CHAPTER II

REVIEW OF RELATED LITERATURE

A number of scholars have researched “Disadvantaged Children and Educational Intervention”. These researches pertain to the Disadvantaged Children from many parts of the world. However, the “Disadvantaged Children of Thailand” have not been researched by any scholar so far. The children of Thailand suffer from many disadvantages due to various reasons. A necessity has been felt for such a research and recommending remedies. This thesis “A Study of Educational Intervention for Disadvantaged Children in Thailand” facilitates easy understanding of the research topics namely, policies, success stories and lessons learned. The theories and dissertations for this study have been divided into the following sections.

2.1 THE CONCEPT OF DISADVANTAGED CHILDREN

Laura Giani (2006) describes “Disadvantaged Children” as the link between migration and education. There are many assumptions for the migration of “Disadvantaged Children” and their education and the author suggests an ambivalent picture. However, poverty and the poor standard of education in the country are also strong arguments explaining these linkages.

World Bank (2006) explains that the term “Disadvantaged” relates to an individual who has not been able to avail the opportunity provided by the society and the Government, such as access to primary education, higher education or a job for economic independence and self-support, which is regarded as a fundamental right of all individuals in a community and the society. The expression “Disadvantage Child” implies the transition of a child from childhood to youth resulting in an uncertain future with possible developmental delay, with little or no qualifications and limited opportunities for his/her progress. Similarly by the expression “Disadvantaged Youth” we mean the transition of a youth
towards adulthood with limited skills, opportunities and a risk of reduced earnings or destitution. The “Disadvantaged Children and Youth” hardly have any access to housing, health care and education. This may create the feeling of being excluded from the community they live in. As a result they migrate to urban areas but are incapable of participating in the social life and are unable to assume any social responsibility for their actions.

James J. Heckman (2006) has elucidated that the investment in “Disadvantaged Children” is a necessity. He has explained the process of life cycle skills formation in which the early age inputs affect the later age outputs in the children. He has explained that the economic and social anomalies in the society, lack of skills and personality development could be traced, to a great extent, to the family background.

Inclusion International (2005) “Disadvantaged Children” are broadly those children who are not enrolled or are at risk of not completing their education: children who attend schools that do not meet fundamental quality standards: and children with disabilities or children from other highly vulnerable groups, such as street children, migrant children or girls from certain ethnic minority areas.

UNESCO (2003) has defined ‘Disadvantaged’ as “children and adolescents who, due to their economic situation, ethnic origins, geographical location or gender did not have access to basic education and training programmes and therefore ran the risk of being excluded from employment or any significant income-generating activity in adulthood. Some had never attended school while others had dropped out before getting basic literacy or having acquired the skills needed to earn a living as an adult”.

UNCHS (1998) have defined the “Disadvantaged Children” as an at-risk group for whom periodic health examination is very appropriate and is a requirement”.

...
Ellen Lipman and David R. Offord (1994) have enunciated that the “Disadvantaged Children” are a high risk group, with increased risk of morbidity and mortality and also experience lifelong difficulties. Their conditions cry for appropriate intervention and timely medical assistance.

2.2 THE EDUCATION SYSTEM IN THAILAND

2.2.1 The National Education Plan (2002-2016).

The aims of the National Education Plan are as follows:

*All-round and Balanced Human Development*

(1) To develop people of Thailand to have access to learning and benefit from learners and inculcate and strengthen morality, integrity, ethics and desirable values and characteristics.

(2) To develop skilled manpower in science and technology for self-reliance and enhanced competitiveness.

*Building a society of morality, wisdom and learning*

(3) To develop an educated society with a view to create knowledge, cognition, good behavior and integrity of the people. Also, to create infrastructure for application and dissemination of knowledge and learning.

(4) To promote research and development to increase the knowledge and learning of Thai people and Thai society.

*Development of Social Environment*

(5) To promote and create a social and cultural capital to limit, decrease and eliminate structural problems for social justice.

(6) To develop technology for education and systematization of resources and investment for education, religion, art and culture.

*The Strategies*

The main strategy is to strengthen moral and ethical values and enhance the quality of education at all levels. Three major strategies have been identified by Chaturon Chaisan (2005: 3), they are:

(1) Proactive strategies for enhancing quality of higher education.

(2) Strategies for children of all categories of disability: Disadvantaged Children: those without legal status or nationality: and stateless and marginalized children with enhanced performance of offices at the educational service areas and educational institutions.
(3) Strategy for development of educational Information and Communication Technology (ICTs): and International Affairs.

2.2.2 The Education System (Lifelong Learning (LLL))

The Constitution of the Kingdom of Thailand B.E. 2540 (1999) and the National Educational Act (1999) serve as master legislation on education in Thailand, leading to significant reformation in education and learning. The government private and local administrative councils operate the schools and impart free education to all Thai children up to grade 12. Ministry of Education (2004: 20-26) envisages three types of education as follows:

2.2.2.1 Formal Education

(1) The Basic Education: it is provided before higher education covering pre-primary, six years of primary education, three years of lower secondary education and three years of upper secondary education. The following institutions provide basic education:

The Early Childhood Development Institutions: The Childcare Centers, Child Development Centers, Initial Care Centers (for disabled children and those requiring special needs and early childhood development) impart early education. The schools are run by the State and also Private Agencies. Some schools are also run by Buddhist or other religious organizations and institutions. Learning centers are organized by non-formal educational agencies, individuals, families, communities, community organizations, local administration organizations, private organizations, professional bodies, religious institutions, hospitals, medical institutions, welfare institutions and other social institutions. These institutions were previously covering only six years of primary education that is compulsory education. But now it has been extended to nine years covering six years of primary education and three years of lower secondary education.

(2) The Higher Education is provided in Universities, colleges and other types of institutions. It is divided into two levels i.e., the associate degree and degree levels.

The Associate Degree or Diploma level: The colleges and institutions that offer higher education at associate degree or diploma level are Rajabhat Universities, Rajamangala Institute of Technology, state and private
vocational colleges, as well as colleges of physical education, dramatic arts and fine arts. The majority of courses offered are related to vocational and teacher education, which requires two years of study.

The Degree Level: This study programmes require two years of study by students who have completed diploma courses and four to six years of study by those who have finished upper secondary education or equivalent courses. The first professional qualification is a bachelor’s degree obtained after four years of study. In the fields of Architecture, Painting, Sculpture, Graphic arts and Pharmacy, five years of study are required for a Bachelor’s degree. The fields of Medicine, Dentistry and Veterinary science require six years of study. In some of these disciplines, additional study will be required before professional qualifications and allow the candidates to practice in his or her field, before the degree is awarded. Advanced studies of at least one year but generally of two years, combined with a thesis, lead to the award of a master’s degree. A doctorate is awarded in certain fields and requires additional three years of study following a master’s degree. An advanced diploma or Certificate may be obtained after one year or two years of course work. It is designed for students who already possess a degree or professional qualification. The provision of formal education mentioned above can be classified into the following types:

The Vocational Education is imparted in the general stream of basic education. The career and technology related education is imparted to the school children at both primary and secondary levels to provide them with work experience and basic knowledge for career preparation and technological application. Formal technical and vocational education and training is conducted at three levels i.e., upper secondary, leading to the lower certificate of vocational education: post secondary, leading to a diploma or the associate’s degree in vocational education and at University level, leading to a degree. To being with, the upper secondary level provides eight major fields of study, namely, trade and industry, agriculture, home economics, fishery, business and tourism, arts and crafts, textile and commerce. Credit accumulated by learners will be transferable within the same or between different types of education, regardless of whether the credits have been accumulated from the same or different educational institutions,
including learning from non-formal or informal education, vocational training and work experience.

*The Technical and Vocational Education and Training* are provided in educational institutions belonging to the public and private sectors, enterprises, or those organized through co-operation of educational Institutions. In brief, vocational education is provided through formal programme, dual vocational training programme and the credit accumulative programme. For the formal programme, students learn theoretical and practical subjects in schools and spend a semester in the workplace. The credit-accumulative programme provides opportunities for adults who are unable to participate in full-time study at an institution. An assessment system for validation of their experiences is provided to evaluate their knowledge and skills. In addition, credit accumulated can be transferred within the same or between different institutions.

3. **The Special Vocational Education** includes

(a) The sports schools that provide admission and full financial support to students with a particular talent for sport from all over the country.

(b) The dramatic arts and fine arts colleges offer certificates equivalent to lower and upper secondary education.

4. **The Education for Ecclesiastics**: the general education is also provided to novices and monks in general ecclesiastic schools in various Buddhist temples. They are offered lower and upper secondary education curricula equivalent. Apart from general subjects, the courses include learning units related to religious practices, Buddhist doctrine and the Pali language. There are also two Buddhist Universities in Bangkok with various campuses elsewhere offering courses at undergraduate and graduate levels.

5. **The Specialized Education**: This is offered both at basic and higher education levels and is provided by ministries, bureaus, departments, state enterprises and other public agencies in accordance with their needs and expertise, in conformity with the national education policy and standards. Courses are offered for graduates from primary schools to upper secondary schools, both from
general and vocational streams. All responsible agencies have developed their own curricula as follows:

(a) Curricula for the training of professional soldiers and police include the curriculum of Preparatory school for the Armed forces Academies, curricula of the Military, Naval, Air force Academies and Police cadets and curricula for preparing Warrant officers for graduates from lower and upper secondary schools.

(b) Curricula for specific technicians include those for training Military technicians to work in the Armed forces and those for training specific technicians for various agencies.

(c) Curricula for Medical science are organized for secondary school graduates requiring (1)–(4).

(d) Curricula for other specific purposes are organized for graduates from lower secondary schools, both in general and vocational streams and general upper secondary schools.

2.2.2.2 The Non-Formal education: The non formal education is provided by both public and private bodies to those outside the school system, i.e. early childhood population, school-age population who have missed formal schooling and over-school-age population:

(1) The Provision of Non-Formal Education for Pre-School Children: This educational service is provided to children in 2-6 years age group or up to 6 years from birth. (The early childhood development in centers established by local communities for children in 3-6 years age group and the child development of the private sector organization).

(2) The Provision of Fundamental Education for Literacy: This educational service is provided to promote literacy among adults aged 14 years and above who are illiterate. To eradicate illiteracy, Non-Formal education, is currently organized as follows:

(a) The literacy campaign, with volunteer teachers and volunteer village tutors, has continued to promote the eradication of illiteracy among the adult population.
(b) The functional literacy programme, organized for illiterate adults, emphasizes the integration of literacy and problem solving skills for the improvement in the quality of life.

(c) The promotion of Thai language usage for Thai Muslims in five southern border provinces.

(d) The hill areas education: aiming to provide educational services to promote literacy among the hill tribes.

(3) The Provision of General Non-Formal Education: This educational service provides continuing education programmes for those having no chance to have formal education from primary to higher levels and is normally organized in public schools or official premises, factories or other organizations. Learners are awarded the same qualifications as those in the formal school system. The learning process is organized in three ways: classroom learning, distance learning and self-learning.

(4) The Non-Formal Vocational Education: This educational service is offered, through polytechnic colleges, industrial and community colleges, regional institutions and provincial skills training centers. Non-Formal vocational, technical education and training can be broadly divided as under:

(a) The training course for vocational certificate: This programme is designed for primary school graduates who have no chance to study at a higher level. It is organized to provide educational opportunities to target populations in rural areas through training in vocational skills and promotion of quality of life, leading to a certificate equivalent to that of general lower secondary school.

(b) The short-term vocational training: is provided in many areas by both public and private institutions and agencies. These courses are offered for a period of from 3 hours to 1 year depending on the content and objectives. Educational institutions as well as related agencies, such as skill development institutions, offer re-employment training and upgrading training. At present, short-term vocational training programmes are designed to serve the needs for self-employment and lifelong learning.

(c) Interest group programme: Teaching and learning activities are organized according to the individual needs and interests of the general public.
Those having similar interests can form a group of 5-15 persons and can receive training for a period of up to 30 hours.

(d) Non-Formal programme for certificate in vocational education: This educational service is offered through distance learning to lower secondary school graduates, for those working in public organizations and private enterprises and those who are unemployed. This programme requires at least 3 years of study, except when there is a transfer due to academic performance or experience.

(5) Quality of life Improvement activities: This educational service is offered for education, welfare and public services and provides training activities to the general public, concerned with improvement of quality of life.

2.2.2.3 Informal Education: enables learners to learn by themselves according to their interests, potential, readiness and the opportunities available from individuals, society, environment, media or other sources of knowledge as follows:

(a) Informal education programme is provided by libraries, museums and science/technology centers, as well as by mass media i.e. radio, television, newspapers, magazines etc.

(b) Informal education programme of community learning networks such as community learning centers, village reading centers, sub-district health Offices, sub-district agricultural offices, as well as natural learning sources in each community.

(c) Learning from various sources as follows: 1) Local wisdom which includes culture and the body of knowledge in each community 2) Local media which plays an important role in passing on knowledge and social values through several kinds of performances 3) Families which are the learning sources from birth for all people and 4) Networking through co-operative activities. It could be perceived that all ministries are involved in providing informal education to promote lifelong learning. The services provided include educational activities or academic and professional programmes for different target groups relating to the responsibilities of each ministry.
2.2.3 The School Year

The first semester of the school year begins on May 17 and ends in the first week of October. After a three-week recess, the second semester begins on November 1 and continues till the second week of March. The long summer vacation is from the third week of March till May 16 and the cycle begins again. Classes are held from Monday to Friday, during which period the students receive approximately six hours of instruction daily.

2.2.4 The School Lunch

The school lunch program varies from school to school. Students, whose families are able to provide for their children, bring their own lunch boxes as children in the United States do. Nutrition programs are available where needed and, in larger schools, lunch snacks can be purchased if students do not bring their own. What students bring from home is supplemented with snacks to eat and soft drinks, especially in small schools that cannot afford a full lunch program. In others, the schools supplement what is brought from home or offer one full course of food with rice, curry, fried items and dessert. Some schools have items available, ranging from a main dish, soyabean milk, dessert and juice. In model schools, the lunch program is fully sponsored by the local school. Students participate by growing fruits and vegetables in school gardens. They help the teachers in preparing the meal, serving and cleaning up afterwards. Book keeping and record-keeping become part of their responsibility.

2.3 THE SPECIAL AND WELFARE EDUCATION FOR THE DISADVANTAGED CHILDREN IN THAILAND

The special and welfare education is provided to children who are hearing and visually impaired, mentally retarded, physically challenged or health-impaired. Other groups of children who need special education are learning-disabled, autistic, emotionally or behaviorally disordered, as well as gifted and talented children. The teaching and learning of special education is organized in Special and Inclusive schools. Three types of curricula are used and practiced. They are:
(a) Special curricula offered in special schools such as the school for the deaf and the school for the blind:

(b) Regular curricula used in inclusive schools, which may be modified to meet the special needs of children.

(c) Welfare education is provided for those who are socially and culturally disadvantaged. Students are not only provided with free education, but also with accommodation, food, clothing, equipment, textbooks and other necessities. They are given special vocational training relevant to the locality of a particular school by Ministry of Education, (2004: 20-26).

The objective *Prevention is better than cure* is highlighted in Thailand. The aim of education for the Disadvantaged Children is to educate and create awareness of the social evil and to rehabilitate them by imparting life and vocational skills and to render them capable of self sustenance. The orphanages and schools play an important role in the prevention of disadvantages to children, through a well structured curriculum, by providing positive role models and opportunities for participation. With such education, the Disadvantaged Children will have an opportunity to analyse the reasons for their disadvantages and overcome them with the help of expert psychologists and guides.

**Aksion Plus Organization (2004)** has noted that the school counselor is capable of being a role model to change individual and collective behaviour and knowledge. Social workers and school counselors could be great and powerful advocates for the rights of young people. The organization has noted that a change in role of psychosocial help in the area where the project has been implemented is required. A creative and innovative combination of school activities with extracurricular and community based activities is felt to be ideal. The change in behavior necessitates inclusion of targeted groups and giving opportunity to young people to practice the new knowledge and new behaviors to enable them to make it integral and sustainable, in addition to information and education. It has recommended decentralization of project management and reporting. Schools should have their local plan of activities. Additionally, better project planning and documentation would be intangible assets. Projects such as teachers training and participatory teaching methods should function in parallel with other interventions in the education system.
Jay P. Greene and Greg Forster (2004) have suggested that the schools are not helpless in the face of obstacles to student learning. The Group has observed that some schools rise to the occasion of teaching disadvantaged student population while others do not. The selection of the school and testing its accountability has a bearing on the standard of education of the Disadvantaged Children. Education experts have stressed that the school inputs, money and students’ background suggest what kind of schools make a difference and how much students learn.

Terri Thompson and Charles Ungerleider (2004) have reported that, the schools must implement policies and practices which ensure equal opportunity to males and females and eliminate gender discrimination in instruction and the management of student behaviour.

Peter Bill Larsen (2003) has argued that the social exclusion of “indigenous and tribal children: assessing child labour and education challenges” due to discrimination and cultural marginalization may result in failure of the education for the Disadvantaged Children. He recommends the rights-based approach to ensure education for all. It evaluates projects and policies and makes recommendations for providing quality education and to combat exploitation of child labour.

Nadeem Ilahi (2001) has indicated that the “transformation in household welfare affect girls disproportionately”. He has recommended that the safety nets to protect family by way of augmenting the income and provision of means for child care can help to keep the girls in school.

Prasert Chutha (2001) opines in “Health Training” that responsible organizations should consider and use the findings from present study in improving the efficiency of the mental health program for the disabled and Disadvantaged Children in the future.

Chantima Panjawatana (2000) has inferred of “Non-Formal Education” that the children have learned subjects of their interest, owing to courteous
instructions with appropriate material and activities oriented towards agricultural and life skill activities. She has also inferred that the teaching processes were found to be deficient, because of inadequate instructional material, equation between instructors and learners and shortage of learning facilities.

Christopher Heady (2000) has remarked the “effect of Child labour on learning achievement” that the children who are supporting their families by their earnings do not have any incentive to learn and become disinterested in education. Also the child labour has contributed to dwarfing the interest to learn. Overall it has resulted in lack of motivation to learn.

Martin Ravallion and Wodon Quentin (2000) have dealt with the “subsidies and concessions for enrolment on child labour and schooling”. He has established a strong link between the subsidy which serves as a motivational factor and the school attendance. However, he has been skeptical about its impact on the child labour of girls as compared to that of boys.

Basanta K. Pradhan and A. Subramanian (1999) have recommended that the solution for drop out problem of the students lies in reorienting the educational sector for transformation of skill enhancement by privatizing it. The role of the state should be reduced to support only the basic education at the primary level.

Sudharshan Canagarajah and Helena S. Nielsen (1999) have documented the “effect on child labour as against the school attendance”. He has brought out the influence of Poverty and also the household composition. They have recommended measures to increase participation in education.

Poonsuk Shuaytong (1998) has mentioned that the “health training” providers should consider developing a training program on sex education for the industrial youth workers and their parents also should be subjected to similar programs to maximize their guiding roles with their children. He has also recommended that young adults must be educated which gives them opportunity to learn and develop confidence.
Judy Montreevat and Margaret Ponsakunpaisan (1997) have brought out that “young hill tribe women in Northern Thailand”, commenced acquisition of basic human rights and needs even at the cost of risking their reputation. The rights they wanted were to attend school at a higher level than primary education and also to experience life outside the highland community.

C.P. González and group have recorded that certain modifications in academic curriculum was necessary, with a customized Individualized Educational Plan (IEP) based on the child’s performance. He has recommended administration of certain specialized tests in order to diagnose the child’s learning dysfunction. Based on the outcome with respect to each child, the IEP is required to be designed and put into practice.

Judith L. Ladd has pertinently said that the teacher should be a good listener and be approachable and accessible and learn how to communicate with the children, know the measures to reduce their anxiety. The teachers also should ensure that the children are not stressed during the transition. The successful students must be convinced that the same methods and practices that made them successful in elementary school will also make them successful as middle-school and high school students.

2.4 RESEARCH STUDIES ON KNOWLEDGE AND ATTITUDES

2.4.1 Knowledge and Attitude on Reproductive Health Education and Behaviour

According to IWHC (2007), the efforts to educate and improve the sexual and reproductive health and rights of young adolescents, must be made at all levels. Involvement of communities, neighbourhoods, families, schools and health service organizations must be co-ordinate at state and national levels. The aspects that must be addressed an emergency basis are elimination of all forms of sexual abuse, trafficking of children and child marriage. All fields of education of the Disadvantaged Children is needed specifying the necessity of different groups of young people, with a view to design and implement holistic programs. Such programmes should be aimed at developing the skills, confidence, knowledge base of the Disadvantaged Children and to train teachers, social workers, health-
care providers, law enforcement personnel and others in the community. This effort will bear fruit in yielding response more effectively in young adolescents. It is very necessary to document such efforts meticulously, to include baseline research, systematic assessment of substance, processes and outcomes. The documentation will be of immense help in building the evidence base for the posterity. Amendments and modifications as required can be introduced for future policies and programs. The future of many young adolescents will depend on this continuous and ongoing process.

_Linnéa Warenius and group (2007)_ have stipulated that the male and female lack adequate information about human reproduction system and STIs, including HIV. To avoid misconceptions and myth, they also need clear information on contraceptives and masturbation. Responses indicate that young people would welcome guidance and support related to contraception, pregnancy, abortion, STIs/HIV, love and relationships. Culture, religion and gender are important factors influencing sexuality and sexual abuse. These issues must be taken into consideration when developing youth-friendly programmes for young people.

_Mittal Anuj and S.S.Kushwah (2007)_ have discussed that among adolescents in general and girls in particular, discrimination must be eliminated. This step will have to be initiated by trained staff by using reliable and innovative methods.

_Dilip Kumar (2006)_ in “a socio-medical assessment of the sexual and reproductive health of adolescents in Bihar” recommended that by imparting sex education and knowledge about contraception to teenagers as an integral part of education, teenage pregnancies can be discouraged.

_J.A. Page and group (2006)_ have stated that the learners were glad to have been given this information and many provided evidence of how the module made impact on their lives and sexual behaviour. They also felt that the knowledge had empowered and motivated them to control their own lives.
**Joshi BN and group (2006)** have documented that medical screening by physicians, parental involvement and support by adolescent friendly educational centers is necessary to encourage help seeking behaviour of adolescents, apart from health and life skill education. Such involvements are also necessary for counseling, referral and follow up actions.

**Kelly Ladin and group (2006)** have suggested that, media have equally important associations with sexual intentions and behavior of adolescents as other contextual factors and should be considered along with family, church, school and peers as an important influential factor. The media should be included as yet another powerful instrument and should receive increased attention of practitioners and researchers who aim to reduce adolescents’ participation in sexual risk behavior.

**L.E. Meuwissen and group (2006)** have recorded that the doctors have become more sensitive to the need to improve their communication skills and are positive about the programme. This study has confirmed provider related barriers that adolescents face and reinforces the importance on the quality of care and quality of medical sciences. Participation in the programme has resulted in increased knowledge, improved practices and to some extent, attitudinal changes. A competitive programme with technical support to the participating doctors can prove to be a promising strategy.

**Shaikh Babar Tasneem and Rahim Syed Tariq (2006)** have remarked that adolescents and young adults in Pakistan believe that sound Knowledge of Sexual and Reproductive Health knowledge should be imparted to promote the health of mother and child and also family. Peers, media and a family doctor may be the acceptable sources of Information on the Sexual and Reproductive Health. Life skills programs are a must involving unmarried girls and young men to create awareness and the magnitude of the problem.

**The Centers for Disease Control and Prevention (2006)** have recommended encouragement of everyone to have a reproductive life plan and
increase public awareness by imparting preconception health, provide risk assessment and counseling during primary care visits.

**Warunee Fongkaew and group (2006)** have stressed that adults must accept the critical role of providing opportunity, assistance and guidance, so that, Youth Leader Trainers and young Youth Leaders can develop their capacity, in an atmosphere of trust and respect. Furthermore, parents, educators and adults need to act as positive role models. They must encourage and foster positive, holistic and constructive thoughts in young people. Empowerment of youth to accept responsibility for their actions for a conductive future environment and re-invent traditional human values of Thai culture is important. This is mandatory for their own benefit and also that of, their families, communities and the country. The importance of providing an opportunity to every party to be involved in each stage of HIV/Sexually Reproductive Health programme development, implementation and evaluation must be highlighted.

**WHO (2006)** has recommended to plan and implement programmes on Sexual and Reproductive Health needs, to Promote and Protect the Sexual and Reproductive Health of Adolescents in many parts of the world.

**Yingying Zhou and group (2006)** have opined that the necessity to improve the knowledge and change the Knowledge towards Reproductive Health and Sexuality are important along with the life skills training program, for scaling-up its implementation. There is a need to conduct analysis of every individual and assess effects more closely.

**Yong Liang Liu (2006)** has observed that the advocacy is the crucial element in promoting adolescent sex and behaviour. The experience of Youth Reproductive Health Project has indicated that promotion of sex and behaviour for adolescents is a very important function.

**Adolescence Education (2005)** has made a mention about the provision of practical guidance on the ethical concerns of collecting information from young people. It is intended for researchers and programme managers working with
children and adolescents in international settings, including those affected by HIV/AIDS. The booklet highlights key issues to consider, from the early stages of planning and throughout the process of information gathering. It was originally developed for use with young people affected by HIV/AIDS. The guidelines can also be applied to other sensitive situations, including sex abuse, human trafficking and displacement.

**Arunrat Tangmunkongvorakul and group (2005)** have revealed that the sexually active young women are vulnerable in seeking support and care from partners, parents and service providers. Those who experience adverse outcomes of sexual activity, such as unwanted pregnancy or infection, facing indifference, victimisation, or threat of abandonment by their partners, opt for clandestine and unsafe abortion and seek the counsel of peers and drugstores rather than parents and providers. At the service provider level, young women face threatening and judgmental knowledge, indifferent counseling and violation of confidentiality. This is in marked contrast to the treatment of young men, who generally meet with more sympathetic and positive response.

**Bo Wang and group (2005)** have recommended provision of comprehensive Sex Education and Reproductive Health service to unmarried Chinese youth which may help to reduce the rate of sexual coercion and promote increased use of contraceptives. This will also result in decrease of unwanted pregnancy. The group has observed that the life skills training, contraceptive education and distribution are important components of comprehensive sex education programs in highly developed regions in China.

**Lakkana Thaikruea and Surangsri Seetamanotch (2005)** have showed that, the behavior of men of Phuket who are homosexuals differed from those who are from the Northern or Northeastern region who have displayed greater tendency to work in the sex trade. Few local male homosexuals from the sub-districts of Kartu and Talang districts have publicly acknowledged themselves as gay for reasons which included their behavior being contrary to the Muslim religion and their family’s acceptance. Some got married to females in order to disguise the identity of sexual practice.
Lee Gatiss (2005) has observed that the counselor who wishes to avoid abortion must be aware of the problems associated with unwanted pregnancy. If we are to encourage marriage, we must be sensitive to the cultural and societal pressures on widespread cohabitation. Counseling rape victims can be particularly difficult, if there is a baby involved, considering the emotional and physical trauma caused by the crime itself. Though less serious, there are issues relating to sexually transmitted diseases. Even when there are no physical consequences to worry about, there could be spiritual and emotional scars to deal with. Research shows that, couples who engage in pre-marital sex are more likely to divorce in the long-run.

S. Parwej and groups (2005) have observed that the conventional education strategies for improving the Reproductive Health Knowledge of adolescent school girls were effective, but that of education for peer has been found wanting.

The News Nation (2005) The authors have stressed that, the training courses on behaviour have significantly helped a group of young men and women to understand physical changes in girls and boys during adolescence and has dispelled their misconception about sex determination of child and improved their knowledge of HIV/AIDS. Good knowledge about hygiene during menstruation has also increased by a great margin. The girls have also become more skilled to avoid pre-marital sex and youths to avoid sexual abuse.

Supat Sinawat (2005) has enumerated that sex education in Thailand is still a sensitive issue due to conservative elements in society, even though it has been taught in primary and secondary schools (as "family life planning") for over 20 years. Because people today are becoming sexually active at younger ages, it is important to have sex education implemented in primary schools, as the stage of secondary school may be late for many people.

Anju Malhotra and group (2004) have recommended creation of an environment for good Reproductive Health for youth by generating a better
understanding and a new mindset in the communities and leading to a substantial increase in demand for such services, even among the disadvantaged.

**A. August Burns and group (2004)** have provided an insight into the necessity for the providers to understand the peculiarities of youth and also training for working with them. This is particularly important for out of school youth who are reluctant to go to a traditional clinic due to which the services must go to all possible places such as the workplaces, social venues and sports settings. Accessibility to services (such as flexible hours and locations) can be particularly important for out of school youth. The group has also stressed on the importance of the community and policy support, opportunities to improve Knowledge, Attitude and Behavior related to Reproductive Health and HIV and easy access to youth-friendly services. The needs of out of school youth are often more pronounced and require greater creativity and effort in imparting education to them. Without these efforts, millions of youth who are school dropouts or who never attended school are likely to face greater Reproductive Health and HIV risks in the future.

**Kathia Van Egmond and group (2004)** found that, health indicators for reproduction were observed to be poor among the women living in Kabul, a section often considered to be the most privileged to meet the Reproductive Health needs of Afghan women. The socio-cultural aspects of their situation especially their decision making abilities need to be addressed. A long standing commitment from agencies and donors is required, in which the education of women should be placed as a cornerstone of the reconstruction process of Afghanistan.

**K.C. Chaudhuri (2004)** has affirmed that there is a need to evolve information education and communication strategies to focus on the increasing awareness on Reproductive Health and gender related issues. A socio-cultural research is very much a requirement to find the right kind of sexual health services for young girls and boys.
Tijuana A. James-Traore and group (2004) have recommended that the teacher training should (1) Cover Reproductive Health/HIV content, teaching methodologies, teacher skills, personal knowledge and teachers HIV-risk behaviour. The content should address medical and physiological aspects of Reproductive Health/HIV as well as the social and cultural environment that shapes young people’s development and sexual and other relationships. The teachers must have information about the full range of Reproductive Health/HIV issues, including abstinence, contraceptive methods and condom use so that they can teach those if found appropriate depending on the age of students and the community environment. It is necessary for the teachers to learn participatory methods of teaching and develop communications, assertiveness and other interpersonal skills required to work with clarity and confidence. Teachers reflect their own knowledge and values about the topic and their behaviors regarding HIV risks. (2) Teachers must be willing and motivated to teach Reproductive Health/HIV and be trustworthy with youth. While all teachers should have basic level knowledge about Reproductive Health/HIV issues, those who have a strong motivation to help youth circumvent the challenges of adolescence, should get special training opportunities. Initial exposure to the contents can change the thinking of some, allowing other potential candidates to emerge. It could also be used to eliminate those who are not suited to the goals of Reproductive Health/HIV programs. Both male and female teachers should be trained so that the teaching of Reproductive Health/HIV does not become associated with a particular sex. Boys and girls benefit from interactions with teachers of both sexes as they learn about gender roles, expectations and relationships between males and females. Students are less likely to listen to, learn from and confide in teachers as they feel that the teachers are not credible, are unapproachable or even take advantage of them.

WHO (2004) has recommended that the programme planners and policy makers should determine the original clues where the evidence lays as to what influences sexual and Reproductive Health outcomes. It is clear that there is a need for a broader research based on the risk and protective factors related to adolescent sexual and Reproductive Health in developing countries. Particularly, there is a need for both longitudinal research to determine causality and for
research that clearly defines the contextual factors that influence behaviour. Moreover, the use of common indicators of risk and protective factors as well as outcomes would assist in comparing findings across studies. However, it is equally clear that it cannot wait until all the data is in, also should act and build programmes on what the present evidence suggests and are the best practices and the best bets.

Karen Hardee and group (2003) have found that most young people in Asia and South East region begin their sexual lives within marriage, although as the age at marriage rises an increasing number begin to engage in premarital sex. While programs can and should promote delayed initiation to sex, regardless of when the sexual activity begins, young people need to be adequately prepared for their sex lives and relationships instead of “being kept in the dark” until marriage. Also, programs can help prepare young people for sexual relationships by increasing their understanding of sexuality and the choices they can make to protect their Reproductive Health. Correspondingly, addressing adolescent and youth Reproductive Health necessitates a multicultural approach that focuses on minimizing vulnerability of girl and promoting gender equality, schooling and expanding life options for both females and males. Every country has to make more progress in this regard.

Mulugeta Kibret (2003) has categorically mentioned that young people engage in sexual relationships at an early age without protection or with unsafe non-conventional methods. He has recommended that access to family planning information services and family life education programmes must be improved. It must be based on the needs and experience of young people as a potential solution to alleviate their Reproductive Health problems.

Peer to Peer (2003) study shows that younger children seek the advice of their parent more than adolescents, who tend to depend more on their friends and the media. This phenomenon must be made use of, to talk to young children about issues of sexual health, STDs and HIV which can leave a lasting impression. This will help provide children with information that is authentic, accurate and reflects personal values and principles.
S.D. Gupta (2003) has suggested that (1) it is necessary to promote and strengthen the public health care system at all levels with clearly specified strategies and activities focusing on adolescent population. The public health system must develop additional facilities and equipment and enhance additional resources. (2) Development of a systematic and in-depth assessment of adolescents’ health and development needs is a necessity. The assessment should be participatory and reflect the perspective of adolescents. It will require biomedical, social and psychological research to understand the issues related to adolescents’ behavior, myths and misconceptions, practices and risks associated with sexual and reproductive behavior. (3) Development of interventions to modify various levels of school curricula to incorporate lessons on reproductive biology, sexual health and contraception, is a necessity. Teacher training programs can be organized to impart the teaching skills necessary for presenting these issues to young populations in classrooms. (4) Involvement of parents in reproductive education and one-on-one, home-based counseling, which could result in a path-breaking success. This would require that parents be educated, be able to change their perceptions and knowledge about reproductive and sexual health and show a willingness to initiate age appropriate dialogue with their children. (5) Activation of youth Fora, at village level to remove myths and misconceptions about sexual health and channel the energy of youth and adolescents in constructive and income-generating activities.

Smarnjit Piromruen and Sen Keoyote (2003) have found that there is an increasing effort in countries in the region and elsewhere to employ a peer approach in their adolescent programs and activities to facilitate delivery of the message and acceptance. The impact of peer education in promoting necessary changes among adolescents in attitudinal and behavioral changes with regard to reproductive and sexual health is found to be of utility value. From these initiatives, the experiences in the use of the peer approach have grown, which in turn have generated materials that document key strategies and lessons learned. This book synthesizes these experiences and shares lessons learned as well as offering guidelines to enable policymakers and program implementers to learn from others and possibly adopt/adapt those strategies that will have the greatest potential to succeed in their own setting.
Bhakta B. Gubhaju (2002) has recognized that the “Reproductive Health” research should focus on both unmarried and married adolescents to learn early sexual maturity and premarital sex among adolescents.

Barbara S. Mensch and group (2002) have stated that lack of adequate employment opportunities may be a threat to Adolescent Reproductive Health than risky sexual behavior. Effective economic policies can be a remedy to this problem.

David J. Kolko and Cynthia C. Swenson (2002) have elucidated “treating physically abused” that it is necessary to understand the abuse experiences, exposures to violence and exposing thinking errors, negative attributions to help abused children to manage anxiety and anger and develop social skills with safety plans.

Iwu D. Utomo (2002) has based that the compulsory behaviour should start in elementary school as studies and promote long-term healthy behaviours, including the biological as well as the socio-cultural aspects of behaviour such as moral positioning, relationship skills, sexual negotiating skills, gender equality in Reproductive Health Behaviour and responsibilities, drugs, alcohol and sexual risk reduction skill and dealing with peer pressures. Parents also should be equipped with appropriate knowledge on Adolescent Reproductive Health, so that they can be used as the first agents to pass knowledge on Reproductive Health issues.

Osman Abali (2002) has brought out that a number of children started experiencing severe psychological symptoms immediately after the earthquake. Psychological support and treatment should be started as soon as possible in such circumstances.

UNFPA and group (2002) have emphasized that the energetic programs must give special attention to reach younger adolescents, particularly girls, with information and protective strategies. The discussion must also revolve around youth centers and how Love Life should continue to attract substantial number of
both boys and girls to youth centers, first by offering such activities as basketball and netball and access to computers, music and entertainment and then giving them the opportunity to enroll in sexual health courses.

**Chamaimas Banpapong (2001)** has stressed that the sex education should be geared up towards improving knowledge and preventive measure from sexual abuse from elementary school level.

**Ministry of Health (2001)** has mentioned that the improvements in Sexual and Reproductive Health services should be oriented towards, quality delivery, increasing knowledge, understanding of outcomes and their determinants. Education health promotion programs and services for all sectors should encourage discussion not only about sexual behavior between partners but also to promote positive sexuality. They should provide information about and skills for practicing safer sex from initiation of sexual behavior, alternative ways to express relationships and sexual intercourse, reducing the number of partners and the emotional, social and spiritual dimensions of sexuality. Increase in the ability of families/caretakers to support their children and young people and examine these issues with reference to the specific age, ethnicity, disability and population group cultural norms to make healthy sexual and Reproductive Health decisions for them, is recommended. Addressing negative knowledge towards disabled people by groups such as parents and professionals and determining how issues faced by disabled people related to their sexuality and sexual and Reproductive Health needs can be addressed. Moreover, personal knowledge, skills and behaviour to increase understanding of individuals, skills teach them the values which will ensure appropriate health and education across the lifespan for everyone.

**Wanee Pinprateep (2001)** has observed that the policy of Reproductive Health should receive more attention and issues of Reproductive Health among foreign migrant workers, need to be addressed to help reduce the problems of the birth of foreign children, the problem of unsafe abortion and promote the quality of life of these workers. With regard to the improvement of the policy
management, the system should aim at coordination among government organizations, in the administration of foreign migrant workers more efficiently.

Laura Sedlock (2000) has brought out the benefits and challenges of providing Reproductive Health information and services to youth in 10 to 14 years age group. Reaching this age group can delay the first intercourse and can help them make the transition to adulthood smooth?

Warunee Fongkaew (1999) has found that, communication with friends through naturally occurring social network: (1) Programs that serve youth, should use life-skills training and network mobilization strategies that have been successful in their target population. (2) Links must be promoted among health promotion centers, the department of social welfare, juvenile courts, secondary and tertiary educational institutions and other governmental and non-governmental organizations which play important role in the success of this program. (3) Behaviour material should be adapted into formats that are appealing and entertaining to youth, using language and terminology that youth understand.

J.A. Lipovsky and group (1998) have brought out four primary components of the abuse clarification process. They are (a) Clarification of the abusive behaviors. (b) Assumption of offender’s responsibility for the abuse. (c) Offender’s expression of awareness of the impact of the abuse on the child victim and the family. (d) Initiation of a plan to ensure future safety.

2.4.2 The Adjustment
Michael Sommers (2008) has confirmed that children from unhappy families have lower self-esteem and higher levels of behavioral problems. Such, children recourse to yelling as a legitimate way of solving problems.

Michele L. Ybarra and group (2007) have brought out that pediatricians should help parents assess their child's behaviors globally online, in addition to focusing on specific types of behaviors. In conclusion he has stated that the content and focus of most Internet safety and prevention messages is on meeting people online correctly. However, concern about sharing personal information
seems to be less warranted than a focus on extinguishing harassing behaviors. Moreover, engaging in many different kinds of online risky behaviors explains online interpersonal victimization more than engaging in specific individual behaviors.

**Amberley R. Buxton and group (2006)** have elaborated that, between trauma and other issues, how clients believed themselves and their lives changed.

**Julie R. Morales and group (2006)** have explained the effects and the important influence of life’s events that stress on children's adjustment in disadvantaged communities.

**Darling N. Caldwell and group (2005)** have brought out that once demographic characteristics and prior adjustment were controlled, adolescents who participated in extracurricular activities reported higher education levels, more positive knowledge towards schools and higher academic aspirations.

**Mayuree Nirattharadorn (2005)** has indicated that, early detection of ante partum depression is likely to help adolescent mothers to decrease risks of post partum depression and enhancing their self-esteem and providing them with social support that can help decrease maternal depression.

**Sucheera Phattharayuttawat and group (2005)** have recorded that it will be more direct and meaningful to detect the mental health, illness and poor quality of life in Thai communities.

**David Schultz and group (2001)** have suggested that low level of emotional knowledge occurs with many important aspects of early social adaptation of children.

**Suwat Srisorrachatr (2001)** has interpreted that the connotation of violence were different to different genders. Women perceived mental abuse as family violence, while men felt only physical abuse as violence. Non-violent behaviour included the participants keeping quiet, to be glared at, to rush away, to
forbid the spouse to make friends, to call the spouse unattractive, to have non-consensual sex, to try to sell the partners belongings or to force wives to work outside. The participants perceived these actions and behaviours as non-violent because these were ways to solve family problems. Men had different meaning of performed actions in contrast to their wives. The actions or behaviour, which women consider as emotional abuse, were to growl, to push, to intimidate and to assault. Men considered physical abuses to be family violence only if wives were injured. If not, it was considered an accident with no intent to hurt wives. Participants did not mention sexual abuses. Only men mentioned that having sexual relations was a means to apologize after a quarrel or beating wives. Women performed social interventions for family violence by bringing friends to get out of the situations. Men did not want to intervene with friends because they considered family problems to be private. Health volunteers also felt that domestic violence were habitual behaviour of couples that should not be interfered with by the professionals. Community leaders were the most concerned, about solving family violence.

**UNICEF (2001)** has suggested that (1) the society should be sensitive to changes in children's behaviour, as that is an indication that parents should sit down and talk to them about what caused the changes. (2) Children should be taught to trust their own feelings and assure them that they have the right to say “No” to what they sense is wrong. (3) Carefully listen to fears of children and be supportive in all your discussions with them. (4) Children should be taught that no one should approach them or touch them in a way that makes them feel uncomfortable. If someone does, they should tell teachers or parents immediately.

**C.E. Ezzell and group (2000)** have suggested that the peer and family support are particularly important for psychological functioning, particularly for internalizing the problems of physically abused children.

**Jaroonrat Rodniam (2000)** has said that the intervention should provide more understanding of life events among adolescents and the importance of social support in enhancing their self-esteem. It is necessary to develop appropriate
measures in schools to foster self-esteem among adolescents particularly with reference to the school nursing services.

Judy Montreevat and Margaret Ponsakunpaisan (1997) have observed that the young hill tribe women in Northern Thailand are strongly influenced by the rapidly changing socio-economic forces around them, as well as the interventions of government and international development projects with intent to improving their quality of life. It had become a matter of adapting to a new life style which changed social and emotional environment. With decreasing capacity and right to practice traditional agriculture, they were compelled to seek new sources of income.

2.4.3 HIV/AIDS

Deodatus Conatus and Vitalis Kakoko (2006) have recommended that the government should establish appropriate long term counseling mechanisms to provide continuous psychological support and care among teachers who are tested positive for HIV.

UNESCO (2006) has suggested that (1) steps should be taken up to strengthen the standard of skills-based health education for prevention of HIV/AIDS and related issues. (2) Review the HIV/AIDS education programmes being imparted under government auspices, through private agencies and NGOs and establish a working group. (3) Provide guidance to educational authorities and to civil-society organizations on the conduct of HIV/AIDS education programmes. (4) Provide resources and train teachers for awareness of HIV/AIDS. (5) In refugee or internal displacement situations where HIV/AIDS awareness and prevention education programmes are being imparted in camps, conduct separate programmes for neighboring populations.

Yamamoto Tadashi and Itoh Satoko (2006) have recommended that the capabilities of local authorities and communities to manage the extensive endeavors of the HIV/AIDS program must be evaluated. The firmness of Thai society needs to be ascertained and its ability to cope with the AIDS threat must be tested, as financial support from the Central Authority is likely to decrease.
Adolescence Education (2005) has opined that, all–wife, husband, lover, children and any other people, must be made aware of how HIV spreads, both sexually and through products that are related to handling blood, so that they can protect themselves. There are many things that can be done to hasten and increase this understanding, by (1) educating yourself, your family and most importantly your children about HIV infection and AIDS. (2) Emphasize on the benefits and joy of one faithful, lifelong partner. (3) Encourage community groups, residents associations and clubs to discuss HIV and AIDS. (4) Discuss with teachers the need for sex education in schools which, in addition to the biology of reproduction, emphasizes values and the responsibility and caring aspects of sexual relationships. This would encompass discussion on the transmission and prevention of sexually transmitted diseases including HIV and AIDS. (5) Initiate discussions on making condoms more widely and discreetly available, so that sexually active people can protect themselves from HIV and other sexually transmitted diseases. Many people feel inhibited about buying condoms in busy, public places such as supermarkets. Therefore installing condom vending machines in nightclubs and toilets for men and ladies could be considered.

Augustina Situmorang (2005) has observed that in Indonesia, the HIV education has entered the policy making circles through conferences and the preparation of policy-oriented papers.

Sathja Thato and group (2005) have observed that the Thai vocational students practiced unsafe sex and many had unplanned pregnancies and suffered from STD.

Warunee Fongkaew and group (2005) have recommended that to undertake activities on their own, initiate creativity and share knowledge on sexuality education and HIV prevention messages with students in schools, youth and adult. The use of partnerships and the participatory process mobilized parents, teachers and school administrators to play a proactive role in sexuality education and HIV prevention for adolescents in schools, resulting in the integration of the program into the school curriculum.
T. Boler and P. Aggleton (2004) have recommended that the life skills must be taught to young people, partly due to the necessity of information-based HIV/AIDS education. However, implementing life skills education in schools has proved to be problematic, especially where teaching concepts are very formal.

Tharawan K. and group (2003) have described that the participants considered Thai women generally vulnerable to HIV infection because of the unlikelihood of use of condom with their husbands and because women cannot control extramarital behavior of their husbands. Women apparently face particular risk after child bearing: as some Thai men may have alternate sex partners during the average 6–9 months pre partum abstinence. Women and men to a lesser degree were interested in potential micro-biocides, although they voiced many thoughtful questions about the products and about efficacy trials.

Karoline Moon (2002) has opined that understanding the HIV/AIDS prevention program is very effective and efficient to reduce HIV transmission and determine change of behaviour.

NCPFC (2002) has established that, (1) Mechanism for consolidating HIV/AIDS prevention program in Vietnam, needs more concerns right from Central to grassroots level. (2) The actions of NGOs, private organizations and community in HIV/AIDS prevention program must be speeded up. (3) More financial resources for the program mobilized and (4) the information on successful implementation of HIV/AIDS programs in Thailand should be exchanged with and applied in Vietnam.

HKCOG (2001) lays down the guidelines that, (1) intervention of HIV infection in pregnancy should be implemented through public education, social support, funding for laboratory costs and manpower. (2) Information about HIV infection and implications of HIV antibody test should be provided to patients before testing. Post test counseling should be arranged for HIV positive patients and should take into account the psycho-social needs, as well as the medical care plan for the patients.
H. Stewart and group (2001) have brought out that, information on the HIV prevention needs of school-based youth must be provided. It should focus on select key variables including HIV knowledge, attitude towards people infected with HIV/AIDS, confidence in acquiring and using condoms and reported sexual behaviour. The information and other data obtained from the studies have helped to shape the school-based interventions by informing teachers about student needs. It can also be helpful to others for planning HIV prevention programmes for youth in similar settings.

UNICEF (2001) has suggested the need for the promotion of healthy knowledge towards sexuality. Effective AIDS education encourages students to think of their sexuality in a healthy, guilt-free way. Explicit talk about arousal, desire and sexual activities that do not transmit HIV, such as genital touching, is very essential. Abstinence, the best way to avoid HIV infection, should be made part of the curriculum, but simply advocating abstinence is not enough. The discussion should be free of moralistic overtones that imply that it is always wrong to have sex.

UNICEF (2001) has recommended that (1) HIV related issues must be integrated into education about Reproductive Health, life skills, substance use and other important health issues. (2) It should be ensured that prevention and health programmes should not only teach young people the biomedical aspects of Reproductive Health but also on how to cope with the increasing complex demands of relationships, based on life-skills approaches. (3) Prevention and health programmes should be commenced at the earliest possible age and certainly before indication of sexual activity. (4) The prevention and health programmes must be extended to the whole educational setting, including students, teachers and other school personnel, parents, the community around the school, as well as the school system.

Avimanyu Panda (2000) has mentioned that to convey meaningful messages about AIDS/STDs to adolescents in school, it may be imperative to discuss Reproductive Health issues with their available curriculum and learning objectives and issues related to AIDS/STDs prevention.
Kavungnal J.J. and group (2000) have noted that youth require intensive intervention. Even though the subject is introduced in the curriculum, no one teaches it because of the taboo and stigma attached to it. Colleges require special teams well equipped with modern methodologies of health education which will reach the inner core, thus enabling success in prevention and control of HIV/AIDS.

Yi JK (1998) has suggested that respondents were not comfortable discussing their HIV and safe sex concerns with their sexual partners. The respondents were also not comfortable discussing the need for culturally sensitive HIV/AIDS education for Vietnamese students, especially for those who are sexually active. HIV prevention interventions should be directed toward this minority ethnic group to maintain the currently low rates of HIV infection.

2.4.4 The Drugs

De Souza and group (2002) have noted that the study finds that children engaged in drug trafficking are from the poorest families. They have low level of schooling and participate in trafficking to gain power and prestige. The paper includes a review of the literature on child labour and drug trafficking, quantitative and qualitative profiles of children involved in drug trafficking and policy recommendations.

Jakgree Suntharow (2002) has enunciated that the parent should be concerned in prevention and suppression of narcotics against the existing influence of narcotics in the children and society by educating people about the legality and ill-effects of narcotics.

Wisit Muensuwan (2001) has suggested that family institutes should establish relations in the family which are a link of positive relations between juveniles and parents. The Commission of Narcotic Protection and Suppression whose duty is to protect and suppress the use of drugs, schools and religious institutions must cultivate and form the behavior of juveniles to abide by the recognized tenets of the society. The National Police Bureau should seek constructive assistance in prevention and suppression of drug use by co-ordinating
with community leaders and professional groups to further the anti-drug use campaign.

Prapaporn Poogpan (2000) has deduced that Amphetamine is the single most addicted substance among young adults in 17-18 years age groups. The group has observed that these young adults had generally finished lower secondary level of education, unemployed, had their families with above-average income and parents were in business. This Drug Abuse required a concerted treatment for more than a year. Most of these drug-addicted adolescents had an overall moderate adaptation, high adaptation for neither food nor nausea, recreation, no constipation, but with low adaptation on drowsiness. Their concept had an overall moderate adaptation, with the feeling that quitting Drug Abuse would invigorate their body, but still felt that their face looked worn out. Yet most of them had a high self confidence in adaptation. They still felt that family members were keeping an eye on them. They thought that with recurrent Drug Abuse, they could seek therapeutic treatment again; they, in fact, felt confused and could do nothing when returning home. Their moral, ethical and spirituality level had an overall high adaptation, but they still felt that they were a burden to the family and the economy. They had an overall high adaptation on role but low adaptation on observation of abnormal symptoms and their reports to the nurses. They were not in a position to express their inner feelings to the family when problems arose. Most drug addicted adolescents had a moderate adaptation and were interdependent, with their preference of being alone. While faced with trouble, they would not dare make their own decision, but consult friends, nor dare talk or work, except when others ask. Besides, they expected their family members to pay more attention to them than what they received previously.

Ketkaew Raksachart (1999) has enumerated that (1) youth, who had lower education level, got higher self concept scores about his body more than the one who had higher education level. (2) Youth who had been using drug for less than 2 years got self concept scores about his body, personal life, society and drug addict appearance much more than one who had been addicted to drugs for more than 2 years. (3) The first offence youth got self concept scores higher than the recidivism got.
Leena M. Kirjavainen (1999) has reported about Drugs and Trafficking that the problems in the Northern region–Chiang Rai and Payao districts have been well documented and publicized in the local and international media. Recently, however, new trends are emerging and there is a shift from the traditional drugs to modern ones. Drug Abuse has become a labour problem as the employers in industrial estates and agricultural enterprises give these pills to the labourers as “boosters” and “energizers”. It is well known that powerful “masterminds” are behind these actions and it is very difficult to interfere. It has been particularly reported that young women have committed suicide, trafficking in child labour has increased and more and more children are born with HIV/AIDS.

2.4.5 The Parents

Michael Sommers (2008) has submitted that to find out, the families who considered themselves as strong and happy had eight main characteristics that kept the families together namely, communication, togetherness, sharing activities, affection, support, acceptance, commitment and resilience.

Christine G. Whitmire (2007) has brought out that abilities of children to help themselves had a moderately strong, positive correlation with knowledge of adolescent parents towards non-physical forms of corporal punishment. Although casual relationships were not established with these research findings, they lend support to current research on this topic which suggests that a nurturing, non-abusive environment with appropriate expectations by the parents enhances language and motor development in young children.

Christina K. Holub and group (2006) have established that there is a need for health services to target the subgroup of adolescent mothers, including both prenatal and parenting support. Early intervention to increase maternal adjustment and decrease emotional distress should remain a priority, in facilitating the most optimal maternal and child health outcomes.
Araxi P. Macaulay and group (2005) have suggested that effective parenting practices have a robust protective effect on drug use of youth in multiple ways that extend beyond parenting effects.

Joseph J. Maiorano and Ted G. Futris (2005) have elaborated that implementation of social and parenting skills program for males, in the correction system, has been found to improve knowledge of participants about themselves, their role as fathers and their understanding of positive parenting practices. The Group also has opined that this program could help participants become less of a security risk during the remainder of their sentence and have reduced rates of recidivism following their release. When participants positively engage in the lives of their children, their children may be less likely to engage in at-risk behaviors that could lead to imprisonment.

Redd Zakia and group (2005) have reported that, parent and adolescent closeness should result in (1) ongoing parental awareness programme and monitoring the whereabouts of adolescents and companions, becoming joint activities. (2) Involvement of parents in schooling activities of children, special events (contact, for absent parents) in schools and expectations of success of the child. (3) Coordination in terms of parent-adolescent communication, discipline and style (warm, supportive, firm limit-setting, not harsh or permissive), conflict resolution and enhancement of problem solving skills. (4) Parental mental health (reduction in parental stress and aggravation), service utilization and social support and (5) Parents attending the school, educational attainment and parental employment.

David J. Kolko and Cynthia C. Swenson (2002) have suggested that parents must assist in the management and development of child, expectations and cognitive distortions, behavior management and discipline. Also, the parents should facilitate family communication and problem solving and assess factors that contribute to reduce risk, as well as various clinical disorders resulting from experiences of physical abuse of the child.
Jakree Suntharow (2002) has recommended that there should be leverage and strengthening of the family institution, allowing the family members to be aware of positive relationships within their own family by providing warmth love, mutual connection and particularly parents should behave as good role models for the child.

Paradee Boonperm (2001) has indicated that most families had moderate knowledge of sex education and adolescent sexuality and displayed moderate willingness towards giving sex education. Knowledge, attitude and methods of parents delivering sex education were far from satisfactory. The families must be encouraged and supported to develop their ability to deliver more effective sex education.

Trairat Fapakasit (2000) has inferred that both family and social environment were the relative forces which pushed the street children to leave their families. He has opined that employment of the teachers and counselors is one of the most effective ways in managing the problems of street children.

2.4.6 The Intervention Programme
Yuan Hsiang Chu (2005) has highlighted the importance of introduction, guidance and communication of issues related to sex by peer educators which they have acquired from their own experiences and sex education intervention.

Fariha Haseen and group (2004) have recommended flexibility in providing valuable information on the process of implementing a culturally-sensitive intervention. Implementation of system for distribution booklets in schools should be considered as preparatory work with communities, parents and teachers. Therefore flawless documentation is necessary to ascertain whether this approach can be scaled up.

L.A. Sanci and group (2000) have observed that the design of the intervention program of Reproductive Health using evidence based educational strategies has proved to be an effective and faster way to achieve sustainable improvements in knowledge, skill and self perceived competency.
2.4.7 Mass Media and Communication

WHO (2006) has suggested that communication programmes can influence HIV-related outcomes among young people, although not for every variable or in every campaign. The strongest evidence points to changes in knowledge, interpersonal communication and use of condom. However, there is a need to continue to build the evidence base for the effectiveness of mass media campaigns among youth. It should also focus the comprehensive programmes that are being implemented with combination of television, radio and other supporting media. For policy-makers: Mass media have the potential to reach millions of people with life-saving messages that can change behavior. The large-scale campaigns must be closely co-ordinate with other interventions (such as those that co-ordinate are school-based or clinic-based) to maximize their effects. Moreover, for programme development and delivery staff, to achieve large-scale effects, mass media programmes should be developed and implemented through multiple channels with mutually reinforcing messages. Mass media interventions should be tailored for young people and campaign materials should be pre-tested involving young people.

Thailand NGO (2005) has reported that media must play more intense and better roles in promoting child development and build capability of their personnel. Better access to sources of knowledge and creative media should be ensured for benefit of children. The local area and community organizations also should play more effective roles in promoting local media for them. Also, Mass Media should provide with information useful for children and families, while more educational documentaries for children should be produced, with incentive provided to the producers. Moreover, a consumer organization as well as hotline services should be established to investigate and monitor the quality of media and protect child consumers to prevent children from accessing pornographic or harmful Internet websites.

Akim J. Mturi (2003) is of the opinion that communication of sex-related matters or sex education in schools does not lead to promiscuity. All interested stakeholders should be involved in this exercise. Meanwhile, parents should be encouraged to discuss sex-related issues with their adolescent children at home.
The government may attempt to use the village chiefs to encourage parents to talk to their adolescent children.

**Duangrutai Pongpaitoon (2001)** has elaborated that exposure to sex education information via mass media and specialized media particularly through Magazine/Journal and Video/VCD are better co-related with knowledge about sex education. Exposure to sex education information through personal media and specialized media particularly through teachers and textbook is also co-related with knowledge toward talking and imparting sex education.

**Yasmeen S. Qazi (2001)** has deduced that the need for more education on sexuality and Reproductive Health is required to counsel to the parents, to help them communicate more effectively with their children. The programme should also prepare other responsible persons such as teachers and health care providers to understand adolescent development and to be able to provide appropriate information about sexuality and reproduction to adolescents.

**Judith Lee Ladd** has recommended that the parents should create an atmosphere for open communication with child, even if, child tells you everything now that will change later. Being a good listener keeps these channels open. Parents should learn how to communicate with the school authorities. They should identify as to who should be contacted in the school and practice making connections with the new system and new people in the child's school. The parents should not be inhibited to volunteer at the school to see their child in action.