CHAPTER V

CONCLUSION AND SUGGESTIONS

The extensive collection of data, analysis and research for “A Study of Educational Intervention for the Disadvantaged Children in Thailand” have revealed the magnitude of the problem and the crisis faced by the youth who are the future citizens of the country. The menace caused particularly by Drug Abuse and HIV/AIDS, is likely to destroy the very social fabric in the country. In the light of these problems, this research has been done with the intention of finding a plausible solution and to suggest remedial measures which if implemented at the national level, are likely to regain what has been lost by the youth and prevent further loss. The summary of the research has been listed out in this chapter and the recommendations have been accordingly submitted. It is hoped that this chapter will impress upon the users the seriousness of the problem and the measures for effective Education Intervention.

5.1 OBJECTIVE OF THE STUDY

The major objectives of the study were:

(1) To study the Knowledge regarding HIV/AIDS, Drug Abuse and Reproductive Health Education amongst the Disadvantaged Children in the Orphanages in Thailand.

(2) To study the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour in the Orphanages in Thailand.

(3) To study the Adjustment of the Disadvantaged Children in the Orphanages in Thailand.

(4) To study the effectiveness of Educational Intervention on knowledge, attitude and adjustment of the Disadvantaged Children in the selected Orphanages in relation to gender, education levels and age in Thailand.

(5) To suggest measures to improve the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education
and their Attitude towards Reproductive Health Behaviour and Adjustment of the Disadvantaged Children in the Orphanages in Thailand.

5.2 HYPOTHESIS OF THE STUDY

The following are the hypothesis of the study:

(1) There is no significant difference between male and female in their Knowledge towards HIV/AIDS, Drug Abuse and Reproductive Health Education.

(2) There is no significant difference between male and female in their Attitude towards Reproductive Health Behaviour.

(3) There is no significant difference between male and female in their Adjustment.

(4) There is no significant difference in the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education in terms of the following background variables:

(a) Age

(b) Education level

(5) There is no significant difference in the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour in terms of the following background variables:

(a) Age

(b) Education level

(6) There is no significant difference in the Adjustment of the Disadvantaged Children in the Orphanages in terms of the following background variables:

(a) Age

(b) Education level

(7) There will be significant improvement in the Knowledge of the Disadvantaged Children toward HIV/AIDS, Drug Abuse and Reproductive Health Education after the Educational Intervention programme.

(8) There will be significant improvement in the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour after the Educational Intervention programme.

(9) There will be significant improvement in the Adjustment of the Disadvantaged Children after the Educational Intervention programme.
(10) There will be significant improvement in male compared to female in their Knowledge on HIV/AIDS, Drug Abuse and Reproductive Health Education, the Attitude towards Reproductive Health Behaviour and the Adjustment in the Orphanages in Thailand.

(11) There will be significant difference in the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education and their Attitude towards Reproductive Health Behaviour and Adjustment before and after Educational Intervention in Thailand.

5.3 MAJOR FINDINGS OF THE STUDY

The major findings of the study have been discussed under three heads namely, the knowledge, the attitude and the adjustment of the Disadvantaged Children in Orphanages in Thailand.

5.3.1 The following are the objectives of the study

(1) To study the Knowledge regarding HIV/AIDS, Drug Abuse and Reproductive Health Education amongst the Disadvantaged Children: On the whole one can say that only few of the children had very good Knowledge regarding HIV/AIDS, drug abuse and Reproductive Health Education.

(2) To study the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour: we find female sample had higher attitude (98.3%) as against male sample (98.3%). Lastly, none of the subjects were found in the highest score range, 225-280.

(3) To study the Adjustment of the Disadvantaged Children: As far as the total adjustment is considered, we find that none of them under best adjustment (since least scores indicate better adjustment) and the sample of 528 did not have very good adjustment.

(4) To study the effectiveness of Educational Intervention on knowledge, attitude and adjustment of the Disadvantaged Children in the selected Orphanages in relation to gender, education levels and age: On the whole, we find that (1) the selected sample had lesser knowledge, moderate attitude, and higher levels of maladjustment among total selected sample of 528
children. (2) Gender-wise we did not come across any difference in knowledge, attitude and adjustment (except for emotional adjustment) and (3) however, age and education levels had significant influence over knowledge and total adjustment scores.

In summary, we find that Educational Intervention given by the investigator for Disadvantaged Children had maximum gain in terms of knowledge, attitude and adjustment. We find that in knowledge we find increased knowledge in all the components and total knowledge scores, which help them to gain better insight. In attitude, the attitude has been changed drastically towards favourable side, indicating a positive change in their mental picture regarding the Reproductive Health Education. The Educational Intervention programme has changed the adjustment style in all the areas-home, health, social and emotional towards more comfortable living. Lasyly, not many of the secondary variables had significant influence over the changed scores like gender, age and education levels on knowledge, attitude and adjustment.

5.3.2 The following are the Hypothesis of the study

(1) There is no significant difference between male and female in their Knowledge towards HIV/AIDS, Drug Abuse and Reproductive Health Education: Male and female children did not differ significantly in their scores on knowledge scores.

(2) There is no significant difference between male and female in their Attitude towards Reproductive Health Behaviour: A significant difference was observed between male and female children their mean attitude scores.

(3) There is no significant difference between male and female in their Adjustment: female children were more maladjusted (Mean 30.81) than male children (Mean 30.08) in emotional adjustment area. And in total adjustment (t=1.381; P=.168) we did not find significant differences, hence on the whole one can say that male and female children had similar adjustment scores.
(4) There is no significant difference in the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education in terms of the following background variables:

(a) **Age groups:** In total knowledge as well as in components-HIV/AIDS, Drug abuse, Reproductive Health Education, and in total knowledge scores F-tests revealed significant differences among children with different age groups. A common trend observed across different components as well as in total scores was that as the age increased, the knowledge scores in various components as well as in total knowledge scores increased linearly and significantly.

(b) **Education level:** Grade-wise comparisons revealed significant differences among children studying in different education levels in total knowledge as well as in components-HIV/AIDS, Drug abuse, Reproductive Health Education and in total knowledge scores. A common trend observed across different components as well as in total scores was that as the education levels increased. No difference in the mean scores of children in grades 7 and 8 only children in grade 9 had highest scores and differed significantly from children in other education levels.

(5) There is no significant difference in the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour in terms of the following background variables:

(a) **Age groups:** As far as the Attitude towards Reproductive Health Behaviour is considered, age of the children did not have significant influence.

(b) **Education level:** When Attitude towards Reproductive Health Behaviour is compared grade wise education levels as such did not have significant influence over the attitude scores.

(6) There is no significant difference in the Adjustment of the Disadvantaged Children in the Orphanages in terms of the following background variables:

(a) **Age groups:** In adjustment factor, children with different ages differed only in total adjustment. Though we find a linear decrease in scores (lesser scores better adjustment), only children in age groups differed significantly from children in the age groups of 14, 15 and 16 years.
(b) **Education level:** Except for social adjustment factor, in rest of the areas of adjustment and in total adjustment scores children studying in different education levels did not differ significantly. In total adjustment also, education levels did not give significant influence.

(7) **There will be significant improvement in the Knowledge of the Disadvantaged Children toward HIV/AIDS, Drug Abuse and Reproductive Health, after the Educational Intervention programme:** In total knowledge scores between pre-test to post-test scores a significant difference was observed. This increase of scores could be attributed to effective Educational Intervention for Disadvantaged Children. In Reproductive Health Education also, between pre-test to post-test scores we find a significant increase. This increase of scores from 4.37 to 8.63 could be attributed to the effective Educational Intervention for Disadvantaged Children.

(8) **There will be significant improvement in the Attitude of the Disadvantaged Children towards Reproductive Health Behaviour after the Educational Intervention programme:** So, one can say that effective Educational Intervention has definitely increased the attitude of the intervened sample for more favourable side.

(9) **There will be significant improvement in the Adjustment of the Disadvantaged Children after the Educational Intervention has programme:** In all the areas of adjustment, significant improvements were observed from pre to post test situation. All the “t” values were found to be highly significant. Educational Intervention has improved the level of adjustment among Disadvantaged Children from pre to post test situation.

In total adjustment in the pre test, the group had 98.80 scores, which had been reduced to 80.57 scores. The decrease in the total adjustment scores shows effectiveness of intervention for better adjustment.

As far as, in emotional adjustment in concerned, we find a decrease of 6.16 scores, which is found to be highly significant. One can say that Educational Intervention has positively worked to improve emotional adjustment.
(10) There will be significant difference in the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education and their Attitude towards Reproductive Health Behaviour and Adjustment before and after Educational Intervention in Thailand.

(1) Influence of Gender, Age and Education levels on the Knowledge of the Disadvantaged Children towards HIV/AIDS, Drug Abuse and Reproductive Health Education:

(a) Gender: Overall we find a significant change ($F=944.954; P=.000$) in the mean pre to post test knowledge scores.

(b) Age groups: When the knowledge scores are verified for pre and post test situation a significant $F$-value was observed ($F=451.151; P=.000$). Also, this change was not found to be significant for children in different age groups ($F=1.832; P=.147$). One can infer that age of the child did not have significant influence over gain scores in knowledge.

(c) Education levels: When the knowledge scores are verified for pre and post test situation a significant $F$-value was observed ($F=819.760; P=.000$) irrespective of the education levels. However, this change was not found to be significant for children in different education levels ($F=1.226; P=.298$). One can infer that grade of the child did not have significant influence over gain scores in knowledge.

(2) Influence of Gender, Age and Education levels on Attitude towards Reproductive Health Behaviour:

(a) Gender: In Attitude scores towards Reproductive Health Behavior overall we find a significant change ($F=1245.599; P=.000$) in the mean pre to post test attitude scores. However, when the change in the attitude scores are verified against the gender, a non-significant differential change was observed in the mean attitude scores of male and female children were observed.

(b) Age groups: In Attitude towards Reproductive Health Behaviour, between pre and post test situation a significant $F$-value was observed ($F=698.611; P=.00$). Also, this change was found to be significant for children in different age groups ($F=3.123 P=.029$).
(c) **Education levels:** In Attitude scores towards Reproductive Health Behaviour, verified for pre and post test situation a significant F-value was observed (F=1132.051; P=.000) irrespective of the education levels.

(3) **Influence of Gender, Age and Education levels on Adjustment:**

(a) **Gender:** As far as the adjustment score is considered, on the whole irrespective of the gender, we find a significant change (F=3238.247; P=.000) in the mean pre to post test adjustment scores. When the change in the scores is verified against the gender for total adjustment scores, a non-significant differential change in the adjustment was observed between male and female children.

(b) **Age groups:** When the adjustment scores are verified for pre and post test situation a significant F-value was observed (F=1519.836; P=.000). However, this change was not found to be non-significant for children in different age groups (F=0.857; P=.466). One can infer that age of the child did not have significant influence over gain scores in adjustment.

(c) **Education levels:** In adjustment scores too we find a significant change from pre and post test (F=2867.658; P=.000) irrespective of the education levels. However, this change was not found to be significant for children in different education levels (F=0.469; P=.627). One can infer that grade of the child did not have significant influence over gain scores in adjustment.

### 5.4 DISCUSSION

The goal of the focus group is that the participants understand why they should seek the opinion of Disadvantaged Children in Orphanages by finding out. The distribution of Cartoon booklets, CD training and games in the programme resulted in sensitization and evinced interest. In fact, many northern states of Thailand, have either poorly understood or have not fully appreciated the HIV/AIDS, Drug Abuse, Reproductive Health Education and Behaviour. It is becoming more evident that this neglect can seriously jeopardize their needs and future well-being.

The activities suggested that the HIV/AIDS, Drug Abuse and Reproductive Health Education and Behaviour were highly appreciated and can
be improved by two-way communication. The investigation for development of policies and programme for the Disadvantaged Children indicated that six policies are required to be addressed for the effectiveness of the programme as:

(1) There is a great need to help the Disadvantaged Children observe certain guidelines of the programme to develop skills and life plan. It should be taught by teachers, parents, wardens, psychologists, social workers and health care takers who are culturally sensitive.

However, the Reproductive Health and Behaviour should be included in the curriculum for grades 4-12. It will be too late to start from grades 7-9. Thus: the Ministry of Education has to prepare a new policy to include this subject in the Basic Education Curriculum at the earliest.

This has been further confirmed by Iwu Dwisetyani Utomo (2002: 11-12), who has stated that the school-based compulsory Reproductive Health-Sexuality Education should start in elementary school as studies in the US have confirmed that intensive early childhood programs, promote long-term healthy behaviours including the biological and the socio-cultural aspects of behaviour namely, moral positioning, relationship skills, negotiating skills, gender equity in Reproductive Health Behaviour and responsibilities, drugs, alcohol and sexual risk reduction skill and also dealing with peer pressures.

(2) The Thai culture and tradition have been pushed to backseat by the foreign culture and the desire for materialistic pleasures. Increasing modernization has led to major changes in the Thai family life styles, the impact of which has necessitated the old and traditional methods of education and socialization which children kept learning for a long time. However, absence of such education has made them grow up with wrong values of life and against the morality. The schools should introduce textbooks with contents on behaviour programme, in interesting and meaningful perspectives which give clear information.

The community sensitization in support of children to improve the Knowledge on HIV/AIDS, Drug Abuse and Reproductive Health Education and Behaviour must be followed appropriately and extensively.
This is further confirmed by studies by Linnéa Warenius and group (2007: 533-534) that the male and female lack adequate information about human reproduction and STIs, including HIV. To avoid misconceptions and myths, they need clear information on contraceptives and masturbation. Responses indicate that young people would welcome guidance and support related to contraception, pregnancy, abortion and STIs/HIV, and also on love and relationships. The culture, religion and gender are important factors influencing sexuality and sexual abuse. These issues need to be taken into consideration while developing youth-friendly programmes. Kavungnal J. J. and group (2000: 13) have recommended that the youth require intensive intervention by special teams well equipped with modern methodologies of health education which reach the inner core enabling success in prevention and control of HIV/AIDS.

(3) It appears that in Thailand, the media has caused a change in sex related values among adolescents. With the misuse of Internet in getting information on sex related issues supplemented by the use of cell phone (clip video), magazines, VCD, DVD, booklets and other mass media, problems of sexually abused children have increased. Therefore, textbooks, booklets and other mass media should be distributed to the children, for effectively acquiring more Knowledge, Awareness in the Attitude of children, HIV/AIDS, Drug Abuse, Reproductive Health Education and knowledge for improvement of Children, Parents and Adjustment to guidance.

This is further confirmed by Thailand Report (2005) that media plays more and better roles in promoting child development and build their personality. In addition, better access to sources of knowledge and creative media should be ensured for the Disadvantaged Children in local areas and community organizations.

Mass Media: It should be clearly assigned to provide useful information to children and families while more informative coverage for children should be produced, with incentive to the producers. Moreover, a consumers’ organization and hotline services should be established to investigate the quality of media to
protect child consumers. Better blockage must be used to prevent children from accessing pornographic or harmful Internet websites.

(4) Many Thai children today have greater freedom than their predecessors but have problems created by the families and by themselves, after they have been sexually abused or because their family could not understand children behaviour and could not teach and support them. This is especially true of those the Disadvantaged Children who have moved away from home. The quality of education in their schools must be improved as the traditional values are increasingly being challenged, often resulting in conflicts between children and the family.

This is further confirmed by studies by Iwu Dwisetyani Utomo (2002: 13) who has opined that parents should be equipped with appropriate knowledge on behaviour of children, so that parents can be used as the first agents to pass knowledge on Reproductive Health issues. The problem is that parents do not have enough knowledge in this field. It is also problematic because parents are reluctant to talk to their children about sexuality because of cultural, psychological and communication barriers. After all, parents never had the experience receiving any information relating to sexuality when they were children. Educational programs for parents should be developed if the government wants to rely on parents as a source of behaviour.

However, Ministry of Health (2001) has brought out that to improve sexual behaviour stress should be on improving access to services, improving the quality of service delivery and increasing knowledge and understanding their outcomes and determinants. It is essential to minimize the cost of services which has to be affordable. Better integration and linkage between both the existing Reproductive Health services and sexual health services should be encouraged.

Different sections of the community have different levels of knowledge, values, behaviour and awareness about different sexual and Reproductive Health issues and sexuality constraints. The approach that is used to increase the awareness and understanding of one sector may not be appropriate for other
section in the society. Moreover, education, health promotion programmes and services for all sections should encourage discussion not only about sexual behaviour between partners but also promote positive sexuality. They should provide information about skills for practicing safer sex.

From the initiation of sexual behaviour, alternative ways to express relationships and sexual intercourse must be taught including the reducing number of partners and the emotional, social and spiritual dimensions of sexuality. All members of society must endeavor to learn about the complex nature of sexuality, sexual behaviour and motivation as follows:

(a) Explore societal views. Focus must be shifted to the determinants including societal issues, structural issues (social, environmental, educational, cultural, emotional and spiritual) and power imbalances in relationships and aspirations, the role of communities in improving sexual and Reproductive Health.

(b) Increase the ability of families/caregivers to support their children and young people and examine these issues with reference to the specific age, ethnicity and disability, population group, cultural norms to make healthy sexual and Reproductive Health decisions for them.

(c) 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 could be addressed. The personal knowledge, skills and behaviour must increase understanding of individuals and teach them to value themselves (personal identity and self worth).

(5) With the educational programmes and strategies, Thai children should learn and practice self-protection and gather knowledge on the Child Rights. They should be able to learn the realities of the HIV/AIDS, Drug Abuse, Reproductive Health Education and Behaviour. This is further confirmed by Thailand Report (2005) that recommends:

(a) Specific measures for children in need of special protection: “welfare should be provided along with development services targeting poor families, families at risk and families with AIDS or affected by AIDS and families with
very old caregivers. Basic services for children should be focused on proactive and preventive actions by detecting children at risk and intervene before they fall into more severe situations and access should be improved to ensure that families and children can get to it when needed. Also, they should be protected and national plans must be progressively implemented to combat trafficking in children and women and to eliminate the worst forms of child labour, according to the ILO Convention No. 182”, by Worst Forms of Child Labour Convention, 1999.

(b) Rights of children: “planning and implementation of justice concerning rights of children must be provided with comprehensive support e.g. detection, withdrawal, rehabilitation, reintegration and job skills training with full participation of children, families and communities to ensure smooth reintegration. Also, increase in number, quality and training must be offered to ensure ethical conduct and awareness of children’s rights. Also, should be guaranteed through issuance of birth registration or certificates to ensure access to basic social services. Nationality should be granted to children of ethnic minority families who have lived in the country for generations as well as to children of Thai parents who failed to register their birth”.

(6) Especially the STDs, HIV/AIDS and Drug Abuse have come to stay and spread in Northern Thailand. This is confirmed by Leena M. Kirjavainen (1999) that drug problems in the Northern Region–Chiang Rai and Payao districts have been well documented and publicized in the local and international media. The narcotic problems are most severe in the urban and sub-urban areas, where increasing number of children are addicted to using and selling narcotics, such as "Ya-Ba" Pills (LSD and amphetamines). Drug Abuse has also resulted in labour problem as the employers in industrial estates and agricultural enterprises give these pills to the labourers as "Boosters" and "Energisers". It is public knowledge that powerful "Masterminds" are behind these actions and it is very difficult to interfere. Particularly, it has been reported that young women have committed suicide, trafficking in child labour has increased and more and more children are born with HIV/AIDS to the drug addicted parents”. This is particularly tragic for the youth, since sterility, criminality and death are the common consequences.
Thus we should teach and train them to get the Knowledge of HIV/AIDS, Drug Abuse and Reproductive Health Education and Behaviour. All these point to the need for an educational effort which will impart the necessary information and skills to the children, who are the future of the country with a better quality of life. This is confirmed by studies by UNICEF (2001) that the nation must become sensitive to changes in children's behaviour and teach them to trust their own feelings and assure them that they have the right to say “No” to what they feel is wrong. In addition the programmes should teach children that no one should approach them or touch them in a way that makes them feel uncomfortable. If someone does, the matter should be reported to teachers or parents immediately.

(7) Education programme should help Disadvantaged Children to build self-esteem, self-value to provide life plan, develop into fully respected human beings and develop friendly relations with other people around them. As the Thai Disadvantaged Children have been neglected, there is a need to improve them including good knowledge by understanding themselves, their family, friends and other people in their community and society.

This is further confirmed by studies by Warunee Fongkaew (1999) that programs that serve the youth should use life-skills training and network mobilization strategies that have been successful in their target population. In addition to health promotion centers, the department of social welfare, juvenile courts, secondary and tertiary educational institutions and other governmental and nongovernmental organizations are important for the success of the programme. The behaviour materials should be prepared in formats that are appealing and entertaining to youth, using language and terminology that the youth understand.

5.5 SUGGESTIONS OF THIS STUDY

This research work suggests measures to improve the Knowledge of HIV/AIDS, Drug Abuse and Reproductive Health Education also it includes the Attitude towards Reproductive Health Behaviour and the Adjustment of the Disadvantaged Children as follow:

5.5.1 The gender: After the Intervention Programme, the male had scored less than the female, who were 14 years old. They were studying in grade 8. This
is further confirmed by studies by Ekarin Itthiwatana (2000) and Trairat Fapakasit (2000) that most of them commit crime against juvenile crimes like stealing, snatching and running away, fleecing, robbery, fraudulence and trespassing at the age of over 14.

It has also been confirmed by Aama Milan Kendra and group, (2002) that most of the female aged 10–14 went to school. After the course, girls favored late marriage and wanted to learn income-generating skills. Laura Sedlock, (2000) has confirmed that 10–14 year, is an important age group for imparting Reproductive Health programs. It is confirmed by Leena M. Kirjavainen (1999) that there are numerous, serious socio-cultural and economic problems in the society, which the Northern Region families are facing, according to the researchers as the economic crisis is hitting Thailand hard.

In the urban areas, unemployment is increasing and in the rural areas, additional problems and hardships are being experienced by families because of the seasonal migrants returning to their homes increasing poverty, unemployment and social problems. Judy Montreevat and Margaret Ponsakunpaisan, (1997: 289-306) have brought out that, a few years ago, young hill tribe women in Northern Thailand commenced acquisition of basic human rights and needs even risking their reputation. The rights they wanted were to attend to school at a higher level than primary education and also to experience life outside the highland community.

5.5.2 The knowledge: The result of this study that female girls more disadvantaged in Northern Thailand lacks data. It simply does not have access to the data of HIV/AIDS, Drug Abuse, Reproductive Health Education, for the physical and emotional changes that take place during this period of life. This is further confirmed by DISHA (2006) that this is particularly true that girls and young women, whose ability to take advantage of existing Reproductive Health services, education options and new economic opportunities is severely constrained and occurs in the context of early marriage and childbearing. To help improve the life and health conditions of young people, policy and program interventions need to address the lack of adequate services, the limited set of
opportunities as well as the social and familial constraints such as limited mobility for girls and the pressure to marry daughters at young age. This suggests that interventions need to address the multiple spheres of young people’s lives in order to improve the lives of youth in a sustainable way.

Disadvantaged Children of 14 years age group, studying in grade 8 lack knowledge. This finding suggests that the need to improve their school curriculum through the wardens, social workers, teachers, psychologist and others with mass media, with corrected and clear information will be more effective.

Ideally, the wardens, social workers, teachers and the school curricula should provide information and guidance about behaviour. However, given the social and cultural context, they shall discuss “sensitively” the effect on the Disadvantaged Children. Policies and behaviour programme could take several approaches to address the need for better behaviour and guidance. Especially it should provide counseling to Disadvantaged Children, help them communicate more effectively with friends and other Disadvantaged Children in the Orphanages. Other responsible persons such as the wardens, social workers, teachers and psychologists, health care providers must understand the need for the development of the Disadvantaged Children and be able to provide appropriate information about behaviour to the Disadvantaged Children.

The result of this study is that in the knowledge score tests, it was considered “Medium” when tested for the Knowledge of HIV/AIDS, Drug Abuse and Reproductive Health Education. The gap in the Attitude and Behaviour could be narrowed by providing information and successful services of Reproductive Health programme. That will substantially increase knowledge and change the behaviour. It can be achieved by a thorough understanding of the motivation for general changes in behaviour and adjustment. This is further confirmed by studies by Terri Thompson and Charles Ungerleider (2004: 16) that the schools need to implement policies and practices which ensure equality of opportunity for males and females and eliminate sex discrimination in instruction and the management of student behaviour.
This study suggests that, each sub-group of children has special needs for which different approaches are necessary. Also, in Thailand almost all classes are of mixed gender. A strategy must be so devised as to reach each sub group and gender. This is further confirmed by Bangkok Post (2005) that single-sex classes for some subjects could be a powerful tool in helping male do better, as well as benefiting girls and suggests that single-sex classes lead to better-performing students.

5.5.3 The Attitude: The result of this study is that the Disadvantaged male changed their Attitude significantly better than what the female did. This study finds that, it might be the difference in the freedom offered to male at Orphanages by the Wardens, Social Workers, Teachers, Psychologists and Health Care givers, which gave them more exposure and wider spectrum of Knowledge regarding HIV/AIDS, Drug Abuse and Reproductive Health Education.

Moreover, female were more restricted and change was determined by post-conflict characteristics and complexities of society with patriarchal values deeply ingrained. They had restrictions to follow and were not given complete freedom to change their life style. This may have an impact on their negative attitude as compared with male.

This is confirmed by the News Nation (2005) at a seminar that behaviour helps develop morality, life skill and positive knowledge among the youth, as it addresses them with social and family values. The underlings need training on Reproductive Health and to disseminate health education among the youth to understand physical changes in male and female during adolescence and to dispel their misconception about sex determination of child and improve their Knowledge of HIV/AIDS. However, correct knowledge of the hygiene during menstruation has also increased by a great margin. The girls also became more skilled to avoid pre-marital sex and youth to avoid sexual abuse.

In addition, the behaviour of the Disadvantaged Children after Intervention Programme was found to be more positive and relaxed. This is confirmed by Poonsuk Shuaytong (1998: 330-337) that young adults need education programs
which give them ample opportunity to learn and earn their trust. Therefore the health care providers should consider developing a training program on sex education for the industrial youth workers. Also their parents should be entitled to similar programs in order to effectively maximize their guiding roles with the underlings. There is a need for greater dissemination of information with services, to contribute effectively to bring about positive change in the Attitude of the Disadvantaged Children in the Orphanages towards Reproductive Health Behaviour.

This is confirmed by Mittal Anuj and Kushwah S.S. (2007: 143) who state that the school should provide Reproductive Health problems to all adolescents who should discuss them, particularly among girls. In addition, discrimination of girl child must end. Adolescent health programs should be initiated by trained staff by using authentic study material. K. C. Chaudhuri, (2004: 797-801) has confirmed that there is a need for evolving information, education and communication strategies to focus on raising awareness. A socio-cultural change is needed to find the right kind of sexual Health services for young female and male.

The result of this study is that grade 8 could not change there Attitude on Reproductive Health Behaviour. This is further confirmed by Aksion Plus organization (2004) that the school counselor could be a model to change not only individual behaviors but collective attitude as well. It has helped to shift the mentality about the role of psycho-social help in the areas where the project was implemented. However, change in behaviour does not take place due to information and education alone. It requires other approaches, such as inclusion of targeted groups and giving opportunity to young people to practice the new attitude and new behaviors in order to make them integral and sustainable.

5.5.4 The Adjustment: The result of this study is that, 13 years old children studying at grades 7, 8 and 9 could not change after Adjustment. Judith Lee 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 of the same methods and practices that made them successful in elementary school will also make them successful as middle-school and high school students.

This study finds that, the Awareness of Adjustment in Orphanages has improved after the Intervention Programme was presented by Mass Media.

The Disadvantaged Children became more open to changes and exposure to Awareness and Orphanages’s Adjustment. This might have led to a significant improvement in their knowledge. This is further confirmed by studies by Kelly Ladin and groups (2006: 186-192) that those adolescents who are exposed to more sexual contents in the media and who perceive greater support from the media for teen sexual behaviour have shown strong intentions to engage in sexual intercourse and more sexual activity. Mass Media are an important factor for the sexual socialization of adolescents and the influences of media should be considered in research and Interventions to reduce sexual activity.

5.6 EDUCATION IMPLICATIONS OF THIS STUDY

In a developing country like Thailand the Disadvantaged Children are the future assets to the nation. Their contribution should be very much appreciated in the development of all fields like academic, cultural, technical etc. The contributions of the Disadvantaged Children are very much necessary. So, they should be taken care of.

Special school programme should have a great role in helping the Disadvantaged Children to manage their emotional outbursts. Every Disadvantaged Child should be provided with an opportunity to study at his own pace. By inclusion the able and the disabled Disadvantaged should be given the chance to study and get empowered.

Reproductive Health Education and Behaviour and Life Centered Curricula should be planned and implemented in schools suitable for both normal
and the Disadvantaged Children for promoting their interest in learning in the school atmosphere. This should support the emotional development and mental health education of the Disadvantaged Children. The Disadvantaged Children also should be free to express their feelings while working with children who are academically and socially disadvantaged.

Inclusive school and Orphanages should provide educational opportunities to children with special needs in special schools that enable them to become good Thai Citizens.

Guidance and counselling services should be a part of the school system and guidance should be provided to parents. Also, parent and teacher association should discuss the general academic problems of both the able and disabled Children and take necessary steps to tackle them.

5.7 RECOMMENDATIONS FOR FUTURE STUDIES

The following three paths are suggested for future research:

(1) The study of the Disadvantaged Children type by type or case study should be in-depth for collection of data of the Knowledge, Attitude, Behaviour and Adjustment towards Behaviour and Sexual Health Education.

(2) Interview with each type of the Disadvantaged Children separately will yield desired information and results as Thai society is shy and un-willing to answer the questionnaires on Behaviour and Sexual Health Education.

(3) The Disadvantaged Children and associated functionaries must be impressed upon and motivated to study the subject in depth to reap the maximum dividend and bring about areas of change in the very knowledge and outlook of the Thai society towards this less Disadvantaged Children and usher in a new era where both this Advantaged and Disadvantaged Children walk hand in hand in the spirit of Love and Concern and compassion for one another.