# STEER PEER MOBILIZER (SPM) MODEL FOR HIV/AIDS RISK REDUCTION AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN MSM HOTSPOTS, CHIANG MAI PROVINCE

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# รูปแบบกลุ่มแกนนำผู้ขับเคลื่อนการลดความเสี่ยงในการติดเชื้อ เอช ไอ วี เอดส์ ของกลุ่มชายที่มีเพศสัมพันธ์กับชายในแหล่งรวมตัวของจังหวัดเชียงใหม่

นางกรกนก เมืองประเทศ

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การวิจัยเชิงปฏิบัติการแบบการมีส่วนร่วม ครั้งนี้มีวัตถุประสงค์ เพื่อศึกษาผลของการใช้รูปแบบกลุ่มแกนนำผู้ขับเคลื่อนการลดความเสี่ยงในการติดเชื้อ เอช ไอ วี เอดส์ ของกลุ่มชายที่มีเพศสัมพันธ์กับชายในแหล่งรวมตัวของจังหวัดเชียงใหม่ โดยการนำเทคนิคการมีส่วนร่วมของชุมชน มาช่วยส่งเสริมสนับสนุนให้เกิดความร่วมมือ และความตระหนักในสาระสำคัญของการลดพฤติกรรมเสี่ยงในการติดเชื้อ เอช ไอ วี เอดส์ ของกลุ่มกลุ่มชายที่มีเพศสัมพันธ์กับชาย

การศึกษาวิจัยครั้งนี้ มีขั้นตอนการ ดำเนินการวิจัยที่สำคัญ 9 ขั้นตอน : 1) สร้าง และประสาน ความร่วมมือกับทุกภาคส่วนที่มีส่วนได้ส่วนเสีย 2) จัดประชุมร่วมกับองค์กรพันธมิตร 3) การสำรวจข้อมูลพื้นฐานของแหล่งรวมตัวของกลุ่มชายที่มีเพศสัมพันธ์กับชาย 4) การคัดเลือกแหล่งรวมตัวเพื่อการศึกษา, 5) การคัดเลือกกลุ่มแกนนำทางความคิดของกลุ่มชายที่มีเพศสัมพันธ์กับชาย 6) การสร้างกระบวนการการเรียนรู้แบบมีส่วนร่วมกับกลุ่มแกนนำทางความคิด 7) การดำเนินการฝึกอบรม แกนนำ 8) การลงมือใช้ปฏิบติการการแทรกแซงโดยแกนนำทางความคิด และ 9) กระบวนการประเมินผลการเรียนรู้และผลของการพัฒนาศักยภาพแกนนำทางความคิด ซึ่งแกนนำฯที่ผ่านการอบรม ได้รับมอบหมายให้ถ่ายทอดข้อความและมีการสนทนากับเพื่อนของพวกในแหล่งรวมตัวต่างๆ โดยใช้กลยุทธ์การเปลี่ยนแปลงพฤติกรรม ที่ได้อบรมมา การประเมินผลสำเร็จของการใช้รูปแบบแกนนำนี้ พิจารณาจาก คะแนน การ ทดสอบความรู้เกี่ยวกับเอชไอวี / เอดส์และทัศนคติและพฤติกรรมทางเพศ รวมถึงพฤติกรรมเสี่ยงที่จะติดเชื้อเอชไอวีของกลุ่มประชากรที่ศึกษาก่อนและหลังปฏิบัติการของแกนนำฯ ซึ่งพบว่ามีความ แตกต่างของความรู้ และ ทัศนคติและพฤติกรรมทางเพศ อย่างมีนัยสำคัญ นอกจากนั้นพฤติกรรมเสี่ยงที่จะติดเชื้อเอชไอวีก็ลดลงด้วย (P <0.001) ปัจจัยที่มีผลต่อการยอมรับ และนำรูปแบบการแกนนำไปปฏิบัติ ก็คือ เนื้อหาในโปรแกรมการฝึกอบรมและทักษะการเป็นวิทยากรกระบวนการของผู้จัดการอบรม

สรุป : รูปแบบ แกนนำผู้ขับเคลื่อนการลดความเสี่ยงในการติดเชื้อเอชไอวีของกลุ่มชายที่มีเพศสัมพันธ์กับชาย ในจังหวัดเชียงใหม่ ที่ได้นำกลวิธีและ กระบวนการมีส่วนร่วม มาผนวกใช้ร่วมกับกลวิธีผู้นำทางความคิดนี้ สามารถช่วยส่งเสริมสนับสนุนให้เกิดการลดพฤติกรรมเสี่ยงในการติดเชื้อเอชไอวีในกลุ่มชายรักชายในเชียงใหม่ได้อย่างมีนัยสำคัญทางสถิติ และเป็นรูปแบบการพัฒนาที่มีความสอดคล้อง และเหมาะสมกับบริบทของประเทศไทยเป็นอย่างยิ่ง

สาขาวิชา...วิจัยเพื่อการพัฒนาสุขภาพ… ลายมือชื่อนิสิต…….....

ปีการศึกษา .....2554..... ลายมือชื่อ อ. ที่ปรึกษาวิทยานิพนธ์หลัก.....

ลายมือชื่อ อ. ที่ปรึกษาวิทยานิพนธ์ร่วม.....

# # 4989725020: MAJOR RESEARCH FOR HEALTH DEVELOPMENT

KEYWORDS : STEER PEER MOBILIZER (SPM) / MSM / HOTSPOT / HIV/AIDS RISK REDUCTION BEHAVIOR/ INTERVENTION.

KORNKANOK MUANGPRATADE: STEER PEER MOBILIZER (SPM) MODEL FOR HIV/AIDS RISK REDUCTION AMONG MEN WHO HAVE SEX WITH MEN IN MSM HOTSPOTS, CHIANG MAI PROVINCE. ADVISOR: ASST.PROF. RATANA SOMRONGTHONG, Ph.D., CO-ADVISORS: SURASING WISRUTARATNA, Ph.D., 150 pp.

This study aimed to establish a key MSM well-liked persons who were taught to endorse actively and visibly the importance and acceptability of behavioral change, as well as to convey strategies for change implementation, and produce reductions in MSM population who engaged in high-risk activities especially produce concomitant and population-wide increases in HIV/AIDS prevention's concern, they are called as "Steer Peer Mobilizer (SPM).

The study using a Participatory Action Research approach was conducted. The research involved 9 steps: 1) Established a partnership with stakeholders, 2) Organize a meeting with partner organizations, 3) Baseline survey, 4) Selection of MSM hot spots, 5) Identification of Steer Peer Mobilizer (SPM), 6) Formulation of Learning Process, 7) Conducting a training of SPM, 8) Implementation of SPM and 9) Evaluation of Learning Process and Outcome of Capacity Development. In the model implementation process, 20 trained SPMs were assigned to convey message and having conversations with their 3 identified peers focused on the utilization of behavioral change strategies. Pre-test and post test intervention scores of HIV/AIDS knowledge and attitude and sexuality as well as HIV infection risk behavior of the study group were compared to reveal the level of changes affected by the intervention. The primary outcome was the differences of HIV/AIDS knowledge and attitude and sexuality perception at 3 months after intervention completed. The secondary outcomes were the reduction of HIV risk behavior at 3 months after intervention completed.

The result showed that HIV/AIDS knowledge and attitude and sexuality perception of the study group were significantly higher when compared between pre-intervention test and the post-test . The mean scores of HIV/AIDS knowledge and attitude and sexuality perception after intervention were higher than those before intervention ($P<0.001$). Also those of them after intervention were higher reduced in HIV risk behavior ($P<0.001$).The factors that effect on the acceptance of SPM model were training program contents and facilitation techniques used by the research team. Increasing of HIV/AIDS knowledge, awareness, and concern as well as reduction in HIV risk behavior were positively effect on the success of HIV/AIDS prevention pram for MSM group.

Conclusion: Steer Peer Mobilizer (SPM) model with the focus of participatory action process significantly brought in a reduction of HIV risk behavior among MSM in Chiang Mai. This development model is documented as an innovative approach consistent to Thai context.

Field of Study: Research for Health Development Student's Signature……..

Academic Year:..…2011…… Advisor's Signature……..

Co-advisor's Signature ...……

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| HIV | Human Immuno Deficiency Virus |
| AIDS | Acquired Immuno Deficiency Syndrome |
| MSM | Men who have Sex with Men |
| POL | Popular Opinion Leaders |
| NGO | Non-governmental organization |
| CBO | Community-Based Organization |
| SPM | Steer Peer Mobilizer |
| TG | Transgender |
| BCC | Behavior Change Communications |
| DIC | Drop-in Center |
| MSW | Male Sex Worker |
| FSW | Female Sex Worker |
| STI | Sexually Transmitted Infection |
| USAID | United States Agency for International Development |

# CHAPTER I

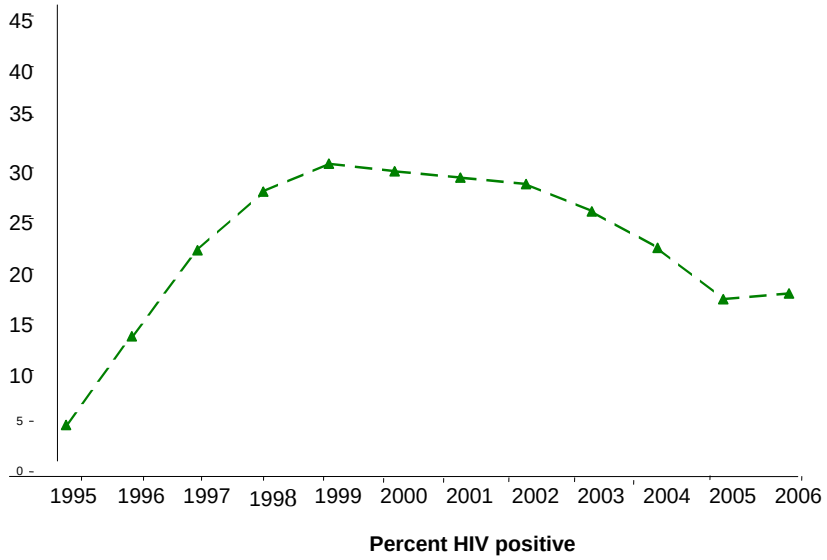
# INTRODUCTION

## 1.1 Rationale and Justification

Thailand, a Southeast Asian country with a total population of about 64 million people is known to the world as a model for effective AIDS control programs in a developing country. The public health infrastructure in Thailand quickly adapted to the AIDS epidemic, and prevention efforts went into effect in the 90's with the creation of the AIDS Division within the Department of Communicable Disease Control (CDC) of the Ministry of Public Health (MOPH) (UNAIDS: 2002). What emerged was the *100% Condom Use Program,* which later became the model program for other developing countries (Rojanapithayakorn et al.: 1996, Hannenberg et al.: 1998, Hannenberg et al.: 1994). In this program, the government aggressively enforced a 100% condom policy among brothel-based female sex workers (FSW) in Thailand. That commitment by the highest level of authority in Thailand in the early 90's prevented a very rapid epidemic from increasing further. Consequently, HIV prevalence and incidence rates dramatically decreased (Ministry of Public Health [MOPH], 2005). In addition to free condom distributions, MOPH also promoted AIDS education in the brothels, as well as in schools. Children in elementary schools were taught about AIDS. The result was a control of the epidemic, with a significant drop in incidence rates among the general population (UNAIDS: 2002). Although

prevalence among female sex workers was as high as 30% in 1999 (see Figure 1.1) (The Status and Trend of HIV/AIDS/STI Epidemics in Asia and the Pacific, 2005).

**FIGURE 1.1: HIV prevalence among female sex workers in Thailand, 1989 - 2000**




Thailand's HIV-prevention campaigns have been relatively successful, reducing the estimated number of new HIV infections from 142,819 in 1991 to 19,500 in 2004 (Ministry of Public Health [MOPH], 2005). However the AIDS crisis in Thailand continues to grow as the estimated more-than half- million Thais infected with HIV progress to symptomatic AIDS, even as new infections occur. HIV/AIDS is not distributed evenly throughout Thailand. The northern region has been particularly heavily affected, especially the upper north, while the northeast is the least affected in terms of HIV prevalence (MOPH, 2005). However, there remains considerable concern about the potential for 'new' outbreaks of the disease in Thailand.

Empirically, only a few of developing countries in the world would have effective public policy to critically move on HIV/AIDS prevention and control programs on a national scale, but Thailand is an exception. In the 1990s, a massive

program that began to control HIV reduced visits to commercial sex workers by half, raised condom usage, decreased the prevalence of STIs (Sexually Transmitted Infections) dramatically, and achieved substantial reductions in new HIV infections (UNAIDS, 2004). Thailand through this, it is a reminder that success has been derived from well funded, politically supported and comprehensive prevention programs which have saved millions of lives as shown in a critical reduction of new HIV infections from 143,000 in 1991 to 19,000 in 2003 (UNAIDS, 2004). Nevertheless, not few but over 500,000 people in Thailand are living with HIV/AIDS, and in 2009 the data indicated 28,000 people died from AIDS (UNAIDS, 2010). Unless past efforts are sustained and new sources of infection are addressed, the striking achievements made in controlling the epidemic could now be put at risk. Factors such as an increase in risky sexual behavior especially among MSM group of population and a rising number of STI cases (National AIDS Prevention and Alleviation Committee, 2010) have led to concerns that Thailand could face a resurgence of HIV and AIDS in coming years.

The Thai AIDS epidemic is a full-growth one, induced by heterosexual transmission. While the epidemiology of HIV among Thai female sex workers has been extensively studied, men who have sex with men (MSM) and male sex workers (MSW) populations have been less studied and have very different characteristics. MSM and MSW are understudied in Thailand for numerous reasons, one being stigma and discrimination from different facets of society, particularly from the government (Celentano D.D., 2005). In Thailand, homosexuality is tolerated, but not really accepted. Furthermore, MSM and MSW are hard-to-reach populations. It is hypothesized that these special populations are contributing significantly to the “hidden epidemic” of HIV

in Thailand. Therefore, studying the social, behavioral, and biologic mechanisms in these populations will have remarkable public health implications for Thailand.

**Men Reporting Same-sex Behaviors in Thailand remain at high risk for HIV infection.** In Thailand, men are required to serve a two-year term in the military (one year if they have a bachelor degree). Process of recruitment is haphazard, and is conducted at the district level. In this connection, several studies have been conducted among this population to measure HIV prevalence and incidence and associated risk factors. In these studies, between 3-17% of mostly 21 year old conscripts reported same-sex behavior (Hannenberg R, Rojanapithayakorn W, 1997; Beyrer C. et al., 1995; Jenkins RA. et al., 1999; Kitsiripornchai S. et al., 1998; Nelson KE., 2002). And throughout the 90s, having had same-sex behaviors became increasingly associated with HIV infection: significant odds ratio of 2.78-3.52.

In 2003, among a total of 1,121 MSM recruited in Bangkok venues, 17.3% were found to be HIV-positive. In 2005, among a total of 821 MSM, 754 male sex workers (MSW), and 474 transgender (2049 individuals in all), recruited through similar Bangkok venues as well as venues in Chiang Mai and Phuket, 28.3% were found to be HIV-positive. This high prevalence indicates a need for more effective behavioral and biomedical interventions. A cohort of MSM is now being recruited to evaluate feasibility of potential HIV prevention research (Van Griensven, 2003-2005).

***Challenges to MSM Programming***

The challenges in developing MSM programming are highly influencing to social responsibility. First, many MSM do not identify themselves, and thus are

hidden from MSM-specific programming. This group is composing of most masculine-acting MSM, who may view sexual encounters with transgender individuals as heterosexual. Male sex workers are another group of people that often fail to identify as MSM. Even defining a particular group as male sex workers is considered a crucial problem since we have seen that exchange of money is common among many MSM who would not characterize themselves as sex workers. MSM programming is inhibited by stigma associated with male-male sex. Discrimination can be resulting in the missing of condoms and lubricant in places where male-male sex existed, such as in saunas and parks. Various campaigns aimed at MSM may be prohibited or denied funding, so that appropriate prevention messages are not available. Stigma is present at many levels. Male-male sex is illegal in 11 of the 23 countries surveyed, and in around other 12 countries MSM are subject to discretionary ill-treatment, certainly by police. Those providing or accessing HIV/AIDS prevention programming are often harassed, so MSM may avoid getting involved in providing or accessing this programming. When MSM venues are disregard, the only remaining possibility is stealthy deal with, which are greatly more likely to involve unsafe behaviors. The disregard of MSM relationships results in higher numbers of sexual partners and lower self-esteem, again leading to unsafe behaviors. Finally, the absence of a spoken, self-identifying MSM population obstructs the implementation of Western models and innovations of HIV prevention and behavior change, which are based on establishing behavior norms in a self-reinforcing community. Some successes have been achieved, however, in building Asian MSM communities that emphasize an integrated rather than individualized MSM identity. This suggests that HIV infection prevalence is still moderate but will increase unless behavioral changes among MSM population are quickly implemented.

Experience in many health promotion areas supports the essence of social influence as a determinant of population risk behavior patterns (Coates TJ., 1988; Mc Kusick L, Coates TJ, Wiley J, and Morin S, Stall R., 1987; Kelly J.A., 1990). Gay men who successfully implement risk reduction report greater peer support for behavior change than their unsuccessful counterparts (Kelly J.A. et al., 2004:305; Kelly J.A. et al., 2004:16; Rogers EM., 2004:16) while beliefs that one's friends have already made remarkably changes and that these changes will be well accepted predict compliance with HIV/AIDS risk reduction recommendations (Kelly J.A. et al., 2004:16; Rogers EM., 2004:16). Reductions in high-risk sexual behavior among homosexual men in urban centers appear linked to new norms in the gay communities of large cities which discourage high-risk activities such as unprotected anal intercourse and encourage precautionary steps such as condom use or other safer sex modifications (US Bureau of the Census, 1986; Campbell DT and Stanley JC, 1963). Persons frequently seek the advice of friends concerning steps needed to reduce risk for AIDS (Van Griensven F., 2006).

From a community intervention perspective, HIV early prevention efforts could be enhanced by developing practical strategies for introducing new behavioral protocols and social norms that can encourage individuals to avoid high-risk activities and launch risk reduction precautions. To be most effective from an early prevention perspective, however, these changes must precede rather than follow dissemination of a wide spreading HIV infection in a risk population. Unfortunately, almost no experimental study has yet been pointed to the question of how best to produce these community-level behavioral changes.

Community-based interventions that can reduce the prevalence of high-risk sexual behaviors in vulnerable populations are great need in our efforts to prevent HIV transmission (Kelly J.A., Sikkema K.J., and Holtgrave D.R., 1999). One type of community-level program shown to be effective in the research literature is known as the 'Popular Opinion Leader' (POL) approach. POL uses ethnographic techniques to systematically identify popular and socially influential members of the target population and recruits and trains these popular individuals in how to communicate HIV risk. Diffusion of innovation theory posits that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population (Kauth M.R,, St Lawrence J.S, and Kelly J.A., 1991). Once visibly modeled and accepted by natural opinion leaders, innovations then disseminate throughout a population, influencing others, so that interventions to change high risk behavior in groups with a high prevalence of HIV infection is required. The main purpose of this research was to experimentally test an AIDS prevention intervention based on diffusion of innovation/social influence principles. Because HIV/AIDS risk behavior levels remain high among gay men in Thailand, the project targeted homosexual men in their hot spots.

The HIV/AIDS epidemic in the Asia-Pacific region is native as well as cross-border in nature; and is concentrated in specific **"hotspots"**, usually urbanized areas, and specific sub-populations in those hotspots while at the same time having the potential to spread from one hotspot to another due to high mutability patterns. The sub-populations are best defined by the high-risk behaviors of injecting drug users, multiple and concurrent sexual partners, plus unprotected sex. Accordingly, this

current research proposes an attractive intervention, a Steer Peer Mobilizer model which is modified from the original idea of POL for motivation of safe sexual behavior among MSM in the available hotspots in Chiang Mai.

Due to sex is a complex and sensitive issue especially in a conventional society. To increase MSM's knowledge about safe sexual behavior for HIV/AIDS risk reduction, hence, require several factors of which the significant ones are: *messages* should be explicit and accurate, serve the reproductive health needs, and appropriate to the various stages of adults' lives. *Material* should be attractive and appropriate to ages and gender, and *method* should involve young adults themselves in the learning process. Their concerns, experiences, and needs have to be valued and respected according to the people-centered concept. Since Popular Opinion Leader (POL) is the biggest social influences in MSM' social lives**,** this study modified POL model with an application of participatory learning process that is considered highly influence to movement and potentiality of MSM key leaders to fully display roles and ability to promote sexual and health knowledge's perception and practice among MSM. Significantly this project is working to ensure that its prevention interventions target at-risk populations especially MSM group. Identifying and targeting interventions to match the needs of target populations is complicated, particularly when HIV/AIDS epidemics involve such groups that are often disregarded and discriminated against. Stigmatized populations are frequently hidden and hard to reach with any services and intervention programs. Absolutely, the current research strongly desires to examine the development of the intervention that draws from the strength of the successful model of POL and combines with the essence of participatory learning process in

order that the ultimate goal of HIV/AIDS risk behavior reduction and prevention of HIV infection among MSM can be achieved.

## 1.2 Research Questions

1.2.1 What is the knowledge, attitude, and practice on HIV/AIDS risk reduction gathering by SPMs?

1.2.2 How to promote HIV/AIDS risk reduction behavior to MSM group?

1.2.3 What is the plan setting by involvement of SPMs on HIV/AIDS risk reduction and prevention?

1.2.4 How to manage the participation of SPMs in HIV/AIDS risk reduction and prevention among MSM group?

1.2.5 Does SPM model reduce HIV/AIDS risk behavior among MSM group in their hot spots?

## 1.3 Research Objectives

1.3.1 General Objective

To establish a key MSM or so called “SPM” of widely known, trusted, and well-liked persons who were taught to adopt actively and visibly the importance and acceptability of behavioral changes, as well as to convey strategies for change implementation, and produce reductions in the proportion of men in the population who engaged in high-risk activities especially produce accompanying and population-wide increases in HIV/AIDS prevention’s concern.

1.3.2 Specific Objectives

1.3.2.1 To develop the SPM intervention to reduce HIV/AIDS risk behavior and promote safer sex practice in MSM group.

1.3.2.2 To examine the effects of SoupPM intervention on sexual and reproductive health attitudes and intentions to have safer sexual behaviors.

1.3.2.3 To examine the *acceptability* of the SPM intervention among SPM group.

1.3.2.4 To describe the target populations sexual risk.

1.3.2.5 To reduce HIV associated risk among the target population.

**1.4 Research Outcomes**

1.4.1 The primary outcome was an eligible role model MSM or so called "SPM model" who were taught and conceptualized to be supporting and agreeable to the importance and acceptability of behavioral change among MSM population.

1.4.2 The secondary outcomes

The SPM model could produce an increasing rate of condom use among MSM group at various MSM hotspots in Chiang Mai province as well as brought about a decrease in unprotected anal intercourse among all studies population and produced a greater accurate knowledge about HIV/AIDS infection and risk.

**1.5 Scope of this study**

Between March to September 2011, a participatory action research approach has been implemented starting with an establishment of partnership between the researcher and community-based organizations and followed by conducting a meeting with partner organizations, conducted a baseline survey to assess HIV infection risk behavior and AIDS knowledge of MSM population at all MSM hot spots, selection of MSM hot spots, recruitment of Steer Peer Mobilizers (SPMs), organized the Popular Opinion Leader training camp for SPMs at the Holiday Garden Hotel, Chiang Mai for

4 days, and afterwards all 20 trained SPMs convey strategies for change implementation by contracting to have conversations with 3 peers according to their own developed plans of activities for providing knowledge to their peers in their responsible hot spots as well as conducted a pre-intervention survey with each of their peers, post intervention survey was carried out at three months following the completion of the intervention in all targeted MSM hot spots. Ten among sixty of peers group were selected and received individual in-depth interview at one week after the completion of the intervention. The final step of this research as a part of evaluation of the project implementation was a reflection session and sharing experiences among SPMs and MSM community-based organizations to summarize what they learned of the project and their personal development and learning.

**1.6 Operational Definitions**

Brink and Wood (1994) suggested that every variable state in the purpose of the study should be operationally defined. The following terms were defined as:

1.6.1 ***Men who have sex with men*** or ***males who have sex with males*** (**MSM**) refers to men who engage in sexual activity with other men, regardless of how they identify themselves; many choose not to accept social identities of gay or bisexual. The term was created in the 1990s by epidemiologists in order to study the spread of disease among men who have sex with men, regardless of identity (UNAIDS, 2008). *MSM* is often used in medical literature and social research to describe such men as a group for clinical study without considering issues of self-identification.

As a constructed behavioral category, the term MSM had been in use in public health discussions, especially in the context of HIV/AIDS, since 1990 or earlier, but the coining of the initial's by Glick *et al.* in 1994 "signaled the crystallization of a new

concept” (Young RM and Meyer IH, 2005; Glick et al., 1994). This behavioural concept comes from two distinct academic perspectives. First, it was pursued by epidemiologists seeking behavioral categories that would offer better analytical concepts for the study of disease-risk than identity-based categories (such as "gay", "bisexual", or "straight"), because a man who self-identifies as gay or bisexual is not necessarily sexually active with men, and someone who identifies as straight might be sexually active with men. Second, its usage is tied to criticism of sexual identity terms prevalent in social construction literature which typically rejected the use of identity-based concepts across cultural and historical contexts. MSM are not limited to small, self-identified, and visible sub-populations. *MSM* and *gay* refer to different things: behaviors and social identities. *MSM* refers to sexual activities between men, regardless of how they identify, whereas *gay* can include those activities but is more broadly seen as a cultural identity. *Homosexuality* refers to sexual/romantic attraction between members of the same sex and may or may not include romantic relationships. *Gay* is a social identity and is generally the preferred social term, whereas *homosexual* is used in formal contexts, though the terms are not entirely interchangeable. Men who are non-heterosexual or questioning may identify with all, none, a combination of these, or one of the newer terms indicating a similar sexual, romantic, and cultural identity like *bi-sexual* and;

***Men who have Sex with Men (MSM)*** refers to a diverse population that includes any men who have had sex with one or more men. It is an inclusive term that is based solely on behavior and does not take sexual identity or attraction into account. The term includes MSM who consider themselves to be gay, bisexual, heterosexual, are questioning their sexual orientation, or do not identify their sexual orientation in any of these ways. It encompasses a wide range of MSM, including men who form a

lasting relationship with a primary male partner, men who participate in organized gay communities and those who do not, men who have both male and female partners, male sex workers, and men who engage in sex with male partners only in all-male settings such as prisons and militaries. Some transgender persons are MSM and should also be considered when addressing the needs of MSM and other most-at-risk populations. The term “MSM” has thus been adopted in an attempt to focus on behavior rather than identity, and to include all men who have sex with men, regardless of how they see themselves. It encompasses males who define themselves either by their sexual behaviors (e.g., gay men) or by their feminine gender identities (*katoey*), in addition to their masculine-identified sexual partners.

In this study, ***Men who have Sex with Men (MSM)*** particularly refers to all men who have sex with men, regardless of their sexual identity, sexual orientation and whether or not they also have sex with females, and/or refers to a biological man reporting at least one of the following behaviors in the last 12 months:

- insertive oral sex with another man; and/or
- receptive oral sex with another man; and/or
- insertive anal sex with another man; and/or
- receptive anal sex with another man.

1.6.2 **Steer Peer Mobilizer (SPM) refers to** a popular person among MSM group with potentiality and commitment to help in changing risky sexual norms and behaviors among MSN in their venue-based area.

1.6.3 **Hotspot refers to** a lively and popular area with a precise location of something or entertainment places in which MSM like to go individually or in a group to have fun, relax, conversation, working or to find new friends or sexual partners.

1.6.4 **Participatory Action Research** (PAR) is a recognized form of experimental research that focuses on the effects of the researcher's direct actions of practice within a participatory community with the goal of improving the performance quality of the community or an area of concern (Dick, 2002). In addition, PAR involves utilizing a systematic cyclical method of planning, taking action, observing, evaluating (including self-evaluation) and critical reflection prior to planning the next cycle (O'Brien, 2001; Mc Niff, 2002), and

**Participatory Action Research (PAR)** is research which involves all relevant parties in actively examining together current action (which they experience as problematic) in order to change and improve it. They do this by critically reflecting on the historical, political, cultural, economic, geographic and other contexts which make sense of it. Participatory action research is not just research which is hoped that will be followed by action. It is action which is researched, changed and re-researched, within the research process by participants. Nor is it simply an exotic variant of consultation. Instead, it aims to be active co-research, by and for those to be helped. Nor can it be used by one group of people to get another group of people to do what is thought best for them - whether that is to implement a central policy or an organizational or service change. Instead it tries to be a genuinely democratic or non-coercive process whereby those to be helped, determine the purposes and outcomes of their own inquiry." (Wadsworth Y., 1998)

In addition, PAR refers to the process that some people in the organization or the community participated together with the researcher through the course of the research from the start to the end of research result discussion, as to involve the target people with problems identification or searching problems of their community together with the research team. It is the process of the people in the organization or

the community as the powerful and enthusiastic participants in the research. The steps to conduct PAR especially require full participation from both people and researcher in; (Kemmis, S., & McTaggart, R.,2000)

- Participation in the study of problems and origins of the community;

- Participation in the search, design and development method to fix and reduce the community problems or to create something new for the community benefit or response to the need of community;

- Participation in planning of policies, works or projects to solve and reduce the community problems;

- Participation in utilizing the limited resources for the community benefit;

- Arranging and effectively improving the administrative development;

- Arranging funds in the community projects in accordance to own ability;

- Performing work according to the policies, work plan, structure and activities to reach the goal;

- Controlling, assessing and maintaining the project and the existing activities.

**1.7 Expected Outcomes and Benefits**

We anticipated that the Steer Peer Mobilizer model could have the following outcomes:

1.7.1 An increasing in condom use among MSM

1.7.2 A decrease in unprotected anal intercourse

1.7.3 Greater accurate knowledge about HIV/AIDS infection and risk behavior among MSM.

1.7.4 An increasing in awareness of an easily HIV infection among MSM group and leading to a better self-protection.

# CHAPTER II

# LITERATURE REVIEW

With a special aim of this research to establish a key men who have sex with men (MSM) or so called “SPM” who are widely known, trusted, and well-liked persons as well as they have received a Popular Opinion Leader (POL) peer education training to encourage them recognizing in the importance and acceptability of behavioral change strategies for changing implementation, and produce reductions in the MSM population who engaged in high-risk activities especially produce a wider increases in HIV/AIDS prevention’s concern. Researcher searched electronic databases, current journals, manuscripts submitted by various researchers, bibliographies of relevant articles, conference proceedings, and other reviews for published and unpublished reports from 1988 through 2009 and also asked local NGOs staff working in HIV prevention about new and ongoing studies that could construct and indicate the important facts and incredible lesson learns which can be summarized as follows:

2.1 Preliminary Studies

2.2 The Body of Knowledge Contributes to Model Development

2.3 MSM Quantitative and Qualitative Findings

2.4 HIV/AIDS Knowledge and Perception on Safe Sex among MSM

2.5 Participatory Action Research

2.6 Conceptual Framework of the Study

**2.1 Preliminary Studies**

This study was based on intersectoral-collaboration with several institutions in Thailand which include both community-based NGO's and government organizations. The following are preliminary studies on MSM and MSW in Thailand that the collaborating investigators have conducted to date.

**Chiang Mai Male Sex Workers Prospective Study:** The last and only large-scale study among male sex workers was done by my study team in collaboration with Dr. Chris Beyrer from Johns Hopkins University in 1995, using a prospective cohort design in 17 sex establishments in Chiang Mai (Kunawararak P et al., 1995; 9: 517-521). From 1989-1995, we had total enrollment of 1172 male sex workers. The median age of the sex workers was 20 years, with 13 % being under 18 years. 57% described themselves as heterosexuals. Median number of clients was 2 per week and the median price for sex was US $14. 58% reported always using condoms. Incident rates among male sex workers in our study ranged from 0 per 100 person years in 1989 to its peak of 16.8 per 100 person years in 1992, the overall incident rate was 11.8 per 100 persons per years.

**Chiang Mai Male Sex Workers Cross-sectional Study:** In 2000, formative research was conducted, using qualitative research methods to assess the men who have sex with men (MSM) situation in Chiang Mai. The result was appalling; many high school, college and university level students were practicing unprotected anal

intercourse, believing that they were not at risk. Furthermore, an escalating medium for anonymous sexual encounter are the internet chat rooms. Most Thai MSM reported having used oil-based lubricant with latex condoms during sexual activities. Oil can tear latex condoms. These findings suggest that adolescent males are practicing unsafe sexual behaviors [unpublished manuscript].

In June 2003, a cross-sectional behavioral risk survey was conducted among 198 male sex workers in 15 sex establishments highly frequented by MSMs in Chiang Mai, as part of the national sentinel surveillance (Guadamuz T.E. et al., 2004). In this survey, HIV prevalence was 7%, median age was 22 years, median number of clients was 2 per week, and the median time of sex work was 9 months (4 months for current establishment). Median payment per session was US $20. 17% had no formal education and 62% had less than 12 years. 65% of MSW described themselves as heterosexuals. Within the past month, 31.7% of MSW had casual sexual encounters, 76.8% reported always using condoms with male clients, 90% reported always using condoms with female clients, 55% reported always using condoms with casual sex partners, and 20.6% reported always using condoms with regular sex partners. Approximately 30% of MSW interviewed had used oil-based lubricants like lotion, soap, Vaseline, shampoo, and oil. This quantitative data confirms the earlier qualitative findings and therefore raises a red flag that indeed this population is engaging in risky behaviors, but there is still insufficient endorsement and measure to reduce this challenging situation.

**Bangkok Men who have Sex with Men Cross-sectional study**: This study was the first surveillance among MSM in Bangkok, and was carried out by van Griensven and his team at the Thailand Ministry of Public Health-US Centers for

Disease Control and Prevention Collaboration HIV/AIDS (TUC) (Van Griensven F., 2005, 19: 521-526). A community-based sample of MSM residing in Bangkok metropolitan area was assessed for HIV prevalence and associated risk factors. MSM were recruited from mapped venues where sexual activities took place using a venue day time sampling technique. The venues included saunas, public parks, and karaoke bars. This study was the first time the venue day time sampling was used in a developing country setting. A total of 1,121 MSM were assessed. HIV prevalence was 17.3%, median age was 25 years, 42.5 % completed university education, 43.8% had ever had an HIV test, and 36% reported unprotected sexual intercourse within the past 3 months. Lower education, recruitment from a park, self identification as homosexuals, and multiple male sex partners were significantly associated with HIV prevalence in a multivariate analysis.

**HIV Risk and Change of Sexual Behavior:** Not few men who have sex with men and bisexuals have never been thinking they are at higher risk than other group of populations. So far as we have known that HIV/AIDS affected MSM population since early years and they have put strong efforts to educate themselves about HIV/AIDS transmission (Hope, 1995a). Empirically, anyone's especially bisexuals who think and continue to believe in HIV/AIDS as a gay disease are those at particular risk. One study found that while bisexuals believed they were at higher risk than homosexuals, however they did not think they were more at risk than heterosexuals (Hope, 1995b).

Some studies have also explored the unbelievable discovery regarding HIV transmission, although the existing evidence has shown some significance but was affected from the previous studies. HIV was believed to be transmitted by semen in

pools, by sweating, shaking hands and sharing toilets (Hassad Rossi, 1993; Hope, 1995b). Royes was told by informants that “men who have sex with women can’t get AIDS,” and “if you look healthy you don’t have HIV or AIDS” (1993: 9). Hassad’s informants also believed that prayer, antibiotics, food and rest could cure HIV/AIDS.

Many comprehension findings are that although there has been some behavior change and unbelievable increasing of HIV awareness among MSM population since the early epidemic, however the perceives to behavior changed practice was still questionable. Royes (1993) found that although knowledge of condoms was high, their use was unpredictable. While over 90% of informants in a later study endorsed condom use as an effective way to reduce HIV infection, only about half were actually using them (Hassad Rossi, 1993; Hope, 1995b). Particularly, among the group of male sex workers, a recent study showed that the numbers of female sex workers who used condom are higher at three times when compared with MSM sex workers, this results indicated to the need to approach MSM as a different and specific group. Their results were sometimes so strange with previous studies. For example, they did not suffer from feelings of guilt or low self-esteem noted in other research. They did not believe that having sex with same gender was worse than any other “sin,” and had high self-esteem, considering from their opinions on their own attractiveness. The researchers considered MSM “a particularly vulnerable group” (Campbell & Campbell, 2001), due primarily to low use of condoms and other safer sex practices.

The study of Coates TJ in 1988 found that reductions in HIV/AIDS high-risk practices among gay men in big cities have been attributed, in part, to evolving social norms that now discourage risky practices and advocate the adoption of precautionary measures (Coates TJ. cited in Kelly J.A., 1988)

In 1997, Mc Kusick L. et. al studied the influential role of peer norms on HIV risk behavior patters which is further highlighted by findings that gay men who successfully reduce their high risk practices report greater peer support for making these changes (Mc Kusick L. et al., 1997). There is another similar study conducted by Kelly JA et. al that confirmed the result of strong associations between risk behavior levels and perceptions of the social/peer acceptability of condom use (Kelly JA et al., 1990).

A recent report on the results of a preliminary investigation on the effect of training popular opinion leaders in the gay community of a small city to serve as behavioral change endorsers to their friends and acquaintances predicted that "trendsetters" who endorse innovations can help to refine behavioral norms and standards (Johnson WD et al., 2008).

A series of studies has shown that interventions based on the POL model can reduce the prevalence and frequency of high-risk sexual behaviors in populations of men attending gay bars in small US cities, generally by magnitudes of approximately 30% from baseline risk behavior levels (Kelly et al., 1991, 1992, and 1997). The same effects replicated across several different community trials, including one large randomized multi-city trial (Kelly et al., 1997).

In the latter trial, there were large population-level reductions in mean frequency of unprotected anal intercourse (from 1.68 occasions in the past 2 months at baseline to 0.59 at 1-year follow-up) and increases in proportion of condom-protected anal intercourse (from 45 to 67%) in large community samples of men attending gay bars where the POL intervention had been conducted. In the trial’s

control cities, where AIDS education materials alone were distributed, no behavior change effects were found.

In addition to studies specifically evaluating the POL model, interventions that included the recruitment and training of popular opinion leaders as a program component have produced similar behavior change outcomes in a randomized community-level trial with inner-city women (Sikkema et al., 2000), a study with male commercial sex workers (Miller et al., 1998), and in a community intervention with young gay men (Kegeles et al., 1996).

Recently, there have been several reports of peer education programs for gay men in the United Kingdom that did not yield positive findings with respect to reductions in population-level high-risk sexual behavior. These included a project undertaken with gay men attending five gyms in London (Elford et al., 2001, 2002b) and a study carried out in gay bars in Glasgow and Edinburgh, Scotland (Flowers et al ., 2002).

The US studies examined as outcomes any unprotected anal intercourse occurring with male partners in the past 2 months, while the UK studies used outcomes reflecting unprotected behavior with casual or status-unknown partners during the past 3/12 months. In contrast to positive results found in the US studies, pre- and post-intervention surveys of gym and bar patrons in the UK projects did not show sexual risk behavior change and the studies' authors concluded that peer-based programs were not effective under the circumstances in which they were tested.

A review of HIV Risk Behavior Reduction following Intervention with Key Opinion Leaders of Population: An Experimental Analysis studied by Jeffrey A. Kelly et..al. suggested that AIDS risk behavior knowledge scores were high among men in each city even before intervention about AIDS was not a critical dimension in the populations studied and that intervention methods which induce behavior change implementation and social acceptability of changes are needed. Second, while it was anticipated that the intervention would alter perceptions of social norms, the norm measure did not reflect changes parallel to the population behavior shifts. Generalized changes in sexual behavior may precede peer norm changes rather than cause the initial adoption of risk reduction. In that case, elements of the intervention responsible for population behavior change may have included frequent safety prompts delivered by credible peers, conversational dissemination of suggestions for implementing precautionary changes, legitimization of making risk reduction changes by opinion leaders, or other factors.

A controlled trial study implemented in the United States provides persuasive evidence that peer education can bring about a significant reduction in high risk sexual behavior among homosexual men. For example, peer educators recruited from “gay” bars in small towns made a crucial impact upon sexual behavior at a community level. The proportion of homosexual men who engaged in unprotected anal intercourse (UAI) decreased by about one third following the peer led intervention whereas no change was observed among men using bars in towns without the intervention (controls) (Kelly JA et al., 1992; 82:1483–9, Kelly JA et al., 1991; 81:168–71, and Kegeles SM, Hays RB, and Coates TJ, 1996; 86:1129–36).

## 2.2 The Body of Knowledge Contributes to Model Development

**Diffusion of Innovations Theory** which is considered the root of this study where applied as a principal conceptual framework and guiding how this research should move forward. The theory seeks to explain how, why, and at what rate new dimensions of thought and innovation can spread through cultures. Everett Rogers, a professor of rural sociology, popularized the theory in his 1962 book *Diffusion of Innovations*. He said diffusion is the critical process by which an innovation is communicated through certain channels over time among the members of a social system. The origins of the diffusion of innovations theory are varied and bridge across multiple disciplines.

The concept was first studied by the French sociologist Gabriel Tarde (1890) and by German and Austrian anthropologists such as Friedrich Ratzel and Leo Frobenius (The Building of Cultures, 1982). Its basic epidemiological or internal-influence form was formulated by H. Earl Pemberton (1936, 1 (4): 547-556), who provided examples of institutional diffusion such as postage stamps and compulsory school laws. In 1962 Everett Rogers, a professor of rural sociology published *Diffusion of Innovations*. In the book, Rogers synthesized research from over 508 diffusion studies and produced a theory for the adoption of innovations among individuals and organizations. The book proposed 4 main elements that influence the spread of a new idea: the innovation, communication channels, time, and a social system. That is, diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. Individuals progress through 5 stages: knowledge, persuasion, decision, implementation, and confirmation. If the innovation is adopted, it spreads via various communication

channels. During communication, the idea is rarely evaluated from a scientific perspective; rather, subjective perceptions of the innovation influence diffusion. The process occurs over time. Finally, social systems determine diffusion, norms on diffusion, roles of opinion leaders and change agents, types of innovation decisions, and innovation consequences. To use Rogers' model in health requires us to assume that the innovation in classical diffusion theory is equivalent to scientific research findings in the context of practice, an assumption that has not been rigorously tested.

The origins of the diffusion of innovations theory are varied and span across multiple disciplines. Rogers identifies six main traditions that impacted diffusion research: anthropology, early sociology, rural sociology, education, industrial, and medical sociology. The diffusion of innovation theory has been largely influenced by the work of rural sociologists.

The key elements in diffusion research are: Innovation, Rogers defined as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption" (Rogers, 1983: 11); Communication channels is "the means by which messages get from one individual to another" (Rogers, 1983: 17); Time "the innovation-decision period is the length of time required to pass through the innovation-decision process" (Rogers, 1983: 21); Rate of Adoption is the relative speed with which an innovation is adopted by members of a social system (Rogers, 1983: 21, 23); and Social system which is defined as a set of interrelated units that are engaged in joint problem solving to accomplish a common goal (Rogers, 1983: 24)

The Mechanism of diffusion of innovation theory is a five–step process. This process is a type of decision-making. It occurs through a series of communication channels over a period of time among the members of a similar social system. Ryan

and Gross first indicated the identification of adoption as a process in 1943 (Rogers, 1962: 79). Rogers categorizes the five stages (steps) as: awareness, interest, evaluation, trial, and adoption. An individual might reject an innovation at any time during or after the adoption process. In later editions of the Diffusion of Innovations Rogers changes the terminology of the five stages to: *knowledge, persuasion, decision, implementation, and confirmation.* However the descriptions of the categories have remained similar throughout the editions.

Throughout the diffusion process there is evidence that not all individuals can absorb an equal amount of influence over all individuals. In this sense there are Opinion Leaders, leaders who are influential in spreading either positive or negative information about an innovation. Rogers relies on the ideas of Katz & Lazarsfeld (1995) and the two-step flow theory in developing his ideas on the influence of Opinion Leaders in the diffusion process (Katz Elihu & Paul Felix Lazarsfeld, 1955). Opinion Leaders have the most influence during the evaluation stage of the innovation-decision process and late adopters (Rogers, 1961; 2: 219). In addition opinion leaders have a set of characteristics that set them apart from their followers and other individuals. Opinion Leaders typically have greater exposure to the mass media, more cosmopolitan, greater contact with change agents, more social experience and exposure, higher socioeconomic status, and are more innovative. Persons frequently seek the advice of friends concerning steps needed to reduce risk for AIDS. Diffusion of innovation theory posits that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population (Ross MW and Carson JA, 1988; 88:239-241).

**2.3 MSM quantitative and qualitative findings**

The surveillance of HIV prevalence among populations of men who have sex with men in Thailand has presented an alarming result as Men who have Sex with Men (MSM) in Thailand remains at high risk for HIV infection. In 2003, among a total of 1,121 MSM recruited in Bangkok venues, 17.3% were found to be HIV-positive. In 2005, among a total of 821 MSM, 754 male sex workers (MSW), and 474 transgenders (2049 individuals in all), recruited through similar Bangkok venues as well as venues in Chiang Mai and Phuket, 28.3% were found to be HIV-positive. This high prevalence indicates a need for more effective behavioral and biomedical interventions. A cohort of MSM is now being recruited to evaluate feasibility of potential HIV prevention research. (Van Griensven, 2003 – 2005).

In 2007, the largest estimated proportion of HIV/AIDS diagnosis among adults and adolescents in the U.S. were men who have sex with men (MSM). This category accounted for 53% of the overall diagnoses and 71% among men (Williams R, 2006). According to a CDC study, HIV prevalence in the MSM population of the U.S. varies widely by ethnicity. "As many as 46% of black MSM have HIV" while "the HIV rate is estimated at 21% for white MSM and 17% for Hispanic MSM (Petersen NJ et al., 1976). In the United States from 2001–2005, the highest transmission risk behaviors were sex between men (40–49% of new cases) and high risk heterosexual sex (32–35% of new cases) (Shapiro CN, 1993). HIV infection is increasing at a rate of 12% annually among 13–24-year-old American men who have sex with men (STD Surveillance, 2006). Experts attribute this to "AIDS fatigue" among younger people who have no memory of the worst phase of the epidemic in the 1980s and early 1990s, as well as "condom fatigue)" among those who have grown tired of and disillusioned

with the unrelenting safer sex message. The increase may also be because of new treatments. In developing countries, HIV infection rates have been characterized as skyrocketing among MSM (Christopher K Fairley et al., 2005; 183 (4): 172–173). Studies have found that less than 5% of MSM in Africa, Asia, and Latin America have access to HIV-related health care.

The Empowerment project in California and Oregon also reported a significant reduction in the frequency of unprotected anal intercourse with both regular and casual partners following a peer led intervention 9 Kegeles SM (Kegeles SM, Hays RB, Coates TJ, 1996;86: 1129–36, Rogers E, 1983). These peer education programs applied on a diffusion of innovation model whereby popular opinion leaders engaged in conversation with other homosexual men to promote HIV risk reduction (Rogers E, 1998; 74:87–9, Kelly JA, 1994:297–317). According to this model, behavior change initially adopted and endorsed by the opinion leaders gradually diffuses throughout the population. The model is well suited to community level HIV prevention campaigns that typically require the initiation, diffusion, and long term maintenance of behavior change (APHA 134$^{th}$ Annual Meeting and Exposition, 2006).

Ethnographically driven outreach successfully targeted and enrolled a hard-to-recruit population, members of which generally considered themselves well - informed induces of risk behaviors (Elford J, Sherr L, Bolding G, et al., 2000).

In urban areas, MSM typically meet for social and sexual purposes at MSM businesses such as clubs/discos, karaoke bars and saunas. MSM also commonly meet in public toilets and public parks, although they will go elsewhere to have sex. One 2005 study identified more than 300 places in metropolitan Bangkok alone where MSM meet to look for or engage in sex. Some social support is available for MSM,

but only in Bangkok and Chiang Mai—both have MSM drop-in centers operated by local CBO's. There are now drop-in centers for male sex workers and transgender sex workers in Bangkok and Pattaya, consequently. In general, utilization of support services by MSM is very, very low and usually limited only to circles of friends who know someone who already attends or works there. Friends are important sources of support. Families are also important and for most MSM, family always comes first. Because families are so important, they generally do not completely reject MSM, except in non-urban or very poor families where they will be thrown out if they are not contributing financially. This is especially true for transgender MSM who can't find regular work (Flowers P, Frankish JS, and Hart GJ., 2000).

**2.4 HIV/AIDS Knowledge and Perception on Safe Sex among MSM**

HIV transmission is well understood but personal risk is not. MSM know about HIV prevention practices and tools (condoms and non-oil based lubricants), but still do not use them consistently (UNAIDS, 2006). There is poor knowledge regarding other STIs and prevention practices. A lot of written information on HIV/AIDS prevention is available, including for MSM. Mass media campaigns were more common 5-10 years ago; there is one current MSM HIV campaign ("Sex Alert") underway targeted to MSM venues and websites, but it is very subtle. Access to HIV prevention services for MSM is largely by word of mouth, although there is some advertising and limited promotion during outreach efforts (The Nation, 2006).

MSM is tailored to subgroups. However, the hidden MSM population—which is thought to be much, much larger than any other group—is not being reached at all and has no access, since these men have no contact with these resources. Transgender

MSM have limited access to HIV/AIDS prevention information because of general reluctance to support or understand their issues (UNAIDS, 2000).

Condom used in Men population are reported as most men engaging in unprotected anal sex at high levels, although condoms and lubricant are readily available in convenience stores; condoms are inexpensive, but lubricant is not. Many MSM businesses have condom vending machines, and most saunas have condoms and lubricant available for free (at least one of each), either in the locker or at the front desk. In rural areas there are no condoms and lubricant available. MSM mostly know how to use condoms but are less aware of the importance of lubricant. MSM often have sex with females as well, and condom use depends on who the partner is: committed partner, less use; Western foreigner, more use; other Asia foreigner, less use; Thai partner of the same age, much less use. There have been reports of increased unprotected sex and dramatic increases in HIV sero-prevalence rates among MSM (from 17.3% to 28.3% in only two years). Almost all substance use among MSM is limited to alcohol. There also may be some underground drug use that is missed by prevention workers because it is highly illegal and considered “unacceptable” by ordinary people (Van Griensven et al., 2009).

**2.5 Participatory Action Research (PAR)**

Participatory Action Research; PAR should be the most appropriate method for the development or problems-solution for people to deal with the community’s problems at least involved the following 3 parties.

- Firstly, the villagers consisted of the core leader group, problems dealing group.

- Secondly, the community developer from the government agencies, private development agencies or the religious organizations.
- Thirdly, the subject scholars as the researchers who wanted to acquire modern knowledge for the specific process for the community problems-solving, as the guidelines to create the theory used appropriately with the problems including the research method and ethical.

All three parties had employed PAR to create the learning process in order to develop the analyzing capability and problem solving effectively among the villagers.

Pairat Dhaecharin (1973: 6-7) presented the step in work participation to achieve the purposes and development policies:

1. Participation in the study of problems and origins of the community including its need.

2. Participation in the search, design and development method to fix and reduce the community problems or to create something new for the community benefit or response to the need of community.

3. Participation in planning of policies, works or projects to solve and reduce the community problems.

4. Participation in utilizing the limited resources for the community benefit

5. Arranging and effectively improving the administrative development.

6. Arranging funds in the community projects in accordance to own ability.

7. Performing work according to the policies, work plan, structure and activities to reach the goal.

8. Controlling, assessing and maintaining the project and the existing activities.

Panthip Ramasoota (1996:42-43) gave the participating research method in details:

1. The community should be ready for equally participated in the research by preparing each step before starting the projects, such as, building the community, promoting the decision-making process of community in arranging problems according to priority or selecting the representative and the project joint venture.

2. Local researchers must be trained to give knowledge regarding the local situation, the roles of the local researcher, the community management, pattern of leader, support and public relations.

3. The local researcher set up the design, such as, split the selected problems to be solved by each section. Next, designing the data collection methods, instruments, data collection procedures, including to estimate the sample size, instruments formulation, designed questions and asking methods.

4. Trainees were trained how to collect data.

5. The team of local researchers together compiled results, analyzed data and gave the conclusion. They had given their observation and comment towards the findings and analyzed the reason for such data to be concluded in general with the advices.

6. Results discussion with the community aimed at the return of the derived data to the community for verification and validity. Analyzed and summarized the issue or advice the research team in the form of roles play including group meeting or other methods, such as, exhibition of pictures or graphic varieties in the public or the community to arouse the opinion and feeling of the locals.

PAR is a popular method used in teaching adult learners in low-income communities, and others how to explore, challenge, and react to their own needs. It is

gaining popularity among community youth workers, as well as middle and senior high school teachers as a successful methodology for engaging youth voice in the classroom. According to McIntyre, A. (2008), "Youth PAR projects are typically centered on issues of intimate, structural violence: educational justice, access to quality healthcare, the criminalization of youth, gang violence, police brutality, race/gender/sexuality oppression, gentrification and environmental issues." PAR is also increasingly used in service learning projects and provides the basis for a variety of secondary approaches such as Triple Task Method.

Robin McTaggart (1989) presented the 16 tenets of Participatory Action Research to the Third World Encounter on Participatory Research on September 3 – 9, 1989 in Managua, Nicaragua. He indicated the significant illustration and screening of the practice of participatory action research as a part of its key practitioner during the 1980s. The 16 tenets of Participatory Action Research (PAR) are composed of;

1. PAR is a crucial death to developing social practice by altering it and actively learning from the consequences of change.

2. PAR is contingent on authentic participation that concerning a continuing circuit of planning**,** practicing (implementing plans), observing (systematically), reflecting and then re-planning and so goes around the circuit again. The procedure can be induced in different ways:

- Collect primary data in the area of general interest (a reconnaissance), feedback on it, and then making a plan for modified action;
- Make an inventory change, gather data on what happens, reflect, and then build more delicate plans of action.

3. PAR is alliance: those handle for action are involved in improving it. The alliance group is covering from those most fully participated to fully participated as many as possible of those influenced by the practices related.

4. PAR establishes self-critical communities of people participating and partnership in the research procedures of planning, acting, observing and reflecting. It has aimed at building communities of people accepted to realizing themselves about the association between circumstance, action and consequence, and to relaxing themselves from the institutional and personal constraints that seems to block their power to live by their intervention, and freely chosen social values.

5. PAR is a systematic learning process in which people perform reasonably through sustaining disclose to unexpected and responsive to opportunities. It is considered as a process of using critical intelligence to inform and develop action, so that social concern becomes significance (critically informed, committed action).

6. PAR involves people in building theory concerning their practices. This involves them in being curious about and inclining to understand the interrelationship between circumstances, action and consequences in their own lives. The theories that participatory action research employed may be expressed primarily in the form of rationales for practice. These founding rationales are thus subjected to critical consideration through the participatory action research process.

7. PAR requires that people induced their practices, perspectives and definitions about institutions to the investigation by gathering compelling evidence for substantiation.

8. PAR involves not only keeping records which describe what is happening as accurately as possible but also collecting and analyzing the groups judgments, reactions and impressions about what is going on.

9. PAR involves population in objectifying their own experiences**.** This can be done by keeping a personal daily note in which population record their progression and their feedback about two parallel sets of learning: (a) relating to the practices themselves (how the individual and accumulative practices are developing) and (b) relating to the process of learning the practices (how the action research project is carrying out).

10. PAR is a political process because it involves people in initiating and making changes that will affect others. For this reason it may create resistance to change, both in the participants themselves and in others.

11. PAR involves making critical consideration of the institutionally structured situations (projects, programs, systems) in which population work. The obstacle to change felt by a researcher is relating to conflicts between the proposed new practices and the accepted practices (e.g. concerning communication, decision-making and educational work) of the institution. This finest analysis will help the participatory action researcher to act politically by (a) involving others participatory in the research process and convincing them to explore their practices, and (b) by working in the broader institutional context towards more rational understandings, more just processes of decision-making, and more fulfilling forms of work for all involved.

12. PAR starts with a small scale by working on minor changes which individuals can easily manage and control, and then working towards more expanding patterns of change. These might include criticizes of vision of institutions which might lead to ideas for the general reshapes of projects, programs or system-wide policies and practices. Participants should be able to present evidence-based data on how they articulated the thematic concern which holds their group together, and on how they established authentically shared agreements in the group.

13. PAR starts with small cycles of planning, acting, observing and reflecting which can help to define issues, ideas and assumptions more clearly so that those involved can define more powerful questions for themselves as their work progresses.

14. PAR starts with small groups of coordinators but broadens the community of participating action researchers so that it gradually includes more and more of those involved and affected by the practices in question.

15. PAR allows and acquires participants to initiate records of their improvements: records of their changing activities and practices, records of the changes in the language and discourse in which they describe, explain and justify their practices, records of the change in the social relationships and forms of organization which characterized and constrain their practice, and records of the development of their expertise in the conduct of action research. Participants must be able to demonstrate evidence of a group climate where people expect and give evidence to support each other's claims. They must show respect for the value of rigorously gathered and analyzed evidence – and be able to show and defend evidence to convince others.

16. PAR allows and requires participants to give a reasoned explanation of their social (educational) work to others because they can show how the evidence they have compiled and the critical reflection they have conducted have supported them to create a developed, tested and critically examined rationale for what they are doing. Having developed such a rationale, they may legitimately ask others to justify their own practices in terms of their own theories and the evidence of their own critical self-reflection.

To summarize, the Participatory Action Research (PAR) is the process that some people in the organization or the community participated together with the researcher through the research from the start to the end of research result discussion as the beginning of study with problems, searching problems together with the subject scholar. It was the process of the people in the organization or the community as the powerful and enthusiastic participants in the research.

Absolutely, the researchers chose PAR methodology in order to (1) create a strong program combining the knowledge of researchers and the expertise of community to increase the relevancy of the program to local MSM, (2) increase the effectiveness of the program by fostering ownership by MSM leader and peer network, (3) allow participants to serve as experts regarding the culture of their communities, and (4) promote a more rigorous evaluation of the intervention. The methodology afforded the opportunity for practitioners to tailor the prevention message for MSM population, while allowing researchers to ensure that the project remained theory driven and methodologically sound.

## 2.6 Conceptual Framework of the Study

In this research, a **Diffusion of Innovation Model** or sometimes it is called as **Social Diffusion Theory (SDT)** is thoroughly applied for drawing and shaping the research conceptual framework. This theory seeks to explain how, why, and at what rate new ideas and technology spread through cultures. Everett Rogers, a professor of rural sociology, popularized the theory in his 1962 book *Diffusion of Innovations*. He said diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. The origins of the diffusion of innovations theory are varied and span across multiple disciplines.

Its basic epidemiological or internal-influence form was formulated by H. Earl Pemberton (1936), who provided examples of institutional diffusion such as postage stamps and compulsory school laws. In 1962, Everett Rogers, a professor of rural sociology published *Diffusion of Innovations*. In the book, Rogers synthesized research from over 508 diffusion studies and produced a theory for the adoption of innovations among individuals and organizations. The book proposed 4 main elements that influence the spread of a new idea: the innovation, communication channels, time, and a social system. That is, diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. Individuals progress through 5 stages: knowledge, persuasion, decision, implementation, and confirmation (Rogers Everett M., 1983). If the innovation is adopted, it spreads via various communication channels. During communication, the idea is rarely evaluated from a scientific standpoint; rather, subjective perceptions of the innovation influence diffusion. The process occurs over time. Finally, social systems determine diffusion, norms on diffusion, roles of opinion leaders and change agents, types of innovation decisions, and innovation consequences.

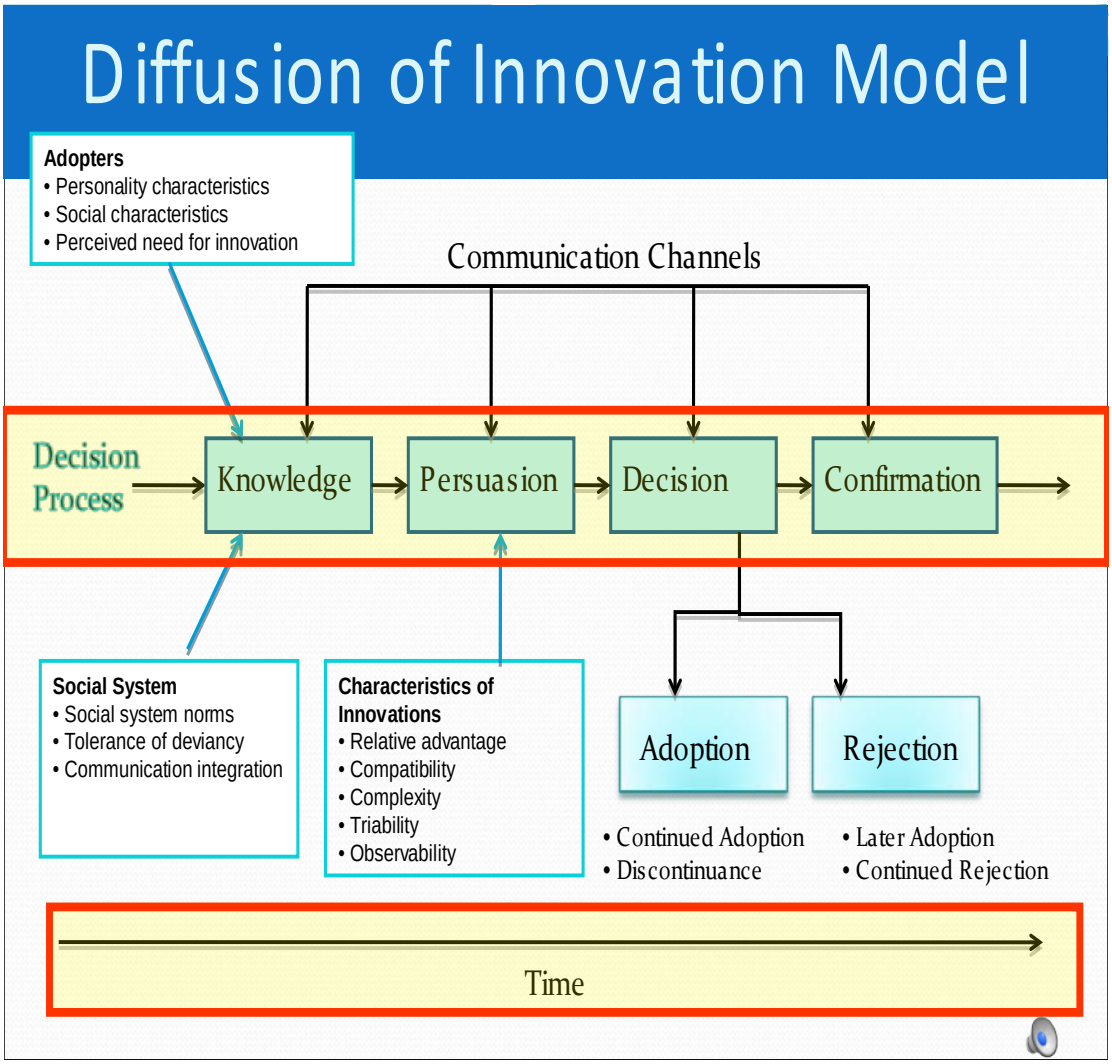
The origins of the diffusion of innovations theory are varied and span across multiple disciplines. Rogers identifies six main traditions that impacted diffusion research: anthropology, early sociology, rural sociology, education, industrial, and medical sociology. The diffusion of innovation theory has been largely influenced by the work of rural sociologists. The key elements in diffusion research are: ***Innovation*** as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption" (Rogers, 1983: 11), ***Communication*** channels which is "the means by which messages get from one individual to another (Rogers, 1983: 17), ***Time*** "The innovation-decision period is the length of time required to pass through the innovation-decision process" (Rogers, 1983: 21), ***Rate of adoption*** is the relative speed with which an innovation is adopted by members of a social system (Rogers, 1983: 21-23), and ***Social system*** as a set of interrelated units that are engaged in joint problem solving to accomplish a common goa (Rogers 1983: 24).

The mechanism of Diffusion of an innovation occurs through a five–step process. This process is a type of decision-making. It occurs through a series of communication channels over a period of time among the members of a similar social system. Ryan and Gross first indicated the identification of adoption as a process in 1943 (Rogers, 1962: 79). Rogers categorizes the five stages (steps) as: awareness, interest, evaluation, trial, and adoption. An individual might reject an innovation at any time during or after the adoption process. In later editions of the Diffusion of Innovations Rogers changed the terminology of the five stages to: *knowledge, persuasion, decision, implementation, and confirmation.* However the descriptions of the categories have remained similar throughout the editions.

Regarding the opinion leaders within a social system, Rogers mentioned that throughout the diffusion process there is evidence that not all individuals exert an equal amount of influence over all individuals. In this sense there are Opinion Leaders, leaders who are influential in spreading either positive or negative information about an innovation. Rogers relies on the ideas of Katz & Lazarsfeld (1995) and the two-step flow theory in developing his ideas on the influence of Opinion Leaders in the diffusion process (Katz Elihu & Lazarsfeld Paul: 1955) Opinion Leaders have the most influence during the evaluation stage of the innovation-decision process and late adopters (Rogers, 1962: 219). In addition opinion leaders have a set of characteristics that set them apart from their followers and other individuals. Opinion Leaders typically have greater exposure to the mass media, more cosmopolitan, greater contact with change agents, more social experience and exposure, higher socioeconomic status, and are more innovative.

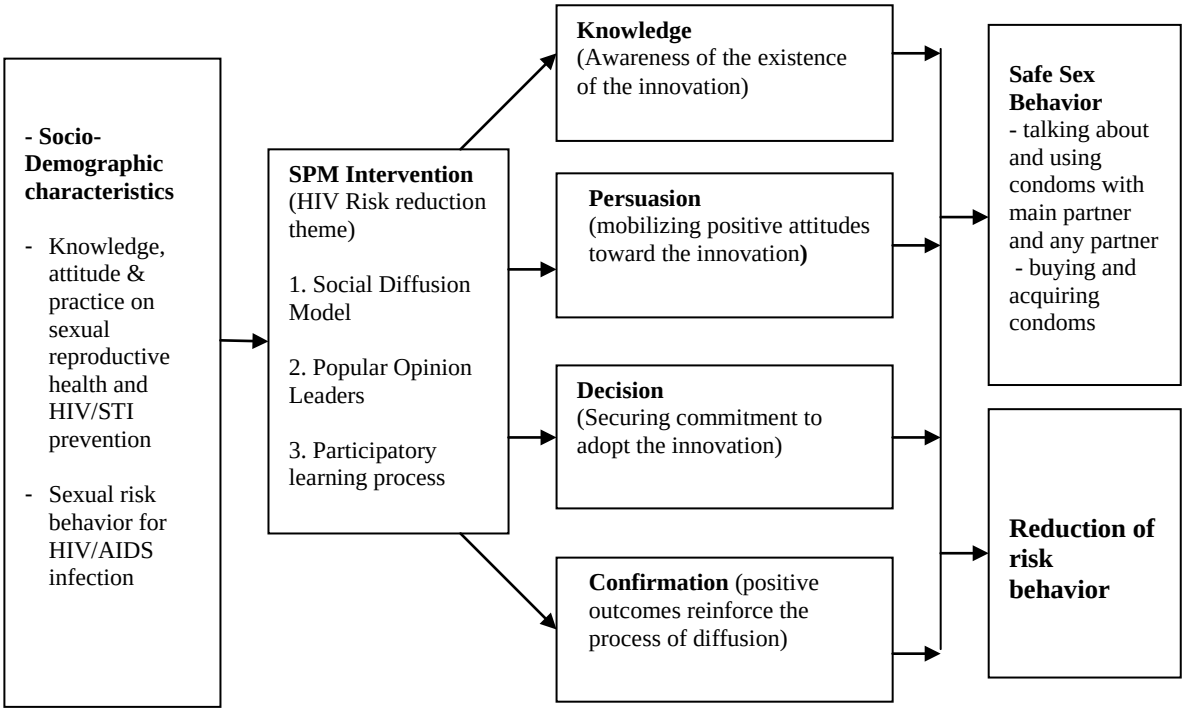
This theory used five stages of diffusion progresses: 1) knowledge (awareness of the existence of the innovation), 2) persuasion (mobilizing positive attitudes toward the innovation), decision (securing commitment to adopt the innovation), implementation (operationalization in use)**,** confirmation (positive outcomes reinforce the process of diffusion) as shown in figure 2.1. The researchers applied this framework because of its potential relevance and applicability to real-life problems of MSM community. The framework allows for consistent exploration of integration in a holistic manner for each critical health system arms through the participatory action approach. The conceptual framework and the analytical approach presented in this study are not intended to serve only the research questions as mentioned above, but resumed at addressing any unanticipated events in varied contexts.

**Figure 2.1: Diffusion of Innovation Model and Conceptual Framework**




By Everett Rogers, a professor of rural sociology who firstly popularized the theory in his 1962 book "*Diffusion of Innovations*".

**Figure 2.2: Research Conceptual Framework**



# CHAPTER III

# RESEARCH METHODOLOGY

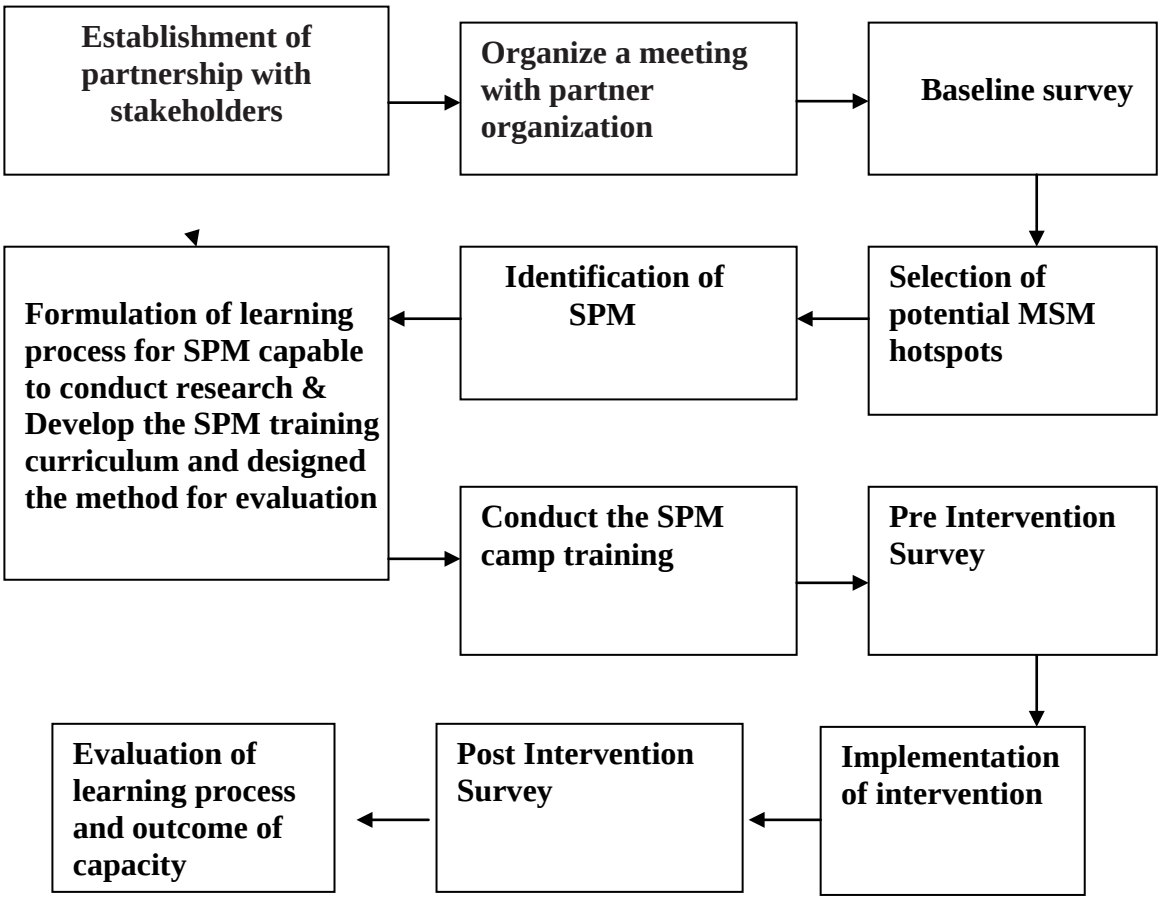
The research methodology chapter is consisted of 6 parts. The first part is s a conceptual framework of research design which included population and setting, and recruitment of target population. Secondly - research instruments consisted of a survey form on knowledge and perception on HIV/AIDS and Sexuality and self-report sexual risk behaviors, and a modified POL training package. Thirdly - contained validity and reliability of the instruments, fourthly - data collection procedures, the fifth part is data analyses, and the last is the presentation of considerations.

## 3.1 Conceptual Framework of Research Design

This study used a Participatory Action Research (PAR) design and was viewed as the first step and holistic approaches of the project aimed at providing MSM population with the knowledge and skills they have been requiring for protecting themselves from HIV infection. This design included 9 essential procedures starting from 1) to establish partnership with stakeholders, 2) organizing a meeting with partner organizations, 3) conducted a baseline survey of which its results could reflect socio-demographic data, HIV/AIDS knowledge and perception, and risk behaviors of MSM population at various MSM hotspots then was utilized as critical information to support the decision for selection of the studied MSM hotspots, 4) Selection of MSM hot spots, 5) Identification of Steer Peer Mobilizer (SPM), 6) Formulation of Learning

Process in conducting research and training curriculum development 7) Conducting a training of SPM, 8) Implementation of SPM intervention, and 9) Post Intervention survey plus in-dept interview with target population. This design exactly permits a systematic comparison of pre- to post intervention risk behaviors to control for extraneous factors that might be responsible for changes and to replicate the same intervention in the targeted communities. Under the umbrella of PAR processes this study has focused on the design of a single group intervention, which is the Steer Peer Mobilizer (SPM) intervention group with none of control group. The ultimate goal of this designed to assess the SPM intervention in reduction of HIV risk behavior of MSM group as well as to increase knowledge and perception on HIV/AIDS through the employment of pre-test and at post-test study after the 3 month disseminative SPM intervention. The total of the SPM intervention time period is 3 months.

**Figure 3.1**: **The Format of Research Design and Methodology**



**3.2 Population and Settings**

3.2.1 Target Population

The overall target populations were men the group of men who have sex with men living in Chiang Mai province.

3.2.2 Study Area

This study was conducted in Chiang Mai Muang city, selected because it is a tourist attraction area with revealed alarmingly high rates of high-risk sexual behavior as well as high incidence rate of HIV/AIDS infection among MSM groups in Thailand. Due to the geographical distance from Bangkok and as a center city of Northern region, there are many different types of MSM hot spots and entertainment places that tend to attract large, stable crowds of homosexual men and serve as the primary social setting in each town's MSM community. Consequently, 20 popular MSM hot spots included both entertainment places and natural social groups which are considered as stylish places for MSM group such as beer bars, saunas, karaoke shops, public park, massage houses, beauty salon, bouquet shop, gay bar, and gas station in Chiang Mai province were purposively selected based on level of popularity and baseline survey result. Afterwards, theses 20 popular and potential hot spots were approached by research team for receiving the intervention. And from these 20 locations of MSM hotspots, then 1 well-recognized MSM in each target MSM hotspot of any ages was recruited to be SPM.

3.2.3 Study Population

The studied population consisted of 2 main groups of MSM;

3.2.3.1 **A group of Steer Peer Mobilizers (SPM)** who were selected and identified through the process of snow ball sampling technique. The selection of SPM

was done after the 20 target hotspots identified. The member of MSM club or gangs, bar waiters or bartenders, owners of service shops and outreach staff from MPlus (a local Community-Based Organization (CBO) who familiar with MSM population were advised by research team to observe social interaction patterns within the selected MSM hot spots. Then each could make unobtrusive behavioral observations and discussed with MSM attended each selected hot spot for a few days, recorded first names and a physical identifier for 1 or 2 persons observed to socialize and be greeted positively most often by men in the hot spots. The names receiving nomination are considered key popular people or SPM with the existing total of 20 SPMs. These all selected SPMs receiving 4 days training and afterwards they practiced at least three times of conveying of strategies for behavioral change in reduction of risk behavior to their target peers as well as they contacted to have conversations or group sessions with peers to review and reinforce these efforts. At the first contacted and the 3 months follow up contacted to each peer in June until September 2011, each SPM collected a pre-intervention test and post-intervention test respectively by using a self-report risk behavior survey form and HIV/AIDS knowledge and perception questionnaire.

3.2.3.2 **A group of MSM peers** who were identified by each SPM after the training completed totally 60 target peers. They had been receiving disseminative SPM intervention between June to September 2011.

The MSM population who were eligible for participation in this research were selected according to the following criteria:

- Thai males who come to MSM hotspots located in Chiang Mai Muang district at the period of research.

- Having a residence/ residing in Chiang Mai more than 3 months
- Aged 18 years or older
- All occupations
- Be able to read and write
- Be a frequent visited to the targeted MSM hotspots
- Be sacrifice own time for the benefit of the public with the courage to express own opinion.

### 3.3 Research Instruments

This research has employed several kinds of research tools as follows;

**3.3.1 A survey form of knowledge and perception on HIV/AIDS** used to collect preliminary data on HIV/AIDS knowledge and perception and population AIDS risk characteristics of SPM and their peers in the studied areas which were administered at baseline, pre-intervention test and post-test. The entire instrument had been developed by the researcher. It was prepared by compiling the related literature and reviewing pertinent with the subject and existing researches which covered the contents and the objectives of the present research. It was divided into three parts (used 30-45 min/questionnaire) as follows:

**3.3.2 A Self-report sexual risk behaviors** as a tool to assess socio-demographic data, the level of risk via frequency of engagement in risk behaviors, and detailed event-level data related to the co-occurrence of other factors (e.g., alcohol use or primary vs. secondary partners) that could facilitate engaging in risk behaviors, including lifetime and recent partners; vaginal, anal, and oral intercourse within the past three months; frequency of condom use, and frequency of having sex with

temporary partners. There are also open-ended questions on condom use obstacles and voluntary counseling and testing (VCT) services they received. This form was administered to collect the data at baseline survey and at pre-intervention test and post-test. Supplementary, **a self-report sexual risk behavior** is a foundation of sexual health-related research, particularly when related to assessing risk-related outcomes such as HIV. Despite their frequency of use, the capacity of self-report measures to provide an accurate account of actual behavior are questioned (Brody and S., 1995) and ways to enhance their accuracy should be a critical focus when administering such measures (L. S. Weinhard et al., 1998). Self-reported assessments of sexual behavior is inclined to a number of measurement concerns that could affect the reliability and validity of a measure ranging from participants literacy level and understanding of behavioral terminology to recall biases and self-presentation or confidentiality concerns resulting form stigmatization of the behavior in question (L. S. Weinhard et al., 1998). Hence, the decision to incorporate a self-report measure of sexual risk behaviors is often one of practicality. Self-report measures are both inexpensive and more feasible than behavioral observation given the private nature of most sexual risk behaviors. It is important to consider the way in which measures of self-reported sexual risk behaviors was collected during the research development phase. Frequently self-report measures are self administered, but can also be explored from an interviewer either face-to-face or over the phone; such approaches help to address literacy and comprehension puzzles but may increase potential for self-presentation bias. The delivery of risk behavior assessments via the internet or computer can increase a sense of privacy and may reduce self-presentation biases (D. Morrison-Breedly, M. P. Carey, and X. Tu: 2006). Similarly, it is important to select a self-report sexual risk measure that meets the studies assessment needs. Dichotomous

(yes/no) evaluation of engagement in risk behaviors (Risk Screening), assessing the level of risk via frequency of engagement in risk behaviors (Risk Assessments), and detailed event-level data related to the co-occurrence of other factors (e.g., alcohol use or primary vs. secondary partners) that may facilitate engaging in risk behaviors (Risk-event Data) are non-equivocal serving very distinct functions in evaluating self-reported risk behavior (L. S. Weinhard et al., 1998). Attention should also be paid to the period of time in which self-reported risk measures ask individuals to recall the occurrence/frequency of engaging in risk behavior, generally recalling frequency of risk behaviors over a period of approximately 3 months supports recall accuracy (K. E. E. Schroder et al., 2003).

**3.3.3 The training curriculum and program for SPM** which was outlined and designed by SPM themselves together with the research team through the brainstorming discussion process. The standard POL training package originally developed by Kelly JA et. al and often used in much similar research was also brought in use as reference and guidance to shape up the scope of training curriculum. The training curriculum comprised 4 major sessions as following details;

**Session 1: 5 steps to build SPM recognizing in the significance of HIV / AIDS and reducing risky behavior**

**Step 1** : Introduction of the Popular Opinion Leader-POL concept

**Step2**: Description of basic knowledge about HIV / AIDS: the virus and the immune system.

**Step 3**: Identifying the risks of HIV infection at various levels.

**Step 4**: Identifying strategies to create change for the reduction in risk behavior such as;

- There is no anal sex, if will, need to use condoms.
- Do not allow for exchanging fluids.
- Just touch the outside.
- how to tell and protect your partners on safe sex

**Step 5**: Summary of lesson learns and answer questions, and then introduce the scope of the next session. As it is the subject concerning to beliefs and misconceptions, how can the social standard and values affecting to behavior change, and strategies that will make talking about HIV / AIDS is possible and practical. (Social skills they needed to serve as risk reduction endorsers to their peers).

**Session 2**: **5 processes of social change through effective communication.**

2.1 Review of the Session 1.

2.2 Explanation on various fault beliefs and misconceptions i.e.

Misconception: I should have unsafe sex in order to show that I care and believe in my partner.

Fact**:** You both have been having sex with other men.

Misconception: I'm safe if I wash my anal after had sex without condom.

Fact: Washing anal after sex may increase more risk.

Misconception: safe sex is not fun.

Fact: You can make sex as safe as a fun activity.

2.3 Explain the use of standard social behavior for behavioral change.

The idea came from the research finding that Social Standards plays a key role in enabling people with or without risk, so SPM is required;

1. Reinforces the benefits of having safe sex to their partners.

2. Talk about his own benefits received from having safe sex. This method is not only to send a message to anyone but also help to push ourselves to continue with safe sex behavior, thus SPM will be a good example to others in the network.

2.4 **The 6 elements of effective communication to reduce risky behavior**.

2.4.1 Stressing as AIDS is a serious problem, but we can stop it.

2.4.2 Using creative thinking method for explanation any issues.

2.4.3 Using the straightforward /clear conversation to explain what is the meaning of safety.

2.4.4 Provide advice on safe sex behavior.

2.4.5 Not use instruction or lecture approach

2.4.6 Discuss in a safe and comfortable area.

2.5 Summary of the Session 3.

This section covers three main issues.

1. People have different beliefs and misconceptions, but SPM can help to shape up ideas and then tell others.

2. Many people are vulnerable because of the social standards in their own community could not support those people to have safe sex.

3. SPM can change the social standard by using a dialogue on d reduce risks with other people.

**Session 3: A conversation on how to talk about risk reduction.**

3.1 Introduction.

- Explain why many people do not communicate about risk reduction, such as

not sure where and when to start and not sure if people have safer sex or not.

- Describe the function of opinion leader or SPM as to establish networking, promote the belief that safe sex is the right thing need to do, capable to do, and engage to social acceptability.

3.2 Review the contents of messages on effective communication for risk reduction before delivery to the target MSM.

3.3 Explain how to distribute BCC material or information about AIDS prevention to their communities.

3.4 The practical session: All trainees started practicing the delivery of messages and communication with their peers or target MSM in their own community regarding HIV/AIDS prevention and risk reduction.

3.5 Summarizing all lesson learns from Session 3. This section covers two main matters;

1) Practicing of the 6 elements of effective communication to reduce risky behavior.

2) Identified 3 names of peers and fill up the monitoring form and submit.

**Session 4: 5 Steps to conduct a dialogue about reducing risk and inspire the group.**

4.1 Review of conversations about risk reduction.

4.2 Review of information that can be inserted in such conversations.

- AIDS is worrisome in the MSM community.

- Changes in behavior can reduce or eliminate the risk.

- Behavioral changes to reduce or eliminate the risk that to benefit themselves and their partners.

- Safe sex is something new.

- Safe sex is easy, just decide in advance what to do or not do any
- Talk about safe sex with partners in advance.
- Prepare to get condoms and to have close at hand.
- Avoid drugs or alcohol when having sex.
- Using himself as a good example.

4.3 Present the information and start a conversation about HIV/AIDS situation and the spread of HIV infection among men who have sex with men.

4.4 Present the information and start a conversation about the factors That affect risk behaviors for HIV infection.

4.5 Principles of inspiration with the target group.

- To indicate the great benefit received from having conversations with their friends.
- Reinforcing the participants through their cooperation of having Conversations with their friends more frequency as at least 4 times each.
- Asking for cooperation and commitment from all trainees based on the foundation of trust and faith with each other.
- Asking participants for showing up hands or giving signature in order to confirm that they will have conversations with their friends in front of every ones.

**3.3.4 Video recorder** used to tape the role play and demonstration of peer education practice performed by SPM during the training sessions.

**3.3.5 Action plan and monitoring form** for SPMs recording descriptions of their conversations related to message for reduction of risk behavior and other

significant recommendation, telephone number or contact address of their MSM peers who were approached.

**3.3.6 Group discussion guideline** has been used with selected SPMs aimed at the brainstorm activities that widely open for the SPMs group to express vision and opinion towards the HIV risk reduction strategies and approaches that might be effectively and proactively implemented in MSM community. There were highlighted issues existed in the guideline such as *"Do you think we as SPMs will help other guy people to reduce the risk of HIV infection or not, and how ?",* and *"Due to we often meeting together with lots of friends at our various MSM hotspots such as parks, sports fields, beauty salon shop, gas stations, coffee house, Karaoke and so on and how do you think if we are helping to spread knowledge about HIV infection and talking to them about reducing the risk of infection, is it feasible or not and in which approach ?,* these issues were arranging the MSM opinion' dependency on the risk reduction approach should be applicable to serve their social network. Besides, this group process could help widely encouraging the SPM recognized their social responsibility in helping other risk people safer from HIV infection as well. Some other example of questions existed in the guideline included such as;

- *Do you think that any of your MSM friends know about HV infection rate as of 1 in 4 of the total MSM in Chiang Mai are infected with HIV, then? If they know, where or who they heard from.*
- *What dimensions or aspects that MSM tend to talk or ask about HIV infection?*
- *Do you think to help your MSM friends to reduce their risk of HIV infection? If yes, what kind of help do you want to offer to them?*

- *As you know well that our research team invites all interested MSM like you to participating in the training of opinion leaders in order to help other MSM friends reducing the risk of HIV infection among MSM people in Chiang Mai. We as the research team are confident that everyone will be able to help your friends become aware of the risk of HIV infection more and more. Also you all can lead them to the point of having a chance to talk sexual behavior openly and exchange ideas with everyone. What do you think you can help your friends or not? And how do we help them?*

**3.3.7 Telephone in-depth interview guideline** has been used with purposively selected peers of SPMs, 10 among 60 peers were picked up the names and received interviewed. The outline contents comprised 5 major topics with 30 sub-questions such as socio-demographic data of the peers, the location where the peers meet their MSM friends, communication among MSM to reduce the risk of HIV infection, types of risk of HIV infection for MSM, the use of condom, and opinion about SPM approach. The examples of interview topics are as follows:

- How old are you?
- Are you Chiang Mai native? Where are you from ?
- How long have you been in Chiang Mai ?
- Now you are working as ….?
- You highest education is ….?
- How do you meet or gather with your MSM friends, at where, and how often ?
- What the numbers of MSM friends you regularly meet with?
- What the purposes to meet with your MSM group of friends?
- You get information about AIDS and sexually transmitted diseases from where?

- Do you ever talk about HIV/AIDS and sexually transmitted diseases? with whom, at what time, and where?

- What are causes that you want to talk about HIV/AIDS and sexually transmitted diseases?

- You talk about HIV/AIDS and sexually transmitted diseases in what way, please give examples of your talks?

- You talk about AIDS and sexually transmitted diseases, in particular issues?

- When you talk about HIV/AIDS and sexually transmitted diseases with your friends, how they feel or response ?

- Do you think MSM are at risk of HIV infection or not?. Why?

- Do you think that you are risky getting infected with HIV? Why?

- Do you worry that you are infected with HIV ? Why?

- Do you think your MSM friends are at risk of HIV infection ? Why?

- Do you suspect that some of your friends infected with HIV ? Why?

- Do you use condoms, Why?

- Do you use condoms with whom? Why?

- You do not use condoms with whom? Why?

- How do you feel about using condoms?

- What do you think that's why some people do not use condoms?

- What decision making criteria do you use for choosing and buying condom (brand, size, color, taste, smell, price, etc.)?

- Do you use lubricants? What kinds you used?

- How do you feel and perceive when you talk with your friend who is SPM ?

### 3.4 Data Collection and Procedures

There are 13 steps of research procedures launched in this research as follows;

**3.4.1 Established a partnership** between the researcher and community-based organizations working on MSM programs that have a strong commitment to the implementation of the project.

**3.4.2 Organize a meeting with partner organizations** to clarify and create understanding about the process of participatory research, problematic situations, development of implementation plans and approaches, and development of curriculum and tools for evaluating outcomes of the project.

**3.4.3 Baseline survey** to establish risk behavior levels among gay men, anonymous interview of baseline data on population AIDS risk characteristics was conducted at all MSM hot spots. Several men entering the target places may be approached at the door, before drinking, and at individual tables to voluntarily giving interview that elicits socio-demographic information, sexual risk behavior and practices (including the number of sexual partners, occurrences of unprotected anal intercourse, and condom use during sex) over the past 3 months. Respondent perception of peer norms concerning the acceptability of safer sex practices was assessed using true-fault rating scale. Items assessing risk behavior knowledge were included in initial surveys. A check was conducted after several baseline surveys to reveal such overlapping cross sections of visits to each hot spots among the gay male population.

**3.4.4 Selection of MSM hot spots:** Following the baseline population assessments in all MSM hot spots existing in Chiang Mai (beer bars, saunas, karaoke shops, public park, massage houses, beauty salon, bouquet shop, gay club), **20 popular and potential hot spots** were selected to receive the intervention while AIDS prevention posters and brochures are generally available everywhere in entertainment-based places of Chiang Mai. The desk review and discussion was employed with inclusively participation of 3 CBO staff, 1 community health expert from Chiang Mai provincial health office, one public health expert from Ministry of Public Health, and researcher to assess the potential hotspots with respect to the different criteria on both qualitative response from CBO experience working with various MSM hotspots for many years, environmental factor affecting to possible cooperation we require from each hotspots such as to practice as a researcher and receive training, number of existing peer network at each hotspot, and especially life style of the members of that hotspot. Furthermore the research team were asked to give weights to the respective sub criteria, and then a multi-criteria analysis was done with the combination of individual expert rankings and weightings resulted in overall group consensus rankings regarding the priority of hotspot. The overview of consensus rankings presented a rather mixed opinion as well as no hotspot case clearly scored high on all criteria, however finally CBO's perspective and opinion were considered as priority for making decision.

**3.4.5 Identification of Steer Peer Mobilizer (SPM):** To identify key popular MSM, peers, bar waiters or bartenders and outreach staff from MPlus, a local Community-Based Organization (CBO) who familiar with population members were advised to observe social interaction patterns within the selected MSM hot spots. Each

made unobtrusive behavioral observations at the selected hot spots for a few days, recording first names and a physical identifier for 1-2 persons observed to socialize and be greeted positively most often by men in the hot spots. The names receiving nomination were considered key popular people or SPM.

**3.4.6 Formulation of Learning Process:** The learning process of SPM is essential to be established through the self-act process of the SPM and research team. This is to encourage the participants understanding the significance of their participation in solving their own and their community's problems by conducting the research and self-development, strategic planning, self-planning of work, project and other activities. They might need the initial support, such as, adapting the conceptual trend and learning, research techniques, data collection and cooperation in analyzing derived data in order to create their learning for their own benefit till for their healthy MSM community. Research team explained how to conduct the activity as well as to facilitate and encourage each SPM help each other to analyze and write the significant of daily contact to their peers.

**3.4.7 Develop capacity-building curriculum for SPM and develop methods for evaluation.** Curriculum for training of SPM was developed through involvement of community-based organizations working on MSM intervention programs and SPM themselves. Through needs assessment and reflection sessions, the core content was designed by using the standard POL training package originally developed by Kelly JA et. as a guideline. All SPMs brainstormed and worked together to initiate and make plans of activities for providing knowledge to their peers in hot spots, and to make plans for implementing and evaluating such activities. Researcher and MSM

community-based organizations team serving as support providers and assistance in terms of knowledge, techniques, methods and other enabling factors required for conducting and summarizing peer-led activities.

**3.4.8 Conducting a training of SPM and pre-test of SPM:** The training consisted of four days learning and practicing, presentation, discussion and group sessions led by CBO outreach staff. In the session one, the SPMs were updated and reviewed basic epidemiology of HIV infection, high-risk behavior, and precautionary changes needed to reduce risk and misconceptions concerning risk. They discussed the steps that can be used to successfully implement risk reduction, including: keeping condoms readily available if sexually active; avoiding drug or alcohol used before sex; discussing precautions in advance with sexual partners; resisting coercions to engage in high-risk practices; and self-reinforcing for behavior change efforts. Session two, the facilitator described and discussed on characteristics of effective health promotion messages: sensitizing others to the potential threat of AIDS; stressing that HIV infection can be prevented by behavior change; identifying specific behavior changes needed to reduce risk; suggesting strategies for implementing these changes; using his self as an example in order to avoid a "preachy" tone (i.e. beginning statements with "I am learning to." rather than "You should"); and gradually introducing the positive value and desirable benefits of behavior change. In the third session, SPM demonstrated conversational examples which incorporated the characteristics discussed in session two. Following the discussion of the agreement, participants role-played how they would initiate conversations, incorporating these message characteristics. Researcher and one Mplus CBO member observed this social skill rehearsal, provided feedback and suggestions. After becoming proficient in the role-

plays, each participant identified three MSM peers with whom he could initiate conversation in the next week. Action plan and monitoring forms are then discussed and drafted among SPMs with supportive comment provided by the facilitator, then this form would be used for recording the descriptions of conversations with their identified peer. **Session four** reviews outcomes of the real-life conversations. The researcher, Mplus CBO staff and SPMs then settings strategies, and times which would afford opportunities to initiate additional conversational contacts with other peers. The session was concluded with discussion emphasizing the participants' important role in stressing the benefits of behavior changes to prevent HIV infection among MSM group in their own hotspot. In addition, before and after the training program, each SPM was asked to role-play standard, simulated peer educational conversations. At the end of training, researcher, facilitator, and other Mplus CBO members had dialogue and round table discussion with all SPMs. It was the afternoon activity to exchange visions and express opinion in different issues especially hearing the feedback from SPMs.

**3.4.9 Pre-implementation survey**: Each SPM at the first contact with each his identified peer, he collected data by using the 2 set of questionnaires at anywhere.

**3.4.10 Implementation of intervention:** The objective of the intervention is to establish a highly motivated of already known, trusted, and well-liked persons who were trained to enroll actively and visibly the importance and acceptability of behavioral change, as well as to convey strategies for change implementation. Each SPM contracted to have conversations with peers as well as group sessions to review and reinforce these efforts. To stimulate conversational opportunities further, each

SPM agree to place a designed T- shirt with similar logo of special posters throughout the MSM hotspots. This ambiguous logo is intended to elicit numerous questions by others and allow participants to explain and to deliver additional endorsement messages taught in the sessions. At the same time, each SPM collected observe and use a monitoring form to record descriptions of their conversations related to message for reduction of risk behavior and other significant recommendation, telephone number or contact address of MSM who are approached.

**3.4.11 Post Intervention survey:** Three months following completion of the intervention in all targeted MSM hot spots, post-test survey then applied with all target SPMs/ peers in order to indicate the change in population's sexual risk behavior and HIV/AIDS knowledge and perception between pre intervention survey and its post intervention surveys both from SPMs and their peers reflection.

**3.4.12 In-depth Interview** by telephone: The researcher gathered data from 10 purposive selected SPM's peers with different status. In-depth interview by telephone was carefully conducted in order to receive the most accurate data from the interviewees. The interviewer used an in-dept interview guideline via a constructive relationship to have conversation with interviewees, in such a way the interviewees felt easy, comfortable, and having confidence to share their opinion and reflection as much as possible. The in-depth interview by telephone went smoothly as the interviewee felt familiar with the researcher when talking about their opinion leaders or SPM they liked and also with the interviewee's kind cooperation, the data was naturally provided.

**3.4.13 Evaluation of Learning Process and Outcome of Capacity Development**: In the final step, reflection sessions and sharing experiences covering both process and outcomes were conducted as a part of evaluation of the project implementation through SPM and MSM community-based organizations fully involvement. Process evaluation was conducted by participatory observation of participants during project implementation and self reflection of what they learned of the project and their personal development and learning.

## 3.5 Outcome Measurement

There were 2 sets of outcomes from this research are measured;

3.5.1 Before and after the training program, each SPM were asked to complete the pre and post tests on HIV/AIDS knowledge and perception including to role-play standard, simulated peer educational conversations. A rating of the tape recorded role-plays was given by trainers for pre and post practice conversations. These rates will reveal that, after training, the SPM become more frequently exhibited skills taught in the program or not. These checks were able to confirm social skill acquisition and conversational assignment compliance by the SPM.

3.5.2 At the first contact with each peer and 3 months after the intervention, SPM accompanied by one Mplus staff used a questionnaire; measuring knowledge and perception on HIV/AIDS prevention as well as information, motivation, behavioral skills, sexual behavior, and self-reports of actual risk and preventive behaviors, with all identified MSM peers or of a total 60 people. Furthermore, among these 60 SPM' peers, 10 have received telephone in-depth interviewed in order to confirm what their actual sexual behavior that can be used to support the validity of information gained from the questionnaire.

### 3.6 The Intervention

The SPM intervention package is the product of extensive collaboration between researcher who modified and developed the intervention and Mplus Foundation as MSM Community-based organizations who is mainly responsible for implementing the intervention. There are three-stage process is used:

3.6.1 Identifying and encouraging the compliance of popular and well-liked opinion leaders or SPM to take on risk-reduction supportive roles.

3.6.2 Training of SPM to effectively disseminate risk-reduction endorsement messages within their own social networks.

3.6.3 Supporting and empowering successive waves of SPM to help reshape social norms to encourage safer sex among MSM peers

### 3.7 Content Validity and Reliability of the Instruments

Data Validity and Reliability for Quantitative data were as follows:

3.7.1. Content validity was conducted by asking the following four experts to validate the breastfeeding questionnaire:

- A public health academician
- A peer education specialist
- A MSM technical advisor from local MSM NGO
- A qualitative research specialist

The experts reviewed the content validity of the questionnaire and self-reported risk behavior form as well as language appropriateness that related with the objective and gave comments and recommendation for revision of the instrument.

3.7.2. Reliability of the HIV/AIDS knowledge and perception and sexuality questionnaire which had been revised to ensure content validity was tested with 30 subjects who had characteristics similar to those of the study population. The Cronbach's alpha coefficient was used to determine the reliability of the questionnaire.

## 3.8 Data Analyses

Data analysis consisted of quantitative and qualitative data analysis which could be detailed as follows:

### 3.8.1 Quantitative Data Analysis

For quantitative data, the researcher used SPSS version 12 for statistical analysis (SPSS Inc, Chicago, IL, USA). Results were presented as adjusted odds ratio (OR) with 95% confidence interval (CI). P-value< 0.05 was considered to be statistically significant.

3.8.1.1 Conducting data coding and data entry

3.8.1.2 Checking and cleaning data

3.8.1.3 Analysis of data using descriptive and inferential statistics

3.8.1.3.1 Categorical data was expressed by percentage and comparison was made by the T-test

3.8.1.3.2 Descriptive statistics were derived for the percentage; means and standard deviation of the perceived knowledge, perception, and sexuality towards HIV/AIDS of the population at the baseline survey.

3.8.1.3.3 Test of difference between mean scores of the perceived knowledge, perception and sexuality toward HIV/AIDS before and after the

intervention in the population group was carried out by using paired t-test with statistically significant at 0.05.

3.8.1.3.4 The relationship between factors that were associated with HIV risk behavior reduction was determined by using the multivariate logistic regression analysis. Results were presented as relative risk with 95% confidence interval (CI). A P-value < 0.05 was considered statistically significant.

### 3.8.2 Qualitative Data Analysis

The qualitative study began with recording all summary points that obtained from group discussion and in-depth telephone interview in order to create an overview situation from small details which determined as an inductive approach. This was followed by writing a descriptive report in analytical description style. The researcher analyzed the aligning purpose and supportive factor for promotion of risk reduction behavior as well as to indicate the supportive factors for both enabling and obstacles.

## 3.9 Ethical Considerations

The Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University, Thailand approved the research protocol. All participants were given adequate information, and consent was obtained from each participant that they could withdraw from the study at any time with no effects. The confidentiality of the participants was respected.

# CHAPTER IV

# RESULTS

The findings of this study are presented in both descriptive and analytical findings. Descriptive findings illustrated the results from each study phase which covered the acceptance and effectiveness of Steer Peer Mobilizer (SPM) model launched in men who have sex with men (MSM) to reduce HIV risk behavior after the four months intervention completed in which included the results from group discussion of SPMs, the SPMs training evaluation, and in-depth telephone interviews of SPM peer group. The analytical findings could explore the level of HIV/AIDS knowledge and perception and sexuality of the MSM studied group that derived from the “Survey Form on HIV/AIDS Knowledge and Perception and Sexuality”. The set of questions in this questionnaire composed of 3 parts for pretest and posttest of the study group; Part 1: The demographic data of the population; Part 2: Knowledge and Perception of HIV/ AIDS; and Part 3: MSM and Sexuality of which used for pretest and posttest. Besides, such a declining in HIV risk behavior could be empirically exhibited in this chapter as it was elicited from “Self-reported survey form on HIV/AIDS Risk Assessment that included both ended and open-ended questions. The quantitative and qualitative results were supportive mutually shown in both tables and description. The additional discovery points were retrieved as qualitative feedback from 2 parts; in-dept group discussion of SPMs and individual telephoned in-dept interview of SPMS’ peer group.

**4.1 A preliminary review of baseline survey**

Before the baseline survey taken, the purposive selection of target hotspots for engaging in the baseline survey was initially done. The criteria for choosing the MSM hotspots for baseline data collection included such as the hotspots where composed of regular daily member or clients at least 15 persons, located in Muang Chiang Mai, easy to approach, differences in venue types, and be advised by Mplus CBO who best known about the background information of all existing MSM hotspot in Chiang Mai, The list of approached MSM hotspots are shown in the below **Table 4.1**.

**Table 4.1: Number of MSM hotspots where baseline survey conducted.**

| **Types of hotspots** | **Number** |
|---|---|
| Beer bar | 4 |
| Cabaret show house | 2 |
| Sauna | 4 |
| Beauty salon shop | 3 |
| Guy Massage/ Spa house | 3 |
| Guy bar | 4 |
| Karaoke shop | 4 |
| Internet/ game cafe | 4 |
| Group in public park | 2 |
| Group in educational institution | 2 |
| Group at volley ball sport field | 3 |
| Group at gas station | 1 |
| Bouquet shop | 1 |
| Natural social group | 2 |
| Modeling group | 3 |
| | 1 |
| Total | **43** |

In the baseline survey, the target MSM hotspots where popular among MSM included bar beer, sauna, karaoke shops, internet café, bouquet shop, beauty salon, community sport fields, public park, coffee shop, guy pub, cabaret show, massage and spa shop, natural MSM gang, and MSM group in educational institutions were approached and data were collected by Mplus CBO staff and accompanied by the researcher. We used many kind of approaches to pick up MSM for answering the questionnaires for instances counting of the numbers of men who entered to each hotspots in order to make sure that the number of member at each hotspot are big enough for choosing, because we considered that a too small group might not have any opinion leader there. Absolutely, a total of 43 MSM hotspots were approached, and then two MSM from each of the 43 totally 86 respondents who shown their willingness and generous in answering the questionnaire were interviewed. Although AIDS prevention posters and brochures were generally available in entertainment-based venues throughout Chiang Mai city, no significant differences in population risk behavior were found among different attributions of hotspots. HIV/AIDS knowledge and perception and sexuality of MSM group at baseline survey are varied in all 3 parts of the questionnaires. The mean scores of knowledge and perception on HIV/AIDS and sexuality was quite low among all at those various hotspots of Chiang Mai city (M = 86) on knowledge, perception, and sexuality about HIV/AIDS as shown in the **Table 4.2**.

The socio-demographic characteristics of the respondents by baseline survey have shown in the following table 4.2. It was evenly distributed between the youth i.e. those less than 20 years and older men, with the oldest being 40 years. Nearly 50 percents had a secondary education, which is higher than in the general

population, particularly among men. So either MSM tend to be better educated or, and this is more plausible, MSM of lower educational levels are less likely to reveal their sexuality and therefore are not known/not available for interviews. Although the distribution by area of residence does not reflect the national picture, it should be noted that MSM tend to move away from rural areas into larger towns and cities where they can live their sexual orientations outwardly and with more freedom of expression.

**Table 4.2: Number and percentage of respondents at baseline survey classified by demographic characteristics.**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Age** | | |
| Less than 20 years | 4 | 34.9 |
| 20-30 years | 54 | 62.8 |
| 31-40 years | 28 | 2.3 |
| Total | 86 | 100.0 |
| X= 22.86 SD=.42 | | |
| max= 40 min=18 | | |
| **Education Attainment** | | |
| Primary Education | 10 | 11.6 |
| Secondary /Vocational Education | 40 | 46.5 |
| Bachelor Degree | 24 | 27.9 |
| Master Degree | 2 | 2.3 |
| Others: Diploma | 10 | 11.6 |
| Total | 86 | 100.0 |
| **Marital Status** | | |
| Single | 78 | 90.7 |

| | | |
|---|---|---|
| Married | 8 | 9.3 |
| Total | 86 | 100.0 |

**Table 4.2: Number and percentage of respondents at baseline survey classified by demographic characteristics (Cont.)**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Occupation** | | |
| College/ university students | 17 | 19.8 |
| Government officials | 6 | 6.9 |
| State enterprise officials | 8 | 9.3 |
| Private company employee | 10 | 11.6 |
| Merchandiser/ Trade worker | 4 | 4.6 |
| Agriculturist | 12 | 13.9 |
| Own business | 9 | 10.5 |
| General employee/ worker | 12 | 13.9 |
| Others | 8 | 9.3 |
| Total | 86 | 100.0 |
| **Place of Birth** | | |
| Chiang Mai | 55 | 63.9 |
| Chiangrai | 11 | 12.8 |
| Khon Kaen | 2 | 2.3 |
| Lumpoon | 6 | 7.0 |
| Mae Hongsorn | 2 | 2.3 |
| Payao | 5 | 5.8 |
| Pitsanuloke | 1 | 2.3 |
| Rayong | 2 | 2.3 |
| Sukhothai | 1 | 1.2 |
| Suphanburi | 1 | 1.2 |
| Total | 86 | 100.0 |
| **Duration of times living in Chiang Mai** | | |
| Less than 1 months | 18 | 20.9 |
| 2 months – 11 months | 2 | 2.3 |
| 1 – 5 years | 6 | 7.0 |

| | | |
|---|---|---|
| 6 - 10 years | 5 | 5.8 |

**Table 4.2: Number and percentage of respondents at baseline survey classified by demographic characteristics. (Cont.)**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| 11 years and over | 55 | 63.9 |
| Total | 86 | 100.0 |
| X= 14.56 SD=10.1 max= 40 min= 0.3 | | |

In this study, the data related to the report of HIV infection risk behavior of MSM at baseline survey was explored in addition to the survey of HIV/AIDS knowledge and perception and sexuality. MSM at 43 hotspots were asked about their sexual behavior specifically in the past three months see details in the below Table 4.3.

**Table 4.3: Previous sex practices of the MSM population at baseline survey classified in numbers and percentages.**

| Items of Questions | Number | Percentage |
|---|---|---|
| **Last time had sex with** | | |
| Man | 72 | 83.7 |
| Both man and women | 4 | 12.8 |
| Never had sex | 3 | 3.5 |
| Total | 86 | 100.0 |
| **Last time had sex with man both insertive and receptive anal sex** | | |
| Never had sex | 3 | 3.5 |
| Within one week ago | 32 | 37.2 |

**Table 4.3: Previous sex practices of the study group at baseline survey classified in number and percentages (Cont.)**

| Items of Questions | Number | Percentage |
|---|---|---|
| Over one week but not later than one month | 34 | 39.5 |
| Over one month but not later than three months | 6 | 7.0 |
| Over three months | 11 | 12.8 |
| Total | 86 | 100.0 |
| **Addictive substance used during last week** | | |
| Never | 33 | 38.4 |
| Alcohol/ beer | 48 | 55.8 |
| Hashish | 1 | 2.3 |
| Amphetamine | 3 | 3.5 |
| Alcohol & Hashish | 1 | 2.3 |
| Total | 86 | 100.0 |
| **Drug used before had sex last week** | | |
| Used | 20 | 23.3 |
| Not used | 66 | 76.7 |
| Total | 86 | 100.0 |
| **Condom used with regular partner within last week** | | |
| Used | 33 | 38.4 |
| Not used | 32 | 37.2 |
| No regular partner | 21 | 24.4 |
| Total | 86 | 100.0 |
| **Condom used with temporary partner within last week** | | |
| Used | 48 | 55.8 |
| Not used | 21 | 24.4 |
| No temporary sex partner | 17 | 19.8 |
| Total | 86 | 100.0 |

| | | |
|---|---|---|
| Now, you have condom with you | | |
| Yes | 50 | 58.1 |
| No | 36 | 41.9 |
| Total | 86 | 100.0 |

**Table 4.3: Previous sex practices of the study group at baseline survey classified in number and percentages (Cont.)**

| | | |
|---|---|---|
| **Kinds of lubricant used when having anal sex** | | |
| Saliva | 4 | 4.6 |
| Saliva with cream-based lotion or oil lotion | 1 | 2.3 |
| Saliva with water-based lubricant | 9 | 10.5 |
| Cream lotion or Oil lotion or Water-based lubricant | 1 | 2.3 |
| Cream lotion or Oil lotion or Water-based lubricant or Saliva | 1 | 2.3 |
| Water-based lubricant | 60 | 70.9 |
| Never had anal sex | 9 | 10.5 |
| Total | 86 | 100.0 |

## 4.2 Demographic Data of the Studied Groups

The main findings of the survey are presented in this section with the frequencies of all the questions being included. The results confirm some of the findings derived from the group discussion among SPM members that to be presented in the following part.

To understand the location and characteristics of MSM hotspots where were selected for receiving the intervention see the figures in below Table 4.4. It illustrated that the most of SPMs are from existing MSM groups of one university, 2 vocational schools, and 1 technical college. Secondly, 3 SPMs were from guy bar/ karaoke, and another 3 from natural social groups or we called MSM gang who like

to join and meet each other almost everyday at a specific meeting point such as in front of cinemas, department stores, evening markets etc. or in anywhere they like.

**Table 4.4: Number and types of MSM hotspots where the study group of SPM affiliated to.**

| Types of hotspots | Number |
|---|---|
| Guy bar/ Karaoke | 3 |
| Sauna | 1 |
| Beauty salon shop | 2 |
| Guy Massage/ Spa house | 1 |
| Internet/ game cafe | 1 |
| Group in public park | 2 |
| Group at educational institution | 4 |
| Group at volley ball sport field | 1 |
| Total | 20 |

4.2.1 Demographic data of ***SPM group*** (Table 4.5)

**Age:** Most of the MSM who were trained to become the SPM group were between 31-40 years of age (62.8 percents), followed by the younger age group of target MSM between 21-30 years (34.9 percents). The average age of target SPM was 25.1 years old. The youngest was 20 years old, and the oldest was 42 years old.

**Education attainment:** Nearly half of the study group was from Secondary school level and the remaining half from Bachelor or higher level (40 percents each) followed by those completed primary school level at 20 percents.

**Occupation:** The distribution of occupations among SPM group is eventually among whom are on education, working in private company; do own business**,** and working as general employee or workers. Only 1 SPM is a merchandiser or trade worker**.**

**Place of Birth:** Majority of SPMs was Chiang Mai natives, there are only 2 from 2 neighboring provinces of Chiang Mai; Chiangrai and Phrae.

**Duration of times living in Chiang Mai :** Most of SPMs have been living in Chiang Mai more than 31 years or 70 percent among all. This data could support the figures related the place of birth above that majority of SPMs are Chiang Mai natives.

**Table 4.5: Number and percentage of the study group of SPM classified by demographic characteristics**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Age** | | |
| 21-30 years | 3 | 34.9 |
| 31-40 years | 15 | 62.8 |
| 41 years and over | 2 | 2.3 |
| Total | 20 | 100.0 |
| X= 25.1 SD=.60 max= 42 min=20 | | |
| **Education Attainment** | | |
| Secondary Education | 1 | 5.0 |
| High school/ Vocational school | 12 | 60.0 |
| Bachelor Degree | 7 | 35.0 |
| Total | 20 | 100.0 |

**Table 4.5: Number and percentage of the study group of SPM classified by Demographic characteristics (Cont.)**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Marital Status** | | |
| Single | 18 | 90.0 |
| Married | 2 | 10.0 |
| Total | 20 | 100.0 |
| **Occupation** | | |
| Collage/ University student | 5 | 25.0 |
| Private company employee | 5 | 25.0 |
| Merchandiser/ Trade worker | 1 | 5.0 |
| Own business | 4 | 20.0 |
| General employee/ worker | 5 | 25.0 |
| Total | 20 | 100.0 |
| **Place of Birth** | | |
| Chiang Mai | 18 | 90.0 |
| Chiangrai | 1 | 5.0 |
| Phrae | 1 | 5.0 |
| Total | 20 | 100.0 |
| **Duration of times living in Chiang Mai** | | |
| Less than 10 years | 1 | 5.0 |
| 21 – 30 years | 3 | 15.0 |
| 31 - 40 years | 14 | 70.0 |
| 41 and over | 2 | 10.0 |
| Total X= 24.3 SD=.70 max=42 min=0.7 | 20 | 100.0 |

4.2.2 Demographic data of ***SPM peer group*** (Table 4.6)

**Age:** Most of the SPM peers in this study were between 21-30 years of age (59.0 per cent), followed by the age of below 20 years (31.2 per cent). The average

age of this target MSM of SPMs peer group was 25.10 years old. The youngest was 20 years old, and the oldest was 42 years old.

**Education attainment:** Nearly half of the study group was from high school and vocational school level and the remaining half from bachelor degree level (34.4 percents) followed by those completed secondary school of 16.4 per cent.

**Occupation:** Majority of SPMs peer was private company employees of 41.0 percents and followed by on study group and general employee at the same percent of 16.4.

**Place of Birth:** Majority of SPM peer was Chiang Mai natives at 70 percents, when the rest of 30 percents from different provinces of all regions with exception from the South.

**Duration of times living in Chiang Mai :** Most of SPM peer have been living in Chiang Mai less than 10 years or 40.9 percents and follow by a group of whom living since births or for 31-40 years (34.5 percents).

**Table 4.6: Number and percentage of the study group of SPM Peers classified by demographic characteristics**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Age** | | |
| Less than 20 | 19 | 31.2 |
| 21-30 years | 36 | 59.0 |
| 31-40 years | 4 | 6.5 |
| 41 years and over | 2 | 3.2 |
| Total | 60 | 100.0 |
| X= 25.10 SD=.60 max= 42 min=20 | | |

**Table 4.6: Number and percentage of the study group of SPM Peer classifie by Demographic characteristics (Cont.)**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| **Education Attainment** | | |
| Primary education | 1 | 1.6 |
| Secondary Education | 10 | 16.4 |
| High school/ Vocational school | 25 | 41.0 |
| Diploma | 1 | 1.6 |
| Bachelor Degree | 21 | 34.4 |
| On studying bachelor degree | 3 | 4.9 |
| Total | 60 | 100.0 |
| **Marital Status** | | |
| Single | 57 | 93.4 |
| Married | 3 | 4.9 |
| Divorced | 1 | 1.6 |
| Total | 60 | 100.0 |
| **Occupation** | | |
| On Studying | 10 | 16.4 |
| Private company employee | 25 | 41.0 |
| Merchandiser/ Trade worker | 2 | 3.0 |
| Own business | 6 | 9.0 |
| General employee/ worker | 10 | 16.4 |
| Other | 8 | 13.1 |
| Total | 60 | 100.0 |
| **Place of Birth** | | |
| Bangkok | 1 | 1.6 |
| Chaingrai | 1 | 1.6 |
| Chiang Mai | 43 | 70.0 |
| Lampang | 1 | 1.6 |
| Lampoon | 2 | 3.3 |
| Rayong | 2 | 3.3 |

**Table 4.6: Number and percentage of the study group of SPM Peer classified by Demographic characteristics (Cont.)**

| Demographic Characteristics | Number | Percentage |
|---|---|---|
| Sukhothai | 1 | 1.6 |
| Nakhonsawan | 1 | 1.6 |
| Nan | 2 | 3.3 |
| Phayao | 2 | 3.3 |
| Phrae | 2 | 3.3 |
| Roi-Ed | 1 | 1.6 |
| Samutprakran | 3 | 4.9 |
| Total | 60 | 100 |
| **Duration of times living in Chiang Mai** | | |
| Less than 10 years | 25 | 40.9 |
| 21 – 30 years | 12 | 19.6 |
| 31 - 40 years | 21 | 34.5 |
| 41 and over | 3 | 4.9 |
| Total | 60 | 100.0 |
| X= 24.3 SD=.70 max=42 min=0.7 | | |

### 4.3 Knowledge, Perception, and Sexuality Related HIV/AIDS

The measurement of knowledge, perception, and sexuality related HIV/AIDS was done with the target MSM in this study who was 60 peers of SPMs with the utilization of a constructed questionnaire. The questionnaire consisted of

69 items covering 3 topics; general knowledge on HIV/AIDS as of 42 items, perception towards HIV infected cases as of 12 items, and the topic on sexuality with 15 questions. Each item required True or Fault answer. The answer key for this test are prepared and then used for checking the scores of each respondent. The criteria to indicate the level of knowledge and perception on HIV/AIDS and sexuality was set in three levels; scores of less than 45 is low, 45-60 is moderate, and 60-69 is good. The total scores were then calculated into percentage and compared between pre-test and post-test, the three months after the intervention ended.

When considering to the average scores of knowledge about HIV/AIDS before intervention in all studied participants (N = 60), it was interestingly found at 26.72, maximum scores was 32 and 21 Minimum scores.

The average scores of knowledge after intervention in the study group was significantly increased to 39.52, and the highest scores was 40 while the minimum was still high as 35.

Moreover, when statistical significant was set at 0.05 and then to be calculated by comparing between before intervention and post, it was found significantly statistically difference between the two times tested (p-value = 0.001). The details were described in the below Table 4.7.

As for the perception toward HIV/AIDS infection and a person with HIV/AIDS tested, the questions could also elicit the beliefs, feelings, and intention to behave of the respondents. The mean scores was calculated from the total scores and then separated into three levels: 3-5 as low, 6-9 fair, and 10-12 as good perception. Comparing before and after intervention, it was found that there was

much difference between the two times tested (T-value = 11.038). The details were described in the below **Table 4.7**

**Table 4.7: Differences of mean scores of knowledge on HIV/AIDS, perception towards HIV/AIDS, and sexuality between Pre-test and Post-test**

| **Area of Measurement** | Pre-test | Post-test | T-Value |
|---|---|---|---|
| **Knowledge on HIV/AIDS** (Total 42 scores) | X = 26.72<br>S.D. = 0.0657 | X = 39.52<br>S.D. = 0.0972 | 13.202**<br>.000 |
| **Perception on HIV/AIDS** (Total 12 scores) | X = 5.44<br>S.D. = 0.1695 | X = 8.54<br>S.D. = 0.0914 | 11.038**<br>.000 |
| **Sexuality** (Total 15 scores) | X = 6.81<br>S.D. = 0.2144 | X = 14.06<br>S.D. = 0.1047 | 15.857**<br>.000 |
| **Overall knowledge, perception and sexuality on HIV/AIDS** (Total 69 scores) | X = 38.96<br>S.D. = 0.1560 | X = 61.45<br>S.D. = 0.0920 | 15.161**<br>.000 |

** (P<0.01)

### 4.4 HIV Infection Risk Behavior of the Studied Group (SPM Peer Group)

The data related to the self-report of HIV infection risk behavior of the target MSM were elaborately collected to explore and indicate the status of their sexual risk behavior during the last three months. At pre intervention period and post intervention period, Sixty MSM peers of 20 trained SPMs from the 20 target MSM hotspots were specifically asked about their sex partnerships and condom use

behaviors. Addictive substances used, drug used, and consistent condom use with sexual partners both regular and temporary ones, types of lubricant used and carrying condom were the primary outcomes of the study that can trustfully imply the state of risk behavior at the period of measurement. The data received from this two periods then was compared and finally could illustrate the highlighted reduction of sexual risk behavior of the target MSM see details in the below Table 4.8.

**Table 4.8: Comparison of Sexual Risk Behavior of the Study Group at Pre-intervention and Three Months post-intervention classified in number and percentages.**

| Items of Questions | Practice at Pre-intervention period | Practice at Post-intervention period | T-Value | Sig. |
|---|---|---|---|---|
| **Addictive substance used during last week**<br>- Never used<br>- Used (Alcohol/ beer, Hashish, Amphetamine, others) | X = 2.3934<br>S.D.=0.8373 | X = 2.2131<br>S.D.= 0.6544 | 1.333** | **.188** |
| **Drug used before had sex last week**<br>- Not used<br>- Used | X = .5738<br>S.D. = 0.4986 | X = .3607<br>S.D. = 0.4841 | 3.418** | **.001** |
| **Condom used with <u>regular partner</u> within last week**<br>- Used<br>- Not used | X = 0.1639<br>S.D. = 0.3732 | X = .5574<br>S.D. = 0.5330 | -5.850** | **.000** |

**Table 4.8: Comparison of Sexual Risk Behavior of the Study Group at Pre-intervention and Three Months post-intervention classified in number and percentages. (Cont.)**

| Items of Questions | Practice at Pre-intervention period | Practice at Post-intervention period | T-Value | Sig. |
|---|---|---|---|---|
| **Condom used with <u>temporary partner</u> within last week**<br>- Used<br>- Not used | X = .6066<br>S.D. = 0.4925 | X = .7705<br>S.D. = 0.4240 | -3.430** | **.001** |
| **Now having condom with you**<br>- Yes<br>- No | X = .1803<br>S.D. = 0.3876 | X = .5082<br>S.D. = 0.5040 | -5.410** | **.000** |

Regarding to the questions concerning how and why the MSM peers not used condom with their sex partners, the answers have shown as "don't like because to get slow climax”, “no condom at the time had sex”, “partner don't like to use”, “don't like because make me feel uncomfortable and not enjoy”, “expensive”, “got drunk with no consciousness”, “in hurry so no time to put”, “using condom make me not feel spasm”, and “Shy to use”. Absolutely, theses ideas and answers were raised caused by they have never be on awareness of their risk. So it should be emphasized on awareness raising to let MSM knowing good and bad of no prevention.

### 4.5 Practical Processes of SPM Model Implementation

One of the potential results derived from the implementation of SPM model as well as essential to be documented is the practical processes existed at MSM hotspots in Chiang Mai. The lessoned learns from SPM model implementation is presented here in this chapter as following details;

**Step1: Establish a partnership between the researchers and local GOs and NGOs that have a strong commitment to the implementation of the project.**

The first walk of this project was to establish relationship with both local Government Organizations (GO) and Non-government Organizations (NGO). In this study, we put much more interests at particularly NGOs have been working and using community-based approach or we called them as a Community-based Organization (CBO). This process resulted in the identification of HIV-prevention NGOs who highly motivated and placing their interests and strong concern at MSM group wellness. In Chiang Mai where more than one HIV-prevention service provider had been found, we used both a citations across multiple databases and expert recommendations from national and international sources to identify which GO and NGO appeared well-established and had a large scale of direct service HIV-prevention activity. The director and core outreach team of 3 selected GOs and 3 NGOs were invited to participate in the first meeting. Some GOs and NGOs could not be contacted even after repeated attempts. After explanation of project objectives and research process and discussions about concerns on sexual risk behavior of MSM group of population with community-based organizations (CBO) in Chiang Mai, then MPlus foundation as one of MSM CBO volunteered and

showed strong intention to become partner organizations. In this case, the most-established and active GO and NGO from Chiang Mai included Provincial Health Office (PHO) of Chiang Mai, Bureau of AIDS (BATS), TB, and STIs and M-Plus Foundation were agreeable and invited to participate in this study. It was not possible to locate all major HIV-prevention GOs and NGOs in Chiang Mai in this study. A Working Group (WG) consisting 4 staff of Mplus, two public health professionals from Chiang Mai Provincial Health Office (PHO) and one public health expert from BATS. Accordingly, so they worked together with the research team to implement the project.

**MPlus+** is a non-profit organization in Chiang-Mai, Thailand that serves the gay, lesbian, and transgender communities. They are doing groundbreaking work and going to parks where quick, anonymous, and often rough, dangerous MSM sex is taking place. They are bringing condoms and safe-sex information to the parks, at the point where it is most needed. MPlus has established a drop-in center and clinic where its target group can be tested and treated for STIs or referred for anti-AIDS therapy. The gay, lesbian, and transgender communities are comfortable using the center where health educators, with accurate information, and counseling services are available. MPlus workers use the condom project art pin program to introduce condoms to their target groups. Mplus uses the video program and condom pin making at festivals, community events as well as at their drop in center. Mplus works primarily with sexual health for MSM. The term MSM covers the three focus groups of Mplus: The general MSM, which includes gay and bisexual men (using a western terminology); male sex workers who often self-identify as heterosexual; and transgender, male-to-female. These three groups are addressed on their own through a variety of focused interventions and outreach. Mplus has a wide span of

activities such as workshops, English education for male sex workers, and handing out condoms and information at places where men meet to have sex. They have also had activities with local schools informing about safe sex, stigma against sexual minorities and activities that promote familiarity with condoms, such as making condom pins and condom flowers. Mplus also offers face-to-face counseling, phone counseling and plans to set up online counseling. Mplus currently consists of about 1000 members, spanning all the three focus groups.

**Step 2: Organize a meeting for partner organizations to clarify understanding about the process of participatory research, problematic situations, and development of implementation plans and approaches.**

The research team and working group joined together in a small group meeting to clarify the work process, based on the principle of working in a partnership, and participation throughout the project. The meeting focused on the debates and exchange of opinions on HIV/AIDS prevention program for MSM specific group. The concept and model on Steer Peer Mobilizer (SPM) was also presented and discussed in this meeting. The main purpose of this consultation meeting is for the project partners to jointly develop strategy to enroll as well as endorse MSM opinion leaders to the SPM model implementation project in the targeted areas f Chiang Mai province with the following specific objectives.

1. To gain mutual understanding on the project's aim, objectives and expected outcomes among all implementing partners and selected key stakeholders,
2. To jointly review and provide inputs to the drafted research planned and activities to promote safe sex behavior among MSM population at various hotspots in Chiang Mai,

3. To brainstorm on the potential key implementation strategies, and
4. To gain a consensus on the next steps of the research procedures.

The consultation meeting was conducted in a highly participatory and flexible manner that could ensure the optimal inputs from participants. It has involved 22 participants representing implementing partners and potential partners from both government and non-government agencies from Bangkok and Chiang Mai including Chiang Mai Provincial Health Office, Office of Disease Prevention and Control Region 10, Chiang Mai Red Cross Station, AIDSNet, Mplus, Rainbow Sky Association of Thailand, Bureau of AIDS, TB, and STIs, and research team. The consultative meeting was started with making presentation on the background of the project and anticipated interventions that might be contributing towards the overall goal of the research project. Identification of core elements and processes for the implementation of the project was crucially presented and shared with the members. In addition the researcher is expected to use this activity as a basis to develop an implementation plan and approaches incorporating the following key elements: structural barriers to effective prevention for MSM and solutions to those barriers including core elements for increasing risk reduction behaviors among MSM population group; and identification and documentation of best practices in Thailand on MSM Prevention. The next step after this consultative meeting was collaboratively designed and set up that included the use of data and other information emerging from this consultation as well as other appropriate assessment/ consultations, design and concise a model framework for actual practicing by the MSM opinion leaders or so called SPMs.

**Step 3: Selection of MSM hotspots:** Following the baseline population assessments in all MSM well-liked hotspots existing in Chiang Mai (beer bars, saunas, karaoke shops, public park, massage houses, beauty salon, bouquet shop, gay club), **20 popular and potential hotspots** were selected to receive the intervention. However, a Pre-selection of hotspots procedure was essential to be carried out by considering from the numbers of 43 MSM hotspots we mapped and approachable at the baseline survey, the research team and working group selected a shortlist of 20 cases on the basis of research-related criteria and additional information obtained from various CBO and government agencies. The research related criteria used at this stage were the following: Is the problem researchable by means of a concentration of HIV risk behavior?, Does the MSM hotspot concern a clearly distinctive area?, Is it to be expected that lessons can be learned from the MSM hotspot case on a more general level than just local level?, Can we group different MSM hotspot cases under the umbrella of one type of hotspot?, Does the pre-selection sufficiently reflect the diversity of submitted case proposals?, and Do MSM hotspot cases already have sufficient scientific attention in other (current or recent) studies? Absolutely, the 31 MSM hotspots that were pre selected for the analytical deliberative procedure included 6 Guy bars, 3 Sauna, 4 Beauty salon shops, 5 Guy Massage/ Spa house, 3 Internet/ game café, 4 Groups in public parks, 4 Groups at educational institutions, 1 Group at department store and 1 Group at volley ball sport field. These hotspot cases were further assessed in the selection procedure in which a multi-criteria analysis was used for structuring all relevant information. Firstly, the analysis of Hotspot using desk research method, we conducted desk research with respect to each of the short listed MSM hotspot cases, focusing on four main angles: demographic angles, public health angles, social

angles, and research aspects. The public health aspects was investigated by the experts from Provincial Health Office and Office of Disease Prevention and Control Region 10 and were mainly based on available data in Chiang Mai and international literature. For the demographic and social aspects we decided to collect information from CBO workers as they can provide valuable insight into the societal dimension of cases relevant to their working region and involving local actors. The local public health workers are part of a broader health promotion network of which as well as the local CBO is also part. We met and discussed with them asking to make an assessment of their perception on MSM risk behavior, Do local health authority know about the problem?, Do they complain and concern about the problem?, Where we can easily reach MSM group?. The list of potential MSM hotspots were raised and discussed crucially. Finally, 3 Guy bars, 1 Sauna, 2 Beauty salon shops, 2 Guy Massage/ Spa house, 1 Internet/ game café, 2 Groups in public parks, 4 Groups at educational institutions, and 1 Group at volley ball sport field were selected to be the target studied areas.

**Step 4: Identification of Steer Peer Mobilizer (SPM):** To identify key popular MSM or later called as Steer Peer Mobilizer (SPM), therefore peers, bar waiters or bartenders and outreach staff from MPlus, a local Community-Based Organization (CBO) who familiar with MSM population members were advised to observe social interaction patterns within the selected MSM hotspots. Each making unobtrusive behavioral observations at the selected hotspots for a few days, recording first names and a physical identifier for 1 or 2 persons observed to socialize and be greeted positively most often by men in the hotspots. The names receiving nomination were considered key popular people or SPM. On the other

hand, the natural groups such as groups in public parks, groups at educational institutions , group at volley ball sport field were approached leading CBO staff who are MSM and quite familiar with the groups. The CBO staff could identify whom are mostly acceptable and well-liked persons by their friendly-network.

**Step 5: Formulation of Learning Process:** The learning process of SPM is essential to be established through the self-act process of the SPM and research team. This process could help to encourage the participants understanding the significance of their participation in solving their own and their community's problems in case they agreed to involve in conducting the research, increasing self-development, recognizing the strategic planning process, able to do self-planning of work, project and other activities. They certainly acquired the initial support, such as, adapting the conceptual trend and learning, research techniques, data collection and cooperation in analyzing derived data in order to create their learning for their own benefit till for their healthy MSM community. The research team started to sparkle the learning life of SPM by using participatory group discussion approach that could make them all trust and feel enjoy when having talks together and then not so long as during the first meeting they became realized that involving in the research arm not difficult but useful for their learning. Continuity of having group or individual discussion between SPM and research team were made at anytime we met each other in order to booster the SPM recognition and acceptability to move the research forwards hand in hand. Starting from encouraging the target group understanding the significance of action research till we received full participation from them is the highlight of this practical process.

**Step 6: Develop capacity-building curriculum for SPMs and develop methods for evaluation.** Curriculum for training of SPMs need to be developed through involvement of community-based organizations working on MSM intervention programs and SPMs themselves. Through needs assessment and reflection sessions, the core contents were discussed and designed by using the standard POL training package originally developed by Kelly JA et. as a guideline. All SPMs brainstormed and worked together to initiate and make plans of activities for providing knowledge to their peers in their MSM hotspots, and to make plans for implementing and evaluating such activities. Researcher and MSM community-based organizations team serving as support providers and assistance in terms of knowledge, techniques, methods and other enabling factors required for conducting and summarizing peer-led activities. The use of a participatory brainstormed process to gather information regarding SPM acceptability and training facilitator responses, therefore the reaction was concurrently optimistic. Participants of the reflection session shared MSM perception and concerns to reduce their risk of getting HIV, recording several significant examples when selected SPM asked, ‘Are we having *REAL* class today?’. Training facilitators especially appreciated the chance to advise participants the ‘tools’ to convince using condom rather than a ‘standard message’ that was directive. Teaching life-skills, especially those associated with peer pressure, generated a strong positive response from the facilitators. Several areas of interest to these facilitators related directly to PAR. For instance, training facilitators noted that the design of the lessons accommodated different learning and practicing styles, including facilitating personal efforts. Using optional examples suggested prior to implementation, training facilitators were able to emphasize different points within the lessons, guiding them to fit their particular

teaching styles, while remaining true to the lesson content. Training facilitators also emphasized the value of local and cultural background to accommodate diverse participant's needs. Focus group participants affirmed the use of real-life scenarios to which participants could relate. Training facilitators praised the infusion of racial diversity, slang and youth language into the presentations, and reported great MSM efforts and enthusiasm about them. The facilitators agreed that researchers' weighting of facilitator input was important and also emphasized the importance of participatory training to their effectiveness in teaching the curriculum. They appreciated being treated as professionals through adequate training, stipends and professional development credit. Finally, the group generated several ideas to reinforce core strategies that were incorporated in the Booster plan for Phase 2 of implementation.

**Step 7: Conducting a training of SPM:** The training consisted of four days learning and practicing, presentation, discussion and group sessions facilitated by CBO officer who is an expert on Behavioral Change Communication (BCC) strategy used. The training sessions had been focusing on building the communication skills of the key MSM to help them effectively communicate HIV risk-reduction information to other MSM friends within their social network in spontaneously initiated conversations. With further discussion emphasizing the participants' important role in stressing the benefits of behavior changes to prevent HIV infection among guy men in their own MSM hotspots are considered very essential. In session one, the facilitator reviewed basic epidemiology of HIV infection, high-risk behavior, and precautionary changes needed to reduce risk and misconceptions concerning risk. They discussed the steps that can be used to

successfully implement risk reduction, including: keeping condoms readily available if sexually active; avoiding excessive intoxicant use before sex; discussing precautions in advance with sexual partners; resisting coercions to engage in high-risk practices; and self-reinforcing for behavior change efforts. Session two described characteristics of effective health promotion messages: sensitizing others to the potential threat of AIDS; stressing that HIV infection can be prevented by behavior change; identifying specific behavior changes needed to reduce risk; suggesting strategies for implementing these changes; using self as an example in order to avoid a "preachy" tone (i.e. beginning statements with "I am learning to. . ." rather than "You should. . ."); and personally endorsing the positive value and desirable benefits of behavior change. In the third session, leaders modeled conversational examples which incorporated the characteristics discussed in session two. Following discussion of the enactments, participants role-played how they would initiate conversations, incorporating these message characteristics. **The role play activity was started** once the participants are comfortable with one another (perhaps after one or two sessions), introduce the concept of role-playing in learning to communicate about HIV infection and AIDS. An appropriate situation to role-play was used as follows:

"Surapol heard on the TV the other day that bisexual men or intravenous drug users can get AIDS easily and need to protect themselves. He is worried because his sexual partner always used drugs. He decided to talk to him about it, but he refused to discuss the matter. He said that he could never get AIDS. Asked the group to describe the role-play and their feelings while acting out the role-play and discussed barriers to communication, especially the issue of unprotected sex, and ways to get around them. Ask participants about situations requiring communication about HIV infection and AIDS to friends, and coworkers. Stress the importance of passing on accurate

prevention information to others. Group leaders and assistants observed this social skill rehearsal, providing feedback and suggestions. After becoming proficient in the role-plays, each participant identified three gay friends with whom he will be able to initiate an endorsement conversation in the next week. Monitoring forms were provided for recording descriptions of these conversations. Session four reviewed outcomes of the real-life conversations; most participants reported positive reactions from others. The leaders and other participants then problem-solved persons, formulating strategies, and setting times which could afford opportunities to initiate additional conversational contacts with other peers. All members agreed to initiate and monitor at least 10 more peer conversations over the next two weeks. The session concluded with further discussion emphasizing the participants' important role in stressing the benefits of behavior changes to prevent HIV infection among gay men in their own community. Fortunately, of the 20 opinion leaders who began the intervention, all 20 attended and completed all the sessions. Later review of participants' self monitoring forms indicated that 20 peer conversations were monitored after the facilitators assigned all SPM to have practicing conversation with one each of MSM friends over the next night session. This probably underestimated the number of conversations which actually took place because peer conversations were likely to have continued beyond the monitoring phase. In addition, before and after the training program, each SPM was asked to role-play standard, simulated peer educational conversations. Ratings of the tape recorded role-plays were made by trained judges, susceptible to whether practice conversations were pre- or post-intervention. These rates revealed that, after training, the opinion leaders more frequently exhibited skills taught in the

program (data available on request to author). These checks confirm social skill acquisition and conversational assignment compliance by the opinion leaders.

The evaluation of training was crucially conducted and summarized at the end session of the training by using group feed back process with the response shown as following details;

- *"We know each other's ideas, we share ideas so I think it's really nice to participate in this training because in Chiang Mai we don't get the chance to talk with other MSM friends and express our opinions about awareness on sexual risk behavior even though it is a very crucial issue we need to concern as the top priority."*
- SPMs excited for opportunity to speak about a sensitive topic such as to reveal what hidden topics generally they had never talked that with any ones before.
- SPMs liked the Exchanging Water Game especially because it allowed them to see the linear process of what was happening if they have sex without using condom.
- Analyzing the factors affecting risk behavior allows them to go insight and become more awareness when they would have sex with any MSM.
- The groups wanted the training team to come back to do more participatory workshops.
- Training of SPMs is really essential and needed!
- Community-based organization and provincial health sector needs to be familiar with MSM community
- Discussions were rich but important to control time to give proper time for each exercise.

- Smaller groups of no more than 6 participants are ideal.
- Participatory exercises worked to get beyond education, awareness, and outreach!
- We felt empowered and eager to make other MSM friends felt empowered too.
- We are so impressed and felt this training is *another fantastic training session! SPM training is always accessible, empowering and totally relevant; nothing else makes MSM group recognizing the risk reduction behavior so importance"*
- *"Participatory approaches give me more confidence to assist MSM friends with knowing and understanding their perception, attitude, real sexual practices and options."*
- *"…by far the most informative, useful and well presented training that I have ever attended"*
- *"Excellent – answered all my questions and more. Gave me so much reassurance and confidence. Really, really high quality day…"*

It can be concluded that the overall evaluation of the SPM training is quite useful as well as could help to stimulate and influence SPM enjoy practicing and endorsement of HIV risk reduction behavior with their peer network.

**Step 8: Implementation of SPM intervention:** Due to the major objective of the SPM model intervention is to establish a highly motivated and well-liked persons who were trained to enroll actively and visibly the importance and

acceptability of behavioral change, as well as to convey strategies for change implementation. Each SPM has contacted to have conversations with their peers to review and reinforce these efforts. At the same time, each SPM has observed and used a monitoring form for recording descriptions of their conversations related to message for reduction of risk behavior and other significant recommendation of MSM who were approached.

**Step 9: Evaluation of Learning Process and Outcome of Capacity Development**: In the final step, reflection sessions and sharing experiences covering both process and outcomes were conducted as a part of evaluation of the project implementation through SPMs and MSM community-based organizations fully involvement. Process evaluation was conducted by participatory observation of participants during project implementation and self reflection of what they learned of the project and their personal development and learning.

In addition, at one month and two month completion of intervention, the meeting to feedback performances and discussion during performances at their hotspots were informally organized at Mplus meeting room, the SPMs led discussions to identify obstacles, root causes, effects, solutions and responsible agents for the problems and the solutions illustrated in their performances. One of the SPMs acted as a ‘moderator’, he led lively debate among SPM members and was the basis for social network actions for change. Performance discussions and evaluations contributed greatly to the breakdown of silence and stigma barriers, enabling free discussion of sensitive issues. Hidden traditions and practices that are contributing HIV infection risk behavior were revealed and discussed. SPM

participants shared their uncomfortable feelings at these meetings heightened awareness of the dangers of many practices. There were a tendency to blame young MSM: *"It is really hard to deal with young MSM who always perform improper manner at various places without ashamed such as shrilly, tried to do sex harassment with other men at everywhere they wanted. Young MSM should be contented with what they should perform and not seek men for fun. There should be a frank discussion of the need to stop many risky practices"*. Another SPM mentioned *"Other MSM friends wanted wider distribution of condoms, more HIV/AIDS education and more support from CBOs and government to restrain or regulate harmful sexual-related practices.*"

Through their participation in this action research, SPMs felt more collective responsibility for the problem, and felt motivated to make changes in their hotspots. SPMs who participated in the action research program were encourage by the research team to identify and analyze problems and to focus on solutions. Issues that were illustrated in the meetings were reinforced and documented by research team. From the point of view of addressing the behaviors of young MSM, the project provided the first chance for them to present issues relating to their hidden lives, from their own perspective. This was very important because of the general people have tried to blame MSM people, since MSM who are most affected by the HIV epidemic, their performances quickly went to the root causes related to lack of access to resources and opportunities, rather than focusing on individuals' misbehaviors.

## 4.6 Qualitative Results of SPM Model Implementation

### 4.6.1 In-depth group interview of SPMs

The qualitative results derived from the in-depth group interview were documented according to the major themes of questions therein the guideline for group interview discussion with SPMs as shown in the appendix C. The group interview took place on the next day after the SPMs camp training completed.

Before starting the group interview, the pre interview discussion therefore provided the opportunity to firstly catching any emerging issues or concerns in relation to the research circle so as to enable the researcher to be more prepared both before the intervention, and complement any later reflections. These pre interviews can also be seen as part of a collaborative exercise to include the research participants in the planning stage of the research. A joint researcher and research participant activity which helped in raising issues and in promoting interest in the thematic concern, therefore catalytic validity and also allowing participants to contribute to the design and direction of the model implementation and to refine the method further. This data is therefore presented here, in this participatory method of the study for two reasons. Firstly to demonstrate how the participants were included in the planning stages of the action research cycle, before the action and observation stages began in earnest in the form of the action research procedure. Secondly, data from the pre and mid/end interviews cannot be compared. This is due to both the nature of the questions themselves and consequentially the responses. The pre interviews were supposition. In the pre interviews members were asked if they thought the certain content would be useful. They were asked to imagine and suppose if the certain content would be beneficial. The pre interviews were therefore never meaningless. By the mid-interviews, members would have commenced and experienced part of

the participatory action research procedure and therefore could be asked if it *had been* useful and beneficial. In other words, they would then be commenting on a real experience as opposed to an imagined one. Therefore, the reflections and tentative findings of this pre interview are considered to be part of the planning stage of the action research cycle, as the model implementation process had not yet begun. That is they are not the *result* of action research but rather are part of the planning stage.

Most of the participants in the in-depth group discussion described themselves as straight-gay or exclusively gay. But they said that there were many people who they knew that do not feel the same way. Some of them had felt fated and suffered, and said that other MSM might not felt the same way about themselves. They stated on many reasons why they were different because their socialization is different, economical constraints and sexual preference. They described MSM people as *closeted, shy, living in denial, afraid, cautious and curious.* There were persons who thought that those people don't necessarily gather, while others gathered freely at clubs, restaurants, social activity events, and many mainstream public places.

In this group process, the starting point of discussion was the question about "WHAT do you think **MSM or guy life in Chiang Mai is**? Since the group moderator asked to individuals by name to get the discussion started and later to the group in general, and then the MSM or guy life in Chiang Mai was summarized as:

**"***The gay life in Chiang Mai is noticeable and tolerated and even accepted. In Chiang Mai a gay can retire and find a male companion easily and live life comfortable and affordably. There are accommodations that cater to the gays and*

*there are massages that are male oriented. So anyone who is gay and is thinking of finding male partners where they can live life out of the closet and not be persecuted, or stared at, Chiang Mai has many places for them. There are a group of bars that cater to the gay. The way to tell if it is a gay bar is if the bar tender is a male and you do not see any females there available for bar fines. Now this is very generalized and for the bars that employ a male bartender and do not have any ladies working there, so they are. Entertainment created for and catering to the gay community would be Cabaret where males dressed as females perform musical numbers. Also a new restaurant has taken over from the downtown and features a male dressed as a lady and entertaining the clients. At times when people are grocery shopping at a large shopping centre such as the Central, we can see an older male accompanied by a young Thai male. Absolutely, the male is gay and living here long term perhaps with a male companion.*

When turn the point to what feeling the participants have when we talking about sexual behaviors among MSM, one member stated that *"It was the first time that I could talk openly about sexual relation with new friends without scare or shy because we have felt trusted each other and seem like we are all a same team with same destination and it is a must for us to help other friends".* Another one said that *"I have mostly agreed with the high prevalence of HIV transmission caused by unprotected anal sex existed among our group".* One members of the group said that he knew someone who is HIV infected and feel sympathy to him because he was rejected by many friends obviously. One person said that he does not want to know anyone at all. "I am just too afraid of that thing. I am not sure if I could deal with it at all." Most group members said they think it's likely you could catch AIDS because of having unprotected sex and oral sex.

Regarding the subject of **condoms and negotiating for condom use**, most people said they used condoms frequently, but mostly with causal partners, and not so regularly with long time partners. One said he had one steady partner and so did not use condoms although he admitted that if he was to have sex with others who is highly attractive, he would use a condom. All the participants said that they were doing something to protect themselves from HIV/AIDS. However, it is really hard for them if anyone suggested them to practice abstinence. When probed the group revealed that for them and most of their friends, abstinence was not the preferred choice. Some member admitted to avoiding having sex with someone if they felt that they had been with someone who was HIV positive. Further discussions revealed that most members of the group insisted that they used condoms every time with both regular and temporary partners. One person insisted that he know many of his friends don't like condoms and sometimes there are no condoms available.

When discussing about the perception of risk of contracting the HIV Virus if no use of condom, one believed that there was a high level of HIV infection in the MSM community and that most members were more at risk than they thought they were. They felt that there needs to be greater education aimed at MSM people.

In return, one asked "Is it necessary to use a condom every time I have sex with my long-term partner? The replied was that "Even though you live together, you may not know if your partner is having sex with other partners, so it is always best to protect yourself. When you have sex with your long-term partner, it is a

good idea to always use a condom and water-based lubricant, that way you don't have to worry about anything and you can enjoy your sexual pleasure. In addition to this question, another one raised "*For oral sex, is it necessary to use a condom"*. The answer is that *"Oral sex is considered to have a low risk for HIV infection unless a person has problems with oral hygiene leading to bleeding gums, sores or has cuts in their mouth. In this case the risk of STI of HIV transmission through oral sex can be high, so if you don't want to worry, and you want to enjoy oral sex, use a condom. You can use fruit-flavoured condoms to make oral sex more enjoyable."*

When asking them back as *"Do you think the MSM will help other people to reduce the risk of HIV infection or not? If ever I wanted to help them how?* Many of SPMs explained that they thought if any other MSM can receive the training like they just completed; the training of key MSM or opinion leader, they have believed other MSM friends will be able to realize and recognize why we as a member of MSM community is a must to help each other at least among our close social net work.

However, the study also investigated whether from the perspective of the participants, the engagement in empowering activities, and working towards change and action, were worthwhile issues to explore. When participants reflected on these possibilities the responses included:

*"Well if it gives use an idea of how to start off helping our MSM friends"*

*"We can sort of start thinking about how to help our friends who are at risk now"*

*"We can get a better understanding about HIV/AIDS and prevent ourselves from"*

*"It would be really good to learn something like that, to be involved in starting up some small group or action plan or something"*

They all agreed on the question of discussing personal issues with their partners, they all agreed that they would discuss personal issues with their long-term partners but not with their short-term partners. This they felt included issues about HIV/STIs. *"Mi have to get to know him first before revealing my personal business to him"* On the contrary, others said that they would want/appreciate a short term partner to tell them of his positivism of STI status before becoming physically involved. Most did not feel that they would still go ahead and have sex if they were told that his man is positive. Most persons felt that they are very confident in communicating with intimate partners and close friends without feeling afraid of losing the person. They all felt that they could as their intimate partner to use a condom and not feel afraid. Upon probing, some conceded that sometimes they allowed *"things to happen without a condom"* because they had *"long fi dis piece"* or they *"felt that the person looked good"* or *"mi did jus fraid"*

On the subject of knowledge and practices, The groups seemed quite confident that they had **information about HIV/AIDS** and prevention. One said *"I gained and learned much more information and is straight people want and need education now… I am the one that have too taught him about condom."* Straight people do not know anything and they are spreading it!" There was a slight difference in the class of the participants since the more educated turned to the Internet and books and media, while the less educated depended on friends, doctors and nurses.

Upon further probing, the participants revealed that they would not be

comfortable to ask and answer the most intimate questions in all of those locations listed. For example, when asked who you would talk to about a sore on your anus, most concluded that they would do so with their partners. It was at this juncture that the whole issue of the "*gate-keepers"* came up. Participants said that they knew very well the persons that they would turn to for that kind of intimate service. They pointed out that within each institution, there were persons that they would go to and there were some that they would not approach at all. Some also said that if they did not know the gay-friendly gatekeepers, they each knew at least one person who would tell them who to go to.

### 4.6.2 Individual In-depth interview of SPM Peers

In-depth telephone interview method was used to collect data from 10 purposive selected SPM peers. The appointment was made individually with each SPM peer with ranging of times. The next 3 days after the implementation of SPM model completed, both before noon and afternoon telephone in-dept interviewed were conducted with all selected cases, most of the SPM peers who from different types of MSM hotspot venue included 2 from guy bar, 2 from groups in educational institutes, and one each from sauna, beauty salon shop, guy massage/spa, internet/ game café, group in public park, and group at volley ball sport field. A few examples of telephone interviews were presented as below:

SPM Peer 1: *"I can negotiate with my partner to use condom, and I feel happy and found so easy to tell him without worried. I believe that I can practice like this again and again. I think use condom every time having sex made me feel good as not use it"*

SPM Peer 2: *"I have felt empowered and developed ideas regarding how to be stronger or get help if we encountered a similar situation especially on how to convince our partner to use condom at every time having sex."*

SPM Peer 3*: "It is true that the person who has many sex partners has a higher probability of getting HIV than a person with only one sex partner. No matter how many sexual partners we have, if we do not use condoms and water-based lubricant, we have a much higher risk of getting HIV. People have sex because it is pleasurable and enjoyable. Having sex is healthy. Having many sex partners may put our more risk of contracting HIV, but if we practice safe sex, we can reduce our risk.*

SPM Peer 4: *"I am working as a hidden commercial sex worker at public parks located in the city. I think it's impossible for me to use condom every time I have sex with my customers. But it is very interesting and useful when I was told by SPM who just approached me last week about how to convince and negotiate with customers for using condom. And is it necessary to use a condom every time I have sex with my long-term partner?"*

SPM Peer 5: *"Even though we live together, we may not know if your partner is having sex with other partners, so it is always best to protect ourselves. When we have sex with our long-term partner, it is a good idea to always use a condom and water-based lubricant, that way we don't have to worry about anything and we can enjoy our sexual pleasure, isn' it?"*

SPM Peer 6: *"What we have learned from SPM here, we can share with somebody else... I think we are stronger because we really start talking about this. This is the first step…""I have felt empowered; developed ideas regarding how to be stronger or get help if we encountered a similar situation especially on how to convince our partner to use condom at every time having sex."*

Summary of main findings from individual telephone interview:

- Education on all levels needed – school, family, community, government and MSM individuals needed for education on prevention of HIV/AIDS endemic.
- Positive role models needed.
- Better socialization of men needed.
- Reverse stigma - so men feel shame rather than women
- Workshops for MSM needed.

# CHAPTER V

# DISCUSSION

The discussion in this study is divided into three parts. The first part is the discussion of all findings derived from this study. The second part presented the strength of this study and the last is the limitations of this study.

## 5.1 Discussion of Findings

This study showed that Steer Peer Mobilizer (SPM) model could significantly increase knowledge and perception on HIV/AIDS as well as reduce in HIV/AIDS risk behavior of MSM group of population. The results of this study provided new information regarding effective intervention to promote safer sex and declining in HIV risk behavior of a high risk group of MSM.

The Joint United Nations Program on HIV/AIDS (UNAIDS) and other organizations adopted the importance of promoting a reduction in high-risk sexual behavior among homosexual men as one effective HIV prevention method (UNAIDS: 2006) along with the enlistment of new norms in the gay communities of large cities which discourage high-risk activities such as unprotected anal intercourse and stimulate forethought steps such as condom use or other safer sex modifications (Joseph JG et al., 1987; McKusickL et al., 1985).

There are many studies evaluating the effect of intervention to promote a reduction in high-risk sexual behavior. However, the evidence of reduction are not significantly shown as Jeffrey A. Kelly et..al. performed a review of HIV Risk Behavior Reduction following Intervention with Key Opinion Leaders of Population an Experimental Analysis studied suggested that AIDS risk behavior knowledge

scores were high among men in each city even before intervention about AIDS was not a critical dimension in the populations studied and that intervention methods which induce behavior change implementation and social acceptability of changes are needed (Jeffrey A. Kelly et..al.: 1989). Empirically, the result of the present study shows significant evidence of HIV risk behavior reduction.

In the present study, discussion of findings will be presented in accordance with the objectives of the study which were to examine;

5.1.1 To develop the SPM intervention to reduce HIV/AIDS risk behavior and promote safer sex practice in MSM group.

5.1.2 To examine the SPM intervention's effects on sexual and reproductive health perceptions and intentions to have safer sexual behaviors.

5.1.3 To examine the *acceptability* of the SPM intervention.

5.1.4 To reduce HIV associated risk among the target population.

**5.1.1 To develop the SPM intervention to reduce HIV/AIDS risk behavior and promote safer sex practice in MSM group.**

This study used a Participatory Action Research (PAR) study design with special aimed to develop the SPM intervention to reduce HIV/AIDS risk behavior and promote safer sex practice in MSM group**..** The process of participatory model development was starting from the establishment of partnership between the researcher and community-based organizations and followed by conducting a meeting with partner organizations, collaborative conducted a baseline survey to assess HIV infection risk behavior and AIDS knowledge of MSM population at all MSM hot spots, selection of MSM hot spots, recruitment of Steer Peer Mobilizers (SPMs),

formulation of learning process, participatory development of training curriculum by and for SPMs including development of methods for evaluation, organized the 4-days training on Steer Peer Mobilizer (SPM) camp at the Holiday Garden Hotel in Chiang Mai for 4 days, and afterwards all 20 trained SPMs conveyed strategies for change implementation by contracting to have conversations with 3 peers according to their own developed plans of activities for providing knowledge to their peers in their responsible hot spots as well as conducted a pre-intervention survey with each of their peers, post intervention survey was carried out at three months following the completion of the intervention in all targeted MSM hot spots. Ten among sixty of peers group were selected and received individual in-depth interview at one week after the completion of the intervention. The final step of this SPM model implementation as a part of evaluation of the project implementation was a reflection session and sharing experiences among SPMs and MSM community-based organizations to summarize what they learned from this study and their personal development and learning.

**5.1.2 To examine the SPM intervention's effects on sexual and reproductive health knowledge and perceptions and intentions to have safer sexual behaviors**

The knowledge, perception and sexuality on HIV/AIDS of the target MSM in this study was significantly increased averagely 67 %. This rate was comparable between pre and post test scores. This figures implied that the SPM intervention could effect on sexual and reproductive health perception of MSM population**.** In addition to this supportive evidence of risk reduction behavior, some incredible and significant responses from group discussion of SPMs could top up and support the conclusion of SPMs have demonstrated their critical roles and are influential factors affecting to

decision making of MSM individuals who they have conversation with on sexual and reproductive health knowledge and perceptions and intentions to have safer sexual behaviors.

### 5.1.3 To examine the *acceptability* of the SPM intervention..

Determinants of the acceptability of the SPM intervention referred to the compliance in dissemination of risk reduction thought of recruited opinion leaders who have agreed to hold at least 9 risk-reduction conversations with 3 friends and acquaintances during the conducted of in-dept group discussion with research team. In addition, when considering to the number of opinion leaders who completed the SPM training, no drop-out as all selected 20 SPMs could accomplish the training with positive feedback that the research team received at the end session of the training.

Reinforcing factors refer to factors promoting and encouraging the effort of SPMs to endorse the risk reduction ideas to their peers.

Enabling factors refer to the resources and skills enabling the SPMs to disseminate the message and having conversation with their friends smoothly and informative including past experience of communication skill they had, supportive and encouragement technique that help to lighting up new perception on HIV awareness and timing allowed for approaching their social network.

From this study, factors that affected the acceptability of the SPM model were perception toward HIV/AIDS infection and self-protection awareness of each SPM. Increasing recognition in the harm of HIV/AIDS and increasing the perception toward self-protection were positive effects on risk reduction behavior.

Increase the ‘acceptability’ of condoms through peer involvement and strong social network was realistic and effective. The current situation has shown that personal and social acceptability of condoms among MSM was very low. MSM

reported that they reduced sexual pleasure, were inconvenient, and were disapproved of by their partners. Condoms need to be ‘normalized’ in the population. Strong peer networks that promote consistent condom use have been raised among the studied group indicated that it possibly effectively reduce risky sexual practices. Targeted media and word-of mouth promotion of condoms would also increase use. MSM hotspots can be used as effective communication channels.

### 5.1.4 To reduce HIV associated risk among the target population

**The HIV risk behavior** of MSM in this study was found dramatically reduced than the evidence at the pre-intervention stage. This rate of risk reduction was higher than the studies done by Kelly JA et al in 1994, however the approach employed by Kelly was found much different. The differences of research methodology, studied populations, geographical locations as well as the years of study are credible explanations for the differences of reduction in HIV risk behavior.

## 5.2 The Strength of this Study

The study design which was participatory action research was one of the strengths of this study. The SPM model with social network involvement to reduce HIV risk sexual behavior is the very first time intervention implementing in Thailand. The SPM model is an effective approach and an important strategy because it explores the participatory learning process which is considered matching with Thai context. The reason to support this saying is based on the study of Kanchana P. (1993) to indicate that a cooperative or participatory learning can increase learner participation in the Thai context as well as it can facilitate the learning process both cognitively and affectively.

The success of the program implies that the incorporation of PAR also was successful. The methodology proved an effective way to utilize combined researcher and community strengths. MSM leaders or in this study so called “Steer Peer Mobilizer (SPM)” believed they were viewed as experts on the needs and nature of their social networks, and were treated as professionals. Especially, the SPM group enjoyed contributing to the data collection procedure and project evaluations in addition to creating the conversation messages and Boosters. PAR methodology enabled MSM community leader to represent their MSM hotspot and cultures. Both SPMs and peers created conversation about safe sex and risk reduction very often rather than the past that seemed and sounded as awareness raised after participating in the development process. Because SPMs were able to identify the finished curriculum as truly representative of their communities and values. Thus, PAR affected all levels of the creation and implementation process, fostering active participation and the emergence of a definitive sense of ownership.

**5.3 The Limitations of this Study**

5.3.1 This study was consisted of qualitative study in some parts which was subjected to opinion, cultural and social beliefs, including specific practices of the group, the application suggested by the study might be limited to population similar to the study group.

5.3.2 Communication channel was another limitation, for example, contacting by telephone interview was difficult during day time.

5.3.3 The length of the follow-up period of this study was relatively short as it was restricted by the funder and resource considerations.

5.3.4 Behavioral data were self-reported and some bias due to social desirability could have occurred. However, this bias should not have changed the conclusion of the study.

5.3.5 There was no generalization.

5.3.6 Fluctuation of population

5.3.7 High cost for data collection.

# CHAPTER VI

# CONCLUSION AND RECOMMENDATIONS

This chapter consists of two major sections; the first section is the conclusion of all discovery and highlights emerged from the implementation of the SPM model. The final section has shown the recommendations for further successfully implementing HIV prevention program for MSM group.

## 6.1 Conclusion

The Steer Peer Mobilizer (SPM) model for the reduction of HIV/AIDS risk behavior among Men who have Sex with Men (MSM) at MSM hotspots in Chiang Mai has aimed to establish a popular opinion leader of MSM to endorse actively and visibly the importance and acceptability of behavioral change, as well as to convey strategies for change implementation, and produce reductions in numbers of men who engaged in high-risk sexual activities particularly and significantly to produce concomitant and population-wide increases in HIV/AIDS prevention's concern. Since and then the participator action research was conducted in Chiang Mai Muang city, targeting at 20 MSM hotspots. The intervention in the target areas focused on 9 core elements and procedures which was critically concluded and presented in the following parts. Implementation of the SPM model in the 20 MSM hotspots ran from June to September 2011. Both quantitative and qualitative methods were used in data collection and analysis. The reliability of the questionnaire was tested with the use of Cronbach's alpha coefficient. The alpha coefficient was 0.921 on HIV/AIDS knowledge and perception and sexuality, and 0.827 for the reduction in risk behavior

of MSM studied population. The paired t-test was utilized to test the differences between pre-intervention outputs and post-test.

### 6.1.1 Core elements and procedures derived from SPM model implementation

In this study there were 9 key steps of an intervention that need to be adapted and cannot be ignored for effectively shaping the social norms and recognition in the significance of HIV/AIDS risk of MSM as the most at risk people. It came from the behavioral theory upon which the intervention or strategy is based, a diffusion of innovation; they were taught to think to be responsible for the intervention's effectiveness. The SPM model has the following 9 core elements:

**6.1.1.1 Establishment of partnership** between the researcher and community-based organizations working on MSM programs that have a strong commitment to the implementation of the project.

**6.1.1.2 Organizing a meeting with partner organizations** which included both GOs and NGOs to clarify understanding about the process of participatory research, problematic situations, development of implementation plans and approaches, and development of curriculum and tools for evaluating outcomes of the project.

**6.1.1.3 Baseline survey VS selection of MSM hot spots:** The conduct of baseline survey is very essential for assessment of existing situation of HIV/AIDS in the high risk venues or in all MSM hot spots existing in Chiang Mai (beer bars, saunas, karaoke shops, public park, massage houses, beauty salon, bouquet shop, gay club), then the selection process to recruit SPM could be started. It is because the baseline data can indicate and guide where to be selected to receive the intervention.

**6.1.1.4 Identification of Steer Peer Mobilizer (SPM):** To identify key popular MSM, peers, bar waiters or bartenders and outreach staff from MPlus, a local Community-Based Organization (CBO) who familiar with population members were advised to observe social interaction patterns within the selected MSM hot spots. Each making unobtrusive behavioral observations at the selected hot spots for a few days, recording first names and a physical identifier for 1 or 2 persons observed to socialize and be greeted positively most often by men in the hot spots. The names receiving nomination were considered key popular people or SPM.

**6.1.1.5 Formulation of Learning Process:** The learning process of SPM is essential to be established through the self-act process of the SPM and research team. This is to encourage the participants understanding the significance of their participation in solving their own and their community's problems by conducting the research and self-development, strategic planning, self-planning of work, project and other activities. They certainly needed the initial support, such as, adapting the conceptual trend and learning, research techniques, data collection and cooperation in analyzing derived data in order to create their learning for their own benefit till for their healthy MSM community.

**6.1.1.6 Develop capacity-building curriculum for SPMs and develop methods for evaluation.** Curriculum for training of SPMs needs to be developed through involvement of community-based organizations working on MSM intervention programs and SPMs themselves. Through needs assessment and reflection sessions, the core content will be designed by using the standard POL training package originally developed by Kelly JA et. as a guideline. All SPMs brainstormed and worked together to initiate and make plans of activities for providing knowledge to their peers in hot spots, and to make plans for implementing

and evaluating such activities. Researcher and MSM community-based organizations team serving as support providers and assistance in terms of knowledge, techniques, methods and other enabling factors required for conducting and summarizing peer-led activities.

**6.1.1.7 Conducting a training of SPM:** The training consisted of four days learning and practicing, presentation, discussion and group sessions led by CBO outreach staff. The training sessions should be focusing on building the communication skills of the key MSM to help them effectively communicate HIV risk-reduction information to others in spontaneously initiated conversations. With further discussion emphasizing the participants' important role in stressing the benefits of behavior changes to prevent HIV infection among guy men in their own MSM hotspots are considered very essential.

**6.1.1.8 Implementation of SPM intervention:** Due to the objective of the SPM model intervention is to establish a highly motivated and well-liked persons who were trained to enroll actively and visibly the importance and acceptability of behavioral change, as well as to convey strategies for change implementation. Each SPM must contract to have conversations with peers to review and reinforce these efforts. At the same time, each SPM will observe and use a monitoring form to record descriptions of their conversations related to message for reduction of risk behavior and other significant recommendation of MSM who were approached.

**6.1.1.9 Evaluation of Learning Process and Outcome of Capacity Development**: In the final step, reflection sessions and sharing experiences covering both process and outcomes were conducted as a part of evaluation of the project implementation through SPMs and MSM community-based organizations fully involvement. Process evaluation was conducted by participatory observation of

participants during project implementation and self reflection of what they learned of the project and their personal development and learning. The conclusion of key characteristics of popular opinion leader or SPM was made and revealed as 1) SPM are trusted and well-liked by their network of friends, 2) SPM can be either male or female but male is the best, 3) SPM are those people who are most often greeted, who greet other the most, and who are sought out for advice by MSM friends.

## 6.2 Recommendations

6.2.1 SPM model seems to be successfully implemented and evaluated with risk populations other than men who have sex with men. SPM model has wide potential for adaptation to risk populations defined by the need for promotion of a risk-reduction supportive social values in the context of shared social networks mobilized around popular, credible, and trusted people (opinion leaders).

6.2.2 Detailed information for SPM should be collected and analyzed for the target population in the targeted community setting, for the subgroups (social networks) internally, the popular opinion leaders in these subgroups, the HIV risk-reduction opinion or social values are required for further promotion, and for strategic behavioral change strategy, including dissemination of HIV/AIDS risk reduction materials.

6.2.3 Methods that are appropriate for the formative work to establish a SPM intervention program include socio-metric surveys or community member ratings of other members in terms of popularity, observational studies of community venues, social networks, popular individuals in networks, and HIV risk attitudes and opinions, interviews of and support from gatekeepers and key informants, focus groups to

develop social marketing media, community surveys of members' knowledge, attitudes, and behaviors , and secondary analysis of existing reports and data sets (e.g., existing needs assessments, risk assessments, market studies, and census studies)

6.2.4 Supportive role of the CBO is required including an implementation plan to ensure that all of SPM's core elements and key procedures are included and followed.

6.2.5 Strengthening the implementation capacity of the MSM steering group and local MSM organizations is required to scale up and increase coverage using best practices for effective and POL-based interventions as soon as possible.

6.2.6 Providing information in educational places like schools, college, and universities to teach young people about the issue of HIV risk reduction and prevention faced by MSM group can also help to reduce the number of social barriers for MSM in the future.

6.2.7 The key process of how to institutionalize and sustain program funding needs to be documented and published.

6.2.8 HIV risk behavior knowledge scores were high among MSM in each hotspot even at the baseline survey; therefore it is suggesting that lack of knowledge on HIV/AIDS was not significant in the studied populations but the strategic intervention methods which promote behavior change and social acceptability of changes are very much critical and essential.

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# APPENDICES

# APPENDIX A

# RESEARCH INSTRUMENTS: THAI

# (EXAMPLE)

# แบบสอบถามเพื่อการวิจัย
# เรื่อง รูปแบบกลุ่มแกนนำผู้ขับเคลื่อนการลดความเสี่ยงในการติดเชื้อ เอช ไอ วี เอดส์ ของกลุ่มชายที่มีเพศสัมพันธ์กับชายในแหล่งรวมตัวจังหวัดเชียงใหม่

**แบบทดสอบความรู้ และทัศนคติในเรื่องเพศ และเอชไอวี และเอดส์**

**คำชี้แจง**: *แบบประเมินนี้ใช้สำหรับการเก็บข้อมูลประชากร ความรู้และการรับรู้ต่อเอชไอวีเอดส์ และเรื่องเพศของกลุ่มชายที่มีเพศสัมพันธ์กับชายเป็นรายบุคคล*

**รหัสผู้ให้ข้อมูล** | | | | | | |

วันที่บันทึกข้อมูล...../...../.....

**1. ข้อมูลด้านประชากร**

1.1 คุณมีภูมิลำเนาเดิมอยู่ในจังหวัด .....
คุณอาศัยอยู่ในจังหวัดเชียงใหม่มานาน .....วัน/ ……...เดือน/ ……..ปี

1.2 วุฒิการศึกษาสูงสุดของคุณ คือ

☐ 1. ประถมศึกษา ☐ 2. มัธยมศึกษาตอนต้น

☐ 3. มัธยมศึกษาตอนปลาย/ อาชีวศึกษา ☐ 4. ปริญญาตรี

☐ 5. ปริญญาโท ☐ 6. ปริญญาเอก

☐ 7. อื่นๆ (ระบุ) .....

1.3 อายุ …….. ปี

1.4 สถานภาพปัจจุบัน

☐ 1. โสด ☐ 2. สมรส

☐ 3. หย่า ☐ 4. หม้าย

☐ 5. อื่นๆ (ระบุ) ..... \

1.5 อาชีพ

☐ 1. กำลังศึกษาอยู่ ☐ 2. ข้าราชการ/ พนักงานของรัฐ

☐ 3. เจ้าหน้าที่รัฐวิสาหกิจ ☐ 4. พนักงานบริษัท

☐ 5. ค้าขาย ☐ 6. งานเกษตรกรรม

☐ 7. ธุรกิจส่วนตัว ..... ☐ 8. รับจ้างทั่วไป

☐ 9. อื่นๆ ระบุ.....

**2. คำถามเกี่ยวกับความรู้และการรับรู้ต่อ เอชไอวี และเอดส์**

โปรดอ่านคำถามข้างล่างและใส่เครื่องหมาย “X” ในช่องที่ตรงกับความเห็นของคุณ หากคุณคิดว่าข้อความนั้น **“ถูก” “ผิด” หรือ “ไม่ทราบ/ ไม่แน่ใจ”**

| คำถาม | ถูก | ผิด | ไม่ทราบ/ ไม่แน่ใจ |
|---|---|---|---|
| 1. เราสามารถติดเชื้อเอชไอวีได้จากการมีเพศสัมพันธ์กับใครก็ตามที่ไม่รู้ผลเลือดเอชไอวีของตนเอง หรือ รู้ว่าผลเลือดเป็นบวก โดยไม่สวมถุงยางอนามัย | | | |
| 2. เราสามารถติดเชื้อเอชไอวีได้จากการนอนในห้องเดียวกับผู้ติดเชื้อเอชไอวี | | | |
| 3. เราสามารถติดเชื้อเอชไอวีได้จากการใช้ห้องน้ำห้องเดียวกับผู้ติดเชื้อเอชไอวี | | | |
| 4. เราสามารถติดเชื้อเอชไอวีได้จากการทักทายโดยการสัมผัสมือกับผู้ติดเชื้อเอชไอวี | | | |
| 5. คนที่ดูเป็นผู้มีสุขภาพดีก็อาจเป็นผู้ติดเชื้อเอชไอวีได้เช่นกัน | | | |
| 6. เราสามารถป้องกันตนเองจากการติดเชื้อเอชไอวีได้โดยใช้ถุงยางอนามัยอย่างถูกต้องทุกครั้งเมื่อมีเพศสัมพันธ์ | | | |
| 7. เราสามารถติดเชื้อเอชไอวีได้จากการถูกยุงกัด | | | |
| 8. เราสามารถป้องกันตนเองจากการติดเชื้อเอชไอวีได้โดยการมีคู่นอนเพียงคนเดียว และคู่นอนคนนั้นต้องไม่เป็นผู้ติดเชื้อเอชไอวี และต้องไม่มีเพศสัมพันธ์กับคนอื่นอีกด้วย | | | |
| 9. เราสามารถป้องกันตนเองได้จากการติดเชื้อเอชไอวีโดยการที่ไม่มีเพศสัมพันธ์กับใครเลย | | | |
| 10. เราสามารถติดเชื้อเอชไอวีได้จากการใช้เข็มฉีดยาร่วมกับผู้ติดเชื้อเอชไอวี | | | |
| 11. เราสามารถป้องกันการติดเชื้อเอชไอวีได้จากการหลั่งข้างนอกเมื่อมีเพศสัมพันธ์ | | | |
| 12. เอชไอวีสามารถติดต่อกันทางน้ำลายและเหงื่อได้ | | | |
| 13. โดยทั่วไปแล้วผิวของผู้ติดเชื้อเอชไอวีจะดูแห้งและตัวก็จะร้อน | | | |
| 14. คนที่ติดเชื้อเอชไอวีจะผอม และผิวซีด | | | |

| คำถาม | ถูก | ผิด | ไม่ทราบ/ ไม่แน่ใจ |
|---|---|---|---|
| 15. ขณะนี้มียาที่สามารถรักษาเอชไอวี และเอดส์ ให้หายได้ | | | |
| 16. เราสามารถติดเชื้อเอชไอวีได้จากการใช้แปรงสีฟันร่วมกับผู้ติดเชื้อเอชไอวี | | | |
| 17. ใครก็ตามจะรู้ว่าตนเองมีเลือดบวกเอชไอวีหรือไม่นั้น ก็ต่อเมื่อได้รับการตรวจหาเอชไอวีแอนติ้บอดี้ (HIV antibody) จากสถานที่ตรวจที่เชื่อถือได้ | | | |
| 18. การสักก็สามารถทำให้ติดเชื้อเอชไอวีได้ ถ้าเครื่องมือที่ใช้ไม่ได้ผ่านการฆ่าเชื้อ | | | |
| 19. เราสามารถใช้หลอดฉีดยาร่วมกับคนอื่นได้ อย่างปลอดภัยไม่ติดเชื้อเอชไอวี ถ้าเราเปลี่ยนเข็มใหม่ทุกครั้ง | | | |
| 20. การมีเพศสัมพันธ์ทางปากปลอดภัยจากการติดเชื้อเอชไอวีมากกว่าการมีเพศสัมพันธ์ทางทวารหนัก | | | |
| 21. เราสามารถมีเพศสัมพันธ์ทางทวารหนักได้อย่างอย่างปลอดภัยถ้าเราไม่หลั่งอสุจิข้างในร่างกายของคู่นอน | | | |
| 22. คนอ้วนท้วนสมบูรณ์มีโอกาสเป็นผู้ติดเชื้อเอชไอวีน้อยกว่าคนผ่ายผอมซีดเซียว | | | |
| 23. คนร่ำรวยมีโอกาสเป็นผู้ติดเชื้อเอชไอวีน้อยกว่าคนที่ยากจน | | | |
| 24. การใช้น้ำลายแทนสารหล่อลื่นก็ยังดีกว่าที่ไม่ได้ใช้อะไรเลย | | | |
| 25. ช่องทางหลักของการติดเชื้อเอชไอวีจากการมีเพศสัมพันธ์ คือการติดต่อโดยทางปากและทางอวัยวะเพศ ไม่ใช่ทางทวารหนัก | | | |
| 26. การกลืนน้ำอสุจิมีอันตรายน้อยกว่าการให้คู่นอนหลั่งอสุจิในทวารหนักของเรา | | | |
| 27. ถ้าเราออกเดทกับใครนานกว่าหกเดือน เราไม่ต้องใช้ถุงยางอนามัยกับเขาได้ | | | |
| 28. มันคุ้มค่าอย่างยิ่งที่จะไปรับบริการการตรวจและให้คำปรึกษาเอชไอวี ถึงแม้ว่าจะต้องอาศัยความกล้าอย่างมาก | | | |

| คำถาม | ถูก | ผิด | ไม่ทราบ/ ไม่แน่ใจ |
|---|---|---|---|
| 29. การเป็นโรคติดเชื้อทางเพศสัมพันธ์โดยไม่ได้รักษาก็ยิ่งจะเพิ่มความเสี่ยงต่อการติดเชื้อเอชไอวีได้มากขึ้น | | | |
| 30. เราสามารถเป็นโรคติดเชื้อทางเพศสัมพันธ์ได้โดยที่เราไม่รู้ตัว | | | |
| 31. เราไม่จำเป็นต้องใช้ถุงยางอนามัยกับคนที่ดูเด็ก และสะอาด | | | |
| 32. การมีเพศสัมพันธ์ทางทวารหนักกับคนสิบคนโดยใช้ถุงยางอนามัยทุกครั้งปลอดภัยกว่าการมีเพศสัมพันธ์ทางทวารหนักกับคนเพียงคนเดียวโดยไม่ใช้ถุงยางอนามัย | | | |
| 33. “ดิปปิ้ง” (การแหย่อวัยวะเพศเข้าในทวารหนักโดยไม่หลั่ง) ไม่สามารถติดเชื้อเอชไอวีได้ | | | |
| 34. ผู้ติดเชื้อเอชไอวีสองคนมีเพศสัมพันธ์กันโดยไม่ใช้ถุงยางอนามัยถือเป็นเรื่องไม่ปลอดภัยสำหรับเขา | | | |
| 35. เอชไอวีเป็นเชื้อที่ติดต่อระหว่างชาวต่างชาติเท่านั้น | | | |
| 36. ถุงยางอนามัยมีเพียงขนาดเดียวเท่านั้น | | | |
| 37. ถุงยางอนามัยทุกยี่ห้อมีคุณภาพเท่าเทียมกัน | | | |
| 38. สามารถใช้สารหล่อลื่นชนิดน้ำมันกับถุงยางอนามัยได้อย่างปลอดภัย | | | |
| 39. การใช้ถุงยางอนามัยชนิดที่มีสารฆ่าอสุจิสามารถป้องกันการติดเชื้อเอชไอวีได้ | | | |
| 40. การขลิบอวัยวะเพศชายสามารถป้องกันการติดเชื้อเอชไอวีได้ | | | |
| 41. เราไม่ต้องใช้ถุงยางอนามัยกับคู่นอนที่เขาได้รับการขลิบอวัยวะเพศก็ได้ | | | |
| 42. การเลียทวารหนักให้กันมีโอกาสเพียงเล็กน้อยเท่านั้นที่จะติดเชื้อเอชไอวี แต่อาจได้รับเชื้อไวรัสตับอักเสบ หรือการโรคติดเชื้อทางเพศสัมพันธ์อื่นๆ ได้ง่าย | | | |
| 43. ควรแนะนำให้ผู้ติดเชื้อเอชไอวีเลิกมีเพศสัมพันธ์ จะเป็นการดีที่สุด | | | |

| คำถาม | ถูก | ผิด | ไม่ทราบ/ ไม่แน่ใจ |
|---|---|---|---|
| 44. ผู้ติดเชื้อเอชไอวี และผู้ป่วยเอดส์จะต้องใช้ถุงยางอนามัยสองชั้นแทนที่จะเป็นชั้นเดียวเพื่อความแน่ใจ | | | |
| 45. ถ้าผู้ติดเชื้อเอชไอวีกินยาต้านไวรัสอย่างถูกต้อง เขาก็จะสามารถมีชีวิตได้อย่างยืนยาวและมีสุขภาพดี | | | |
| 46. ผู้ติดเชื้อเอชไอวีบางคนติดเชื้อมามากกว่า 20 ปีแล้ว | | | |
| 47. เวลาที่ต้องการหาคู่นอนชั่วคราว สิ่งที่ดีที่สุดคือให้คิดว่าทุกคนเป็นผู้ติดเชื้อเอชไอวี | | | |
| 48. การติดเชื้อเอชไอวีเป็นความผิดพลาดของเราเอง | | | |
| 49. โดยทั่วไปคนที่ติดเชื้อเอชไอวีเป็นผู้ที่มีเพศสัมพันธ์ หรือไม่ก็ใช้ยาเสพติดมากกว่าคนที่ไม่ติดเชื้อเอชไอวี | | | |
| 50. บางเมือง เช่น กรุงเทพ มากกว่าหนึ่งในสี่ของชายรักชายที่เที่ยวสถานเริงรมย์ติดเชื้อเอชไอวี หรือเป็นเอดส์ | | | |
| 51. ผู้ติดเชื้อเอชไอวี และผู้ป่วยเอดส์ควรได้รับตรวจนับซีดี-4 เป็นประจำ | | | |
| 52. สำหรับผู้ติดเชื้อเอชไอวี และผู้ป่วยเอดส์ การฝึกจิตใจให้สงบ ออกกำลังกายอย่างสม่ำเสมอ และการรับประทานอาหารอย่างถูกโภชนาการจะช่วยรักษาให้มีสุขภาพดีนานขึ้น | | | |
| 53. คนที่เพิ่งติดเชื้อเอชไอวีสามารถแพร่เชื้อไปสู่ผู้อื่นผ่านการมีเพศสัมพันธ์ที่ไม่ได้ป้องกันได้ง่ายกว่าคนที่ติดเชื้อเอชไอวีมาเป็นเวลาหนึ่งแล้ว | | | |
| 54. คนที่กำลังกินยาต้านเรโทรไวรัสที่มีปริมาณไวรัสในระดับที่ไม่สามารถตรวจพบสามารถแพร่เชื้อเอชไอวีไปสู่คนอื่นผ่านการมีเพศสัมพันธ์ทางทวารหนักที่ไม่ได้ป้องกันได้เช่นเดียวกับผู้ติดเชื้อเอชไอวีที่ไม่ได้รับยาต้านเรโทรไวรัส | | | |

**3. คำถามเกี่ยวกับการมีเพศสัมพันธ์กับเพศเดียวกัน**

| คำถาม | ถูก | ผิด | ไม่ทราบ/ ไม่แน่ใจ |
|---|---|---|---|
| 55. ชายรักชายเกิดจากการที่เมื่อยังเด็ก เด็กผู้ชายอยู่แต่กับเด็กผู้หญิงมากเกินไป | | | |
| 56. ชายรักชายเกิดจากการขาดฮอร์โมนเพศชาย (เทสโทสเตอโรน) | | | |
| 57. การมีเพศสัมพันธ์กับเพศเดียวกันถือเป็นส่วนหนึ่งของแฟชั่น | | | |
| 58. การมีเพศสัมพันธ์กับเพศเดียวกันมีปรากฏในทุกวัฒนธรรม และทุกๆประเทศในโลก | | | |
| 59. การมีเพศสัมพันธ์โดยไม่ใช้ถุงยางอนามัย คนรักเพศเดียวกันจะมีโอกาสติดเชื้อเอชไอวีได้มากกว่าคนรักต่างเพศ | | | |
| 60. การมีเพศสัมพันธ์กับเพศเดียวกันถือเป็นเรื่องธรรมชาติ | | | |
| 61. การอบรม และฝึกสมาธิจะสามารถขจัดความรู้สึกรักเพศเดียวกันได้ | | | |
| 62. พฤติกรรมการมีเพศสัมพันธ์กับเพศเดียวกันเป็นบาป | | | |
| 63. ‘ชายแท้’ จะกลายเป็นชายรักชายได้ ถ้าเขาคบหาสมาคมกับคนที่เป็นคนรักเพศเดียวกันมากเกินไป | | | |
| 64. การมีเพศสัมพันธ์ทางทวารหนักกับผู้หญิงสามารถทำให้คุณเป็นคนรักเพศเดียวกันได้ | | | |
| 65. ในกลุ่มคนที่มีฐานะปานกลางมีคนที่รักเพศเดียวกันมากกว่าคนที่ฐานะยากจน | | | |
| 66. การเป็นฝ่ายรุกโดยการสอดใส่ทางทวารหนักมีความเสี่ยงต่อการติดเชื้อเอชไอวีน้อยกว่าการเป็นฝ่ายรับจากการถูกสอดใส่ทางทวารหนัก | | | |
| 67. ชายรักชายก็สามารถใช้ถุงอนามัยสตรีในการมีเพศสัมพันธ์ทางทวารหนักได้ | | | |
| 68. คนรักเพศเดียวกันเป็นคนที่ทำให้เกิดการแพร่ระบาดของเชื้อเอชไอวี | | | |
| 69. การมีเพศสัมพันธ์กับเพศเดียวกันมีเฉพาะในเมือง ไม่มีในชนบท | | | |

# แบบสอบถามเพื่อการวิจัย
# เรื่อง รูปแบบกลุ่มแกนนำผู้ขับเคลื่อนการลดความเสี่ยงในการติดเชื้อ เอช ไอ วี เอดส์ ของกลุ่มชายที่มีเพศสัมพันธ์กับชายในแหล่งรวมตัวจังหวัดเชียงใหม่

**แบบประเมินตนเองเรื่องความเสี่ยงในการติดเชื้อเอชไอวี และเอดส์**

| **รหัสผู้ให้ข้อมูล** | | | | | | |
|---|---|---|---|---|---|---|

**คำชี้แจง**: *แบบประเมินนี้ใช้สำหรับการเก็บข้อมูลประชากรและพฤติกรรมเสี่ยงของชายที่มีเพศสัมพันธ์กับชายเป็นรายบุคคล เพื่อติดตามการปรับเปลี่ยนพฤติกรรมของ*ผู้ให้ข้อมูล

วันที่บันทึกข้อมูล...../...../.....

**ข้อมูลด้านประชากรและพฤติกรรมเสี่ยงของในชื้อเอชไอวีของกลุ่มชายที่มีเพศสัมพันธ์กับชาย**

1. คุณมีภูมิลำเนาเดิมอยู่ในจังหวัด .....
   คุณอาศัยอยู่ในจังหวัดเชียงใหม่มานาน .....วัน/ …….....เดือน/ …….ปี

2. วุฒิการศึกษาสูงสุดของคุณ คือ
   - ☐ 1. ประถมศึกษา
   - ☐ 2. มัธยมศึกษาตอนต้น
   - ☐ 3. มัธยมศึกษาตอนปลาย/ อาชีวศึกษา
   - ☐ 4. ปริญญาตรี
   - ☐ 5. ปริญญาโท
   - ☐ 6. ปริญญาเอก
   - ☐ 7. อื่นๆ (ระบุ) .....

3. อายุ …….. ปี

4. สถานภาพปัจจุบัน
   - ☐ 1. โสด
   - ☐ 2. สมรส
   - ☐ 3. หย่า
   - ☐ 4. หม้าย
   - ☐ 5. อื่นๆ (ระบุ) .....

5. อาชีพ

☐ 1. กำลังศึกษาอยู่ ☐ 2. ข้าราชการ/ พนักงานของรัฐ

☐ 3. เจ้าหน้าที่รัฐวิสาหกิจ ☐ 4. พนักงานบริษัท

☐ 5. ค้าขาย ☐ 6. งานเกษตรกรรม

☐ 7. ธุรกิจส่วนตัว ..... ☐ 8. รับจ้างทั่วไป

☐ 9. อื่นๆ ระบุ.....

6. **ครั้งล่าสุด**คุณมีเพศสัมพันธ์กับใคร (เพศสัมพันธ์ หมายถึง การสอดใส่อวัยวะเพศเข้าไปในช่องคลอด ทางปาก หรือทางทวารหนัก
ไม่ว่าจะเป็นฝ่ายสอดใส่ หรือฝ่ายถูกสอดใส่ )

☐ 1. ผู้หญิง ☐ 2. ผู้ชาย

☐ 3. ทั้งผู้ชาย และผู้หญิง ☐ 4. ยังไม่เคยมีเพศสัมพันธ์

**(สำหรับผู้ตอบข้อ 2 หรือ 3 ข้างบน)** ครั้งล่าสุดที่คุณมีเพศสัมพันธ์กับผู้ชาย

☐ 1) ภายหนึ่งอาทิตย์ที่ผ่านมา ☐ 2) เกินกว่าหนึ่งอาทิตย์ แต่ไม่เกินหนึ่งเดือนที่ผ่านมา

☐ 3) เกินหนึ่งเดือนมาแล้วแต่ไม่ถึงสามเดือน ☐ 4) เกินสามเดือนมาแล้ว

7. ใน 1 อาทิตย์ที่ผ่านมา คุณเคยใช้สารเสพติดใดๆต่อไปนี้ หรือไม่

☐ 1. ไม่ได้ใช้ ☐ 2. เหล้า / เบียร์ ☐ 3. กัญชา ☐ 4. กาว/ทินเนอร์

☐ 5. ยาบ้า ☐ 6. ยาเค / ยาอี ☐ 7. ป๊อปเปอร์ ☐ 8. อื่น ๆ.....

☐ 9. ไม่ตอบ

8. **ครั้งล่าสุด**ที่มีเพศสัมพันธ์กับผู้ชาย คุณใช้สารเสพติดก่อนจะมีเพศสัมพันธ์กันหรือไม่

☐ 1. ใช้ ☐ 2. ไม่ใช้

9. **ครั้งล่าสุด**ที่มีเพศสัมพันธ์กับ**คู่นอนประจำ** (ผู้ชายที่ตกลงเป็นแฟนกันและคบกันเกินสามเดือน) คุณใช้ถุงยางอนามัยหรือไม่

☐ 1. ใช้ ☐ 2. ไม่ใช้ ☐ 3. ไม่มีคู่นอนประจำ

10. **<u>ครั้งล่าสุด</u>**ที่มีเพศสัมพันธ์กับ**<u>คู่นอนชั่วคราว</u>** (คู่นอนที่ไม่ใช่คู่นอนประจำ) คุณใช้ถุงยางอนามัยหรือไม่

☐ 1. ใช้ ☐ 2. ไม่ใช้ ☐ 3. ไม่มีคู่นอนชั่วคราว

11. ขณะนี้คุณมีถุงยางอนามัยติดตัวหรือไม่

☐ 1. มี ☐ 2. ไม่มี

12. ปกติคุณใช้สารหล่อลื่นประเภทใดเมื่อมีเพศสัมพันธ์ทางทวารหนัก (ตอบได้มากกว่า 1 ข้อ)

☐ 1. น้ำลาย ☐ 2. ครีมโลชั่น หรือ ออยโลชั่น

☐ 3. เจลหล่อลื่นสูตรน้ำ ☐ 4. อื่น ๆ ระบุ.....

☐ 5. ไม่เคยมีเพศสัมพันธ์ทางทวารหนัก

13. คุณคิดว่าอะไรเป็นอุปสรรคที่ทำให้คุณ หรือเพื่อนๆ MSM ทั่วไปไม่สามารถใช้ถุงยางอนามัยได้ทุกครั้งที่มีเพศสัมพันธ์ (เช่น ราคาแพง อายไม่กล้าซื้อ ไม่กล้าบอกคู่นอนให้ใช้ คู่นอนไม่ชอบใช้)

.....

.....

.....

14. คุณเคยไปตรวจเลือดหาเชื้อเอชไอวี หรือไม่

☐ เคย **<u>ครั้งล่าสุด</u>** ตรวจที่..... วันที่ (วัน/เดือน/พ.ศ.).....

**<u>คุณไปฟังผลหรือไม่</u>** ☐ 1) ไปฟังผล ☐ 2) ไม่ได้ไปฟังผล เพราะ.....

☐ไม่เคยตรวจ และคิดว่า.....

☐ 1) ไม่ไป เพราะไม่อยากรู้ หรือไม่อยากตรวจ ☐ 2) ไม่ไป เพราะไม่จำเป็นต้องตรวจ

☐ 3) จะไป แต่ยังไม่กำหนดเวลา ☐ 4) จะไป ภายใน 3-6 เดือนนี้

15. คุณคิดว่าอะไรเป็นอุปสรรคทำให้เพื่อนๆ MSM ทั่วไปไม่อยากไปตรวจเลือดหาการติดเชื้อเอชไอวี (ระบุสั้น ๆ)

.....

. .....

16. คุณเคยไปใช้บริการของศูนย์เพื่อน/ ดรอปอินหรือไม่

☐ 1. เคย ไปใช้บริการเรื่อง

……..

☐ 2. ไม่เคย เพราะ

……

# APPENDIX B

# SPM TRAINING PROGRAM: THAI

# (EXAMPLE)

**หลักสูตรการฝึกอบรม "ค่ายแกนนำผู้ขับเคลื่อนการทำงาน เรื่อง การป้องกันเอดส์ (Steer Peer Mobilizers- SPM) ในแหล่งรวมตัว/ สถานบันเทิงของกลุ่มชายที่มีเพศสัมพันธ์กับชาย (MSM Hotspot/ Entertainment-based intervention) ในจังหวัดเชียงใหม่**

| Session | Learning Method | Purpose |
|---|---|---|
| **Session 1. <u>5 ขั้นตอนในการสอน SPM เรื่อง HIV/AIDS และการลดพฤติกรรมเสี่ยง ประกอบไปด้วย</u>**<br>1.1 แนะนำว่า ผู้นำความคิด (Popular Opinion Leader –POL) คืออะไร<br>1.2 อธิบายความรู้เบื้องต้นเรื่อง HIV/AIDS: การแพร่เชื้อ และระบบภูมิคุ้มกัน<br>1.3 อธิบายความเสี่ยงของการติดเอดส์ในระดับต่างๆ<br>1.4 อธิบายกลยุทธ์ในการสร้างความเปลี่ยน แปลงเพื่อลดความเสี่ยง เช่น<br>- ไม่มีเพศสัมพันธ์ทางทวารหนัก ถ้ามี ต้องใช้ถุงยางอนามัย<br>- อย่าให้มีการแลกเปลี่ยนน้ำคัดหลั่ง<br>- สัมผัสแค่ภายนอก<br>- สอนและป้องกันคู่นอนของตนให้ปลอดภัย<br>1.5 สรุป ซักถามและแนะนำส่วนต่อไป คือ เรื่องความเชื่อและความเข้าใจผิดต่างๆ มาตรฐานของสังคมจะเปลี่ยนพฤติกรรมได้อย่างไร และกลยุทธ์ที่จะทำให้การพูดคุยเรื่อง HIV/AIDS เกิดขึ้นได้และปฏิบัติได้จริง<br>(Social skills they needed to serve as risk reduction endorsers to their peers) | Didactic and group process<br>Role play | - แสดงให้ผู้เข้าอบรมเห็น และเข้าใจถึงอันตรายของเอดส์ และเกิดความตระหนักในประเด็นที่สำคัญคือ เรารู้ว่าจะป้องกันตนเองได้อย่างไรและเราจะสามารถใช้อิทธิพลของเรากระตุ้นให้ผู้อื่นมีกิจกรรมทางเพศที่ปลอดภัย และลดพฤติกรรมเสี่ยงได้อย่างไร |
| **Session 2. <u>5 ขั้นตอนการเปลี่ยนมาตรฐานสังคมผ่านการสื่อสารที่มีประสิทธิภาพ</u>**<br>**2.1 ทบทวนเนื้อหาของ Session 1** | Didactic and group process, games and role play<br>- กิจกรรม: เกมส์หยิบ | - ผู้เข้าอบรมจะได้มีประสบการณ์และเป็นมิตรกับผู้นำความคิดคนอื่นๆ |

| Session | Learning Method | Purpose |
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| **2.2 อธิบายความเชื่อและความเข้าใจผิดต่างๆ**<br>ตัวอย่างเช่น<br>ความเข้าใจผิด: ฉันควรมีเพศสัมพันธ์ที่ไม่ปลอดภัย เพื่อแสดงว่าฉันแคร์และเชื่อมั่นในคู่<br>ความจริง: คุณทั้งคู่ต่างก็เคยมีเพศสัมพันธ์กับคนอื่น<br>ความเข้าใจผิด: ฉันปลอดภัย ถ้าฉันสวนล้างทวารหนักหลังจากถูกสอดใส่แบบไม่ใช้ถุงยางอนามัย<br>ความจริง: การสวนล้างอาจยิ่งเพิ่มความเสี่ยงให้มีมากขึ้น<br>ความเข้าใจผิด: เพศสัมพันธ์ที่ปลอดภัยไม่สนุก<br>ความจริง: คุณสามารถทำให้การเพศสัมพันธ์ที่ปลอดภัยเป็นกิจกรรมที่สนุกได้<br>**2.3 อธิบายการใช้มาตรฐานทางสังคมเปลี่ยนพฤติกรรม**<br>**แนวคิดมาจากงานวิจัยว่า มาตรฐานทางสังคมมีบทบาทสำคัญในการทำให้คนมีหรือไม่มีพฤติกรรมเสี่ยง** เพราะฉะนั้น SPM จะต้อง<br>1. ตอกย้ำให้เห็นประโยชน์จากการมีเพศสัมพันธ์ที่ปลอดภัยต่อคู่ของตน<br>2. พูดคุยประโยชน์ที่ตนเองได้รับจากการมีเพศสัมพันธ์ที่ปลอดภัย นอกจากจะส่งสารไปให้คนอื่นแล้ว ยังเพื่อเป็นแรงผลักให้ตนเองคงพฤติกรรมที่ปลอดภัยนี้ไว้ด้วย เพื่อเป็นตัวอย่างให้เพื่อนคนอื่นในเครือข่าย<br>**2.4 อธิบายองค์ประกอบของเนื้อหาสารเรื่องการลดความเสี่ยงที่มีประสิทธิภาพ**<br>2.4.1 เน้นว่าเอดส์เป็นปัญหาที่ร้ายแรงแต่เราหยุดมันได้<br>2.4.2 เป็นข้อความในเชิงสร้างสรรค์<br>2.4.3 ใช้ข้อความที่ตรงไปตรงมา/ชัดว่าความ | ถุงยางอธิบายระดับความเสี่ยงต่างๆ | - ผู้เข้าอบรมจะได้ทำงานในสภาพแวดล้อมที่เอื้อและสนับสนุนการปฏิบัติงาน<br>- ผู้เข้าอบรมมีโอกาสที่จะทำให้เพศสัมพันธ์ที่ปลอดภัยเป็นมาตรฐานในชุมชนของเขาเอง<br>- ผู้เข้าอบรมสร้างเครือข่ายที่สนับสนุนความคิดในเรื่องเดียวกันกับที่ผู้อื่นคิดอยู่<br>- ผู้เข้าอบรมสามารถแก้ปัญหาร่วมกับคนอื่นๆ ในสถานการณ์เดียวกัน<br>- ผู้เข้าอบรมสามารถฝึกการควบคุมตนเอง |

| Session | Learning Method | Purpose |
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| ปลอดภัยคืออะไร<br>2.4.4 ให้คำแนะนำให้เพื่อนเปลี่ยนมีพฤติกรรมที่ปลอดภัย<br>2.4.5 ไม่สื่อสารแบบสั่งสอนและใช้สรรพนาม ฉัน เพื่อแสดงจุดยืนของตน<br>2.4.6 คุยกันในที่ที่ปลอดภัย คือ ที่ที่สะดวกใจและไม่มีสิ่งรบกวน<br>**2.5 สรุปจบ และแนะนำ Session 3**<br>ประเด็นหลักในส่วนนี้ครอบคลุม 3 เรื่อง<br>1. คนมีความเชื่อและความเข้าใจผิดต่างๆ แต่ผู้นำความคิดสามารถแก้ไขให้ถูกต้องและบอกคนอื่นได้<br>2. หลายคนมีพฤติกรรมเสี่ยงเพราะมาตรฐานสังคมในชุมชนของตนไม่สนับสนุนการมีเพศสัมพันธ์ที่ปลอดภัย<br>3. ผู้นำความคิดสามารถเปลี่ยนมาตรฐานสังคมโดยใช้บทสนทนาเรื่องการลดความเสี่ยงกับเพื่อนและคนอื่นๆ<br>*** ทบทวนองค์ประกอบ 6 ด้านของเนื้อหาสารเรื่องการลดความเสี่ยงที่มีประสิทธิภาพ การนำเสนอครอบคลุมทั้ง 6 ด้านถือว่า SPM สามารถสื่อสารได้อย่างประสบความสำเร็จ *** | | |
| **Session 3: <u>เนื้อหาบทสนทนา และวิธีการสนทนาเรื่องการลดความเสี่ยง</u>**<br>**3.1 บทนำ**<br>- อธิบายสาเหตุที่หลายคนไม่สื่อสารเรื่องการลดความเสี่ยง เช่น ไม่แน่ใจว่าจะเริ่มเมื่อไหร่ ไม่แน่ใจว่าคนอื่นมีพฤติกรรมทางเพศที่ปลอดภัยหรือไม่ ไม่รู้ว่าพฤติกรรมทางเพศที่ปลอดภัยจะเป็นที่ยอมรับหรือไม่<br>- อธิบายหน้าที่ของผู้นำความคิดคือ สร้าง | - Didactic and group process, games and role play<br><br>- กิจกรรม: ซักถาม | - ผู้เข้าอบรมเข้าใจว่าเอดส์เป็นเรื่องที่น่าเป็นห่วงในกลุ่มชายรักชายในชุมชนของตน<br>- ผู้เข้าอบรมเข้าใจและตระหนักว่าการเปลี่ยนแปลงพฤติกรรมสามารถลดหรือกำจัดความ |

| Session | Learning Method | Purpose |
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| เครือข่าย - สร้างความเชื่อมั่นว่าพฤติกรรมทางเพศที่ปลอดภัยเป็นสิ่งที่ถูกต้อง ควรทำ สามารถทำได้ และ เป็นสิ่งที่สังคมยอมรับ<br>**3.2 ทบทวนองค์ประกอบของเนื้อหาสารเรื่องการลดความเสี่ยงที่มีประสิทธิภาพ**<br>**3.3 อธิบายวิธีการนำเสนอสาร หรือข้อมูลเรื่องการป้องกันเอดส์สู่ชุมชน ในประเด็นสำคัญ คือ**<br>- องค์ประกอบของเนื้อหาสารเรื่องการลดความเสี่ยงที่มีประสิทธิภาพ<br>- รูปแบบการสื่อสาร และลักษณะข้อมูลที่ผู้อบรมเคยได้ยิน และชอบแบบใด เช่น ชอบการโต้ตอบกันหรือไม่ อย่างไร, ถ้าเป็นตัวเองจะโต้ตอบแตกต่างกันหรือไม่<br>**3.4 ผู้เอบรมฝึกปฏิบัติ เรื่องการนำเสนอสาร หรือข้อมูลเรื่องการป้องกันเอดส์กับเพื่อน หรือกลุ่มเป้าหมายในชุมชน**<br>**3.5 สรุปจบและแนะนำ Session 4**<br>- ประเด็นหลักในส่วนนี้ครอบคลุม 2 เรื่อง คือ ฝึกองค์ประกอบ 6 ด้านของเนื้อหาสารเรื่องการลดความเสี่ยงที่มีประสิทธิภาพกับเพื่อน 4 คนในระหว่างสัปดาห์และเติมแบบฟอร์มติดตามผลและนำส่ง | - แสดงสถานการณ์จำลองโดยผู้นำการอบรมแสดงบทบาทผู้นำความคิดที่เป็นห่วงเพื่อนและกำลังให้ข้อมูลไปยังผู้นำการอบรมอีกคนที่มีพฤติกรรมเสี่ยงหรือผู้ที่กังวลเรื่องการติดเชื้อ HIV<br>- ผู้นำการอบรมสาธิตบทสนทนาและการโต้ตอบหลายๆ แบบ เพื่อให้ผู้เข้าร่วมเลือกแบบที่ถนัดที่สุดที่นำไปใช้กับเพื่อนได้<br>- ชวนคุยเรื่องบทสนทนากับผู้เข้าร่วมอบรม หลังจากสาธิตเสร็จ<br>- ให้ผู้เข้าอบรมเล่าถึงองค์ประกอบ 6 ด้านของเนื้อหาสาระเรื่องการลดความเสี่ยงที่มีประสิทธิภาพ ผู้นำการประชุมเขียนบนกระดาน<br>- ให้กลุ่มเสนอตัวอย่างบทสนทนา รวมทั้งการแก้ปัญหาในการถ่ายทอดสาร | เสี่ยงได้<br>- ผู้เข้าอบรมเข้าใจและตระหนักว่าการเปลี่ยนแปลงพฤติกรรมเพื่อลดหรือกำจัดความเสี่ยงมีประโยชน์ต่อตนเองและคู่<br>- ผู้เข้าอบรมเข้าใจและตระหนักว่าเพศสัมพันธ์ที่ปลอดภัยเป็นสิ่งใหม่ เป็นมาตรฐานทางสังคมเชิงบวกและคุณกำลังปฏิบัติอยู่<br>- ผู้เข้าอบรมเข้าใจและตระหนักว่าเพศสัมพันธ์ที่ปลอดภัยทำได้ง่ายดาย |

| Session | Learning Method | Purpose |
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| **Session 4 : <u>5 ขั้นตอนต่อเนื่องในการดำเนินบทสนทนาเรื่องการลดความเสี่ยงและสร้างแรงบันดาลใจกับกลุ่ม</u>**<br>**4.1 ทบทวนบทสนทนาเรื่องการลดความเสี่ยง**<br>**4.2 ทบทวนข้อมูลที่สามารถแทรกในบทสนทนา เช่น**<br>- เอดส์เป็นเรื่องที่น่าเป็นห่วงในกลุ่มชายรักชายที่ชุมชนนี้<br>- การเปลี่ยนแปลงพฤติกรรมสามารถลดหรือกำจัดความเสี่ยงได้<br>- การเปลี่ยนแปลงพฤติกรรมเพื่อลดหรือกำจัดความเสี่ยงมีประโยชน์ต่อตนเองและคู่<br>- เพศสัมพันธ์ที่ปลอดภัยเป็นสิ่งใหม่ เป็นมาตรฐานทางสังคมเชิงบวก และคุณกำลังปฏิบัติอยู่<br>- เพศสัมพันธ์ที่ปลอดภัยทำได้ง่ายดาย เช่น ตัดสินใจล่วงหน้าว่าจะทำอะไรหรือไม่ทำอะไรเน้นไปที่การสร้างจินตนาการทางเพศ คุยเรื่องเพศสัมพันธ์ที่ปลอดภัยกับคู่ล่วงหน้า<br>- การมีจุดยืนที่ชัดเจนกับตัวเองและคนอื่น รวมทั้งบอกว่า 'ไม่' เมื่อรู้สึกว่าเสี่ยง<br>- เตรียมถุงยางอนามัยให้หยิบง่ายและมีอยู่ใกล้มือ<br>- หลีกเลี่ยงการเสพยาหรือดื่มสุราเมื่อมีเพศสัมพันธ์<br>- ใช้ตนเองเป็นตัวอย่างที่ดี | - กิจกรรม: ถามความรู้สึกต่อบทสนทนาเรื่องการลดความเสี่ยงที่ได้ไปทำมา อาจเริ่มต้นคำถาม เช่น ใครมีโอกาสสนทนาเรื่องการลดความเสี่ยงกับเพื่อนบ้าง มีใครได้สนทนากับเพื่อนครบ 5 คนบ้าง เป็นต้น<br>- กิจกรรม: ถาม-ตอบ เช่น<br><u>ถาม</u>: จงบอกพฤติกรรมเสี่ยงที่สุดของชายรักชาย<br><u>ตอบ</u>: เพศสัมพันธ์ทางทวารหนักที่ไม่ป้องกัน<br><u>ถาม</u>: กิจกรรมทางเพศที่ปลอดภัยที่สุด คือ<br><u>ตอบ</u>: การถูไถจนถึงจุดสุดยอด การสัมผัสภายนอก การช่วยกันสำเร็จความใคร่ การนวด การกอด การจูบ<br>- ข่าวสาร และข้อมูลสถานการณ์ โรคติดต่อทางเพศสัมพันธ์ และ HIV/AIDS | - ชี้ให้เห็นถึงผลลัพธ์จากกนวนรวมของบทสนทนาที่ผู้นำความคิดได้ทำ<br>- เสริมแรงผ่านความร่วมมือของผู้เข้าร่วมต่อการมีบทสนทนาที่มากกว่า 10 ครั้งขึ้นไป<br>- ขอด้วยวาจา<br>- เซ็นชื่อหรือยกมือให้เห็นว่ามีบทสนทนากับเพื่อนกลุ่มใหม่<br><br>***** สรุป คือ ต้องแสดงให้เห็นถึงอันตรายของเอดส์ แต่สิ่งที่สำคัญกว่าคือ เรารู้ว่าจะป้องกันตนเองได้อย่างไรและเราใช้อิทธิพลของเรากระตุ้นให้ผู้อื่นมีกิจกรรมทางเพศที่ปลอดภัย ***** |

| Session | Learning Method | Purpose |
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| **4.3 นำเสนอข้อมูล และ ชวนคุยเรื่องสถานการณ์ล่าสุดของอัตราการติดเชื้อเอชไอวีและการแพร่ระบาดของเชื้อเอชไอวีในกลุ่มชายที่มีเพศสัมพันธ์กับชาย**<br>**4.4 นำเสนอข้อมูล และชวนคุยเรื่องปัจจัยที่มีผลต่อพฤติกรรมเสี่ยงต่อการติดเชื้อเอชไอวี**<br><br>**4.5 หลักการสร้างแรงบันดาลใจกับกลุ่มที่มีอยู่**<br>- ชี้ให้เห็นถึงผลลัพธ์จากการที่ผู้นำความคิดได้มีบทสนทนากับเพื่อนๆ<br>- เสริมแรงผ่านความร่วมมือของผู้เข้าอบรมต่อการมีบทสนทนาที่มากกว่า 10 ครั้งขึ้นไป<br>- การขอร้องกลุ่มเพื่อนด้วยวาจา บนรากฐานของความสัมพันธ์ส่วนตัว ความเชื่อถือ ความศรัทธาที่มีต่อกัน<br>- เซ็นชื่อหรือยกมือให้เห็นว่า ผู้เข้าอบรมจะมีบทสนนทนากับเพื่อนกลุ่มใหม่ | - กิจกรรม: ถาม-ตอบ | |

# VITA

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| **GRANT:** | |