about a female student who was asked to stay overnight at a friend's house. Her friend had a brother who was HIV-infected. The woman was not sure about her attitude toward people with HIV because she had never met any of them before. The group discussed the cases and came up with solutions. They then talked about the pros and cons of their solutions.

One of the solutions for the problem concerning a friend whose brother had HIV was that the student should not stay overnight in her friend's house. The advantage of this solution was that she would not have to worry about how to behave in front of her

friend's brother and how not to hurt his feelings because she was not sure about her attitude toward HIV-infected people or AIDS patients. Moreover, it was good for her not to stay because she might put herself in jeopardy if the brother forced her into having sex with him. However, the student's decision might lead to misunderstanding between her and her friend and that could possibly sever their friendship. The participants brainstormed in another activity before they had a lunch break.

In the afternoon, the project coordinator joined in the group as one of the leaders. The first activity in this session was about condom use. They showed a wooden model of male genitalia to the audience. The model looked more like a pestle than a man's sex organ. The leaders had the participants play a game that was quite similar to musical chairs by passing the model around to the others in the circle, as one of the leaders played Thai pop music on a small tape cassette player. Whenever the leader stopped the tape, the person who was holding the model lost the round.

After that, the coordinator distributed condom packets to the participants and the group had a discussion about different sizes of condoms and their features. Then, the participants were asked to show the leaders how to tear the packet without damaging the condom inside and how to put the condom on the wooden models. The participants had different opinions about how to put the condoms on; therefore, the leaders and coordinator helped demonstrate the right way to do so. They also talked about the correct way to take the condom off. It was obvious that only male participants discussed this subject. The women did not say anything at all about how to use condoms. The coordinator asked whether anyone had used condoms before. No one answered the

question. Some were just smiling or giggling. After that, they discussed other methods of birth control.

One serious consequence of having unprotected sex was getting HIV. The leaders asked the group about AIDS: what ways they could or could not get the virus. The leaders mentioned that there were some rumors about medicine and herbs that could cure AIDS. Some participants said that the rumors were a total hoax. The peer leaders then concluded that there was still no cure for this disease. They also talked about other misunderstandings, such as the belief that mosquitoes could be HIV carriers. The next topic was drugs and other addictive substances. Finally, the peer leaders summarized the discussions with the help of all the participants. They put an emphasis on the goal of life and how to avoid obstacles (e.g., teen pregnancy, HIV/AIDS, sexually transmitted diseases, and drugs).

In the afternoon, when the leaders noticed that some participants were sleepy, they stimulated participation by telling jokes and doing exercises. However, there were times when the peer leaders gave confusing information. The rest of the group, including the project coordinator, then helped clarify the points by discussing the problems step by step. The men were more opinionated than the women.

The second direct observation of the peer education on HIV/AIDS of the Facts for Life project was on Monday and Tuesday, January 19-20, 1998, at Bangkok Physical Education College in Pathumthani (a suburb of Bangkok). The meeting was the full version of the Facts for Life peer education activity. The staff consisted of three peer leaders, a male and two females, and the project coordinator. At the time the meeting

occurred, the peer leaders were studying at the college. One woman was a junior majoring in Communication Arts, which is also known as Mass Communications. The other two were sophomores majoring in Physical Education. The Communication Arts student attended only the first day of the 2-day meeting because she had to go to class. In this meeting, all of the 12 participants were freshmen majoring in Physical Education. A faculty member, who was in charge of the Red Cross Youth program of the college, had informed the participants about the meeting. They had also heard their friends and upperclassmen talking about the meeting since the Facts for Life staff conducted the pilot project in this college in 1996.

On the first day, January 19, 1998, the meeting took place on the first floor of the college's new auditorium building. The coordinator, who told the group that she was one of the peer leaders, briefed the group on all the parts of the Facts for Life activities, stating that they would have a detailed discussion about HIV/AIDS on the next day of the activity. All peer leaders took turns talking to the audience; however, the meeting was led mostly by the coordinator. The leaders used the same format as that of the first observation. They sometimes asked the quiet participants to answer their questions.

The leaders asked each participant to write down his or her goal in life on the "sun" distributed by the leader. Each sun was made of a red plastic sheet that was cut into a star-like shape with a small piece of paper attached to its surface. Then, they taped their suns on a whiteboard as high as they wanted. Most of the goals were to graduate, to get decent jobs, and to have a happy family life. The leaders introduced the goal formula to the audience. The group discussed the possibility of each goal and the ways to achieve

it. The leaders used illustrations in the flip charts to show the audience the steps to reach the goal and the obstacles they might confront, such as drugs, sexually transmitted diseases, and HIV/AIDS. Before the lunch break, the coordinator concluded that the participants had different ways to reach their goals; however, they must be careful with their steps in life, not to put themselves in danger.

In the afternoon, the leaders divided the audience into two groups for role-playing activities. Each group received a case, which is related to sexual relationship, and they had 15 minutes to present the case to the rest of the audience. The first case was about a man, an A-student, who had unprotected sex with his female classmate because he did not know how to use condoms. The woman became pregnant and had to drop out of high school to stay home with her parents. The man did not have time to study since he had to prepare himself for the role of being a father. His grades plummeted and he could not graduate from high school. His girlfriend's parents did not want him to marry their daughter because they were afraid that the man would not be able to take care of her.

The second case was about a beautiful peasant whose dream was to be a nurse. She studied at an adult education school where she met a classmate, who later became her boyfriend. The woman was conservative about sex; therefore, they did not have a sexual relationship until the day they took a trip out of town and had to stay overnight together in a motel. The woman asked her boyfriend to use a condom and he agreed. When the woman graduated from the adult school, she was able to get into a nursing college. Her boyfriend opened a small business, which was successful. They got married and lived happily ever after.

The presentations were very funny and entertaining. After role-plays, the group members discussed the two cases, whether the people in the cases thought before they acted. The leaders pointed out to the group the effective decision-making process and asked the group to apply it to the problem of the first case, which was about a couple who had to drop out of school. They also talked about abortion as a solution to the problem of teen pregnancy. The group deliberated on the pros and cons of abortion as well as other birth control methods.

The last activity on the first day of the Facts for Life meeting was the preparation for another role-playing activity. The leaders asked the participants to pair off. The participants formed 6 pairs, which consisted of 4 male-female pairs, 1 male-male, and 1 female-female. Each pair received a problem case that would lead to a counseling session. The situations involved a friend who had a particular problem and asked another friend for some advice. The leaders distributed small, colorful notebooks to the participants so they could take notes during the role-playing preparation period. The notebooks were filled with illustrations and important information (e.g., the goal formula, decision-making process, condom use, and HIV/AIDS facts) derived from the Facts for Life manual and flip charts. The leaders encouraged the group to use the notebooks throughout the rest of the meeting. The 6 pairs of participants had to give presentations on the next day.

The meeting on the following day, January 20, 1998, took place in the same building. The peer education activity was moved to a conference room. One leader, the Communication Arts student, was absent because she had to attend classes. Everyone,

including both peer leaders, sat on the floor in a circle. The project coordinator sat in a corner of the room, observing the meeting.

The first topic was about friends as counselors. The topics of most cases were related to HIV/AIDS and sexual issues. Each pair presented the case in the middle of the circle. The cases were presented in the following order:

1. My friends are smoking cigarettes. I have never tried that before. They asked me to join them. What should I do?

2. I am a woman. My friend asked me to stay overnight at her house. Her brother has HIV. Should I go?

3. I want to know more about AIDS. I know that HIV can be transmitted from a person to another by having sex, but is there another way that HIV can be transmitted? I am afraid to ask other people about this because they may think that I have a risk behavior. What should I do if I need this kind of information?

4. I am a woman. My boyfriend asked me to go to his house and stay with him tonight. What should I do?

5. I am a man. My friends asked me to hang out with them tonight. They will go to brothels or massage parlors to visit sex workers. What should I do?

6. I have seen my female friend dating many men, spending only a short time with each. I am worried about her behavior. People may notice this and she may get a bad reputation. What should I do?

After each pair finished the presentation, the two leaders took turns to comment on the pair's performance regarding counseling techniques. The participants were very

interested in the fourth case, which was about a woman who had to make a decision about whether she should spend a night with her boyfriend at his place. The men in the group asked the women what they would say to their boyfriends if the same situation happened to them. The leaders proposed two situations to discuss: what the woman could do if she did not want to go to her boyfriend's place; or if she went there, what she could do to not have sex with him. The participants deliberated their ideas enthusiastically. The women in the group asked the men for advice on how not to fall prey to that kind of situation. They also argued about who had the power to control the situation, the man or the woman. A leader intervened and summarized all the possible ways to solve the case.

The female leader carried on a conversation about prostitution patronage among Thai men. Some men in the group said that if they refused to go to a brothel when asked by friends, their friends would think that they were "chicken" or had no sexual experience [which is shameful among Thai men]. However, other male participants argued that they would not go to a brothel because they did not want to take the risk; they were afraid of getting HIV.

The next topic was condom use. The peer leaders gave every participant a wooden model of male genitalia and a condom. The materials were the same as those in the first observation. The leaders told the audience how to tear the packet without damaging the condom inside. About 40% of the participants, male and female, had never touched condoms before. A woman in the group was afraid of touching the condom because it was "slimy." The leaders then instructed the participants on how to put the

condom on and take it off the model correctly. The peer leaders also led the discussion about the benefits of condom use. The project coordinator asked the participants to call male and female genitalia by nicknames if they felt embarrassed during the conversation about condom use and sexual intercourse. The nickname for the male sex organ was “a rabbit” and the one for the female organ was “a turtle.” Instead of ejaculation, they used the term “winning the race.” All the names came from an Aesop fable.

The project coordinator led all the discussions in the afternoon. The first topic was about drugs. The coordinator used a chart with pictures of drugs and addictive substances as she talked about what drugs could do to the people who took them. The second topic was birth control. While the coordinator discussed different methods of birth control with the group, she showed the audience contraceptives, leaflets with pictures of contraceptive devices, and a condom for women, which attracted the most attention since most of the participants has never seen one before. While she was talking, the group gathered very closely to the project coordinator to see the pictures and other materials she had brought.

The third topic was sexually transmitted diseases. The coordinator showed pictures of patients who suffered from different diseases. There were many close-ups of sores caused by different kinds of sexually transmitted diseases. The leaders also talked about misunderstandings regarding how to cure the diseases. The fourth topic concerned criteria for finding partners for serious relationships.

The fifth topic was how to tell from physical appearance whether a person is infected with HIV. The group concluded that there was no way to tell the difference

between a normal person and one with HIV. The coordinator asked the participants whether they would have their blood checked after being involved in an act that might cause HIV transmission. All participants said they would definitely have their blood tested. However, the coordinator told them that some people might not.

The last topic was about having a premarital sexual relationship. When they were asked whether they agreed with the conduct, 100% of women said no, but 50% of men agreed. The participants then carried on the conversation about the pros and cons of having premarital sex.

The project coordinator asked the participants to take their suns (the pieces of red plastic they had written their goals on) to the meeting. One by one, the participants had to relate their goals in life to all the obstacles they had discussed that day (e.g., drugs and HIV/AIDS) and find out ways to reach their goals. They also talked about what they had learned from the 2-day meeting. The coordinator tape recorded this activity. She would later use the information to improve the Facts for Life program (U. Navy, personal communication, January 20, 1998).

The project coordinator then told a real-life story of a girl who was raped and, as a result, became infected with HIV. The participants were asked what they would do if they were the girl's friends and what they would do if she were their girlfriend. The coordinator also asked whether a married couple, both HIV-positive, should have unprotected sex and whether they should use condoms.

Then, the project coordinator asked the participants whether they would like to join other activities that would help people with HIV and AIDS. All participants agreed.

She ended the meeting by having the participants read their self-portraits to see whether they got everything they wanted from the meeting by checking the notes they wrote on the portraits at the beginning of the meeting. The coordinator collected all the portraits, which were to be used as one way to evaluate the program.

Finally, she gave four different brochures to each participant. The Venereal Disease Division, Ministry of Public Health, published the brochures. The first one was titled “Sexually Transmitted Diseases 1” that was about six sexually transmitted diseases (e.g., syphilis). The information included the causes of the diseases, ways of transmission, and symptoms, as well as prevention techniques (e.g., condom use). The second brochure was titled “Sexually Transmitted Diseases 2” that was about eight diseases (e.g., scabies and herpes). The information included the cause of the diseases, ways of transmission, symptoms, prevention techniques, and telephone numbers of government hospitals and sexually transmitted disease clinics in Bangkok. Both brochures contained colored photographs of male and female genitalia that were infected: one picture per disease.

The last two brochures were the blue-colored “Men and Sexually Transmitted Diseases and AIDS” and the pink-colored “Women and Sexually Transmitted Diseases and AIDS.” The information in both brochures included suspicious symptoms of sexually transmitted diseases, benefits from early medical treatment, health care during treatment, the danger of self-diagnosis and treatment and not seeing doctors, HIV/AIDS, safe sex, condom use instructions, and telephone numbers of government hospitals and sexually transmitted diseases clinics in Bangkok. The brochure for men contained

information that was geared to the male audience, whereas the one for women was geared to the female audience. Both had clear and colorful illustrations.

The project coordinator distributed application forms of the Red Cross Youth Division's volunteer program to the audience. Almost all of the participants appeared to be interested in entering the peer leader training program of the Facts for Life project.

Messages, Sources, and Channels of the Three Campaigns

The Wednesday Friends Club and the Slum Communities project share the same theme of the HIV/AIDS message, which is that people who are not HIV-infected can live with HIV-infected people and AIDS patients in the society. The theme of the Facts for Life campaign is goals in life and how to reach them. Regarding the channels of the three campaigns, all emphasize the use of interpersonal communication supplemented by printed media, such as brochures and booklets, and slide presentations. The Slum Communities project also uses the communities' intercom systems when the staff organizes its HIV/AIDS meetings. These intercom systems allow the communities' residents to listen to the meetings from their homes.

The Wednesday Friends Club. According to Suphonphak (1998) and Suwannawong (1998), the themes of the message disseminated by the staff and volunteer speakers are life stories of HIV/AIDS victims, AIDS prevention, and the fact that HIV cannot be transmitted through casual contacts. During the researcher's five direct observations of the Wednesday Friends Club's meetings, it was obvious that each speaker started from his or her own background first, telling the audience how he or she became HIV-infected. The speakers also talked about the reactions of their families and whether

they were supportive. Then, they talked about their current situations, how they lived their lives, and what they hoped for in the future. After they finished their life stories, they went on to talk about HIV/AIDS prevention, common misunderstandings, and how to live with people with HIV/AIDS.

All of the speakers emphasized the point that it is impossible to tell the difference between a normal person and an infected one. They raised examples by pointing at themselves, showing that they also looked like the people that the audience met every day. The use of a real HIV-infected person as a speaker drew much attention from audience members since they might not have had the chance to meet an infected person before. According to the researcher's observations, after the presentations, the audience also appeared to understand more about this deadly disease from the information given by the real victims.

The Wednesday Friends Club uses its staff and HIV-infected volunteer speakers to disseminate its messages. They have been trained in general HIV/AIDS facts; however, they could not answer some questions, such as "What will happen if a dog or a cat bites a person who is HIV-positive? Will it become infected?" or "Can an animal become a carrier?" These are the questions sometime asked by participants, according to the researcher's direct observations.

The channels used in this campaign are printed media (e.g., brochures and booklets), interactive games (not conducted during the researcher's observations), and interpersonal communications (e.g., informal discussions and question-and-answer conversations).

The HIV/AIDS Prevention for Slum Communities Project. The themes of the message disseminated in this campaign are HIV/AIDS prevention, how to solve AIDS-related consequences, and how to live with people with HIV/AIDS. The campaign itself is divided into three parts. The first part, from January to March, is when representatives from the Health in the Home Section, Thai Red Cross Society, make field trips to slum communities, conducting activities with the project's field staff. [The researcher conducted direct observations during this part of the campaign.] The message in this period is about general knowledge in disease and home care techniques, as well as HIV/AIDS. The message is intended to create some background knowledge among slum dwellers. The second part, the next four to eight months after the first part, is when the project's field staff start conducting HIV/AIDS activities. The message is about HIV/AIDS prevention, what to do after getting infected, and how to live with people who have HIV/AIDS. The last part, which is held near the end of the year, is when the staff recruit people in the communities to join peer leader training given by the staff. The message that specifically targets the peer leaders is about life skills, home care for AIDS patients, and how to create a community network to educate people about HIV/AIDS.

The sources for the project are the representatives from the Health in the Home Section, Thai Red Cross Society, community health volunteers, and the field staff. The Health in the Home officials have been trained to educate people from different demographic backgrounds about the common diseases, such as heart diseases, diabetes, and common colds, as well as about general HIV/AIDS facts. The community health

volunteers are trained by health personnel from the Bangkok Metropolitan Administration.

The channels used in the project are a variety of media (e.g., slides, videotapes, posters, brochures, booklets, and buttons), interactive games, interpersonal communications (e.g., informal discussions and one-on-one conversations), life skill training camps for children 9 to 13 years old (during the third part of the campaign), and the community HIV/AIDS network. The staff members also use the communities' intercom systems to transmit the meetings' messages to slum dwellers in their homes.

Facts for Life: Curriculum for Youth, Red Cross Youth Division. The theme of the message in this campaign is different from the themes of others although the goals are all the same: to change people's behaviors so that they do not contract HIV and to enable them to live normally with HIV-infected people and AIDS patients. The theme of this campaign is about hope that can be reached by having proper life skills. The message in the campaign is about setting goals in life, how to overcome obstacles that may obstruct audience members from achieving their goals, and life skills. Life skills are self-recognition skills, negotiation skills, decision-making skills, and problem-solving skills. The message also deals with sexually transmitted diseases, HIV/AIDS, drugs, and teen pregnancy, all of which are the possible causes of problems in life.

The sources of the campaign are staff from the Red Cross Youth Division, core trainers, and peer leaders who, after being trained, become Red Cross Youth Volunteers.

The channels used in this campaign are printed media (e.g., brochures, posters, flip charts, and booklets), interactive games, role-playing, and interpersonal

communications. Small-group discussions are the most important way of communication throughout the Facts for Life meetings because such discussions allow the peer leaders and audience members to exchange their opinions freely. The staff can clarify any confusing point in the discussions right away.

Media Used in the Three Campaigns

The three Thai Red Cross campaigns use brochures and booklets that come from the same sources: the Ministry of Public Health and the program on AIDS, Thai Red Cross Society. However, the Wednesday Friends Club has also developed its own brochures and handouts. The Club and the Slum Communities project use slides and videotapes whenever they have a chance.

The Wednesday Friends Club. The Club's outreach activities use several kinds of media: handouts, brochures, booklets, slides, and videotapes. As to the direct observations that occurred in small classroom settings, sometimes the speakers do not use any media at all. While they give presentations, they appear to reinforce the HIV/AIDS information the audience has already received from mass media campaigns conducted during the past decade. However, according to Suphonphak (1998), the speakers use slides and videotapes produced by the Thai Red Cross Society in their presentations if the audience is larger than 500. They also use posters in exhibitions if they are allowed to use some space in a particular venue.

The other source of information is the "Jodmaikao Soon Bodang (Red Ribbon Center Newsletter)." The bimonthly newsletter can be obtained free of charge at the Club's office, the Bodang Center, as well as governmental and non-governmental

organizations working on AIDS. It contains updated news about HIV/AIDS findings, medication and treatment, health tips for AIDS patients, stories about outstanding social workers, classified ads, and notes from Club members. It also provides a hot line phone service of the Wednesday Friends Club called “HIV Phone” which is assisted by the Club’s counseling officers.

The HIV AIDS Prevention for Slum Communities Project. The project uses different media in different parts of the campaign. During the first part of the campaign, Health in the Home officials distribute brochures and booklets about heart diseases, blood pressure, and diabetes. The staff use slides about AIDS produced by the Thai Red Cross Society and distribute brochures and booklets about sexually transmitted diseases and HIV/AIDS. In the second part that concentrates on HIV/AIDS prevention and education, the staff use videotapes in group discussions. When they conduct HIV/AIDS knowledge games, they distribute AIDS-motto buttons, t-shirts, and gifts with AIDS motto imprinted as prizes. In the third part, the staff concentrate on the use of core trainers who reinforce the media’s messages that the audience has already received. In addition to the aforementioned media, the staff also distribute comic books with HIV/AIDS prevention themes, notepads with AIDS facts, and condoms during the campaign.

Regarding the newsletter, “Jodmaikao Chumchon Sampan (Community Relations Newsletter),” the project’s staff reported that it was very popular among people in the communities since there were many photographs of the people who joined the project’s activities published in each newsletter. The people whose pictures were in the newsletter were very proud of what they did and also showed them around their communities. That

resulted in an increase in attention from other community members (P. Chotboon, personal communication, January 14, 1998).

Facts for Life: Curriculum for Youth, Red Cross Youth Division. The media used in this campaign can be divided into two categories: the media used during group discussions and the media provided after the discussions. The media used during the discussions are posters with pictures of sexually transmitted disease patients, pictures of AIDS patients in different stages, and drugs (e.g., heroin, marijuana, amphetamine, and Ecstasy). Moreover, flip charts with pictures from the Facts for Life manual are also used so that the discussion leaders do not have to show the illustrations in their manuals to the audience. When the discussion reaches the topic of family planning, the leaders distribute a wooden model of male genitalia to everyone. Then, the leaders distribute condoms and audience members are taught how to put condoms on the models and take them off. In addition to condoms, the discussion leaders also introduce a condom for female and other contraceptives to the audience. The media provided after discussions are brochures and booklets about AIDS, sexually transmitted diseases, and activities of the Red Cross Youth Division.

Interpersonal Communications in the Three Campaigns

According to the researcher's direct observations, the three campaigns appear to use informal conversation as their major approach. The Wednesday Friends Club and Facts for Life favor small-group discussions whereas the Slum Communities project urge the people in the communities to join as many of the activities as possible. The staff of the Slum Communities project as well as the peer leaders of Facts for Life spend some

time on one-on-one discussions. All the three campaigns devote much of their time to question-and-answer periods.

The Wednesday Friends Club. In the presentations, the staff and volunteer speakers use the friendliness approach when they start talking about themselves. The style is informal yet polite. They use a lot of humor to ease the tension among the audience. The speakers ask the audience many questions. If no one answers, the speakers choose a member of the audience to answer each question. The audience sometimes asks questions about how HIV is transmitted. The speakers answer in detail.

The HIV/AIDS Prevention for Slum Communities Project. The field staff members start their campaign in each community by spending time with the people in the community, getting to know them family by family. They organize AIDS-related activities and ask children to join first. Then, the parents and relatives will show more interest in the subject.

Pasuk (1998) said that, when the staff conducts the campaign in slum communities, “the people are not interested in the HIV/AIDS topic, no matter what demographic group they are from. . . . [Therefore,] we have to get acquainted with them gradually. Let them know that [AIDS] is their problem, stimulating their interest. . . . [It is because] one day, they may have to face this kind of problem.”

Facts for Life: Curriculum for Youth, Red Cross Youth Division. The use of peer leaders in a small-group discussion results in an informal atmosphere in which the leaders and audience members get to know each other and call one another by nicknames. Since the peer leaders are in the same age group as the audience, they speak the same

“language,” using slang, talking about pop culture, and listening to the same kind of music.

Between activities, there are some snack breaks as well as a lunch break. During the breaks, the peer leaders and staff are approached by some members of the audience. They ask the leaders intimate questions, the ones they are too shy to ask in group discussions. The leaders spend a lot of time answering these kinds of personal questions.

The Effect of Mass Media on the Three Campaigns

According to Dr. Phoolcharoen (1998), at present, 99% of the Thai people have already heard of HIV/AIDS. Such a high rate of awareness must have been the result of the government’s mass media “blanket” campaigns that were conducted during the first stage of AIDS campaigns in Thailand from 1987 to 1990 (Kunanuson, 1998; Ungphakorn & Sittitrai, 1994). However, many interviewees agreed that mass media could only create awareness and knowledge among the target audience, not attitudinal and behavioral change (Pasuk, 1998; Navy, 1998; Phanuphak, 1998; Carl, 1998; Tienudom, 1998; Chatiketu, 1998). Therefore, a different approach—the use of interpersonal communication—has been applied to the three campaigns by the campaign practitioners of the Thai Red Cross Society.

Although none of the three Thai Red Cross campaigns has had any recent mass media back-up campaigns, mass media messages about HIV/AIDS distributed earlier in Thailand have already affected audience members of the three campaigns by casting aspersions on people who are in risk groups (i.e., intravenous drug users, homosexuals,

and commercial sex workers). Therefore, audience members appear to have already judged themselves whether they belong to the risk groups.

This kind of prejudgment makes it difficult for the staff of the three projects to educate people on the fact that HIV can be transmitted to any individual in Thai society. Only in the Facts for Life campaign that audience members are more open-minded to correct their misunderstandings about HIV/AIDS. The staff members of the other two campaigns have to tackle the prejudged attitudes of their participants before they can actually educate them about HIV/AIDS facts and prevention. According to the researcher's observations, some participants in the meetings of the Wednesday Friends Club and Slum Communities project acted as if they were only observing, not participating in, the campaigns' meetings. However, the mass media have at least given some information in HIV/AIDS to the Thai people from every walk of life.

Overall Evaluation of the Three Campaigns

Of all the three Thai Red Cross campaigns, the one that can cover the largest target audience is the HIV/AIDS Prevention for Slum Communities Project. Between 1993 and 1996, the project conducted the HIV/AIDS prevention activities in 18 slum communities annually and in 1997, the staff went into 10 more communities. Each community has 500-2,000 members. Therefore, the project could reach more than 35,000 slum dwellers. However, the project sometimes has a limitation regarding the venues in which HIV/AIDS presentations take place. The HIV/AIDS slide presentation cannot be organized if there is no space available to set up the screen. During the period the staff conducted a parallel campaign—the HIV/AIDS network campaign—from 1994 to 1996,

it had recruited more than 150 health volunteers from slum communities. These volunteers are now conducting the network activities in their communities.

Although the Wednesday Friends Club can reach many target groups (e.g., high school students and factory workers), the Club has to wait for its target groups to contact the staff to give presentations. Therefore, the Wednesday Friends Club is considered reactive, not proactive like the Slum Communities and Facts for Life projects.

Facts for Life: Curriculum for Youth cannot reach many people at a time because of some limitations, such as the lack of staff, trained peer leaders, and venue (not every school and college has the Red Cross Youth program). However, the staff is able to recruit more peer leaders and plans to promote its campaign among the secondary schools and colleges in Bangkok that do not have the Red Cross Youth activities (Navy, 1998).

Among the three campaigns studied, the Facts for Life campaign is the most effective regarding the results in behavioral change. According to the researcher's direct observations, the participants in the campaign's meetings appeared to be willing to discuss their attitudes, behaviors, beliefs, and misunderstandings about gender differences, sex, and HIV/AIDS. The staff prefers the small group settings in which not more than 12 participants are involved in informal discussions. The direct input from the peer leaders helps the participants develop life skills as well as HIV/AIDS prevention techniques.

The Slum Communities project is able to create a remarkable attitudinal change among its audience members, according to the researcher's observations. Many members of slum communities have joined in the project's HIV/AIDS network in which the people

who once participated in the educational campaign help disseminate the information about HIV/AIDS and home care techniques to other people (Pasuk, 1998).

The Wednesday Friends Club appears to be quite incompetent compared to the other two campaigns because of some limitations, such as the lack of trained HIV-infected speakers and control over the number of meetings, length of presentation, audience, and venue. These limitations result in the ineffectiveness of the campaign in spite of the staff's good will and effort.

The three Thai Red Cross campaigns use interpersonal communication to disseminate their messages; however, the audience has already received other HIV/AIDS messages from mass media during the past decade. Dr. Phoolcharoen (1998) noted that mass media, especially television, played a significant role in creating HIV/AIDS awareness among the Thai population. He estimated that 95% of Thai people have access to television. Therefore, the use of interpersonal communication merely reinforces the mass media messages the audience has already received via televised public service announcements, radio spots, and articles in newspapers and magazines.

Despite such pervasive exposure to HIV/AIDS information, misunderstandings about the disease still prevail in Thai society. Interpersonal communication is a very effective tool to fix the people's misunderstandings, such as "AIDS can be cured by herbal medicine," and undesirable attitudes, which is discrimination against people with HIV and AIDS.

CHAPTER V

Conclusion

Summary and Discussion

AIDS Campaigns in Thailand. Since the death of the first AIDS patient in Thailand in 1984, the country has been fighting continuously against the disease. At first, the Thai government did not inform the general public about AIDS because it viewed the disease as just one of the many communicable diseases Thailand had to deal with (Ungphakorn & Sittitrai, 1994). However, the government later implemented several national AIDS prevention policies and strategies to stop the spread of HIV infections. In 1989, the Minister of Public Health officially announced to the public that HIV/AIDS had become an epidemic and three groups of people were labeled as risk groups: intravenous drug users, homosexuals, and commercial sex workers (Yuntadilok, 1997). The most recent effect of AIDS in Thailand is the problem of the children who are infected through their mothers as well as orphans whose parents died of AIDS. These two problems will be the next challenge to the Thai government as it seeks ways to solve them.

Kunanuson (1998) noted that there were three phases of HIV/AIDS campaigns conducted by the Thai government during the past decade: health education and social campaigns (1987-1990), multisectorial collaboration campaigns (1991-1995), and community mobilization campaigns (1996-present). During the first phase of the government's campaigns, massive amounts of money were spent on dissemination of HIV/AIDS messages through mass media (Ungphakorn & Sittitrai, 1994; Lyttleton, 1996; Yuntadilok, 1997).

In 1991, during the second phase of campaigns, the government founded what was later called the National AIDS Committee (NAC), which has been chaired by every Prime Minister from then on. The National AIDS Committee's most important task is to launch a national AIDS prevention and control plan every five years. At present, the country is under the second AIDS plan (1997-2001), which is called the National Plan for Prevention and Alleviation of HIV/AIDS (Yuntadilok, 1997). It was during this second phase that the Thai government paid more attention to the collaboration with non-governmental organizations (NGOs), both local and international. These smaller organizations could reach larger populations as opposed to the government's campaigns, which appeared to use a top-down approach (Ungphakorn & Sittitrai, 1994). Mass media were also used in this phase.

In the last phase, from 1996 to the present, the government has realized that the use of community-based campaigns is more effective than mass media campaigns when the goal is behavioral change. The government's use of mass media has decreased because the funds now go to small-scaled campaigns conducted at provincial and community levels. Health personnel, trained peer leaders, and local volunteers are now the major disseminators of HIV/AIDS information. These groups of people reinforce the messages delivered by mass media and create a better understanding of the current AIDS situation among the Thai people.

Overall, the campaigns conducted by the governmental and non-governmental organizations have resulted in a decreasing trend of new HIV infections (Nelson et al., 1996; Bodharamik, 1998). Although 99% of the Thai people now know about

HIV/AIDS (Phoolcharoen, 1998), their knowledge does not always translate to attitudinal and behavioral change. Mass media campaigns have been able to inform people about the danger of HIV/AIDS, but such campaigns cannot reach the goal—change of attitudes and behaviors among the target audiences (Pasuk, 1998; Navy, 1998; Phanuphak, 1998; Carl, 1998; Tienudom, 1998; Chatiketu, 1998).

The government is now beginning to conduct more campaigns at the community level as a result of the limitations of mass media campaigns (e.g., high costs and little effects on behavioral change). However, many non-governmental organizations have been conducting a variety of HIV/AIDS information campaigns at this level for many years (Phanuphak, 1998; Carl, 1998; Tienudom, 1998). The Thai Red Cross Society is one of the experts in HIV/AIDS prevention campaigns among non-governmental organizations in Thailand. The Society has conducted many community-based outreach projects in Bangkok and other provinces since the mid-1980s.

The three Thai Red Cross campaigns. This thesis is a case study of three Thai Red Cross campaigns that are being conducted in Bangkok. The researcher found that these HIV/AIDS prevention projects, which are the Wednesday Friends Club, the HIV/AIDS Prevention for Slum Communities Project, and Facts for Life: Curriculum for Youth, have many similarities and differences as follows.

First, the three campaigns are aimed at slightly different target audiences. The staff of the Wednesday Friends Club said that it did not have any specific target group (Suphonphak, 1998; Suwannawong, 1998). However, according to the staff as well as the researcher's observations, the Club's audiences are secondary school and college

students, white-collar workers, and factory workers. The target group of the Slum Communities project is slum dwellers in the Bangkok metropolitan area, whereas the target audience of the Facts for Life campaign is high school and college students. The three campaigns aim at both genders.

According to the researcher's observations, the Wednesday Friends Club has to wait for the public to contact the staff before it can prepare a presentation. It could have reached more people if it had conducted more public relations regarding its activities and proactively sought out target groups for presentations. However, the Club may not be able to fix this problem since many HIV-infected members do not want any publicity of the Club out of the fear that their HIV status will be revealed (Suphonphak, 1998; Suwannawong, 1998). The Facts for Life program is gaining ground because the staff is able to recruit more peer leaders. The program is expanding into high schools that do not have the Red Cross Youth activities (Navy, 1998). The Slum Communities project has attracted many people during the time the campaign has been conducted. The staff creates an AIDS information network of youth and housewives in slums, which will help inform more people about the risks of HIV/AIDS in the future (Pasuk, 1998).

The theme of the messages of the three campaigns is that people who are not HIV-infected can live with people with HIV and AIDS in the society because HIV cannot be transmitted through casual contact. All three campaigns educate their audience members about HIV/AIDS prevention. A distinctive feature of the Wednesday Friends Club's messages is the life stories of HIV-infected volunteers who work as speakers for

the Club's public outreach programs. The Facts for Life project also puts an emphasis on life skills, which are very helpful for its young participants.

Overall, the media used in the three campaigns are picture charts, brochures, and booklets, which are mostly about HIV/AIDS and other sexually transmitted diseases. The Wednesday Friends Club and the Slum Communities project also use slides and videotapes whenever they can find a suitable venue. Besides these so-called small media, the campaigns do not use any other mass media in their activities.

According to the researcher's direct observations, it is obvious that mass media has already informed the Thai people about the danger of AIDS and high risk behaviors (i.e., sharing needles, patronizing prostitutes, and having unprotected sex). However, many people do not apply what they have learned from the media to their lifestyles. The use of interpersonal communication to educate people more intensively about AIDS prevention can help solve this problem by reinforcing the messages disseminated through the mass media and correcting misunderstandings among the people in Thai society. Among the three campaigns studied, the Facts for Life project is the most effective campaign, with the greatest potential to really change the participants' attitudes and behaviors (Navy, 1998; Carl, 1998).

Of all the campaigns, the Wednesday Friends Club's outreach program appears to be the most poorly organized. The Club's presentations are not very informative although the speakers have been trained by experienced health professionals, according to the researcher's observations. However, the Club's staff is willing to send volunteer speakers to any place in the Bangkok metropolitan area. Therefore it is accessible and

also available for every kind of organized meeting, ranging from a group of 10 white-collar workers to a crowd as large as 1,000.

The Slum Communities campaign can cover the largest target audience.

According to Pasuk (1998), the project has already reached more than 35,000 participants from 1993 to the present. Meanwhile, the Facts for Life campaign can reach a much smaller number of people, but the interpersonal communication techniques have been put to use most outstandingly in this campaign. The staff members of the project prefer the small group settings in which not more than 15 people, including the peer leaders, are involved in friendly discussions. The setting as well as interpersonal communication contribute to the active participation of the audience. Moreover, it is easier for the peer leaders to build credibility and trust from such casual yet informational discussions, according to the researcher's direct observations.

The researcher found that the three Thai Red Cross campaigns could benefit Thai society in many ways. First, the Wednesday Friends Club serves as an example of a working groups that is run by all HIV-infected members. Although there are some organizational problems, such as the lack of professional administration, the Club still thrives. Since the Wednesday Friends Club is the first organization founded by HIV-infected people for people with HIV and AIDS, it can be a model for any group of HIV-infected people that needs to form such an organization to serve its own purpose, whether it be counseling service, HIV/AIDS education, or any other activity.

Second, the HIV/AIDS Prevention for Slum Communities Project is a model for AIDS campaigns at the community level. It can reach a huge target group since the staff

members really blend themselves into each slum community they work in, getting to know the members of the community little by little. The project can create a strong bond between the staff and the slum dwellers because they have to work together throughout a year during the time the campaign is conducted. If the community members join in the AIDS network program, they will become well-trained opinion leaders in their community long after the staff members have left.

Third, the Facts for Life: Curriculum for Youth project is a small yet very effective campaign, according to the researcher's direct observations. The campaign staff and peer leaders really reach one participant at a time when they discuss issues about HIV/AIDS together in a small group setting. Participants can ask whatever they want to know about AIDS, sexually transmitted diseases, drugs, birth control, and other problems in life. The program not only teaches young adults about AIDS, but it also helps participants develop many useful life skills, such as decision-making and negotiation skills. The researcher found that after the Facts for Life meetings, the staff, peer leaders, and participants have become friends and they have built an unofficial network of people working on AIDS education.

Contributions to the Literature

Many HIV/AIDS education and prevention campaigns conducted in the United States and Europe have been researched by Western scholars (Brown, 1991; CDC, 1994; de Vroome et al., 1994; Hausser & Michaud, 1994; Moatti et al., 1992; Ratzan, Payne & Massett, 1994; Træen, 1990). As a result, campaign practitioners in the West are well-informed about the effectiveness of AIDS campaigns—which techniques work and which

do not. However, not much research has been conducted on AIDS campaigns in other parts of the world, especially in Southeast Asia. This case study on three Thai Red Cross campaigns, therefore, broadens the research on HIV/AIDS campaigns to include Thailand, one of the countries that began the fight against AIDS a decade ago. This research contributes answers to questions about how to educate and motivate people to change their sexual behaviors as well as how to discuss and overcome cultural barriers involving sexual issues. This case study's contributions to the literature are as follows:

1. The researcher found that it is very important to carefully study the target audience of each campaign since the messages may not be suitable for all groups of people. Mendelsohn (1973) noted that a public communication campaign needed to identify its target as clearly as possible for the campaign to be effective.
2. The social marketing approach that was recommended for campaign design by Atkin and Arkin (1990), Manoff (1985), Solomon (1981), and Wallack (1990) was actually applied to the Facts for Life: Curriculum for Youth campaign during its design process and was thought to be useful for such campaign that targets a specific audience (Carl, 1998).
3. Dr. Wiput Phoolcharoen (1998) noted that television was the major tool in creating HIV/AIDS awareness in Thai society. Therefore, this finding supports those of Atkin and Arkin (1990) as well as Bush and Boller (1991). Lyttleton (1996) found that the Thai government used many public service announcements (PSAs) in many forms and the short ones appeared to be effective in drawing attention from the audience

because they were short and easy to understand. This finding indicates that the advantage of PSAs presented by Bush and Boller (1991) also worked in a different setting.

4. According to the in-depth interviews conducted by the researcher, mass media could only create awareness and knowledge among the Thai population, not behavioral and attitudinal change (Pasuk, 1998; Navy, 1998; Phanuphak, 1998; Carl, 1998; Tienudom, 1998; Chatiketu, 1998). This finding corroborates the study of Alcalay (1983) in which the author found that the role of mass communication in campaigns is not the changing of attitudes and behaviors but reinforcement of existing one.

5. This case study found that to change the attitudes and behaviors of the audience, a campaign needs to be conducted with the use of interpersonal communication. This practice is found in all of the three campaigns of the Thai Red Cross Society. Interpersonal communication was recommended as the best solution for campaign practitioners by Alcalay (1983), Solomon (1981), Flay and Burton (1990), McAlister (1981), Robinson (1981), Williams (1984), Backer et al. (1992), Catford et al. (1984), Maccoby and Solomon (1981), Engelberg et al. (1995), and Sheer and Cline (1995). To train the target audience in skills needed to translate intention into action, McAlister (1981) also suggested the use of interpersonal communication. This approach is regarded as the most effective in the Slum Communities and Facts for Life campaigns.

6. Although all three campaigns studied appear to use a community-based approach, it is the HIV/AIDS Prevention for Slum Communities Project that has put the most effort in the construction of HIV/AIDS community network in the slum communities the campaign has reached. As people in the communities join the network,

they will become more involved in HIV/AIDS educational activities. This kind of involvement is needed for a campaign to be effective, as Maccoby and Solomon (1981) found that “behavior change for better health can be accomplished through sustained community-based education . . .” (p. 115).

7. The three Thai Red Cross campaigns encourage participants to discuss issues about sex, such as teen pregnancy, abortion, family planning, condom use, HIV/AIDS, and other sexually transmitted diseases. Although it is still taboo in Thai society to talk about sex in public, the staff, especially that of the Facts for Life campaign, has removed this cultural barrier by using a friendly, yet polite approach throughout group discussions. Therefore, audience members of the Facts for Life campaigns do not appear to be tense, as they are involved in conversation about sex, according to the researcher’s direct observations. This kind of practice is strongly supported by the finding of Træen (1990) whose suggestion was to urge adolescents to communicate about such taboo issues to promote safer sexual behaviors.

Limitations of the Study

A few limitations of this case study should be noted. Since the study is qualitative, the results cannot be generalized. As a result, it is not possible to show the effect of the Thai HIV/AIDS campaigns at the societal level. However, information obtained from documentary analysis and in-depth interviews provides evidence that, at least, the trend of new infections is falling.

Directions for Future Research

The case study provides several opportunities for future research. First, more research on campaign effectiveness should be conducted in Thailand using the seven steps of Flay and Burton (1990).

Second, each of the three Thai Red Cross campaigns does not have an effective evaluation process. Although the Wednesday Friends Club and the Slum Communities project have had some forms of self-evaluation, such one-sided information is not enough to yield any clear picture of whether the campaigns have been effective. Each of the three campaigns should ask for at least an annual evaluation from outside agencies. The data obtained from such evaluations will enable the staff of the campaigns to solve any organizational, managerial, or campaign problems.

Third, more HIV/AIDS studies are needed to determine the most effective campaign designs for Asian countries where sex is still a taboo issue. The “Facts for Life” concept is a good example, but there should also be other approaches that are suitable for HIV/AIDS-related messages.

Finally, many studies in the West have suggested the use of interpersonal communication in public information campaigns (Backer et al., 1992; Brown, 1991; Catford et al., 1984; Chaffee, 1981; de Vroome et al., 1994; Engelberg et al., 1995; Flay & Burton, 1990; Maccoby & Solomon, 1981; McAlister, 1981; Robinson, 1981; Shah et al., 1991; Sheer & Cline, 1995; Solomon, 1981). Therefore, the link between mass media and interpersonal communication campaigns should be studied more thoroughly. The findings will certainly benefit campaign practitioners throughout the world.

References

AIDS Division (1996). *HIV/AIDS situation in Thailand: HIV/AIDS update (April 4, 1996)*. Bangkok, Thailand: AIDS Division, Department of Communicable Disease Control.

AIDS moves on despite the grim humour. (1995, June 19). *Bangkok Post*, p. 31.

Alcalay, Rina (1983). The impact of mass communication campaigns in the health field. *Social Science & Medicine*, 17, 87-94.

Asian Red Cross and Red Crescent AIDS Task Force (1997). *ART [Brochure]*. Kuala Lumpur, Malaysia: The International Federation's Regional Delegation.

Atkin, Charles K. (1981). Mass media information campaign effectiveness. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 265-279). Beverly Hills, CA: Sage.

Atkin, Charles, & Arkin, Elaine Bratic (1990). Issues and initiatives in communicating health information to the public. In Charles Atkin, & Lawrence Wallack (Eds.), *Mass communication and public health* (pp. 13-40). Newbury Park, CA: Sage.

Backer, Thomas E., & Rogers, Everett M. (1993). *Organizational aspects of health communication campaigns: What works?*. Newbury Park, CA: Sage.

Backer, Thomas E.; Rogers, Everett M.; & Sopory, Pradeep (1992). *Designing health communication campaigns: What works?*. Newbury Park, CA: Sage.

Bodharamik, Yooth (1998, January 21). [Director-General, Department of Communicable Disease Control, Ministry of Public Health, Nonthaburi, Thailand]. Personal Interview, Nonthaburi, Thailand.

Brown, Tim, & Xenos, Peter (1994, August). AIDS in Asia: The gathering storm. *AsiaPacific Issues* (No. 16). Honolulu, HI: The East-West Center.

Brown, William J. (1991). An AIDS prevention campaign: Effects on attitudes, beliefs, and communication behavior. *American Behavioral Scientist*, 34(6), 666-678.

Brown, William J., & Basil, Michael D. (1995). Media celebrities and public health: Responses to "Magic" Johnson's HIV disclosure and its impact on AIDS risk and high-risk behaviors. *Health Communication*, 7(4), 345-370.

Bush, Alan J., & Boller, Gregory W. (1991). Rethinking the role of television advertising during health crises: A rhetorical analysis of the federal AIDS campaigns. *Journal of Advertising*, 20, 28-37.

Cameron, Glen T., & Yang, Jian (1991). Effect of support and personal distance on the definition of key publics for the issue of AIDS. *Journalism Quarterly*, 68, 620-629.

Cappella, Joseph N. (1987). Interpersonal communication: Definitions and fundamental questions. In Charles R. Berger, & Steven H. Chaffee (Eds.), *Handbook of communication science* (pp. 184-283). Beverly Hills, CA: Sage.

Carl, Greg (1998, January 13). [Researcher, Program on AIDS, Thai Red-Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Catford, John C.; Dillow, Ian A.; Nutbeam, Donald; Waters, Estlin W.; & Woolaway, Martin C. (1984). Public health education campaigns are worth while. *British Medical Journal*, 288, 639-640.

Centers for Disease Control and Prevention (1994). *Surgeon General's report to the American public on HIV infection and AIDS*. Rockville, MD: CDC national AIDS clearing house.

Chaffee, Steven (1981). Mass media in political campaigns: An expanding role. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 181-198). Beverly Hills, CA: Sage.

Chaiyapet, Sasathorn (1996). *Handbook on group discussions: Facts for life: Curriculum for youth*. (Available from the Red Cross Youth Division, Program on AIDS, Thai Red Cross Society, 1871 Rama IV Road, Bangkok 10330, Thailand)

Chaiyapet, Sasathorn; Carl, Greg; & Jaiprayoon, Kompak (1996). *Friends tell friends: A peer-based HIV/AIDS curriculum for blue collar and white collar workers*. Bangkok, Thailand: Program on AIDS, Thai Red Cross Society.

Chatiketu, Patanapong (1998, January 12). [Researcher and Ph.D. Candidate, Bangkok University, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Clements, Alison (1992). Thailand stifles AIDS campaign. *British Medical Journal*, 304, 1264.

De Jong, Gordon F.; Richter, Kerry; & Isarabhakdi, Pimonpan (1996). Gender, values, and intentions to move in rural Thailand. *International Migration Review*, 30(3), 748-770.

de Vroome, Ernest M.M.; Paalman, Maria E.M.; Dingelstad, Anita A.M.; Kolker, Lilian; & Sandfort, Theo G.M. (1994). Increase in safe sex among the young and non-monogamous: Knowledge, attitudes and behavior regarding safe sex and condom use in The Netherlands from 1987 to 1993. *Patient Education and Counseling*, 24, 279-288.

Engelberg, Moshe; Flora, June A.; & Nass, Clifford I. (1995). AIDS knowledge: Effects of channel involvement and interpersonal communication. *Health Communication*, 7(2), 73-91.

Flay, Brian R., & Burton, Dee (1990). Effective mass communication strategies for health campaigns. In Charles Atkin, & Lawrence Wallack (Eds.), *Mass communication and public health* (pp. 129-146). Newbury Park, CA: Sage.

Ford, Nicholas, & Koetsawang, Suporn (1991). The socio-cultural context of the transmission of HIV in Thailand. *Social Science & Medicine*, 33(4), 405-414.

Gould, Peter (1993). *The slow plague: A geography of the AIDS pandemic*. Cambridge, MA: Blackwell.

Hausser, Dominique, & Michaud, Pierre Andre (1994). Does a condom-promoting strategy (the Swiss STOP-AIDS campaign) modify sexual behavior among adolescents?. *Pediatrics*, 93, 580-585.

Hyman, Herbert H., & Sheatsley, Paul B. (1947). Some reasons why information campaigns fail. *Public Opinion Quarterly*, 11, 50-61.

Kunanuson, Chaiyos (1998). [Kormoon samrab naksuksaa prinyaatow nangsao Pim Pisalsarakit [Information for Miss Pim Pisalsarakit, graduate student]]. Untitled work.

Limanonda, Bhassorn; Posayachinda, Vichai; Danthamrongkool, Vipaa; & Nokyoongthong, Mayuree (1996). *Report on an evaluation of HIV/AIDS intervention program in northern Thai rural communities: Sanpatong District, Chiang Mai*. Bangkok, Thailand: Institute of Population Studies, Chulalongkorn University.

Limanonda, Bhassorn; van Griensven, Godfried J. P.; & Nokyoongthong, Mayuree (1995). *Report on use of media and health education activities for AIDS prevention: Fieldnotes*. Bangkok, Thailand: Institute of Population Studies, Chulalongkorn University.

Lyttleton, Chris (1994). Knowledge and meaning: The AIDS education campaign in rural northeast Thailand. *Social Science & Medicine*, 38, 135-146.

Lyttleton, Chris (1996). Messages of distinction: The HIV/AIDS media campaign in Thailand. *Medical Anthropology*, 16, 363-389.

Maccoby, Nathan, & Solomon, Douglas S. (1981). Heart disease prevention: Community studies. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 105-125). Beverly Hills, CA: Sage.

Maibach, Edward W.; Kreps, Gary L.; & Bonaguro, Ellen W. (1993). Developing strategic communication campaigns for HIV/AIDS prevention. In Scott C. Ratzan (Ed.), *AIDS: Effective health communication for the 90s* (pp. 15-35). Washington, DC: Taylor & Francis.

Manoff, Richard K. (1985). *Social marketing: New imperative for public health*. New York: Praeger.

McAlister, Alfred (1981). Antismoking campaigns: Progress in developing effective communications. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 91-103). Beverly Hills, CA: Sage.

Mendelsohn, Harold (1973). Some reasons why information campaigns can succeed. *Public Opinion Quarterly*, 37, 50-61.

Merson, Michael J. (1992). AIDS: The world situation. *Journal of Public Health Policy*, 13, 18-26.

Moatti, J. P.; Dab, W.; Loundou, H.; Quenel, P.; Beltzer, N.; Anes, A.; & Pollak, M. (1992). Impact on the general public of media campaigns against AIDS: A French evaluation. *Health Policy*, 21, 233-247.

Muecke, Marjorie (1992). Mother sold food, daughter sells her body: The cultural continuity of prostitution. *Social Science & Medicine*, 35(7), 891-901.

National AIDS Committee. (1997). *National plan for prevention and alleviation of HIV/AIDS*. Bangkok, Thailand: NAC.

Navy, Uemporn (1998, January 23). [Project Coordinator, Facts for Life: Curriculum for Youth, Red Cross Youth Division, Thai Red Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Nelson, Kenrad E.; Celentano, David D.; Eiumtrakol, Sakol; Hoover, Donald R.; Beyrer, Chris; Suprasert, Somboon; Kuntolbutra, Surinda; & Khamboonruang, Chirasak (1996). Changes in sexual behavior and a decline in HIV infection among young men in Thailand. *The New England Journal of Medicine*, 335(5), 297-303.

Paisley, William J. (1981). Public communication campaigns: The American experience. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 15-40). Beverly Hills, CA: Sage.

Pasuk, Manop (1998, January 17). [Project Manager, HIV/AIDS Prevention for Slum Communities Project, Program on AIDS, Thai Red Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Perloff, Richard M. (1991). Effects of an AIDS Communication campaign. *Journalism Quarterly*, 68, 638-643.

Phanuphak, Praphan (1998, January 5). [Director, Program on AIDS, Thai Red Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Phoolcharoen, Wiput (1998, February 9). [Director, AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, Nonthaburi, Thailand]. Telephone Interview.

Population and Community Development Association (n.d.). *Koomue rueng rok AIDS samrab pooborihaan lae wittayakorn* [AIDS manual for executives and public speakers]. Bangkok, Thailand: PDA.

The Program on AIDS, Thai Red Cross Society (n.d.). Bangkok, Thailand: Thai Red Cross Society.

Ratzan, Scott C.; Payne, J. Gregory; & Massett, Holly A. (1994). Effective health message design: The America responds to AIDS campaign. *American Behavioral Scientist*, 38, 294-309.

Robinson, John P. (1981). Mass communication and information diffusion. In Morris Janowitz, & Paul M. Hirsch (Eds.), *Reader in public opinion and mass communication* (pp. 348-362). New York: Free Press.

Roloff, Michael E. (1981). *Interpersonal communication: The social exchange approach*. Beverly Hills, CA: Sage.

Shah, Iqbal; Thongthai, Varachai; Leoprapai, Boonlert; Mundigo, Axel I.; Prasartkul, Pramote; & Chamratrithirong, Aphichat (1991). Knowledge and perceptions about AIDS among married women in Bangkok. *Social Science & Medicine*, 33(11), 1287-1293.

Sheer, Vivian C., & Cline, Rebecca J. Welch (1995). Individual differences in sensation seeking and sexual behavior: Implications for communication intervention for HIV/AIDS prevention among college students. *Health Communication*, 7(3), 205-223.

Sills, Yole G. (1994). *The AIDS pandemic: Social perspectives*. Westport, CT: Greenwood Press.

Singer, Eleanor; Rogers, Theresa F.; & Glassman, Marc B., (1991). Public opinion about AIDS before and after the 1988 U.S. Government public information campaign. *Public Opinion Quarterly*, 55, 161-179.

Solomon, Douglas S. (1981). A social marketing perspective on campaigns. In Ronald E. Rice, & William J. Paisley (Eds.), *Public communication campaigns* (pp. 281-292). Beverly Hills, CA: Sage.

Stake, Robert E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Stroman, Carolyn A., & Seltzer, Richard (1989). Mass media use and knowledge of AIDS. *Journalism Quarterly*, 66, 881-887.

Suphonphak, Malee (1998, January 8). [Counseling Officer, Wednesday Friends Club, Program on AIDS, Thai Red Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Suwannawong, Paisal (1998, January 8). [Project Manager, Wednesday Friends Club, Program on AIDS, Thai Red Cross Society, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Tichenor, Philip J.; Donohue, George A.; & Olien, Clarice N. (1981). Mass media flow and differential growth in knowledge. In Morris Janowitz, & Paul M. Hirsch (Eds.), *Reader in public opinion and mass communication* (pp. 286-295). New York: Free Press.

Tienudom, Nimit (1998, January 22). [Social Worker, Northern AIDS Prevention Project, ACCESS, Bangkok, Thailand]. Personal Interview, Bangkok, Thailand.

Træen, Bente (1990). Awareness of an AIDS campaign directed at Norwegian adolescents. *Health Policy*, 16, 33-41.

Ungphakorn, Jon, & Sittitrai, Werasit (1994). The Thai response to the HIV/AIDS epidemic. *AIDS*, 8(2), s155-s163.

Wallack, Lawrence (1990). Mass media and health promotion: Promise, problem, and challenge. In Charles Atkin, & Lawrence Wallack (Eds.), *Mass communication and public health* (pp. 41-51). Newbury Park, CA: Sage.

Wiel, Brian (1992). *Every 17 seconds: A global perspective on the AIDS crisis*. New York: Aperture.

Williams, B. T. (1984). Are public health education campaigns worth while?. *British Medical Journal*, 288, 170-171.

World Health Organization (1991). *Regional plan for surveillance of HIV infection in the South-East Asia region*. New Delhi: Regional Office for South-East Asia, WHO.

Yin, Robert K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

Yuntadilok, Nuntawun (1997, December). *HIV/AIDS interventions in Thailand*. (Available from the Preventive Behavior and Social Development Section, AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, Nonthaburi, Thailand)

Yuntadilok, Nuntawun (1998, January 21). [Chief, Preventive Behavior and Social Development Section, AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, Nonthaburi, Thailand]. Personal Interview, Nonthaburi, Thailand.

Appendix A

Table of Acronyms

—

Table of Acronyms

AIDS	acquired immune deficiency syndrome
ART	Asian Red Cross and Red Crescent AIDS Task Force
AUSAID	Australian Agency for International Development
BMA	Bangkok Metropolitan Administration
CDC	Centers for Disease Control and Prevention
GDP	Gross Domestic Product
GO	governmental organization
HIV	human immunodeficiency virus
IDU	intravenous drug user
NAC	National AIDS Committee
NESDB	National Economic and Social Development Board
NGO	non-governmental organization
PSA	public service announcement
STD	sexually transmitted disease
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Appendix B

Letter of Approval from the Thai Red Cross Society

No 03414

June 26, 1997

Ms Pim Pisalsarakit
 2197 McLaughlin Ave., Apt. 4
 San Jose, CA 95122-3516
 USA

Dear Ms Pisalsarakit,

In reference to your letter of 24 June 1997 requesting permission to conduct case studies of three projects under the Program on AIDS, Thai Red Cross Society I am please to inform you that the Program on AIDS, Thai Red Cross Society is willing to provide you with both assistance and cooperation in conducting your research here in Thailand. We understand that the three projects concerned are the following:

1. The Wednesday Friends' Club
2. The HIV/AIDS Prevention for Slum Communities Project
3. Facts for Life: Curriculum for Youth, Red Cross Youth Division

We wish you a fruitful stay here as your research may prove beneficial to not only your academic career and the Program on AIDS, Thai Red Cross Society, but to many individuals and organizations through the dissemination of information about our experiences and programming.

If you or your thesis advisors are in need of any additional information, please contact the Program on AIDS at the address below.

Sincerely yours,

Dr. Praphan Phanuphak
 Director

Appendix C

Letter of Approval from the Human Subjects-Institutional Review Board

San José State
UNIVERSITY

**Office of the Academic
Vice President**
**Associate Vice President
Graduate Studies and Research**
One Washington Square
San Jose, CA 95192-0025
Voice: 408-924-2480
Fax: 408-924-2477
E-mail: gstudies@wanoo.sjsu.edu
<http://www.sjsu.edu>

TO: Pim Pisalsarakit
2197 McLaughlin Ave., #4
San Jose, CA 95122-3516

FROM: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies & Research

DATE: December 12, 1997

The Human Subjects-Institutional Review Board has approved
your request to use human subjects in the study entitled:

**"Thai Red Cross HIV/AIDS Prevention Campaigns
in Bangkok, Thailand: The Case of Three
Outreach Projects"**

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Serena Stanford, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at
(408) 924-2480.

The California State University:
Chancellor's Office
Bakersfield, Chico, Dominguez Hills,
Fresno, Fullerton, Hayward, Humboldt,
Long Beach, Los Angeles, Maritime Academy,
Monterey Bay, Northridge, Pomona,
Sacramento, San Bernardino, San Diego,
San Francisco, San Jose, San Luis Obispo,
San Marcos, Sonoma, Stanislaus

IMAGE EVALUATION TEST TARGET (QA-3)

APPLIED IMAGE, Inc.
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved