RESEARCH DOSSIER:
HIV PREVENTION FOR GIRLS AND YOUNG WOMEN
Thailand

This Research Dossier supports the Report Card on HIV Prevention for Girls and Young Women in Thailand produced by the United Nations Global Coalition on Women and AIDS (GCWA). It documents the detailed research coordinated for the GCWA by the International Planned Parenthood Federation (IPPF), with the support of the United Nations Population Fund (UNFPA), United Nations Program on AIDS (UNAIDS) and Young Positives.

The Report Card provides an ‘at a glance’ summary of the current status of HIV prevention strategies and services for girls and young women in Thailand. It focuses on five cross-cutting prevention components:

1. Legal provision
2. Policy context
3. Availability of services
4. Accessibility of services
5. Participation and rights

The Report Card also includes background information about the HIV epidemic and key policy and programmatic recommendations to improve and increase action on this issue in Thailand.

This Research Report is divided into two sections:

PART 1: DESK RESEARCH: This documents the extensive desk research carried out for the Report Card by IPPF staff and consultants based in the United Kingdom.

PART 2: IN-COUNTRY RESEARCH: This documents the participatory in-country research carried out for the Report Card by a local consultant in Thailand. This involved:

- Two focus group discussions with a total of 19 girls and young women aged 15-24 years. The participants included girls and young women who are: living with HIV; in/out-of/school; involved in sex work; living in urban and suburban areas; and working as peer activists.
- Five one-to-one interviews with representatives of organisations providing services, advocacy and/or funding for HIV prevention for girls and young women. The stakeholders were: a country representative of an international NGO; a nurse at a national NGO focusing on sexual and reproductive health; a counsellor at an NGO/government voluntary counselling and testing centre; a programme officer of a United Nations agency; and a Technical Adviser of an international donor agency.
- Additional fact-finding to address gaps in the desk research.
PART 1
Country profile
Prevention component 1: Legal Provision
Prevention component 2: Policy Provision
Prevention component 3: Availability of Services
Prevention component 4: Accessibility of Services
Prevention component 5: Rights and Participation

PART 2
In-Country Research
Focus group discussion: 15-19 year olds, urban areas
Focus group discussion: 20-24 year olds, urban and rural areas
One-to-one interview: Assistant Representative, UN Agency
One-to-one interview: Doctor, Sexual and Reproductive Health and Family Health
One-to-one interview: Youth co-ordinator, HIV/AIDS Programme Officer, International NGO
One-to-one interview: Peer Educator, HIV/AIDS NGO
One-to-one interview: Executive Director, PLHIV network
One-to-one interview: Executive Director, Sexual and Reproductive Health and Family Planning and HIV/AIDS NGO

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ARVs</td>
<td>Antiretrovirals</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<td>CIA</td>
<td>Central Intelligence Agency</td>
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<td>CPA</td>
<td>Center for Persons and Families Affected by AIDS</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information, communication and education</td>
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<td>ILO</td>
<td>International Labour Conventions</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<td>OI</td>
<td>Opportunistic infection</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<td>PPAT</td>
<td>Planned Parenthood Association of Thailand</td>
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<td>SPDC</td>
<td>State Peace and Development Council (Myanmar’s military government)</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>STD</td>
<td>Sexually transmitted disease</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TDN</td>
<td>Thai Drug Users Network</td>
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<td>TNP+</td>
<td>The Thai Network of People Living with HIV/AIDS</td>
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<td>TWAT</td>
<td>Thai Women and HIV/AIDS Task Force</td>
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<td>TYAP</td>
<td>Thai Youth AIDS Prevention Project</td>
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<td>UNAIDS</td>
<td>United Nations Program on AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary counseling and testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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PART 1:
DESK RESEARCH
### COUNTRY PROFILE

#### COUNTRY CONTEXT:


**Main religions:** Buddhist 94.6%, Muslim 4.6%, Christian 0.7%, other 0.1% (2000 census) CIA (2006) *The World Factbook* – Thailand – [https://www.cia.gov/cia/publications/factbook/geos/th.html](https://www.cia.gov/cia/publications/factbook/geos/th.html) (Date accessed 21/10/06).


#### AIDS CONTEXT:


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**PREVENTION COMPONENT 1: LEGAL PROVISION**

(national laws, regulations, etc)

Key questions:

1. **What is the minimum legal age for marriage?**

   “A betrothal or an engagement can be affected only when a man and a woman have attained the full age of seventeen years. If each other of them is under seventeen years of age, the betrothal is void. A minor who reaches the age of seventeen but is under twenty years of age may be betrothed only when the consent of the following persons have been obtained*: both parents if they are both living; either father or mother, in case of death or other parent has been deprived of parental power; adopter where person is adopted; or guardians if person has no parents or parents have lost parental power.”


2. **What is the minimum legal age for having an HIV test without parental and partner consent?**

   18
   http://hivvirus.dmsc.moph.go.th/knowledge.php (Date accessed 01/11/06)
   Details in question no.7

3. **What is the minimum legal age for accessing SRH services without parental and partner consent?**

   “Access to reproductive and sexual health services including family planning have improved in Thailand over the last decade. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that “All Thai citizens at all ages must have good reproductive health throughout their entire lives”(pg14)


4. **What is the minimum legal age for accessing abortions without parental and partner consent?**

   Abortion is illegal according to the Thailand Penal Code, Section 301. “Any woman (who) causes abortion for herself, or allows the other person to procure abortion for her, shall be punished with imprisonment not exceeding three years or fine not exceeding six thousand baht, or both.”
In Thailand, abortion is illegal but it can be done legally when it is performed by a physician on women under only two conditions: when the pregnancy is a risk to the women’s health or when the pregnancy is a result of rape. Induced abortion performed on grounds other than two grounds mentioned above is considered to be a criminal act, according to the Thai penal code, Article 305, enacted in 1997. As per the Thai culture and religious practices, performing an abortion is not a good cultural practice, so most physicians are reluctant to provide abortion.” (p. 2)

Despite the accessibility of family planning services and although the Thai culture does not support abortion, studies suggest 66.6% of women with unplanned pregnancies seek abortion services from abortionists who are non medical-professionals. A recent survey suggests approximately that in 12% of abortion cases the women made an attempt to induce the abortion on themselves using various techniques. The latest hospital-based survey in 1999 conducted by MOPH, DOH, found that a total of 45,990 women were admitted for treatment of abortion complications; 71.5% from spontaneous and 28.5% from induced abortion. 41.2% of all such admissions were in the age group 15-24.” (p. 78)

In Thailand, where abortion is only permitted to preserve the life and health of the pregnant woman, the Medical Council has recommended that a woman’s HIV positive status be recognized as specific grounds for obtaining an abortion.” (Center for Reproductive Rights (2002) Briefing Paper- HIV/AIDS: Reproductive Health on the Line, http://www.crlp.org/pdf/bp_HIV_moline.pdf# search='Thailand%20National%20HIV%2FAIDS %20Policy%20or%20Strategy’ (Date accessed 28/04/06))

5. Is HIV testing mandatory for any specific groups (e.g. pregnant women, military, migrant workers, and sex workers)?

Yes, for key populations such as military recruits, migrants workers and sex workers. “Indeed an ‘AIDS bill’ proposed in 1990 would, among all things, have required all newly discovered cases to be reported within 24 hours and the compulsory testing of ‘high risk’ groups.”


“HIV testing and STD treatment for male teenagers and also for young female sex workers among whom testing is mandatory.”

(http://www.iussp.org/Bangkok2002/S30Tangmunk.pdf#search=Thailand%20sexual%20reproductive%20health%20services’ (Date accessed 06/05/06))

6. Is there any legislation that specifically addresses gender-based violence?

“Women’s Rights in Thailand:

- Respect for women’s equal rights and dignity is well reflected in Thai legislation,
policy and practices. The Constitution clearly stipulates that men and women shall enjoy equal rights. Unjust discrimination and treatment against women are, therefore, prohibited. Women’s roles and contribution are also well recognized in politics, commerce, trade, education, academia, agriculture and the home. This is to guarantee that, in practice, women can express their concerns and initiate changes when and where their rights are not fully respected.

- On the Government side, the Perspective Policies and Planning for the Development of Women (1992-2011) was formulated to address constraints and vulnerabilities encountered by women, and also to identify strategies and actions for the full enjoyment of human rights. Among areas of prime concern, the Plan targets the problems of women and poverty, violence against women, women and health, and women and sexual exploitation. The Plan adopts an integrated, holistic and preventive approach. Therefore, the Plan not only addresses the root causes of problems such as inequality of opportunity or the existence of environments unfavorable to women, but ensures that women are also empowered through programs of education and training, including participation in decision-making.

- On the issue of human trafficking where women and girls are the primary victims, Thailand has for several years undertaken various measures to tackle simultaneously both domestic and cross-border sex trafficking by cooperating in partnership with other governments, international agencies, and non-governmental organizations at national, regional and international levels. The highest level of political commitment to the issue was further injected by proclaiming it as a national agenda.

- As a result of the 2002 bureaucratic reform, the National Commission on Women’s Affairs, formerly under the Office of the Prime Minister, was transformed into the Women’s Affairs and Family Development Bureau, under the Ministry of Social Development and Human Security. The Bureau formulates policies and plans for the promotion and protection of women’s rights. The Bureau also supports activities carried out by government agencies, state enterprises as well as NGOs in the promotion of women development.”

(Ministry of Foreign Affairs, Kingdom of Thailand: Human Rights Promotion, http://www.mfa.go.th/web/24.php (Date accessed 06/05/06))

7. Is there an AIDS Law – or equivalent – that legislates on issues such as confidentiality for testing, diagnosis, treatment, care and support?

Thailand has not enacted an AIDS Law but the Medical Council of Thailand has developed guidelines of HIV/AIDS treatment and care that deals with confidentiality for testing and diagnosis.

http://hivvirus.dmsc.moph.go.th/knowledge.php (Date accessed 01/11/06)

In Thailand, these rights (dignity and rights, the right to health care, the right to information, the right to refuse treatment and privacy rights) are protected by the Constitution of the Kingdom of Thailand (1997; abrogated by the September 19, 2006 military coup), Civil Law, Penal Code Act, Health Professional Law and Consumer Protection Act as follows

1. The right to health care. Clients are entitled to equal access to health care as stipulated in Section 52 of the Constitution of Thailand.

"A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by law.

The public health service by the State shall be provided thoroughly and efficiently and for this purpose, participation by local government organisations and the private sector shall also be promoted insofar as it is possible."
The State shall prevent and eradicate harmful contagious diseases for the public without charge, as provided by law.

HIV patients shall not be declined health service as stipulated in Section 30

“Unjust discrimination against a person on the grounds of the difference in origin, race, language, sex, age, physical or health condition, personal status, economic or social standing, religious belief, education or constitutionally political view, shall not be permitted.

Measures determined by the State in order to eliminate obstacle to or to promote Persons

ability to exercise their rights and liberties as other persons shall not be deemed as unjust discrimination under paragraph three.”

Section 3 Clause 10 of the Medical Ethics (1983) by The Thai Medical Council stipulated that “Medical professionals shall not refuse medical treatment to any individual threatened by illnesses when requested.”

Section 2 of the Announcement of Patient’s Rights

“Patients are entitled to indiscriminate services regardless of economic standing, race, nationality, religion, social standing, political standing, sex, age and physical conditions.”

2. The right to information Patients shall have the right to know and the right to self-determination as stipulated in Section 31 of the Constitution of Thailand.

“A person shall enjoy the right and liberty in his or her life and person.”

Section 3 of the Announcement of Patient’s Rights

“Patients seeking medical service are entitled to receive sufficient and clear information from medical professionals to enable patients to give or refuse consent for treatments, except for the case of emergency.”

3. The right to confidentiality is well recognized since ancient days and as stipulated in Section 34 of the Constitution of Thailand

“A person’s family rights, dignity, reputation or the right of privacy shall be protected.”

Section 323 of the Penal Code Act

“Any individual who has access to other’s confidential information due to his/her duties as a medical physician... and reveal the confidential information shall be punished...”

Section 9 of the regulations on Medical Ethics (1983) of the Thai Medical Council stipulated that

“Medical professionals shall not reveal patients’ confidential information obtained from professional duties without patients’ consent except for cases that are required by law and duties.”

Section 7 of the Announcement of Patient’s Rights

“Patients shall be entitled to strict confidentiality of service, except for patients’ consent and compliance with law.”

“The Thai Medical Council formulated the medical protocol, developed the informed consent form and necessary information for VCT clients as listed in the minutes of the 2/2002 meeting on February 13, 2002 as follows:

1. Physicians shall not refuse treatment on the grounds that the patient is HIV positive.

2. In case of routine medical examinations and medical examinations for job or insurance applications, physicians shall consider the potential benefits and adverse effects on the clients and relevant parties. Throughout the processes of examination, recording and informing; physicians must ensure that the followings are properly implemented:

2.1 Pre-test counseling is compulsory, except for emergency cases. Individual pre-test or group counseling, in case of multiple clients, must be provided. Counselors have to ask clients whether they wish to be informed about the test results.

2.2 Except for emergency cases, clients have to sign the consent form as developed by the Thai Medical Council, or forms containing essential information as provided. Clients have to read and understand “Necessary Information for VCT Clients” as developed by the Thai Medical Council or comprehensive information in simple language. Clients are entitled to ask any question until they are satisfied before
signing their names in the consent form.

2.3 Post-test counseling is compulsory. Informing of test results and post-test counseling must be provided. Informing of test results by telephone or other communication devices shall be prohibited.

2.4 Medical professionals have to ensure confidentiality of the VCT service and do not reveal the test result to other individuals without consent from clients, except for cases that are required by law and duties or necessary cases that must inform relevant health service providers who are at risk. With consent from clients, medical professionals have to notify relevant parties with confidential documents.

2.5 In cases that clients are younger than 18 years old, have not achieved legal status through marriage or are mentally handicapped, unable to understand or make decision in 2.1-2.4; parents or legal representatives of clients shall authorize the VCT services for clients.

3. In cases service personnel or students in the health premise get into contact with clients’ blood or secretions, with potential spread of HIV/AIDS to others and in cases of violation of law, such as rape or assault leading to contact of blood or secretion of the offenders; medical professionals have to urgently inform the necessities of blood test and provide counseling to the blood owners. If the blood or secretion owners do not give consent, medical professionals may conduct the blood test, on the ground that it is an urgent and necessary case.

Clients must review “Necessary Information for VCT Clients” prior to signing the consent form. The content includes

1. Knowledge about HIV/AIDS
2. VCT services
3. Benefits of VCT
4. Potential impacts of VCT
5. VCT clients’ rights

5.1 Except for emergency or essential cases, medical professionals have to explain the test results and their potential impact to VCT clients. VCT can be performed only when clients or their guardians (if clients are <18 years of age) sign the consent forms.

5.2 VCT clients may inquire about the VCT protocol and test results. Medical professionals have to answer clients’ questions and advise clients until they are fully satisfied.

5.3 VCT results are confidential information. Medical professionals have to ensure that the records are treated confidentially. Notification of VCT results to other individuals requires informed consent from VCT clients or clients’ guardians, except for cases that required by law or duties.

5.4 VCT clients may receive VCT services at the health service institution, other health service institutions or anonymous clinics.

5.5 VCT clients may decline the service.


8. Is there any legislation that protects people living with HIV/AIDS, particularly girls and young women, from stigma and discrimination at home and in the workplace?

“Sec. 4 of Chapter I (General provisions) provides for the protection of the human dignity, rights, and liberty of the people. Chapter III (Rights and liberties of the Thai people) deals with the following matters, inter alia: equality and equal protection for all persons before the law, equal rights for men and women, prohibition of discrimination based on, inter alia, sex, age, health condition, or economic standing (Sec. 30); the right to equal access to standard public health services and the right of indigent persons to receive free medical treatment from public health centres, as provided by law, the organization by the State of public health services with the promotion of the participation of local government organizations and the private sector, the duty of the State to prevent and eradicate harmful contagious diseases (Sec. 52); the right of children, youth, and family
members to be protected by the State against violence and unfair treatment, and the
right of children and youth without a guardian to receive care and education from the
State (Sec. 53).”

(World Health Organisation (WHO). Constitution of the Kingdom of Thailand
(adopted 1997), International Digest of Health Legislation http://www3.who.int/idhl-
=IA (Date accessed 28/04/06))

9. Are sex workers legally permitted to organise themselves, for example in unions or support
groups?

Sex work is illegal in Thailand. However, “Although sex work is illegal, the National
Program decided it was more effective to work with those involved than to pursue
enforcement actions that would make sex workers less accessible for prevention
strategies.”

(AIDS Division Bureau of AIDS, TB and STIs Department of Disease Control, Ministry of
Public Health, Thailand, Guide to AIDS Cluster: HIV/AIDS Executive Summary,
http://www.aidsthai.org/aidseth/english/hiv_summary_1.html (Date accessed 06/05/06))

“While not legal in Thailand, the government recognises that sex work takes place and
that it is regulated by a legal framework.”

(Barnett, Tony and Whiteside, Alan (2002) AIDS in the Twenty-First Century: Disease and
Globalization, p. 338)

10. Are harm reduction methods for injecting drug users (such as needle exchange) legal?

From a UNDP 2004 report, “Elsewhere, a smattering of projects – almost all run by NGOs –
have been trying to educate and help injecting drug users avoid HIV infection. One
example is a pilot needle and syringe project that started in the 1990s among the Akha
people in the North. Other examples are the HIV/AIDS Prevention and Care for Hill Tribes
of Northern Thailand and the Mae Chan Harm Reduction projects. The latter providing
needle and syringe exchange services, as well as methadone treatment, in nine hill tribe
villages in Chiang Rai province. The Asian Harm Reduction Network also continues to
produce advocacy materials on HIV and drug use. Generally, the Government has not
been supportive of such projects. Prevention work among injecting drug users, therefore,
remains inadequate with scant coverage. There are recent, promising signs that Thailand
might seize this opportunity. The Minister of Public Health, for example, has reportedly
declared some support for harm reduction activities. In circulation are proposals that the
National Working Group on Harm Reduction (which comprises key individuals and
organizations, including government and UN agencies, as well as the Thai Drug Users
Network) serve as a sub-committee on harm reduction within the National AIDS
Committee. One option might be to draw the Office of Narcotics Control Bureau and
other departments under the Ministry of Justice into Ministry of Public Health-led planning
and implementation of harm reduction activities. These are welcome steps towards a
more comprehensive approach.”

Progress and Challenges, (Thematic MDG Report), pp. 55-6,
http://www.undp.or.th/HIVReport.htm (Date accessed 04/05/06))

From an article titled “Courage in the Face of Death: Thai Drug Users’ Network” on the
Human Rights Watch website: “Drug users have not enjoyed the same recognition in
Thailand. Although an estimated 30 percent of new HIV infections in Thailand by 2005
will be among drug users, the government has never sought to provide services to prevent
HIV in this population. Thailand is one of only a few countries in the world where syringe
exchange—a proven method of preventing blood-borne diseases by allowing drug users
to exchange their used syringes for sterile ones—is unavailable. Thailand has an estimated
100,000 to 250,000 injection drug users of which many are heroin users. Opiate substitution therapy using drugs such as methadone is a central element of HIV prevention for heroin users in most countries. But substitution therapy in Thailand is extremely limited. As of early 2004, only 1 percent of Thai drug users were receiving any HIV prevention services—in a country upon which international praise has been heaped for its national AIDS program. As a result, an estimated 40 to 50 percent of drug users in Thailand are HIV-positive. Very few drug users have access to antiretroviral therapy… TDN’s work has also revitalized Thailand’s National Harm Reduction Task Force, a body representing government, local and national NGOs, and international agencies, with the mandate to review and recommend improvements for drug policy in Thailand. The Task Force is also active in improving the public’s understanding of drug policy issues and developing technical guidelines for opiate substitution and other programs. In response to recent criticisms of the anti-drug crackdown, the Thai government has recently pledged to improve both HIV prevention services for drug users and the availability of humane treatment for drug addiction, which has been virtually nonexistent. TDN’s monitoring capacity and its in-depth understanding of the reality of drug addiction in Thailand make it a key player in ensuring accountability of the government with respect to these pledges.”


“Paisan Suwannawong, director of the Thai Treatment Action Group (TTAG), who spoke from the perspective of a drug user living with HIV, was placed last on an agenda that included Thai Prime Minister Thaksin Shinawatra, United Nations Secretary-General Kofi Annan, and even Miss Universe. As a result of the calculated decision to have Paisan speak last, after most delegates had left the ceremonies, most did not have an opportunity to hear this important address chronicling his life under the Thai crackdown on drug users…."Yet there has been no effective response from the government," he continued. "Even though the Thai government says its current policy is to treat drug users as ‘patients’ not ‘criminals,’ it is still illegal to be a drug user," Paisan told the conference. "There are many harm reduction interventions which have been proven to help IDUs stay free of HIV, including clean needles and methadone. We need those means of prevention in place NOW! And we need access to treatment NOW!"


According to the Thai Drug Users Network Message at the Bangkok HIV/AIDS Conference, their message was to ask the government the following:

"We demand that the Thai government and all countries:
1. Eliminate the policies that promote violence in addressing drug issues. In Thailand, the government must investigate each case of murder or other gross negative consequence following the government’s announcement of its war on drugs.
2. Promote educational campaigns about drugs and drug use that provide comprehensive and factual information. This will result in a well-informed public and not cause drug users to be reviled and discriminated against by society.
3. Rescind any law or policy that violates or leads to the violation of drug users’ human rights, such as mandatory HIV-antibody testing, exclusion from antiretroviral therapy access for HIV-positive drug users, etc.4. Urgently implement programs that aim to reduce the dangers associated with drug use, and provide information to prevent the spread of HIV among drug users. Establish programs to make clean needles and syringes available, which will reduce the spread of HIV and hepatitis among injectors.
5. Cover costs related to prevention, care and treatment for drug users, including rehabilitation, detoxification, and substitution therapy, under the national health care plan.
6. Involve both active and former drug users at all levels to address drug-related problems, including policy development."
7. Clean needles, methadone and ARV treatment.”

http://www.actupny.org/reports/Bangkok/TDUsyringes.html (Date accessed 28/04/06))

Discussion questions:

- Which areas of SRH and HIV/AIDS responses are legislated for?
  Abortion is illegal according to the Thailand Penal code Section 301. (Word Health Organisation (WHO). Thailand Penal code, International Digest of Health Legislation, http://www3.who.int/idhl-rils/frame.cfm?language=english (Date accessed 27/04/06))

  “In Thailand, where abortion is only permitted to preserve the life and health of the pregnant woman, the Medical Council has recommended that a woman’s HIV positive status be recognized as a specific ground for obtaining an abortion.”


- What are the biggest strengths, weaknesses and gaps in legislation in relation to HIV prevention for girls and young women? In Thailand, is action taken if laws are broken (e.g. if a girl is married below the legal age)?

Penal Code:
  “Section 301. Any woman (who) causes abortion for herself, or allows the other person to procure abortion for her, shall be punished with imprisonment not exceeding three years or fine not exceeding six thousand baht, or both.
  Section 302. Whoever procures abortion for a woman with her consent, shall be punished with imprisonment not exceeding five years or fine not exceeding ten thousand baht, or both. If such act causes other grievous bodily harm to the woman also, the offender shall be punished with imprisonment not exceeding seven years or fine not exceeding fourteen thousand baht, or both. If such act causes death to the woman, the offender shall be punished with imprisonment not exceeding ten years and fine not exceeding twenty thousand baht.
  Section 303. Whoever procures abortion for a woman without her consent, shall be punished with imprisonment not exceeding seven years or fine not exceeding fourteen thousand baht, or both. If such act causes other grievous bodily harm to the woman also, the offender shall be punished with imprisonment of one to ten years and fine of two thousand to twenty thousand baht. If such act causes death to the woman, the offender shall be punished with imprisonment of five to twenty years and fine of ten thousand to forty thousand baht.
  Section 304. Whoever attempts to commit the offence according to Section 301 or 302, first paragraph, shall not be punished.
  Section 305. If the offence mentioned in Sections 301 and 302 be committed by a medical practitioner, and (1) it is necessary for the sake of the health of such woman; or (2) the woman is pregnant on account of the commission of the offence as provided in Section 276, 277, 282, 283 or 284, the offender is not guilty.”


- Is there any specific legislation for marginalised and vulnerable groups? If yes, is the legislation supportive or punitive? And what difference does it make to people’s behaviours and risk of HIV infection?
On 16 June 2004, the Royal Thai Government and the State Peace and Development Council (SPDC, Myanmar’s military government) signed a Memorandum of Understanding concerning Burmese migrant workers in Thailand.(18) In a written response to Amnesty International in July 2004, the Thai Government provided an English language version of this agreement. Under Article IX of the Memorandum, terms and conditions of employment should not exceed two years, to be extended up to four years, after which time the migrant worker must return to Myanmar. Article XVIII states that “Workers of both Parties (Myanmar and Thailand) are entitled to wage and other benefits due for local workers based on the principles of non-discrimination and equality of sex, race, and religion.”

Burmese migrant workers generally do not choose to use the Thai public health system, whereby people can receive medical care for 30 baht per visit.(24) Several workers interviewed by Amnesty International said that they did not attempt to use such a scheme because they did not believe that they would receive proper medical care, or because they had experienced discrimination by Thai public health workers. Instead they went to private clinics and paid a much higher fee to receive health care.

Amnesty International is further concerned that both Thai and migrant female workers are frequently dismissed from their jobs if they become pregnant. The organization urges Thai employers not to dismiss pregnant workers and to ensure that female workers do not face discrimination in the workplace. Female migrant workers often do not receive reproductive health care and are particularly vulnerable to unplanned pregnancies and sexually transmitted diseases.

The Royal Thai Government is a state party to the Convention on the Elimination of Discrimination against Women (CEDAW) and is thus obliged not to dismiss female workers on account of marital status; for taking maternity leave; or for becoming pregnant (CEDAW Article 11, 2(a)). Although Thai labour law protects against dismissal of pregnant workers by employers, in December 2004 the Thai Labour Ministry announced that it would deport more than 9,300 pregnant migrant workers, in order to “prevent the problem of stateless children from worsening”.(25) According to reliable sources, in practice both Thai and migrant workers lose their jobs if they become pregnant. In Mae Sot Burmese migrant workers have been dismissed from their jobs and deported to Myanmar because they became pregnant. For example in November 2004 a pregnant migrant worker with two children was deported from Mae Sot to Myawaddy, Myanmar.

http://web.amnesty.org/library/index/ENGASA390012005 (Date accessed 18/11/06)

To what extent are ‘qualitative’ issues – such as confidentiality around HIV testing – covered by legislation?

Details in question no. 7.

How much do girls and young women know about relevant legislation and how it relates to them? Are there any initiatives to raise awareness about certain laws?

The Right to a Healthy Reproductive Life. “Reproductive rights as articulated in the global consensus at ICPD and Beijing include the freedom to decide freely and responsibly if, when and how many children to have, the right to information and access to safe, effective, affordable and acceptable methods of fertility regulation and the right to access health care for safe pregnancy and childbirth. In Thailand, women have become increasingly aware of their reproductive health needs; however, fewer are aware of their reproductive rights. For example, many are yet to be fully empowered, especially in their choice of contraceptive method. By and large in rural health centres, the availability of contraceptive methods tends to be limited to oral pills, injectables and condoms. The 30-baht scheme, while designed to assist the
poor has instead become the determining factor for the kind of contraceptive that is made available and the quality of care provided. In rural health centres, usually only one type of pill tends to be distributed in an attempt on the part of the Government to keep costs low. Should greater choices be in demand, they would only be available at the larger district hospitals. To this end, women’s rights to choice of contraceptives are curtailed. In addition, women tend not to be fully informed about the side effects of contraceptive use. According to studies, in some cases women’s choices have been found to be steered by the health personnel involved in distributing the contraceptives or determined by the method being campaigned by the Government at that time. Women’s rights are also curtailed in the context of abortion, which has been illegal since 1957 following Sections 301-305 of the Penal Code. Abortion is only permissible under instances of rape, assault, incest and if there is a risk of hereditary disease, mental illness or foetal abnormalities. Despite the threat of legal punishment, it is estimated that 200,000 to 300,000 abortions are carried out each year. Concerning reproductive treatments for infertility, ideally women seeking such medical help should be provided as much information as possible. Instead many women have been found not to be inadequately informed about the medical process they are undergoing as well as the chances of success of the treatment. Women’s rights may also be compromised when they are not given adequate counseling and mental and emotional support from medical staff. Many Thai women have little understanding of their rights at the interpersonal level. Contraceptive use, particularly among married couples, is thought to be a woman’s responsibility. They undertake the primary burden of contraceptive choice, the side effects, discomforts, weight gain and other health-associated risks from the use of hormone contraception. Yet they, as with many women across the world, have difficulties in negotiating condom use with men, although this form of contraceptive is the safest choice and has the fewest health risks for women. Thus, although men are seen as initiators of sex, generally women are made to shoulder the responsibility of avoiding pregnancy. To complicate matters, condom use continues to be associated with sex work. However, in circumstances in which married men do not engage in safe sex with SWs, often their wives are also vulnerable to health risks. Hence, there is a need for women to be aware of their sexual rights as individuals for their own protection.” (pp. 37-38) (United Nations Population Fund (UNFPA) (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals, http://www.unfpa.org/upload/lib_pub_file/451_filename_rhwomenthailand.pdf#search=adolescent%20reproductive%20health%20services%20in%20thailand (Date 11/05/06))

• Overall, how is relevant legislation applied in practice? What are the ‘real life’ experiences of girls and young women? What difference does it make to their vulnerability to HIV infection?

"Almost one third of adults living with HIV/AIDS in Thailand are women, and a large proportion of them are women who would appear to be at very low risk of HIV infection. As many as half of new adult infections in Thailand are now occurring among women, most of whom are infected by their husbands or boyfriends. Violence is one of many factors that put women at greater risk of HIV infection. A study in 2000 found that more than 40 percent of Thai women surveyed had been physically and/or sexually abused by a partner. Condom use is almost non-existent in such incidents, and the threat of violence often prevents women from negotiating safe sex. Another risk factor is the customary male expectation that women remain sexually “innocent” and, therefore, also “ignorant” of sexual knowledge (which, by implication, includes knowledge about preventing HIV infection). Unless women and girls are empowered enough to gain and use reproductive and sexual health knowledge, their risks of becoming infected will not diminish. Women also face other challenges posed by HIV/AIDS. When infected, they can encounter severe stigma and discrimination. The burdens of care at both household and community levels are usually borne by women, as the public infrastructure to care for people living with HIV/AIDS is still considered a luxury in most part of the country. These and the other risks and burdens HIV/AIDS imposes on women and girls need to be reflected in more

Sexual Violence Among Thai Adolescents: A Case Study: “A survey of 1,292 male and female secondary school students on issues relating to attitudes towards and experiences of sexual violence revealed interesting results. Most sexual violence offenders were lovers, friends and acquaintances. Female students reported sexual violent acts against their will ranging from verbal abuse, touching and kissing to attempted rape and rape. The survey also found that the proportion of lower secondary female students who survived gender-based violence was greater than upper secondary school female students. It was also found that female students who were more likely to be free from parental control were more likely to be victims of attempted rape or rape. The characteristics of sexual offenders ranged from students who drank regularly to those whose friends often engaged in sexual violent acts themselves. According to the worldview of earlier generations, Thai women were perceived to be the property of men and, hence, this justified man’s violent behaviour towards his wife/lover. 25 percent of male students in the survey agreed that their partners were their property, following cultural norms of preceding generations. Not surprisingly, a much fewer number of female students (12 percent) agreed with this idea.” (p. 26) (United Nations Population Fund (UNFPA) (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals, http://www.unfpa.org/upload/lib_pub_file/451_filename_rhwomenthailand.pdf#search='adolescent%20reproductive%20health%20services%20in%20thailand (Date accessed 11/05/06))

“The number of women approaching crisis centres for help was relatively high. Within the first six months of 2000, the Hotline Foundation provided counselling services on domestic violence and rape to 891 and 131 women respectively. The following year, the Friends of Women Foundation provided services to 869 women on domestic and sexual violence. While reports of physical abuses and rapes have been rising alarmingly in the past decade, it has also been reported that the victims are younger than previously, ranging from 4-15 years of age. In Thailand, studies have found that 15-18 percent of rape victims are left pregnant. Moreover, rape victims have a greater likelihood of using painkillers and sleeping pills than the rest of the population. In addition to suffering physical health problems, victims of gender-based violence are forced to cope with the psychological trauma (both rape trauma syndrome and post-traumatic stress disorder) and emotional humiliation. It is of no surprise that medical costs for treating victims of gender-based violence are about 2.5 times higher than the costs for treating nonvictims. Among efforts that have been introduced to eliminate gender-based violence is the one-stop crisis centre in hospitals for victims of violence. In addition, law enforcers are expected to undergo gender-sensitive training programmes. There have also been a number of community-based activities to prevent gender-based violence. Owing to limited resources, however, crisis centres have been restricted to Bangkok and the immediate surrounding areas. Organizations in the city helping battered women include the Emergency Shelter of the Association for the Promotion of the Status of Women, the Hotline Foundation and the Friends of Women Foundation. Aside from providing counselling on domestic and sexual violence, some of these organizations also provide shelter to victims. The efforts so far, however, have been inadequate for the reasons of lack of funds and the inability on the part of health services and policy makers to view services targeted at gender-based violence victims in a holistic manner. In addition, the Thai Government is in the process of reviewing and drafting a bill facilitated by the advocacy work of the Standing Committee on Women Parliamentarians of the Asian Forum of Parliamentarians on Population and Development (AFPPD). Clearly, this is a reflection of the advocacy role of NGOs propelling the Government’s commitment to addressing gender-based violence.” (pp. 38-39) (United Nations Population Fund (UNFPA)
A study by the Asia Pacific Network of People Living with HIV/AIDS (APN+) found that a quarter of people living with HIV/AIDS in Thailand report being insulted and harassed because of their HIV status. It found that some people with HIV still have to contend with their HIV status being disclosed to family members or neighbours without their consent – in some cases, even by health care workers who should be bound by obligations of confidentiality. In some communities, particularly those in areas less severely affected by the epidemic, attitudes to people with HIV remain ignorant and ill-informed about HIV/AIDS. The study cites examples of people living with HIV/AIDS being shunned by community members, of children being forbidden to play with other children, and even of shopkeepers refusing to serve them. There are also accounts of discrimination against people with HIV in the health system. It was reported that HIV testing occasionally still occurs in hospitals without the informed consent of the patient. Forty percent of people living with HIV/AIDS reported breaches of confidentiality within the health system. Some 56 percent of the people surveyed said they received no pre-test counselling before being tested for HIV and 40 percent received no counselling after being told they had HIV. In the context of limited health resources, many people with HIV felt they were discriminated against indirectly by health care workers who gave priority to other patients. Discrimination against people with HIV in the workplace remains in a major problem. Some people with HIV reported having been dismissed from their jobs once their HIV status became known, being asked to sit separately from other workers or being shifted to less responsible tasks. Often, employers gave other reasons for the discriminatory treatment, making it more difficult to challenge such actions. Many employers in Thailand still require job applicants to test for HIV before employment – maintaining that they have the right to ensure that only "healthy" workers are employed. Lawyers assisting people with HIV say that their clients are fearful of challenging HIV-related discrimination in court because of the loss of privacy this could entail and the worry that it might trigger more victimization. This highlights the extent to which HIV-related discrimination is a reflection of the lack of knowledge about HIV/AIDS. There remains much scope for countering stigma and discrimination experienced by people living with HIV/AIDS, and for shaping a response that upholds the rights and dignity of all those affected by the epidemic.” (p. 73)

Stigma and discrimination continues to undermine the response. Many people living with HIV/AIDS still find themselves routinely hounded and discriminated against. Such discrimination includes being shunned by community members and co-workers, being denied employment or sacked from jobs because of their HIV status, and the breaching of confidentiality within the health system. A public education campaign to defuse stigma and discrimination continues to be a top priority, as does the tightening of confidentiality in the health care system.” (p. 71) (United Nations Development Programme (2004) Thailand’s Response to HIV/AIDS: Progress and Challenges (Thematic MDG Report), sourced from Julic Hamlin 2004, http://www.undp.or.th/documents/HIV_AIDS_FullReport_ENG.pdf (Date accessed 28/04/06))

How do the effects of legislation vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
PREVENTION COMPONENT 2: POLICY PROVISION
(national policies, protocols, guidelines, etc)

Key questions:

11. Does the current National AIDS Plan address the full continuum of HIV/AIDS strategies, including prevention, care, support and treatment?

“Strategy 1: Developing the potential of individuals, families, communities and the broader social environment to prevent and alleviate HIV/AIDS problem
Strategy 2: Establishing health and social welfare services for the prevention and alleviation of HIV/AIDS
Strategy 3: Developing knowledge and research for the prevention and alleviation of HIV/AIDS
Strategy 4: International cooperation for the prevention and alleviation of HIV/AIDS
Strategy 5: Developing a holistic programme management system to integrate the tasks of HIV/AIDS prevention and alleviation”


12. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of girls and young women?

There is no specific mention of girls or young women. However, there is general mention of women and youth, including sex workers. The National HIV/AIDS Plan 2000-2006 does provide for services targeting both women and youth in HIV prevention.


“The Government has tackled the issue of adolescent sexuality through targeted policies and programmes. The policies aimed at reproductive health among adolescents include: (a) the national reproductive health policy, (b) the national youth policy, (c) the national health development plan, and (d) the national AIDS prevention plan. Sex education and life skills education in schools as well as counselling services in schools, hospitals and hotline services have integrated the strategies of increasing knowledge of reproductive health, building skills in problem solving, decision making, and life planning. At the programme level, initiatives taken by the Government are counselling of adolescents and young adults on reproductive health and improving sex education in schools. In spite of the effectiveness of some projects having been questioned, current policy emPHsises raising public awareness about the importance of sex education, fostering positive values in society about teaching sexuality, and promoting sex education in the context of the family, complemented by school health programmes. Computer technology such as the internet has also become important as a conduit for conveying information, promoting health knowledge. Even health columns in the printed and electronic media have targeted health programmes for youth. Telephone hotline services in all public hospitals have similar programmes. For example, programmes reaching out to the Muslims have been introduced with the aim of conveying culturally-sensitive information on human sexuality and reproductive health, as they have been most vehement about voicing their views on parents’ role in sex education rather than having teachers impart knowledge on sex in the classroom. Yet, parents, teachers and service providers continue to feel uncomfortable and less skilled in addressing adolescent sexuality issues.” (United Nations Population Fund (UNFPA) (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards
13. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of marginalized and vulnerable groups, including people who are living with HIV/AIDS?

Yes. Target groups include:

- Young adults in reproductive age group 20-25 years old.
- Young people in and outside of the educational system.
- Groups that are underprivileged and difficult to access such as street children, labourers, the homeless, and prisoners in correctional facilities or juvenile detention centres.
- Narcotic drug users and sex workers.
- Migrant labourers, immigrant labourers and fishermen.

There is mention of providing care for PLWH in the National HIV/AIDS Plan: “To provide access to care and support for at least 80% of the people living with HIV/AIDS and other affected individuals.” (AVERT, HIV/AIDS in Thailand, http://www.avert.org/aidsthai.htm (Date accessed 28/04/06))

“Individuals infected with HIV and people living with HIV/AIDS have the capacity to improve their own health. They are also guaranteed the access to treatment and care under a national health insurance plan.” (National AIDS Prevention and Alleviation Committee (2001) National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006, p. 8)

Targets: 2) “At least eighty percent of persons living with HIV/AIDS and affected individuals will have access to and be receiving appropriate care and support from public, private and community providers of social, economic, educational, and primary health care services.”


Strategy 2: Establishing health and social welfare services for the prevention and alleviation of HIV/AIDS: “Emphasis is given to the development of basic health care, health promotion and social welfare services by enhancing the capabilities of people living with HIV/AIDS to provide their own treatment; by modifying the system of health care for people living with HIV/AIDS to include guarantees of full and fair health care and social welfare for individuals who are affected by HIV/AIDS; and by promoting the capabilities for families and communities to provide assistance and care to people who develop illness or are suffering.”

- Objectives: 1) “To foster administration system for health care and social welfare services that enhance the capabilities of people living with HIV/AIDS and their families and support community participation in the provision of care and assistance.
2) To assure that people living with and affected by HIV/AIDS receive health care support; and to assure that access to basic health care services cannot be discriminated.”
3) To have the public health care and social welfare systems facilitate the prevention and alleviation of HIV/AIDS among members of the general public as well as members of special target groups.”

- Aims: 1) “Capacity-building and support for the role of people with and those affected by HIV/AIDS, community-based organizations, and non-governmental organizations in providing care and assistance to individuals living with and affected by HIV/AIDS. 2) The mandatory provision of proper health care treatment for
HIV/AIDS patients in all hospital facilities with standards of the national health insurance system. 3) Support for the provision of appropriate alternative health care services at facilities in and outside of the formal health care system to provide individuals living with HIV/AIDS with alternative means of care. 4) The provision of social and economic services for people living with HIV/AIDS and their affected family members to improve quality of life and promote economic self-sufficiency in the long-term. 5) The establishment of mechanisms to protect the rights of people living with HIV/AIDS and those affected by the disease. “(National AIDS Prevention and Alleviation Committee (2001) National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006, pp.10-14)

Objectives: “To have families and communities accept, manifest concern for, and live together normally with individuals living with HIV/AIDS.”


Measures for Strategy 1: 2) “Support the establishment of assistance funds for people living with or affected by HIV/AIDS.” 3) “Support community activities that include or involve people living with HIV/AIDS, the members of their families, and others affected by the disease.” (National AIDS Prevention and Alleviation Committee (2001) National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006, p. 13)

Part 4: Basic Strategies – 2.2 “Encourage direct exchanges of knowledge with target groups (young people, people living with HIV/AIDS) in order to foster empathy and develop communication methods that fit the lifestyles of different communities.” (National AIDS Prevention and Alleviation Committee (2001) National Plan for the Prev

Part 4: Strategic Measures:
1. “Encourage the members of target groups, particularly individuals addicted to narcotic substances, foreign sex workers, minority groups, and migrant workers, to change behaviors at risk of HIV infection.
1. Strengthen knowledge and understanding of the sociological and behavioral factors that play a part in causing the at-risk behaviors of target groups.
2. Develop programmes and activities for increasing knowledge and understanding of HIV/AIDS that conform with the surroundings, customs, traditions, beliefs and norms of target groups.
3. Strengthen the capacities of public and private HIV/AIDS workers by supporting studies, activities, and projects that lead to the development of a body of knowledge and strategies for changing the behavior of specific target groups.
4. Employ social measures to promote understanding and sympathy for the problems of target groups such as drug users.
5. Support target group gatherings and activities that reduce the risk of HIV/AIDS infection.
6. Develop and support the participation of target groups in activities for the prevention and alleviation of the HIV/AIDS problem.”


14. Does the National AIDS Plan emphasise confidentiality within HIV/AIDS services?

“The National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006 does not mention confidentiality in HIV/AIDS services. The following language was used:

Under developing counselling and mental health services:
1.1 Modifying the counselling service system at public health service centers to raise quality standard levels.
1.2 Promoting a well-defined structure and system for counseling service work.
1.3 Developing a system for monitoring and evaluation of counseling services.

Under Measure 2: Improve the quality and efficiency of medical services for people living with HIV/AIDS to assure equal access and proper treatment for all patients:

Basic Strategies: 1. Set and assure the attainment of standards for the provision of treatment.

1.1 Develop and establish standard methods for the appropriate treatment of opportunistic infections, prevention of opportunistic infections, and use of anti-viral drugs for hospital facilities at all levels of the health care system.
1.2 Promote and take steps to assure that established standards of care and treatment are adopted.
1.3 Develop mechanisms for monitoring and oversight of care and treatment in health care facilities at all levels in order to assure that standards are being met.”


15. Does the national policy on VCT address the needs of girls and young women?


16. Does the national protocol for antenatal care include an optional HIV test?

“Prevalence rate of HIV infection in pregnant women: The prevalence rate of HIV infection in pregnant women has dramatically decreased since 1995 from 2.3% to 1.04% in 2004. Equally, HIV transmission from mother to child has decreased from 25.5% to 8-9%. The MOPH (Ministry of Public Health) policy on prevention of mother to child HIV transmission (established 1997), encourages health care facilities to provide voluntary counselling and confidential HIV testing to all pregnant women, and to provide antiretroviral drug to HIV positive pregnant women for prevention of mother to child transmission, and replacement feeding to all babies born to HIV infected mothers.” (p. 78)

“Currently 92.2% of pregnant women receive at least 4 antenatal care visits. Most antenatal care is provided in hospitals and/or health centers by medical and health personnel (doctor/nurses/midwives). In government hospitals, antenatal care services are free of charge. Services provided at antenatal clinics include: routine physical examination; voluntary counselling and testing of HIV and Thalassemia; Tetanus Toxoid vaccination; health education, provision of folic acid and iron supplement.” (p. 80)

(WHO (2005) Improving Maternal, Newborn and Child Health in the South-East Asia Region: Thailand, pp78-80, http://w3.whosea.org/LinkFiles/Improving_maternal_newborn_and_child_health_thailand.pdf (Date accessed by 28/04/06))

17. Does the national protocol for antenatal care include a commitment that any girl or young woman testing HIV positive should automatically be offered PMTCT services?

“The prevalence rate of HIV infection in pregnant women has decreased dramatically since 1995 from 2.3% to 1.04% in 2004. Since 1997, the MOPH has established a policy on the prevention of mother-to-child HIV transmission by encouraging health care facilities to provide voluntary counselling and confidential HIV testing to all pregnant women, providing antiretroviral drugs to HIV-positive pregnant women for prevention of mother-
to-child transmission, and by replacement feeding to all babies born from HIV-infected mothers. As a result HIV transmission from mother to child has decreased from 25.5% to 8–9%.” (p. 2)


"Prevalence rate of HIV infection in pregnant women: The prevalence rate of HIV infection in pregnant women has dramatically decreased since 1995 from 2.3% to 1.04% in 2004. Equally, HIV transmission from mother to child has decreased from 25.5% to 8-9%. The MOPH policy on prevention of mother to child HIV transmission (established 1997), encourages health care facilities to provide voluntary counselling and confidential HIV testing to all pregnant women, and to provide antiretroviral drug to HIV positive pregnant women for prevention of mother to child transmission, and replacement feeding to all babies born to HIV infected mothers.” (p. 78)

(WHO (2005) Improving Maternal, Newborn and Child Health in the South-East Asia Region: Thailand, [http://w3.whosea.org/LinkFiles/Improving_maternal_newborn_and_child_health_thailand.pdf](http://w3.whosea.org/LinkFiles/Improving_maternal_newborn_and_child_health_thailand.pdf) (Date accessed by 28/04/06))

"Prevention of Mother-to-Child Transmission of HIV/AIDS: The current national policy guidelines ensure that all pregnant women living with HIV will receive AZT from 28 weeks gestation and during delivery. Every woman will also receive one dose of 200 mg of nevirapine (NVP). The newborn receives a six-week AZT therapy and infant formula for feeding until one year of age. The newborn will also have antibody testing at 12 and 18 months respectively. The evaluation of implementation of the AZT project in 75 provinces showed that 71.4% pregnant women had received AZT and showed good compliance to the drug. In 2000, the number of AIDS cases among children aged 0–4 years from vertical transmission was 547 which had shown a steady declining trend from 1,247 cases in 1997.” (p. 9)


In 2002, “The Government guarantees universal access to services for preventing mother-to-child transmission, and integrates the intervention into the new universal health coverage scheme (the 30 Baht Treat All scheme).”


18. Is there a national policy that protects the rights and needs - including HIV prevention, SRH services, employment opportunities and education - of young women or girls at risk or affected by early marriage?

“Over the last 10 years, additional new reproductive health services have been made available, while existing services have been strengthened. New services include: (a) pilot health care programmes for adolescents, (b) sex education, (c) post abortion care, (d) premarital counselling, (e) counselling on different aspects of women’s health including breastfeeding, (f) prevention of mother-to-child transmission of HIV/AIDS, (g) prevention and treatment of reproductive tract infections, (h) malignancy, (i) infertility, and (j) post reproductive and old age care.”

19. Is HIV prevention within the official national curriculum for both girls and boys?

“There are efforts to integrate HIV/AIDS and sexual health information, in addition to some life skills training, into school curricula...For more than a decade now, schools have been expected to provide students with information about HIV/AIDS in the classroom. For example, the Department of Non-formal Education has integrated HIV/AIDS information into its curriculum and provides life skills to out-of school youth. The Department of Curriculum and Instruction Development, Ministry of Education, has also integrated life skills development into the curriculum. Yet, it is unknown how many education institutions have introduced life skills programming and whether those that did, have sustained the effort. As a consequence, there has been little research to assess the effectiveness of life skills training in achieving behavioural change. Many school administrators and teachers seem less than enthusiastic about incorporating life skills into their work, possibly due to discomfort or a lack of understanding of the concept.”  (p. 48)  

http://www.undp.or.th/documents/HIV_AIDS_FullReport_ENG.pdf (Date accessed 28/04/06))

“...In 2001, the National Youth Bureau, the Office of the Prime Minister formulated a national policy on youth and a long-term plan on children and youth development 2002-2011. The national policy provides directions for the Government in service provision and family and community support for the development of children and youth. The policy statement, however, did not directly address HIV/AIDS although it had implications for the prevention of the disease. For example, the Health and Disease Prevention initiative clearly addresses issues related to HIV/AIDS such as: (a) surveillance of communicable diseases, (b) support directed at schools to become healthy, community environments in order to prevent sexually transmitted diseases, and (c) dissemination of reproductive health knowledge to youths in order to facilitate a deeper understanding of sex education and youth health. Instead HIV/AIDS should have been highlighted in the policy more explicitly since the incidence of the disease is increasing among adolescents. Currently there is a dearth of teaching materials for teachers and youth volunteers or peer educators working at the community level with the exception of the recently launched guidebook on sex. In March 2005, the Ministry of Education launched its first sex education guidebook to be used in a pilot scheme in some 20 to 30 primary and secondary schools. Essentially the Guidebook provides tips on how teachers should educate students on sexuality issues. The guidebook covers six areas – sexual development, interpersonal relationships, prevention of sexual harassment, sexual behaviour, sex-related health issues, and sex within the society and cultural context. As expressed by the Permanent Secretary of the Ministry of Education, the aim of the guidebook is to have teachers form a good grasp of sex and sexuality issues, be openminded and to convey information on sex in a positive light. UNFPA has pledged its support to this initiative and is keen to have the other UN agencies involved in supporting and providing technical assistance to this Ministry of Education project. Should this pilot project be a success, it is planned that the use of the sex education guidebook will be expanded to schools nationwide.”  (pp.30-31) (United Nations Population Fund (UNFPA) (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals,  
http://www.unfpa.org/upload/lib_pub_file/451_filename_rhwomenthailand.pdf#Search='adolescent%20reproductive%20services%20in%20thailand (Date accessed 11/05/06))

20. Is key national data about HIV/AIDS, such as HIV prevalence, routinely disaggregated
by age and gender?

The Thailand Health Profile 1999-2000 disaggregated HIV prevalence by key populations, regions, and age.

(Thailand Ministry of Public Health (2000) Thailand Health Profile, Chapter 5: Epidemiological Transition, http://www.moph.go.th/ops/thealth_44/index_eng.htm (Date accessed 04/05/06))

Discussion questions:

- To what extent are relevant bodies – such as the Ministry of Education, NGO networks, religious organisations, etc – engaged in policy-making around HIV prevention for girls and young women?
- To what extent do those bodies work in partnership or in isolation? What areas of HIV prevention responses (e.g. behaviour change, counselling, treatment, home-based care) have national protocols or guidelines?
- To what extent do those protocols address the needs of girls and young women, including those that are marginalised and vulnerable?
- What does school-based sex education cover? Does it help to build young people’s confidence and skills, as well as knowledge?

Many sex education curricula are available. Some curricula cover self-esteem and life skills development. An example is the “Teenpath” Curriculum that follows the SIECUS Module.

- What does school-based sex education cover? Does it help to build young people’s confidence and skills, as well as knowledge?

Measure 3: “Develop educational programmes, activities, and strategies to improve formal and informal education for people of all ages at all levels of society.”

Basic Strategies

- “Provide administrators with an understanding of the learning process involved in promoting acceptance, support, concern, and behavior to prevent the spread of HIV/AIDS.”
- “Organize activities to build understanding of HIV/AIDS in order to develop an appreciation for the importance of HIV/AIDS prevention work.
- Support the participation of administrators in programme planning, implementation and evaluation.
- Give recognition to administrators who participate in the implementation of HIV/AIDS prevention and alleviation activities.”

“Develop course materials appropriate for the particular social contexts of students at all levels of public and private education that address life skills and healthy behaviors in order to strengthen the process of personality development and promote discipline.”

- “Develop educational processes that place emphasis upon the role of the students and learning from community problems.
- Have educational institutions cooperate with communities to develop life-skills programmes that address local problems through the promotion of healthy behaviors. Encourage members of the community and target groups to work together with instructors and academic planners to develop a curriculum appropriate for the particular social context of the...
• Encourage learning activities that support the programme, such as visits to meet with HIV/AIDS patients, and the development of appropriate skills for living that can be used in everyday life.

• Promote an ongoing process of curriculum review, evaluation, and development so that course materials are relevant and up-to-date.

• Support the integration of HIV/AIDS education into related course content on topics such as narcotics and drug addiction.

• Encourage leadership groups within and outside of educational institutions to participate in exhibitions and other activities to prevent and alleviate the HIV/AIDS problem.

• Build motivation for HIV/AIDS education efforts by arranging competitions and awarding prizes to leadership groups that obtain good results.”

5. “Support and develop work units to provide counseling and advice to young people in order to prevent and alleviate the HIV/AIDS problem.”

5.1 “Develop cooperation among public health offices, schools, and other related work units to provide young people with counseling and advice on HIV/AIDS prevention.

5.2 Develop staff capabilities to provide young people with advice and counseling on HIV/AIDS prevention and alleviation.

5.3 Establish advice and counseling facilities that not only provide appropriate services but also conduct public relations work on behalf of the facility to assure that services are widely utilized.

2. Promote activities that involve the provision of HIV/AIDS advice and counseling by designated individuals at educational facilities, youth health centers, and other appropriate locations.

3. Promote access to counseling services for young people and families.”

“Encourage young people to unite together for the benefit of their communities and society.”

1. “Organize activities that are beneficial for the community as a whole in order to foster appropriate attitudes and social values.

2. Support young people in implementing activities of benefit to the community.

3. Strengthen groups in the community so that they can play a lasting part in the organization of community activities.”


• To what extent do policies help to reduce stigma and discrimination? For example, do they encourage people to stop using derogatory language or ‘blaming’ specific groups for HIV/AIDS?

Part 4: Strategic Measures

“Promote the understanding and cooperation of press and media production personnel in reshaping popular fashions to encourage appropriate changes in sexual values and eliminate fashions that impede the prevention and alleviation of HIV/AIDS.”

Measure 1: Encourage families and communities to accept and live normally together with individuals who have HIV/AIDS.

Basic Strategies:

1. Encourage organizations in the community to work together to provide care for people living with HIV/AIDS.
   1. Use forms of activity that are popular in the community to promote mutual assistance by staging activities that require community members to link up to work for the benefit of the community as a whole.
   2. Encourage community organizations to unite together to address the HIV/AIDS problem by jointly managing prevention, counseling, and hospital treatment programmes and by jointly supporting the establishment of care facilities for people living with HIV/AIDS at primary public health care centers, health stations, temples or other locations in the community.
   3. Develop the capacity of communities to secure support for the implementation activities by having state agencies in the community initiate programmes, such as the establishment of community funds.

2. Encourage teachers, officials, and care providers in community child development centers to understand and adopt appropriate attitudes towards the care of children affected by HIV/AIDS.
   1. Develop initiatives for teachers, child-care providers, and communities that build understand and encourage appropriate attitudes towards HIV/AIDS.
   2. Develop directions and handbooks on caring for children with HIV/AIDS that employ simple language and can be readily understood.
   3. Develop the capacity of child-care providers to give appropriate care to children with HIV/AIDS and children whose lives have been disrupted by the disease.
   4. Support community-run efforts to provide emotional support for children affected by HIV/AIDS.
   5. Develop activities that strengthen the capacity of children affected by HIV/AIDS to resist negative social influences so that they will not be drawn towards lifestyles at risk of HIV/AIDS infection.

3. Strengthen the capacity of communities to understand the economic, social, cultural, and lifestyle dimensions of the HIV/AIDS epidemic and the impact of the HIV/AIDS problem on the community.
   3.1 Conduct public relations campaigns so that people in communities around the country have a proper understanding of HIV/AIDS and its impact on the community.
   3.2 Support the development of community resource volunteers by providing training to existing community public health volunteers, community leaders, and people living with HIV/AIDS.
   3.3 Support ongoing implementation of HIV/AIDS-related activities in communities by village volunteers, young people, people living with HIV/AIDS, and other members of the communities.


- To what extent are different areas of policy provision – such as for HIV/AIDS and antenatal care – integrated or isolated?
Major Components of the PMTCT Program in Thailand: antenatal/intrapartum HIV testing; counseling; short-course ZDV; and formula feeding

Nationally-Supported Mother-Child HIV Prevention Program, Thailand, 1999: VCT for all pregnant women; ZDV for all HIV+ pregnant women from 34 weeks; ZDV for all children born to HIV+ women; infant formula for 12 months to replace breastfeeding; HIV test for infant at 12 months; if +, re-test at 18 months; appropriate care for mothers and children (Voramongkol, Nipunporn (2003) Thailand: Experience of using infant formula for all babies born to HIV positive women, Power Point Presentation, http://www.bpni.org/colloquiumreport/5%20-%20NIPUNPORN%20V.ppt#274,1, Thailand: Experience of using infant formula for all babies born to HIV positive women (Date accessed 04/05/06))

- What policy measures exist in relation to consent, approval and confidentiality? For example, can girls and young women access services such as VCT without having to notify their parents and/or partner? And are they informed of their right to confidentiality?

Details in question no. 7

- Overall, how are relevant policies applied in practice? What are the ‘real life’ experiences of girls and young women? How much do they know about them and how they relate to them? What difference do these policies make to their vulnerability to HIV infection?

The Universal Health Care Scheme requires that patients pay 30 Baht (less than US$ 1) for each time of receiving episode of treatment. Major HIV/AIDS care package consists of: PMTCT; OIs treatment and prophylaxis: provide in all government hospitals; ARV with 3 drugs regimen.

(Chasombat, Sanchai (2002) Ministry of Public Health Thailand - AIDS Division, CDC Department, HIV Treatment and Care in the Thai National Health Care Scheme, from HIV InSite website, http://hivinsite.ucsf.edu/global?page=cr08-th-00 (Date accessed 28/04/06))

- How do the effects of policies vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

PREVENTION COMPONENT 3: AVAILABILITY OF SERVICES

(number of programmes, scale, range, etc)

Key questions:

21. Is there a national database or directory of SRH and HIV/AIDS services for young people?
   A national database or directory of SRH and HIV/AIDS services for young people is not available.

22. How many SRH clinics or outlets are there in the country?
   A report from the Family Planning and Population Division, Dept. of Health, Ministry of Public Health in Thailand, "Based on experiences gained from this project, the relevant

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2 (Refers to the full range of SRH and HIV/AIDS services relevant to girls and young women. These include antenatal care, STI information and treatment, HIV prevention, condoms, VCT and other counseling, positive prevention, treatment of opportunistic infections, care and support, treatment (including ARVs), skills building, economic development, etc.)
research, as well as a recognition of the magnitude of RH problems among Thai adolescents, the Director General of the Department of Health has declared that adolescent-friendly services are the Department’s top priority. He aims to improve the accessibility, availability and quality of counselling and health services for Thai adolescents, with an emphasis on outreach services. To achieve these objectives, the Department of Health will collaborate with health promoting centres, provincial public health offices, provincial hospitals, district hospitals and other relevant governmental and nongovernmental organizations to gain more experience with adolescent-friendly services in various settings. The plan is to establish at least 24 adolescent-friendly corners (“called ‘Friend Corners’”) in the year 2001, and 51 more by the year 2002, at attractive locations such as department stores, youth centres, colleges and universities.”

(Poonkhum, Yupa. Providing Adolescent-Friendly Reproductive Health Services: The Thai Experience, http://www.who.int/reproductive-health/publications/towards_adulthood/40.pdf#search=Thailand%20sexual%20reproductive%20health%20services (Date accessed 05/05/06))

“A notable project is the “Friend’s Corner”, a programme accessible to youth and at affordable costs, was established in almost all the 76 provinces in the country. This project provides a venue in which youth may engage in small informal group discussions and seek consultation on health and sexuality issues. However, evidence suggests that some provincial health departments have had to shut down this programme after finding that it had to allocate more funds toward the 30-baht scheme. In addition, the quality of the service provided is questionable.”


23. At how many service points is VCT available, including for young women and girls?

- From a 2004, UNDP report, Voluntary Counselling and Testing: “Effective voluntary counselling and testing is vital for identifying individuals who can benefit from early treatment, for promoting treatment adherence and bolstering prevention. Unfortunately, there are still difficulties on this front. Voluntary counselling and testing services are available at approximately 1,000 hospitals and clinics across the country. However, the coverage is uneven. According to a survey conducted for UNAIDS in late 2003 people in Bangkok can easily access free or affordable voluntary counselling but less than 50 percent enjoy similar access in rural areas. The survey could not ascertain how many people were actually using voluntary counselling and testing services, though it found that some 12,500 people had accessed services provided by the Thai Red Cross Society in the previous year. Spending on voluntary counseling and testing has increased markedly in 2003 but it accounts for only a fraction (about 2 percent) of total HIV/AIDS expenditure. Concerns have been raised about the counselling and testing components. A review by the World Bank in 2000 concluded that these components were underutilized and raised questions about the overall quality of counselling services. An evaluation of activities for preventing mother-to-child HIV transmission also found that the quality of voluntary counselling and testing services varies across the country. While some hospitals can and do provide systematic and appropriate services (including pre- and posttest counselling), other sites are struggling to do so. Excessive workloads, burnout of staff and inadequate counselling skills are all factors. Of particular worry is the reported lack of privacy and confidentiality for patients. If left unchecked, this fundamentally compromises the benefits of a treatment programme for people living with HIV/AIDS.” (pp. 40-1)

(United Nations Development Programme (2004) Thailand’s Response to...
24. Are male and female condoms available in the country?

From the Thailand Ministry of Public Health, AIDS Cluster website: Condom Promotion Program in Thailand. "The results of the 100% Condom Program and Condom Promotion Program to prevent HIV infection have been satisfied."

1. "100% Condom Program. "During the midst of HIV epidemic among sex workers (SWs), the 100% Condom Program was established to prevent sexual transmission among sexworkers and their clients. The Program was established since 1991 to aggressively response to HIV epidemic. It was expanded throughout the country in a couple of year. At that time, SWs and their clients were at very high risk of HIV infection. In order to interrupt the spread of HIV, an urgent campaign had been launched to encourage consistent condom use between SW and their customers. Up until now, condoms, as subsidized by government, have been distributed to all sex establishments for free. As a result of the program, condom used among SW has been maintained at a level higher than 95%; this has concrete a benefit effect to prevent HIV infection."

2. "Condom Promotion Program. "According to the continuous dynamic movement of sexual behavior, an increasing trend of casual sex has been observed in Thai society. It is essential to revise the plan to enhance the orchestration and congruent evolution of prevention strategies. Consequently, concert efforts in encouraging condom use among casual sexual practices must be conveyed to the general population, particularly those who are at the reproductive age. There are 3 main measures correspondent to promote condom use in general population."

“First by to provide more convenient and accessible outlet of condom by installing condom automatic vending machines in public places. The people are able to buy condom at low price. To support the ongoing, well management measurement is necessary regard to maintain condom use behavior. The second is to enable positive environment for safe sex behavior in Thai society. Awareness of HIV/AIDS among Thai people and to target population, the people at reproductive age has been implemented. And the last measure is to adopt correct and positive attitude to safe sex and to implement sustainable preventive behavior in youth.”

(AIDS Division Bureau of AIDS, TB and STIs Department of Disease Control, Ministry of Public Health, Thailand, Guide to AIDS Cluster: HIV/AIDS Executive Summary, http://www.aidsthai.org/aidsenglish/condom01.html (Date accessed 06/05/06))

From an article titled, "Condom Machine at Schools" in the Bangkok Post: "Despite previous failed attempts by non-governmental organisations, government authorities now seem to be in favour of having condom vending machines installed in public schools and universities. At a recent seminar of Public Health Ministry officials and those attached to the Office of Higher Education Commission, Health Minister Pinit Jarusombat said condom machines could be an effective way of preventing the spread of HIV/AIDS and unwanted teenage pregnancies. His statement was promptly welcomed by Education Minister Chaturon Chaisaeng, who said he did not oppose proper sex education and installation of condom machines in educational institutes. In the past, Thai officials were criticised when they distributed condoms at public places and social functions. Now, the idea has been recognised for helping prevent the spread of HIV/AIDS."


From an article titled, "Chaturon Okay with Condom Machine Plan" in the Bangkok Post:
“The Education Ministry has no objection to the Public Health Ministry's plan to install condom-dispensing machines in schools, said Education Minister Chaturon Chaisaeng yesterday. The scheme had been proposed once before but a fierce outcry from conservatives forced the Public Health Ministry to back down. The plan is being dusted off by health authorities who said it would help contain the spread of HIV/AIDS and other sexually-transmitted diseases among youngsters. Mr Chaturon yesterday said he has no objection to the plan, but suggested that, in light of public sensitivity, schools and universities should have the freedom to decide whether or not to allow condom-dispensing machines on their premises. The institutions which agree to join the project must also work with the Public Health Ministry to organise sex education and HIV/AIDS prevention programmes on their premises, he added. Mr Chaturon said it is imperative that the two ministries work together to systematically promote the right value and perception about sex among the young. "Young people must be made aware of the choice they have and of the proper path they should be taking," he stressed…”


25. Is a free HIV test available to all pregnant girls and young women who wish to have one?

In current practice, voluntary HIV testing is routine for all women starting antenatal care; after receiving information about HIV and other routine antenatal tests, women are encouraged to consent to confidential HIV testing.

http://old.developmentgateway.org/download/125796/Thailand_PMTCT_experience.pdf  (Date accessed 17/11/06))

Antenatal care is covered by the National Universal Health Care (30 Baht scheme).

Thailand’s Public Health Ministry on Wednesday ordered hospitals to stop collecting the nominal 30 baht (US$0.82; € 0.64) it has been charging patients under a universal health care scheme, making treatment free instead.

http://au.health.yahoo.com/061101/40/p/ydhm.html  (Date accessed 17/11/06))

26. At how many service points are PMTCT services (such as nevirapine) available for pregnant girls or young women who are HIV positive?

A study conducted by researchers from the Department of Health, Ministry of Public Health shows the following: “Background: Thailand became the first developing country to launch a national prevention of mother-to-child HIV transmission (PMTCT) program.” “Methods: National policy was established, program plans were developed, counselors were trained, programs services were set up, and a monitoring system initiated as the program was implemented throughout all public hospitals in Thailand (n = 838).” “Results: National policy includes: 1) counseling and HIV testing for all pregnant women, 2) short-course zidovudine (ZDV) for all HIV+ women and their children, and 3) infant formula feeding. Counselor trainings were held in 76 provinces throughout all 12 regions of Thailand. PMTCT activities were established as part of maternal-child health services, and roles and responsibilities were established. Monitoring system data from October 2000 through September 2001 are available for 766 (91%) of public hospitals; 500,167 women gave birth and 97% had received antenatal care (ANC). An HIV test was obtained prior to delivery for 94% of those with ANC and 73% of those without ANC; 5,768 of these women tested HIV+. The HIV prevalence was 1.1% and 5.9% among those with and without ANC, respectively. 77% of HIV+ women with ANC received antenatal ZDV, 88% of infants received ZDV and 81% received infant formula through the program.”

27. At how many service points are harm reduction services for injecting drug users available?

From a UNDP 2004 report, “Elsewhere, a smattering of projects – almost all run by NGOs – have been trying to educate and help injecting drug users avoid HIV infection. One example is a pilot needle and syringe project that started in the 1990s among the Akha people in the North. Other examples are the HIV/AIDS Prevention and Care for Hill Tribes of Northern Thailand and the Mae Chan Harm Reduction projects. The latter providing needle and syringe exchange services, as well as methadone treatment, in nine hill tribe villages in Chiang Rai province. The Asian Harm Reduction Network also continues to produce advocacy materials on HIV and drug use. Generally, the Government has not been supportive of such projects. Prevention work among injecting drug users, therefore, remains inadequate with scant coverage. There are recent, promising signs that Thailand might seize this opportunity. The Minister of Public Health, for example, has reportedly declared some support for harm reduction activities. In circulation are proposals that the National Working Group on Harm Reduction (which comprises key individuals and organizations, including government and UN agencies, as well as the Thai Drug Users Network) serve as a sub-committee on harm reduction within the National AIDS Committee. One option might be to draw the Office of Narcotics Control Bureau and other departments under the Ministry of Justice into Ministry of Public Health-led planning and implementation of harm reduction activities. These are welcome steps towards a more comprehensive approach.”


28. Are there any specific national projects (such as camps, conferences, and training courses) for boys/girls and young people living with HIV/AIDS?

The 10th Thai National AIDS Seminar, July 13-15, is focused on educating teenagers on sexual behavior and HIV/AIDS prevention, said Public Health Minister Suchai Charoenratanakul. About 500 teens are attending the seminar, whose motto is “Our Generation, our decision, our responsibility.” One thousand students from the seminar locations, Suan Dusit Rajabhat University and Suan Sunandha Rajabhat University, will serve as event staff.

According to Suchai, the seminar is addressing teen issues because of their increasingly promiscuous behavior and premature and unprotected sex.

http://www.thebody.com/cdc/news_updates_archive/2005/jul13_05/thailand_teens_aids.html (Date accessed 17/11/06)

29. At how many service points are ARVs available to people living with HIV/AIDS?

From the UNDP 2004 report, “As of 2003, the Ministry of Public Health has been officially committed to ensuring equal access and proper treatment for all people living with HIV/AIDS – including antiretroviral treatment for those who seek it, prevention of opportunistic infections, counselling, home and community-based care. The Ministry set an ambitious initial target of providing antiretroviral treatment for 50,000 people by the end of 2004, in addition to the 20,000 that already have access.” (p. 39)

In 2000, the Ministry of Public Health issued clinical guidelines setting out standard practice for preventing mother-to-child HIV transmission, developed a national policy and launched a national programme based on that policy. By now, AZT was being used in most hospitals in the country. A review of the first year of the programme showed high uptake, and an increasing number of newborns were receiving prophylactic antiretrovirals. Without such efforts it has been estimated that almost 5,000 children each year would have been born HIV-positive by 2003. The national programme is believed to be reducing that number by up to 50 percent.”  (p. 43)

http://www.undp.or.th/HIVReport.htm (Date accessed 04/05/06)

ARVs coverage has expanded to 908 health service institutions in every province. Cumulative enrollment to the ARV program as of 08/06 is 103,861 and 82,340 patients still enroll in the program
http://www.aidsthai.org/arrv03.html (Date accessed 01/11/06)

30. Are there specific positive prevention services, including support groups, for young women and girls living with HIV/AIDS?

“In 2003 the government made an official commitment to ensuring adequate treatment for all people living with HIV, and set targets to improve treatment access. As these plans have been carried out, the third "National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand" (which runs between 2002 and the end of 2006), has worked towards the target of reducing HIV prevalence to less than 1% and providing access to care and support for at least 80% of the people living with HIV and other affected individuals”


“Network of Government Agencies

The HIV/AIDS Prevention and Alleviation Plan involved 10 government ministries, 39 bureaus and three offices having activities related to HIV/AIDS. These agencies worked within their framework and target group. The National Centre for the management of AIDS Prevention and Alleviation was a centre for coordinating work plan, budget plan and for following-up. The activities implemented by these agencies involved campaigning, health education, developing leaders in each group, treatment, care and psychosocial support for people living with HIV/AIDS The budgets to prevent and alleviate HIV/AIDS (pg 10)”


Discussion questions:

- What scale and range of HIV prevention services is available for girls and young women? For example, do programmes go beyond ‘ABC’ strategies? Do programmes cover social issues (e.g. early marriage)?
• To what extent are SRH, HIV/AIDS and broader community services integrated and able/willing to provide referrals to each other? For example, could most SRH clinics refer a girl testing HIV positive to a support group for people living with HIV/AIDS?

By May 2004, however, PLHIV core members were participating in care and support for 7,086 PLHIV (adults and children) receiving ART in 105 public hospitals (19 at provincial level, 86 at district level) and in one woman’s prison.

http://www.who.int/hiv/pub/prev_care/en/thailand.pdf (Date accessed 18/11/06)

• To what extent are HIV prevention services available through ‘non-traditional’ outlets (e.g. religious organisations, youth clubs)?

From the National HIV/AIDS Plan for 2002-2006:
Measure 2: Support Thai society by having religion play a central role in the lives of individuals, families, and the community. Basic Strategies:

1. Support the teaching of religious principles in appropriate contexts as a means of promoting positive lifestyles.
   1.1 Support the participation of religious leaders in the instruction of moral principles at educational institutions.
   1.2 Encourage educational institutions everywhere to have teachers and students regularly engage in religious activities such as prayer and meditation as well as participate in ceremonies on important religious holidays.
   1.3 Modify course curriculums for the study of Buddhism, Islam, and Christianity to include information on the dangers of HIV/AIDS.
   1.4 Support student participation in religious activities by releasing them from other obligations in order to attend.
   1.5 Support the organization of youth morality camps and similar activities that will help young people to develop morals and ethics.
   1.6 Make sustained efforts to promote positive family living in order to foster warm and happy families.

2. Encourage religious institutions to work within the scope of their duties to prevent and alleviate the HIV/AIDS problem.
   2.1 Promote understanding of the HIV/AIDS problem among religious leaders and individuals involved in religious instruction.
   2.2 Encourage religious leaders to find opportunities to promote and incorporate HIV/AIDS education in sermons and other religious activities.
   2.3 Support the efforts and activities of religious leaders and instructors to prevent and alleviate the HIV/AIDS problem.
   2.4 Develop a network of religious activity groups and incorporate HIV/AIDS education into group activities.

3. Support religious activities that promote faith in morality and ethics, and buttress attitudes that place emphasis upon the spiritual as opposed to the material.
   3.1 Support religious activities and customs that develop morals and ethics, such as the ordination of student novices during hot-season school breaks.
   3.2 Support HIV/AIDS education training for Buddhist monks in advance of their return to secular life.
   3.3 Support camp activities for students of various ages to develop the morals of young people.
   3.4 Support moral training activities, daily observance of religious practices, and
participation in activities on important religious holidays.

4. Develop the capacity of ecclesiastical staff to use religion as a vehicle for building social immunity to HIV/AIDS.

Measure 3: Give local entertainment establishments and related individuals an important place in the implementation of activities to prevent the spread of HIV/AIDS in their communities. Basic Strategies:

Support activities that build awareness of both the HIV/AIDS problem and the importance of adopting measures to prevent the spread of HIV/AIDS in entertainment establishments.

1. Arrange HIV/AIDS information training for establishment owners.
2. Support the participation of entertainment establishment owners in planning community HIV/AIDS prevention and alleviation measures.
3. Support the participation of entertainment establishment owners in arranging activities for communities, such as "HIV/AIDS awareness day" campaigns and the creation of "HIV/AIDS information corners" in entertainment venues.
4. Encourage entertainment establishment owners to form groups or networks for cooperating in undertaking HIV/AIDS prevention activities.
5. Build motivation by praising service establishments that cooperate in undertaking activities to prevent the spread of HIV/AIDS in their establishments.

2. Encourage establishment owners to implement measures to promote the use of condoms in their businesses.

1. Build the condom service networks of entertainment establishments to support a policy of promoting condom use.
2. Have establishment owners support condom use by service workers to prevent HIV infection.
3. Support establishment owner participation in promoting service workers’ quality of life through such means as regular medical examinations.
4. Support activities that assist in developing the capacities of service workers so that they are capable of protecting themselves from HIV infection. Support strict enforcement of the law with entertainment establishments and provocative media sources that contribute to the spread of HIV.

4. Promote the use of social measures to control, direct, and oversee businesses that cause people to adopt lifestyles that place them at risk of contracting HIV/AIDS.”


- **Are there community programmes on gender awareness/dialogue for girls/boys and young women/men? Do they explore power differences and social ‘norms’ for sexual behaviour? Is there mentoring, peer support and economic development that targets females?**

From the National HIV/AIDS Plan for 2002-2006: Part 4: Strategic Measures:

4.2.1 “Reshape popular values to promote awareness of the deeper worth of men and women and the importance of responsible sexual relations.”

“Encourage all parties to recognize the role of women and support the participation of women in planning, decision-making and problem solving in public as well as private contexts.”

4.3.1 “Promote appropriate sexual values, gender equality, and sexual relationships that are responsible and safe.”

4.3.2 “Promote activities that develop the capabilities of women at all levels.”
Support and provide women with opportunities to take part in decision making and problem solving, within their communities as well as within their homes.”


- How available is prevention information and support for girls and young women living with HIV/AIDS?
- How available are HIV prevention ‘commodities’ (e.g. condoms)? How are they distributed?
- How much do girls and young women know about the availability of services, such as where to get condoms or ARVs?
- Overall, what does the availability of HIV prevention services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference do these services make to their vulnerability to HIV infection?
- How do the effects of availability vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

**PREVENTION COMPONENT 4: ACCESSIBILITY OF SERVICES**

(location, user-friendliness, affordability, etc)

**Key questions:**

31. Are all government HIV prevention and SRH services equally open to married and unmarried girls and young women?

“From a UNFPA 2005 report: “As society views sexually active unmarried females differently from males, obstacles in accessing health care services by adolescent females continue to persist at various levels. First, unmarried females do not have easy access to the reproductive health care services as the current services available are largely targeted at the married population. The fact that many young women are not eligible to obtain services at the Family Health Division but only the School Health Division compounds the problem. School health services, however, consisting of only general health care and vaccination programmes, tend to be inadequate because they do not provide counselling and contraceptive services. This exclusive provision of reproductive health services narrowly targeted at the married population stems from cultural injunctions that disapprove of women engaging in premarital sex. Second, young women are afraid to seek contraception as this would reveal that they are sexually active and, hence, may be stigmatised. Even if reproductive health services were made available to unmarried women, this group is less likely to take advantage of such services because of the double standards imposed upon men and women regarding their sexual behaviour in society. In a study conducted in 2001, health personnel from public hospitals reported that young, unmarried clients comprised mostly of young males and SWs but seldom were there female adolescents even though services were made available for this group. While young men freely sought treatment for STIs in public health facilities and are not condemned or stigmatised, unmarried women were less likely to access proper information and professional health care services. As such, contraceptive services for adolescents and particularly unmarried women have been regarded as inappropriate and unnecessary despite the recognition of problems arising from unprotected sex among young people. While clinics for adolescents or peer counselling programmes in vocational colleges have been established in the past, the
provision of such services have been short-term. Third, lack of confidentiality, judgmental parents, teachers and service providers, lack of affordability and inconvenient clinic hours are some of the barriers that have prevented adolescents from seeking reproductive health services. Moreover, girls tend to shy away from seeking advice from parents, teachers and service providers because of the sexual double standards that prohibit girls from engaging in premarital sex unlike boys. Since adolescent females are aware of the obstacles they would face when seeking health services in government hospitals, most resort to self-treatment, advice from friends or turn to drugstore proprietors, although these sources of help may not be effective. In contrast to government hospitals, reproductive health providers at NGO facilities have met with greater success possibly as these services tend to allow for confidentiality and even anonymity. Their adolescent-friendly programmes have included telephone counselling, outreach programmes and emergency services for young girls in crisis.”


From a 2005 UNFPA report: “A notable project is the “Friend’s Corner”, a programme accessible to youth and at affordable costs, was established in almost all the 76 provinces in the country. This project provides a venue in which youth may engage in small informal group discussions and seek consultation on health and sexuality issues. However, evidence suggests that some provincial health departments have had to shut down this programme after finding that it had to allocate more funds toward the 30-baht scheme. In addition, the quality of the service provided is questionable.”


32. Are all government HIV prevention and SRH services equally open to girls and young women who are HIV positive, negative or untested?

“Lack of Access to Health services

There are approximately one million ethnic highlanders living in Thailand, half of whom lack citizenship. As a result of their statelessness, the women who comprise half of this indigenous population (which includes hill tribes and Burness refugee are women) are unable to access any and all state services, including health care. Furthermore, women and girls in these migrant and hill tribe population are at elevated risk of contracting HIV/AIDS as a result of lack of protection of their human rights, and vulnerability to discrimination, trafficking, labour exploitation, denial of health care, sexual exploitation and gender-based violence. this population’s lack of access to reproductive health care services, in particular HIV prevention education and condoms, has resulted in disproportionately high rates of HIV/AIDS infection. One provincial hospital even reported that 14% of it’s patients were infected with HIV/AIDS”

(Centre for Reproductive Rights January 19, 2006, The committee on Elimination of discrimination against Women, Re: Supplementary information on Kingdom of Thailand scheduled for review during the CEDAW’s 34th session, http://www.crlp.org/pdf/ltr_shadow_Thailand_Cedaw.pdf (Date accessed 30/10/06))

From a report titled, Reproductive Health of Women in Thailand: Progress and
Challenges Towards Attainment of International Development Goals, “Access to reproductive and sexual health services including family planning have improved in Thailand over the last decade. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that “All Thai citizens at all ages must have good reproductive health throughout their entire lives”. (14) (United Nations Population Fund, UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals,

http://www.unfpa.org/upload/lib_pub_file/451_filename_rhwomenthailand.pdf#search.Progress%20and%20challenges%20in%20women%27s%20reproductive%20health (Date accessed 11/05/06)

33. Are VCT services free for girls and young women?

From a 2004, UNDP report, Voluntary Counselling and Testing: “Effective voluntary counselling and testing is vital for identifying individuals who can benefit from early treatment, for promoting treatment adherence and bolstering prevention. Unfortunately, there are still difficulties on this front. Voluntary counselling and testing services are available at approximately 1,000 hospitals and clinics across the country. However, the coverage is uneven. According to a survey conducted for UNAIDS in late 2003 people in Bangkok can easily access free or affordable voluntary counselling but less than 50 percent enjoy similar access in rural areas. The survey could not ascertain how many people were actually using voluntary counselling and testing services, though it found that some 12,500 people had accessed services provided by the Thai Red Cross Society in the previous year. Spending on voluntary counseling and testing has increased markedly in 2003 but it accounts for only a fraction (about 2 percent) of total HIV/AIDS expenditure. Concerns have been raised about the counselling and testing components. A review by the World Bank in 2000 concluded that these components were underutilized and raised questions about the overall quality of counselling services. An evaluation of activities for preventing mother-to-child HIV transmission also found that the quality of voluntary counselling and testing services varies across the country. While some hospitals can and do provide systematic and appropriate services (including pre- and posttest counselling), other sites are struggling to do so. Excessive workloads, burnout of staff and inadequate counselling skills are all factors. Of particular worry is the reported lack of privacy and confidentiality for patients. If left unchecked, this fundamentally compromises the benefits of a treatment programme for people living with HIV/AIDS.” (pp. 40-1)


34. Are approximately equal numbers of females and males accessing VCT services?

The database on VCT services in Thailand is unavailable due to the health care system reform. Responsibility of treatment and care of HIV/AIDS was transferred to the National Health Security Office (NHSO) on October 1, 2005. NHSO plans to launch an on-line health service database system in April 2007.

35. Are STI treatment and counselling services free for all girls and young women?

No, according to this project. From a 2005 UNFPA report: “A notable project is the "Friend’s Corner", a programme accessible to youth and at affordable costs, was established in almost all the 76 provinces in the country. This project provides a venue in which youth may engage in small informal group discussions and seek consultation on health and sexuality issues. However, evidence suggests that some provincial health departments have had to shut down this programme after finding that it had to allocate more funds toward the 30-baht scheme. In addition, the quality of the service provided is questionable.” (United Nations Population Fund (UNFPA) (2005) Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals, http://www.unfpa.org/upload/lib_pub_file/451_filename_rhwomenthailand.pdf#search='Progress%20and%20challenges%20in%20women%27s%20reproductive%20health' (Date accessed 11/05/06))
36. Are condoms free for girls and young women within government SRH services?

From the Thailand and Family Planning: An Overview Report: “Family planning services are extensive. Methods of contraception have been provided conveniently, largely free of charge, without incentives, and with controls for quality and safety.”

(World Health Organization, Department of Family and Community Health, Regional Office for South-East Asia, Thailand and Family Planning: An Overview Report, http://w3.who.sea.org/LinkFiles/Family_Planning_Fact_Sheets_thailand.pdf, (Date accessed 11/05/06))

From the Thailand Ministry of Public Health, AIDS Cluster: Condom Promotion Program in Thailand. “The results of the 100% Condom Program and Condom Promotion Program to prevent HIV infection have been satisfied.”

100% Condom Program. “During the midst of HIV epidemic among sex workers (SWs), the 100% Condom Program was established to prevent sexual transmission among sex workers and their clients. The Program was established since 1991 to aggressively response to HIV epidemic. It was expanded throughout the country in a couple of year. At that time, SWs and their clients were at very high risk of HIV infection. In order to interrupt the spread of HIV, an urgent campaign had been launched to encourage consistent condom use between SW and their customers. Up until now, condoms, as subsidized by government, have been distributed to all sex establishments for free. As a result of the program, condom used among SW has been maintained at a level higher than 95%; this has concrete a benefit effect to prevent HIV infection.”

Condom Promotion Program. “According to the continuous dynamic movement of sexual behavior, an increasing trend of casual sex has been observed in Thai society. It is essential to revise the plan to enhance the orchestration and congruent evolution of prevention strategies. Consequently, concert efforts in encouraging condom use among casual sexual practices must be conveyed to the general population, particularly those who are at the reproductive age. There are 3 main measures correspondent to promote condom use in general population.”

“First by to provide more convenient and accessible outlet of condom by installing condom automatic vending machines in public places. The people are able to buy condom at low price. To support the ongoing, well management measurement is necessary regard to maintain condom use behavior. The second is to enable positive environment for safe sex behavior in Thai society. Awareness of HIV/AIDS among Thai people and to target population, the people at reproductive age has been implemented. And the last measure is to adopt correct and positive attitude to safe sex and to implement sustainable preventive behavior in youth.”

(AIDS Division Bureau of AIDS, TB and STIs Department of Disease Control, Ministry of Public Health, Thailand, Guide to AIDS Cluster: HIV/AIDS Executive Summary, http://www.aidsthai.org/aidsenglish/condom01.html (Date accessed 06/05/06))

“The volume of condoms the Government distributed free of charge declined dramatically after the economic crisis of 1997-1998, due to a combination of budget cuts and concerns that condoms were in oversupply. A social marketing approach was subsequently adopted. Interestingly, studies found no evidence that this affected the rate of condom use in sex work. By the last 1990s, almost 70 percent of condoms were being privately purchased.”

From an article titled, "Condom Machine at Schools" in the Bangkok Post: "Despite previous failed attempts by non-governmental organisations, government authorities now seem to be in favour of having condom vending machines installed in public schools and universities. At a recent seminar of Public Health Ministry officials and those attached to the Office of Higher Education Commission, Health Minister Pinit Jarusombat said condom machines could be an effective way of preventing the spread of HIV/AIDS and unwanted teenage pregnancies. His statement was promptly welcomed by Education Minister Chaturon Chaisaeng, who said he did not oppose proper sex education and installation of condom machines in educational institutes. In the past, Thai officials were criticised when they distributed condoms at public places and social functions. Now, the idea has been recognised for helping prevent the spread of HIV/AIDS.”


From an article titled, “Chaturon Okay with Condom Machine Plan” in the Bangkok Post: “The Education Ministry has no objection to the Public Health Ministry’s plan to install condom-dispensing machines in schools, said Education Minister Chaturon Chaisaeng yesterday. The scheme had been proposed once before but a fierce outcry from conservatives forced the Public Health Ministry to back down. The plan is being dusted off by health authorities who said it would help contain the spread of HIV/AIDS and other sexually-transmitted diseases among youngsters. Mr Chaturon yesterday said he has no objection to the plan, but suggested that, in light of public sensitivity, schools and universities should have the freedom to decide whether or not to allow condom-dispensing machines on their premises. The institutions which agree to join the project must also work with the Public Health Ministry to organise sex education and HIV/AIDS prevention programmes on their premises, he added. Mr Chaturon said it is imperative that the two ministries work together to systematically promote the right value and perception about sex among the young.

“Young people must be made aware of the choice they have and of the proper path they should be taking,” he stressed…” (Bunnag, Sirikul (2006) Chaturon Okay with Condom Machine Plan, Bangkok Post, http://www.aegis.com/news/bp/2006/BP060106.html (Date accessed 06/05/06))

37. Are ARVs free for all girls and young women living with HIV/AIDS?

Annex 3 Estimated number of people receiving antiviral therapy, people needing antiretroviral therapy, percentage coverage and number of antiviral therapy sites in low- and middle-income countries.

Estimated number of people receiving antiviral therapy = 135,000
Reported number of people receiving antiviral therapy, January-December 2005 = 61,000
Average monthly increase in the number of people living antiretroviral therapy, January-December, 2005 = 1227
Antiretroviral therapy coverage December 2005 = 60%


Exceptional progress has been made by the Royal Thai Government (RTG) in scaling up access to treatment in Thailand, achieving the national treatment target of delivering antiretroviral treatment (ART) to more than 50% of those in need within 2001 to 2004. As of February, some 60,000 PHIVs in Thailand had received ART. Expanding ART coverage has been achieved rapidly through high political commitment and harnessing the full
potential of the strong public health system. Subsequently, in July 2004, the RTG declared its commitment towards the ultimate goal of universal access to ART.


From collaborative effort and continuous pressure from TNP+, the National Health Security Office announced on October 1, 2005 that ARVs was covered by the National Health Security Scheme. However, TNP+ has to work continuously on this issue to ensure that every PLHIV is entitled to ARV.

http://www.thaiplus.net/page3.html (Date accessed 15/11/06)

Thailand's Public Health Ministry on Wednesday ordered hospitals to stop collecting the nominal 30 baht (US$0.82; €0.64) it has been charging patients under a universal health care scheme, making treatment free instead.

http://au.health.yahoo.com/061101/40/p/ydhm.html (Date accessed 17/11/06)

38. Are issues relating to HIV/AIDS stigma and discrimination included in the training curriculum of key health care workers at SRH clinics?

Yes. Review of Counseling in Thailand (Unpublished data by Duangchan A. and Kantamal, L. indicated that from 1991-2002 at least 25 training course on SRH and HIV/AIDS were conducted; five national conference on HIV/AIDS Counselling were organized; ACCTar a technical service center was established in Chiangmai and Albion Street Collaborative center was established in Bumradnaradul Hospital to develop HIV/AIDS counselling curricula, provide technical training to SRH and HIV/AIDS health care workers. In 2000-2001 WHO/SEARO organized 2 intercountry training programs for member countries in Thailand.

Department of Mental Health developed indicators of HIV?AIDS counseling services. Department of Mental Health. 1998. Indicators of HIV/AIDS counseling services. 58p

Are issues relating to young people included in the training curriculum of key health care workers at SRH clinics?

“Programmatic recommendations are clear. Findings suggest, as other studies have, the need for training and sensitisation of providers who serve unmarried youth, and for more stringent recruitment practices that ensure that those providing services to unmarried youth do indeed have positive attitudes and necessary skills to build rapport with young clients.” “Finally, it is essential that policy and programme level ambiguities are addressed, that providers are given clear guidelines on services for unmarried youth and reporting requirements are streamlined to accommodate young people’s needs.”

(Tangmunkongvorakul, Arunrat, Sangworn Sombatmai, Chonticha Ruangyuthikarn, Sobhon Bopodi (2002), Providers’ Perspectives in Addressing Adolescent Sexual and Reproductive Health Needs in Northern Thailand, pp.11-12, http://www.iussp.org/Bangkok2002/S30Tangmunk.pdf#search='Thailand%20sexual%20reproductive%20services' (Date accessed 06/05/06))

Results of the youth friendly service pilot project as reported in the reproductive health division annual report 2005 include

1. Assessment report of “Youth friendly service” 200 copies disseminated to health centers, provincial health offices and relevant networks.
2. A training manual for adolescent health service providers was published. Content includes
   Part 1. Planning and preparation
   Part 2. Curriculum which covers definition of youth, relevant issues in SRH, youth friendly
service, STIs and youth, antenatal care and delivery for youth, unsafe pregnancy termination and contraception in youth

3. Guidelines for setting up youth friendly services in health centres; community general and regional hospitals; and health centres under the Department of Health. The one stop service for youth provide counseling service, other SRH service and case referral.

4. Lessons learned from successful “Friends’ corners” at Chiangmai University and Surin Provincial Health Office.

http://rh.anamai.moph.go.th/plan/report48.doc  (Date accessed 15/11/06)

40. Are there any government media campaigns (e.g. television s and newspaper advertise)ments) about HIV/AIDS that specifically address prevention among girls ad young women?

The Open-minded Talk for Safe Sex Project, a collaborative project of Bureau of AIDS, TB and STIs, TBCA, TNCA and PATH, funded by the Global Fund produced television spots, radio spots and print ads to promote sex communication within the Thai families. One television spot focused on a girl and her mother.

http://www.teenpath.net/openmind/info.asp?ID=5  (Date accessed 15/11/06)
http://www.teenpath.net/openmind/info.asp?ID=7  (Date accessed 15/11/06)

Discussion questions:

- Are HIV prevention services truly accessible to girls and young women, including those that are marginalised and vulnerable? For example, are they: safe? affordable? reachable by public transport? in appropriate languages? non-stigmatising? open at convenient times?

From a report titled “Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals”:

“Access to reproductive and sexual health services including family planning have improved in Thailand over the last decade. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that “All Thai citizens at all ages must have good reproductive health throughout their entire lives”. While a few of the services were already available prior to 1994, Thai government’s commitment to the ICPD, prompted these services to be more fully integrated into the new health care infrastructure. Over the last 10 years, additional new reproductive health services have been made available, while existing services have been strengthened. New services include: (a) pilot health care programmes for adolescents, (b) sex education, (c) postabortion care, (d) premarital counselling, (e) counselling on different aspects of women’s health including breastfeeding, (f) prevention of mother-to-child transmission of HIV/AIDS, (g) prevention and treatment of reproductive tract infections, (h) malignancy, (i) infertility, and (j) postreproductive and old age care.” (pp.14-15)

“The Ninth Development Plan (2002-2006) emPLHIVsizes strategies to promote reproductive health especially among adolescents, to facilitate gender equality in education, to empower women, and to meet the needs of a growing number of older persons in the population. The Plan also calls for improving access to basic services, including reproductive health and family planning services, among the poor and in regions recording lower health indicators compared with the national average.” (p. 15)

“The Government has tackled the issue of adolescent sexuality through targeted policies and programmes. The policies aimed at reproductive health among adolescents include: (a) the national reproductive health policy, (b) the national youth policy, (c) the national health development plan, and (d) the national AIDS prevention plan. Sex education and life skills education in schools as well as counselling services in
schools, hospitals and hotline services have integrated the strategies of increasing knowledge of reproductive health, building skills in problem solving, decision making, and life planning. At the programme level, initiatives taken by the Government are counselling of adolescents and young adults on reproductive health and improving sex education in schools. In spite of the effectiveness of some projects having been questioned, current policy emphasises raising public awareness about the importance of sex education, fostering positive values in society about teaching sexuality, and promoting sex education in the context of the family, complemented by school health programmes. Computer technology such as the internet has also become important as a conduit for conveying information, promoting health knowledge. Even health columns in the printed and electronic media have targeted health programmes for youth. Telephone hotline services in all public hospitals have similar programmes. For example, programmes reaching out to the Muslims have been introduced with the aim of conveying culturally-sensitive information on human sexuality and reproductive health, as they have been most vehement about voicing their views on parents’ role in sex education rather than having teachers impart knowledge on sex in the classroom. Yet, parents, teachers and service providers continue to feel uncomfortable and less skilled in addressing adolescent sexuality issues.” (pp. 26-27)

“Contraceptive Access and Use: Common Barriers”: As society views sexually active unmarried females differently from males, obstacles in accessing health care services by adolescent females continue to persist at various levels. First, unmarried females do not have easy access to the reproductive health care services as the current services available are largely targeted at the married population. The fact that many young women are not eligible to obtain services at the Family Health Division but only the School Health Division compounds the problem. School health services, however, consisting of only general health care and vaccination programmes, tend to be inadequate because they do not provide counselling and contraceptive services. This exclusive provision of reproductive health services narrowly targeted at the married population stems from cultural injunctions that disapprove of women engaging in premarital sex. Second, young women are afraid to seek contraception as this would reveal that they are sexually active and, hence, may be stigmatised. Even if reproductive health services were made available to unmarried women, this group is less likely to take advantage of such services because of the double standards imposed upon men and women regarding their sexual behaviour in society. In a study conducted in 2001, health personnel from public hospitals reported that young, unmarried clients comprised mostly of young males and SWs but seldom were there female adolescents even though services were made available for this group. While young men freely sought treatment for STIs in public health facilities and are not condemned or stigmatised, unmarried women were less likely to access proper information and professional health care services. As such, contraceptive services for adolescents and particularly unmarried women have been regarded as inappropriate and unnecessary despite the recognition of problems arising from unprotected sex among young people. While clinics for adolescents or peer counselling programmes in vocational colleges have been established in the past, the provision of such services have been short-term. Third, lack of confidentiality, judgmental parents, teachers and service providers, lack of affordability and inconvenient clinic hours are some of the barriers that have prevented adolescents from seeking reproductive health services. Moreover, girls tend to shy away from seeking advice from parents, teachers and service providers because of the sexual double standards that prohibit girls from engaging in premarital sex unlike boys. Since adolescent females are aware of the obstacles they would face when seeking health services in government hospitals, most resort to self-treatment, advice from friends or turn to drugstore proprietors, although these sources of help may not be effective. In contrast to government hospitals, reproductive health providers at NGO facilities have met with greater success possibly as these services tend to allow for confidentiality and even anonymity. Their adolescent-friendly programmes have included telephone counselling, outreach programmes and emergency services for young girls in crisis.” (pp.27-28)
From a paper titled, Providers’ Perspectives in Addressing Adolescent Sexual and Reproductive Health Needs in Northern Thailand: “This paper has explored the perspectives of a range of providers on the difficulties encountered in providing sexual and reproductive health services to unmarried youth in a setting in northern Thailand, and has sought their recommendations on ways of promoting young people’s access to services. Findings suggest that providers are aware that unmarried youth are increasingly exposed to risky sexual behaviour, yet face an array of obstacles in acquiring appropriate information and services in an acceptable way. In some instances – notably in describing the nature of the provider-client interaction – barriers expressed by providers complements those articulated by young people. And finally in other instances, obstacles reported by providers go beyond those articulated by young people, providing insights into other policy and programme, and facility level barriers that inhibit the ability of providers to address the needs of unmarried youth in a youth-friendly way…The sample comprised a total of 44 health care providers drawn from 15 diverse sexual health settings providing services to unmarried youth, including government and non-government family planning centres, provincial health offices, subdistrict health centres, STD clinics, and anonymous HIV testing clinics located in Chiang Mai and Lamphun area. Between two and five clinic staff were interviewed at each site, including doctors, staff nurses, health educators, and social workers; a criterion for selection was their involvement in delivering services to adolescents.” “In describing many facility level barriers, providers echoed young people’s concerns. Facility level obstacles, including the lack of privacy in clinic settings, undue waiting times and inconvenient clinic hours for example were acknowledged by providers – as by young people – as factors inhibiting their ability to serve unmarried youth.” “As far as provider-client interaction is concerned, the perspectives of providers show an interesting corollary to those expressed by unmarried youth. The ambivalence about providing services to unmarried youth who are sexually active is evident. Not only do some providers express negative attitudes, but there is a tendency to perceive young clients in a negative light, a lack of understanding of the difficulties young clients may encounter in expressing their needs and admitting their sexual activity status, and the range of fears they may have whether of violation of confidentiality or ability to pay for needed services. Providers also expressed some unwillingness to accommodate the additional time requirements of young people who sought counselling or other services, and some frustration about young people’s unwillingness to reveal their sexual histories and follow up on prescribed treatment.”

“Finally, in describing policy and programme level obstacles, providers added a third dimension of barriers to services for young people that have not been articulated in studies of young people. Providers pointed to the lack of clarity and direction at policy and programme level with regard to services for unmarried youth. Such issues as lack of clarity in whether oral contraceptives could be issued to the unmarried, lengthy reporting procedures, content of reporting that required complete details of clients including names and addresses, poor referral facilities, and lack of co-ordination between various hospital departments and between facility and outreach programmes were described as factors that inhibited them from providing youth friendly services.”

“In general, however, providers favoured special youth friendly service initiatives, some of which have recently been established in Thailand.”

“Programmatic recommendations are clear. Findings suggest, as other studies have, the need for training and sensitisation of providers who serve unmarried youth, and for more stringent recruitment practices that ensure that those providing services to unmarried youth do indeed have positive attitudes and necessary skills to build rapport with young
clients.”

“Also, as other studies have suggested, facilities offering services to youth need to be reoriented to be more inviting to young clients. While convenient timings, privacy in waiting areas and consulting rooms and easier admission procedures are some ways of accomplishing this, it is vital that young people themselves are involved in designing and monitoring the youth friendliness of clinics.” “Special youth friendly initiatives that have been launched offer promising directions for serving young people but their sustainability and potential for upscaling may suggest that efforts be made to incorporate its central features into established facilities.” Finally, it is essential that policy and programme level ambiguities are addressed, that providers are given clear guidelines on services for unmarried youth and reporting requirements are streamlined to accommodate young people’s needs.”

(Tangmunkongvorakul, Arunrat, Sangworn Sombatmai, Chonticha Ruangyuthikarn, Sobhon Bopodhi (2002), Providers’ Perspectives in Addressing Adolescent Sexual and Reproductive Health Needs in Northern Thailand, pp. 3, 11-12)

http://www.iussp.org/Bangkok2002/S30Tangmunk.pdf#search='Thailand%20sexual%20reproductive%20health%20services' (Date accessed 06/05/06)

- What are the cultural norms around prioritizing females and males for health care?
- To what extent are informed and supportive SRH services accessible for girls or young women living with HIV/AIDS?
- What are the client/service provider ratios in different types of HIV prevention services? What is the gender ratio for staff in those services?

The national database of health service is unavailable. The decentralisation of health care system has resulted in a weakening of the capacity of the Bureau of AIDS, TB and STIs as a result of shrinking human resources and declining budget.

- Do services make proactive efforts to attract girls and young women? For example, do SRH clinics have separate rooms for young women so that they do not risk seeing family members or familiar adults?
- What are the attitudes of service providers to girls and young women, including those who are marginalised and vulnerable? Are they kind, non-judgemental and realistic (for example about young people’s sexual pressures and desires)? Can they encourage girls/boys to assess their risks of HIV infection and change their behaviour? Are attitudes generally getting better or worse?
- Do HIV prevention information campaigns, etc, target girls and young women? For example, are they culturally and linguistically appropriate? Are materials distributed through appropriate media and outlets?
- Is there a national monitoring and evaluation framework? Does it encourage data to be disaggregated (according to gender and age) – to help assess the extent to which girls and young women are accessing programmes and services?
- Are referrals and follow-up provided during HIV/AIDS, SRH and antenatal care services for young women and girls?
- Overall, what difference does accessibility to services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?

“Effective voluntary counselling and testing is vital for identifying individuals who can benefit from early treatment, for promoting treatment adherence and bolstering prevention. Unfortunately, there are still difficulties on this front. Voluntary counselling and testing services are available at approximately 1,000 hospitals and clinics across the
country. However, the coverage is uneven. According to a survey conducted for UNAIDS in late 2003 people in Bangkok can easily access free or affordable voluntary counselling but less than 50 percent enjoy similar access in rural areas. The survey could not ascertain how many people were actually using voluntary counselling and testing services, though it found that some 12,500 people had accessed services provided by the Thai Red Cross Society in the previous year. Spending on voluntary counselling and testing has increased markedly in 2003 but it accounts for only a fraction (about 2 percent) of total HIV/AIDS expenditure. Concerns have been raised about the counselling and testing components. A review by the World Bank in 2000 concluded that these components were underutilized and raised questions about the overall quality of counselling services. An evaluation of activities for preventing mother-to-child HIV transmission also found that the quality of voluntary counselling and testing services varies across the country. While some hospitals can and do provide systematic and appropriate services (including pre- and posttest counselling), other sites are struggling to do so. Excessive workloads, burnout of staff and inadequate counselling skills are all factors. Of particular worry is the reported lack of privacy and confidentiality for patients. If left unchecked, this fundamentally compromises the benefits of a treatment programme for people living with HIV/AIDS.” (pp. 40-1)


From an article titled “Teachers fret as HIV/AIDS prevention budget cut” in the Bangkok Post: “Chiang Mai - Schoolteachers in this northern province, where the HIV/AIDS infection rate is one of the country’s highest, have voiced concern over a major cutback in the Public Health Ministry’s budget for AIDS prevention, saying it will increase infection rates among youngsters. According to the Department of Disease Control, this year’s Aids prevention budget has been slashed from last year’s allocation of about 300-400 million baht to just 180 million baht. Sirapong Charoenkusal, deputy principal of Lanna Polytechnical College, a private school, said more than 5,000 condoms had been received by the school for free distribution to students in the years before 2005, when none was given at all by the ministry due to budget constraints. “Currently, we have to rely on ourself to protect our students from the deadly disease,” Mr Sirapong said. The school was the first in Chiang Mai to have provided safe-sex counselling and free condoms to its students in 1995. It has about 4,000 students, mostly male. The school’s health consultant said the condom shortage and lack of budget would set back HIV/AIDS prevention activities and put young people at greater risk of contracting HIV/AIDS. Teenagers felt more at ease obtaining condoms provided at school than buying them from convenience stores, he added. A 15-year-old female student expressed concern over the Aids prevention budget shortage. ‘The condom shortage at our school has made it difficult for us to protect ourselves from sexual diseases and unwanted pregnancies,’ she said. ‘I feel more relaxed getting condoms at school. I don’t want to walk into a shop to buy them.’ She also wanted the school to continue with its safe-sex counselling service. ‘At least we would learn how to protect ourselves from the (Aids) disease,’ she said, adding that the provision of condoms with safe-sex advice was better than setting up condom-vending machines in school. Giving youngsters easy access to condoms, however, has become a controversial issue in the country. Opponents say the practice is tantamount to encouraging young people to be promiscuous. Disease Control Department chief Thawat Suntrajarn said this year’s budget cut was the biggest ever experienced by the department since its launch of the HIV/AIDS prevention programme. With such a small budget, he said, it was virtually impossible for the department to reach its HIV/AIDS control target. The department aims to reduce the number of new infections to 7,500 in 2008 and 6,000 in 2010.”


“Early efforts to limit mother-to-child transmission centred on providing family education
and pre-marital counselling. Young couples in particular were urged to undergo HIV testing before having children. In 1990-1991, a number of general hospitals integrated HIV screening into the regular services provided at antenatal clinics. Soon, screening for HIV was introduced in some community hospitals. One was the infant feeding programme where formula was distributed to lactating mothers who met mean-tested criteria. However, bottle-feeding indirectly hinted at the HIV status of the mother and met reluctance from some mothers. As the decade progressed, a larger share of new HIV infections began occurring among women. Consequently, mother-to-child HIV transmission also increased. A public policy on AZT (zidovudine) provision was still absent, mainly because of high drug costs and technical capacity constraints. A breakthrough soon followed. A trial to examine the effectiveness of short-course AZT for preventing mother-to-child transmission brought encouraging findings: AZT could cut the odds of mother-to-child transmission by up to 50 percent. Several pilot programmes were soon set up, and they yielded promising results. Two regional pilot programmes using short-course AZT were implemented – the first in northern Thailand in 1997, followed by a two-year programme targeting seven north eastern provinces in 1998. These programmes strengthened technical capacity and confirmed that a national version of the programme was feasible, particularly in a country with strong healthcare infrastructure. Doctors were now demanding that the Government support a countrywide programme as a routine part of antenatal care. Meanwhile, the government PL HIVmaceutical Organization began producing some versions of AZT at lower cost – laying the foundations for a more extensive national programme (it could not yet, however, produce all forms of AZT used to prevent mother-to-child HIV transmission). Thus, despite the economic crisis, Government budget support for the programme tripled in 1998-1999, and the number of women receiving AZT increased by a similar margin. It was not all smooth sailing. Discrepancies in clinical practice were still being observed prior to extending the programme across the entire country. For example, in some hospitals confidentiality was being compromised by the lack of private spaces for counselling and by symbols added to mothers’ medical cards (which indicated their HIV status). Not all pregnant women were also able to access antenatal care facilities. One review in 2000-2001, found that 12 percent of HIV-positive women giving birth did not have antenatal care. In 2000, the Ministry of Public Health issued clinical guidelines setting out standard practice for preventing mother-to-child HIV transmission, developed a national policy and launched a national programme based on that policy. By now, AZT was being used in most hospitals in the country. A review of the first year of the programme showed high uptake, and an increasing number of newborns were receiving prophylactic antiretrovirals. Without such efforts it has been estimated that almost 5,000 children each year would have been born HIV-positive by 2003. The national programme is believed to be reducing that number by up to 50 percent. Thailand’s programme for preventing mother-to-child HIV transmission has become regarded as a model for similar efforts in developing countries. The approach taken was urgent but systematic, enabling research findings and pilot programme experiences to be translated quite quickly into a national programme. As with the general HIV/AIDS programme, Thailand also enjoyed specific advantages including strong antenatal care infrastructure and domestic generic production of antiretrovirals that are not present yet in all other countries. “(pp. 41-2).


- How do the effects of accessibility vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
Key questions:

41. Has the country signed the Convention on the Rights of the Child (CRC)?

The date of accession to the CRC was 27 March 1992 (Office of the United Nations High Commissioner for Human Rights (2006)
http://www.ohchr.org/english/countries/ratification/11.htm (Date accessed 04/05/06))

Convention on the Rights of the Child (CRC) on 26 April 1992 and is in the process of taking necessary measures at the domestic level to sign and ratify its two Optional Protocols (the Optional Protocol on the Involvement of Children in Armed Conflict and the Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography)

(Ministry of Foreign Affairs, Kingdom of Thailand: Human Rights Promotion, http://www.mfa.go.th/web/24.php (Date accessed 06/05/06))

42. Has the country signed the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages (CCM)?

The date of accession to CEDAW was 9 August 1985(Office of the United Nations High Commissioner for Human Rights (2006)
http://www.ohchr.org/english/countries/ratification/8.htm (Date accessed 04/05/06))


(Ministry of Foreign Affairs, Kingdom of Thailand: Human Rights Promotion, http://www.mfa.go.th/web/24.php (Date accessed 06/05/06))

43. In the National AIDS Council (or equivalent), is there an individual or organisation that represents the interests of girls and young women?

"Network of Government Agencies

The HIV/AIDS Prevention and Alleviation Plan involved 10 government ministries, 39 bureaux and three offices having activities related to HIV/AIDS. These agencies worked within their framework and target group. The National Centre for the management of AIDS Prevention and Alleviation was a centre for coordinating work plan, budget plan and for following-up. The activities implemented by these agencies involved campaigning, health education, developing leaders in each group, treatment, care and psychosocial support for people living with HIV/AIDS The budgets to prevent and alleviate HIV/AIDS (pg10)"


44. In the National AIDS Council, is there an individual or organisation that represents the interests of people living with HIV/AIDS?

"The link between providing services and national advocacy has most prominently come into play around the issue of extending access to treatment—one of the main priorities of AIDS activism. For example, in Thailand, the Thai Network of People Living with HIV/AIDS
and the Thai NGO Coalition on AIDS encouraged the government to provide antiretroviral
drugs under its national health insurance scheme. In December 2001, the Thai
Government announced that it would extend health care to cover these medicines, and
created a panel with Network representatives to oversee implementation.”

UNAIDS, 2004 Report on the global AIDS epidemic,
e (Date accessed 30/10/06)

45. Was the current National AIDS Plan developed through a participatory process, including
input from girls and young women?

“The National AIDS Prevention and Alleviation Committee would like to express its deep
appreciation to administrators, academic researchers, and other individuals who
participated in drafting and completing the National Plan for the Prevention and
Thailand 2002-2006, Preface)

“Up to the present, HIV/AIDS prevention and alleviation efforts in Thailand have been
undertaken my mobilizing the cooperation of all relevant sectors of society. At the
national, provincial, district, and local levels, government agencies, non-government
organizations, business sector, community-based organizations, and groups of people
living with HIV/AIDS have administered and implemented prevention and alleviation
programs under the auspices of the National AIDS Prevention and Control Committee.”
(National AIDS Prevention and Alleviation Committee (2001) National Plan for the
Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006; Preface)

46. Is there any type of group/coalition actively promoting the HIV prevention and SRH
needs and rights of girls and young women?

The Planned Parenthood Association of Thailand (PPAT). “In Thailand, the United Nations
Population Fund Office in Thailand and the Planned Parenthood Association of Thailand
under the Patronage of Her Royal Highness the Princess Mother which has long been
partners in continuously working on and preventing population problems, and improving
quality of life of the population are well aware of reproductive health problems of
women in Thailand. Such problems have become worrisome with similar nature of those
happening to women around the world especially among young people. The Planned
Parenthood Association of Thailand has defined our own policy in increasing access to
reproductive health knowledge, information and services through extensive knowledge
dissemination and service provision activities for women and empowerment of women in
making their informed choices of family planning and in receiving such information.
Samples of PPAT projects responding to reproductive health problems include
Strengthening Gender-sensitive SRH and HIV/AIDS Prevention for Youths with Community
Commitment in Northern and Southern Provinces of Thailand to promote access to
reproductive health knowledge and services among young people. The project targets
areas where population still lack awareness about women’s reproductive rights, where
certain practices and attitudes prevent women to access to sexual and reproductive
health services, including information necessary and extremely vital for personal health
care of young women and women. (Planned Parenthood Association of Thailand
(PPAT), http://www.ppat.or.th/ (Date accessed 17/05/06))

Women’s Health Advocacy Foundation: “We are a not-for-profit and non-governmental
organization dedicated to promoting and defending women’s sexual and reproductive
health and rights in Thailand through evidence-based advocacy. We believe that sexual
and reproductive health constitutes the core of women’s health. Women’s sexual and
reproductive rights are human rights. We envision the Thai society accepts and
recognizes reproductive health and rights. Our mission is to promote and defend
women’s sexual and reproductive health and rights in Thailand through knowledge-
based advocacy. We seek to realize women’s sexual and reproductive health and rights
within the framework of various existing international human rights agreements, including the Plan of Action from the International Conference on Population and Development. Gender equality and equity, sexual and reproductive rights, client-centered sexual and reproductive health care, and social justice are the core principles informing our strategies to advocate women’s sexual and reproductive health and rights. We recognize women’s health needs as correlating with their age and socioeconomic standing. State laws, policies, and practices should address the changing and diverse health needs of women of all ages, both during policy formulation and service delivery.”

“Our work consist of…

1. Research: we undertake and utilize research that is critical and gender-sensitive, to inform our knowledge-based advocacy.

2. Public Education and Advocacy: we develop and disseminate user-friendly information on issues of sexual and reproductive health and rights towards the empowerment of women at the grassroots level; we cultivates consensus-based policymaking through information sharing, networking, and dialogue among individuals, people’s organizations, non-governmental organizations, government agencies, and research institutes at the local and national levels.

3. Media and Communications: partnership with the media is crucial for our advocacy work; we use various means to liaise with the media and help build their capacity to understand and report on sexuality, sexual health and reproductive health issues.

4. Training and workshop: we intend to share our expertise and experiences in policy and media advocacy with others; in the future we will synthesize our experiences and lessons learnt into a systematic and interactive workshop courses.” (Women’s Health Advocacy Foundation, http://www.whaf.or.th/ (Date accessed 11/05/06))

The Raks Thai Foundation has developed several programs to help women, youth and children affected by HIV/AIDS. The Women and Children Care and Support in high HIV prevalence Areas (WCCS) is located in Chantaburi and Trad provinces in the eastern region and Pattalung province in the south. The project support improved counseling for women with HIV/AIDS, care and support at the community level, strengthening of people with HIV networks and youth mini-projects for prevention.


Centre for Reproductive Rights January 19, 2006, The committee on Elimination of discrimination against Women, Re: Supplementary information on Kingdom of Thailand scheduled for review during the CEDAW’s 34th session, http://www.crlp.org/pdf/ltt_shadow_Thailand_Cedaw.pdf (Date accessed 30/10/06)

47. Is there any type of national group/coalition advocating for HIV prevention (including positive prevention) for girls and young women?

“Which Comes First, a Network or Its Issues?
An interview with women from the Thai Network for Positive People (TNP+) and the Thai Women and AIDS group (TWAT)

Does the positive women’s network exist?

‘It was not our aim to come out as a network of HIV positive women. That hasn’t happened. Instead we are looking at ways of integrating positive women’s issues into the work of TNP+. The empLHIVsis is very much on reproductive rights as the first step.’

How has the network responded to the attempt to put women’s issues on the agenda?

‘Women are working together with TNP+, especially on advocacy around access to care, treatment and support. Through this the women are putting forward the reproductive issues and issues which pertain specifically to positive women.’
‘A network of HIV positive women should have happened a long time ago. We have to ask why has it never become a reality? Women are still seen as part of the national network, but that means that the specific issues of HIV positive women are often obscured. We still need to connect positive women all over Thailand to coordinate together. TWAT is channelling out information, but there is a lack of awareness of what is happening in different parts of the country.’

‘Having the network exist or not doesn’t matter – what matters is how we can ensure that women’s issues are heard or voiced. Starting with how they see the issues rather than the network – once the issues begin to be carried, there will be a network.’

‘A network is regarded as a tool or mechanism through which to move – but what should we move about?

We need to explore the issues – find out what’s really problematic, then think about how to move on them, and this will lead to the establishing of a network.’

**What are the issues that they are exploring to date?**

**Reproductive health**

Sexuality. Women need to understand their own sexuality, and the relationships between men and women – this is a core issue. Other areas to explore are: promoting the female condom; making sure Nevirapine is available to women having children; negotiating within relationships; starting new relationships and looking at power relations at the intimate level.

**Raising women’s voices within TNP+**

‘When feminists talk about policy, for us it’s more important for us to talk about ourselves – to think about what is happening in Thailand. What are the issues for women living with HIV/AIDS?

We want to have more choice for women’s protection, more choice of what women do in their lives. The starting point should be what we think about – not a policy. Change starts with ourselves – the way we treat those around us will be different, our work will also change. Women will start to ask: What is the positive people’s network doing? You say it’s working for positive people, but we don’t see the positive women. It’s not about learning about a lot of theories, but rather asking: What do you really think about yourself? What do you really think about your vagina? Or sex? You might have this dialogue with a counsellor, who asks this kind of question of her clients, but when she is asked the same questions, she doesn’t know how to answer.’

(Date Accessed 29/10/2006)

Centre for Reproductive Rights January 19, 2006, The committee on Elimination of discrimination against Women, Re: Supplementary information on Kingdom of Thailand scheduled for review during the CEDAW’s 34th session, http://www.crlp.org/pdf/ltr_shadow_Thailand_Cedaw.pdf (Date accessed 30/10/06)

48. Is the membership of the main network(s) for people living with HIV/AIDS open to young people, including girls and young women?

**Raising women’s voices within TNP+**

‘When feminists talk about policy, for us it’s more important for us to talk about ourselves – to think about what is happening in Thailand. What are the issues for women living with HIV/AIDS?

We want to have more choice for women’s protection, more choice of what women do in their lives. The starting point should be what we think about – not a policy. Change starts with ourselves – the way we treat those around us will be different, our work will also change. Women will start to ask: What is the positive people’s network doing? You say it’s working for positive people, but we don’t see the positive women. It’s not about learning about a lot of theories, but rather asking: What do you really think about yourself? What do you really think about your vagina? Or sex? You might have this dialogue with a counsellor, who asks this kind of question of her clients, but when she is
49. Are there any programmes to build the capacity of people living with HIV/AIDS (e.g. in networking, advocacy, etc)?

Programmes include:

1. Asia Pacific Network of People Living with HIV/AIDS - Capacity-building, stigma and discrimination research in four countries in Asia-Pacific; documenting human rights violations; advocacy on human rights and discrimination; building on UNAIDS-funded research work by APN+; treatment access; capacity-building within APN+, including the development of clear and workable governance structure; and strengthening the role of the secretariat by seeking funds for a full-time coordinator and defining the role of the secretariat.

2. Center for Persons and Families Affected by AIDS (CPA) - Establishment of legally registered foundation for the center; increase in health services provided to HIV-positive people to include inpatient and outpatient support in selected hospitals in the Bangkok area; increase in number of PLHIV undergoing health care and income-generation training. Health-care support consists of emergency funds; home visits; group and individual psychosocial counseling; and inpatient and outpatient support in hospitals. All health care volunteers have formal training in collaboration with Médecins sans Frontières. The center strives to complement existing or lacking non medical health care services to ensure comprehensive treatment schemes for HIV-positive people. Income-generation support: vocational training in collaboration with private sector, and financial and ongoing occupational support, including education funds.

3. PWHA-NET – Global e-mail forum for PLHIV. (United States Agency for International Development (USAID), Global Network of People Living with HIV/AIDS (GNP+), International Center for Women (ICW) (2004) Directory of Associations of People Living with HIV/AIDS,

   http://www.usaid.gov/our_work/global_health/aids/Publications/docs/hivaiddirectory.pdf (Date accessed 4/05/06)

50. Are there any girls or young women living with HIV/AIDS who speak openly about their HIV status (e.g. on television or at conferences)?

“UNAIDS, May 1, 2006

THAILAND--When married mother Nang Noi was told she had HIV three years ago, the fear of the disease and of the social rejection that might go with it was overwhelming. “I cried for five days straight. I did not think I could go on,” she said.”

(ParntersThailand EForum, http://acw-stigma.blogspot.com/2006/05/positive-partnerships-break-down-aids.html (Date accessed 29/10/06)

“In the process, Kaew’s work has have helped give a human -- and young -- face to HIV/AIDS. Her reaching out in public also underlines the message that people with HIV/AIDS can live productive lives much like any other young person, despite the stigma they have to deal with.

Kaew says she herself is surprised by the feedback she gets from her book and the website. ‘Friends of mine have sent me e-mail with notes saying ‘read this story and you
Discussion questions:

- How are international commitments (e.g. CRC, CEDAW, and CCM) applied within the country?

"Human Rights Promotion in Thailand. The Universal Declaration of Human Rights and other International Instruments on Human Rights:

- In 1948, together with other 47 United Nations member states, Thailand voted in favor of the Universal Declaration of Human Rights, which has served as the foundation for the protection of the inherent dignity, and the equal and inalienable rights of all peoples.

- Thailand adheres to the principles enshrined in the Universal Declaration of Human Rights.

- Thailand has been proactive in becoming a Party to international human rights instruments and has already acceded to five core UN human rights instruments as follows:


2) Convention on the Rights of the Child (CRC) on 26 April 1992 and is in the process of taking necessary measures at the domestic level to sign and ratify its two Optional Protocols (the Optional Protocol on the Involvement of Children in Armed Conflict and the Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography)

3) International Covenant on Civil and Political Rights on 29 January 1997 (ICCPR)

4) International Covenant on Economic, Social and Cultural Rights (CESCR) on 5 December 1999 and


Thailand is also considering signing and ratifying the Convention against Torture, Degrading and Inhumane Treatment.

National Human Rights Plan of Action:
The Plan identifies activities for 20 target groups (children, women, stateless persons, HIV/AIDS-infected people, prisoners, farmers, workers, etc.) and 11 target fields (education, public health, natural resources and environment, housing, religion, information, etc.) with designated implementation government agencies and time frame. Public administration reform, which was launched in 2002 resulting in the dissolution and/or merger of formerly existing governmental agencies as well as the creation of new ones, caused some delay in the full implementation of the Plan.
Promotion and Protection of the Rights of Children in Thailand:

As party to the Convention on the Rights of the Child, Thailand fully adheres to basic rights and principles for the best interests of the child. The National Economic and Social Development Plan has given priority to human development, including child protection and participation. Indicators such as Social Indicators (Basic Minimum Needs), Indicators on Child and Youth Development and Indicators on Child Rights were introduced as guidelines for the effective protection of children’s right.

With regard to other international instruments related to human rights, Thailand also ratified, among others, the following:


(3) UN Convention on Organized Transnational Crimes- Thailand signed the said Convention on 13 December 2000 and later signed on 21 December 2003 two related Protocols- namely, the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children and the Protocol Against the Smuggling of Migrants by Land, Sea, and Air.

Nevertheless, children in Thailand, similar to those in other countries, are faced with new threats to their right to life, survival, development, well being and welfare. Several measures such as law reform and international co-operation have been continuously introduced to cope with these crimes and violations against children. These include the enactment of the Act Concerning Measures of Prevention and Suppression of the Trafficking in Women and Children to combat syndicates of organized trafficking both nationally and internationally; the Prevention and Suppression of Prostitution Act to toughen the punishment of those who exploit children aged below 18 years regardless of consent; the Amended Criminal Procedure Code concerning pornography to cover offences committed on boys as well as girls. Another important achievement is the enactment of the Child Protection Act which came into effect on 30 March 2004 which is intended to provide protection for children from all forms of abuses, exploitation, violence and gross negligence by clearly stipulating that any child below the age of 18 is protected by the State.

Other preventive measures such as education programs and social measures, including the rehabilitation of the child victims have also been implemented.

Furthermore, Thailand attaches great importance to the outcome of the 27th Special Session on Children. Accordingly, Thailand’s draft “National Strategy and Plan of Action for a World Fit for Children” for the year 2005-2015 has been formulated on the basis of the framework of the final document adopted by the 27th Special Session, with the addition of certain aspects which are pertinent to the situation in the Thai society. Public hearing processes on the draft National Strategy and Plan of Action have been completed and it is expected that the revised draft would be ready for submission to the Cabinet of Ministers for approval in early 2005.

Under the newly established Ministry of Social Development and Human Security, the Office of Welfare Promotion and Protection of Children, Youth, the Vulnerable, the Disabled and the Elderly was set up to promote and protect the rights and welfare of the children. The Office was transformed from the National Youth Bureau, formerly under the Office of the Prime Minister. The Office promotes and protects children’s
Women’s Rights in Thailand:

Respect for women’s equal rights and dignity is well reflected in Thai legislation, policy and practices. The Constitution clearly stipulates that men and women shall enjoy equal rights. Unjust discrimination and treatment against women are, therefore, prohibited. Women’s roles and contribution are also well recognized in politics, commerce, trade, education, academia, agriculture and the home. This is to guarantee that, in practice, women can express their concerns and initiate changes when and where their rights are not fully respected.

On the Government side, the Perspective Policies and Planning for the Development of Women (1992-2011) was formulated to address constraints and vulnerabilities encountered by women, and also to identify strategies and actions for the full enjoyment of human rights. Among areas of prime concern, the Plan targets the problems of women and poverty, violence against women, women and health, and women and sexual exploitation. The Plan adopts an integrated, holistic and preventive approach. Therefore, the Plan not only addresses the root causes of problems such as inequality of opportunity or the existence of environments unfavorable to women, but ensures that women are also empowered through programs of education and training, including participation in decision-making.

On the issue of human trafficking where women and girls are the primary victims, Thailand has for several years undertaken various measures to tackle simultaneously both domestic and cross-border sex trafficking by cooperating in partnership with other governments, international agencies, and non-governmental organizations at national, regional and international levels. The highest level of political commitment to the issue was further injected by proclaiming it as a national agenda.

As a result of the 2002 bureaucratic reform, the National Commission on Women’s Affairs, formerly under the Office of the Prime Minister, was transformed into the Women’s Affairs and Family Development Bureau, under the Ministry of Social Development and Human Security. The Bureau formulates policies and plans for the promotion and protection of women’s rights. The Bureau also supports activities carried out by government agencies, state enterprises as well as NGOs in the promotion of women development.

Right to Development (RTD):

Thailand adheres to the right to development as described in the United Nations General Assembly resolution 41/128 in 1986 entitled the Declaration on the Right to Development. The right to development encompasses political and civil rights and economic, social and cultural rights.

RTD is the right to a process of development, in which all human rights and fundamental freedoms can be fully realized in a progressive manner over time. RTD is a process whereby people can be empowered and equipped with basic needs to live a decent life.

Thailand attaches great importance to the implementation of the Declaration on the Rights to Development. The country supports the continued discussion of RTD in the UN Commission on Human Rights (CHR) to find ways and means to realize RTD.

To achieve the full realization of RTD, priority of rights is needed in accordance with each country’s development needs. In this respect, right to education, health, food and housing are high on RTD agenda. Right to health is now materializing by which every person needs to pay only 30 baht (less than 1 USD) to obtain necessary medical
care and services. Right to education is also fully implemented. All Thai people are provided free basic education.

Globalization plays an important part in the RTD process. Coordinated policy and action among concerned agencies, be they financial institutions or development agencies, is needed to put a human face on globalization. Thailand supports the debate on implications of human rights arising from international economic issues under the UN forum. It is anticipated that political awareness can be realized and achieved out of this forum for further consideration and action by concerned agencies, including international financial institutions (the World Bank and IMF).

Human Rights Education:

The promotion and protection of human rights is an ongoing process. Its effectiveness cannot be solely achieved by becoming state party to international human rights instruments or reforming the national legislation. Therefore, human rights education plays a significant role in the promotion and protection of human rights in Thailand. Human rights education is also an integral part of the National Human Rights Plan of Action.

Government agencies dealing with security and law enforcement are required to provide human rights training to their officials. Both the Thai military and police have undertaken human rights training as one of their priorities. Manual on human rights standards and videotapes on issues related to human rights have been disseminated to military and police forces.

The Ministry of Education has also worked to integrate human rights principles into school curricula and activities at all levels.

ASEAN Human Rights Mechanism:

Thailand is supportive of the work of the Working Group for an ASEAN Human Rights Mechanism. Thailand participated in the four Workshops for an ASEAN Regional Mechanism on Human Rights, held in Jakarta in 2001 and 2004, Manila in 2002 and Bangkok in 2003.

Human rights co-operation within the Asia-Pacific Region

Thailand supports development of human rights co-operation within the Asia-Pacific region. The annual Workshops, which have been organized by the United Nations Office of the High Commissioner for Human Rights (OHCHR) and countries within the region, provide opportunities to exchange views and experiences, and to seek possible co-operation in a friendly atmosphere.

Over the past few years, Thailand co-hosted 3 workshops within such framework i.e. the “Inter-sessional Workshop on National Human Rights Actions Plan in the Asia Pacific Region” in July 1999, the “9th Annual Workshop on the Promotion and Protection of Human Rights in the Asia Pacific Region” in February 2001 and the “Intersessional Expert Meeting on National Human Rights Action Plan and Human Rights Education in the Asia-Pacific Region” in October 2004.

Thailand fully supports the four major areas of regional co-operation as adopted by consensus in Tehran in 1998. They are (1) national plans of action for the promotion and protection of human rights and the strengthening of national capacities; (2) human rights education; (3) national institutions for the promotion and protection of human rights; and (4) strategies for the realization of the right to development and economic, social and cultural rights. Thailand also supports the follow up of the implementation of the Declaration and Plan of Action of the World Conference against
Racism, Racial Discrimination, Xenophobia and Related Intolerance. The follow up of the Durban Plan of Action is now part of the major areas of regional cooperation.

Thailand will participate in the 13th Annual Workshop to be held in Beijing, People’s Republic of China in 2005.

Related human rights issues. Human security:

Thailand shares the view that human security encompasses freedom from want and from fear and protecting people from violent and non-violent acts. Thus, human security is comprehensive in nature and intertwined with human rights and human development. Human rights, human development and human security are mutually reinforcing factors. They are fundamental principles in achieving sustainable human development.

Thailand is a strong advocate of human security and also a member of the Human Security Network (HSN) which comprises 12 member countries and one observer country."

(Ministry of Foreign Affairs, Kingdom of Thailand: Human Rights Promotion, http://www.mfa.go.th/web/24.php (Date accessed 06/05/06))

- Is the national response to HIV/AIDS rights-based? For example, does it recognise the SRH rights of women living with HIV/AIDS?

"Measure 4: Promote and support mechanisms for protecting the rights of society members, including people living with HIV/AIDS and their families.

Pictures of success:
- People living with HIV/AIDS, their families, and members of the general public understand their rights as well as the fact that HIV/AIDS infection does not provide a pretext for violating those rights.
- Systems and mechanisms for protecting the rights of people living with HIV/AIDS are developed and strengthened with emphases being given to the development of a harmonious society where people respect each others rights and regard each other as human beings of equal value.

Basic strategies:
- Promote and support the role of various organizations in rights protection.
  - Promote cooperation between state agencies, public interest organizations, and networks of people living with HIV/AIDS in implementing HIV/AIDS-related rights protection programmes.
  - Support the role of and provide opportunities for HIV/AIDS groups and networks to participate in campaigns to address rights violations and protect the rights of people living with HIV/AIDS, members of their families, and members of the general public.
- Support the use of social mores to prevent rights violations.
  - Decrease rights violations by developing the human resources of government agencies, public interest groups, and community organizations so that staff members whose work is related to people living with HIV/AIDS and individuals affected by HIV/AIDS will have an appropriate understanding of the disease.
  - Develop a system of information centers to disseminate information on HIV/AIDS, human rights, and HIV/AIDS-related rights issues.
  - Conduct campaigns to prevent rights violations by building understanding and developing appropriate attitudes towards human rights and HIV/AIDS-related rights among members of the general public and specific target groups including the staff members of state agencies, public interest groups, and local political administrations.
- Support the use of social mores in order to protect rights.
Develop the human resources of government agencies, public interest groups, and community organizations so that staff members whose work is related to people living with HIV/AIDS and individuals affected by HIV/AIDS will have necessary rights protection skills.

In developing the quality and reach of counseling services, make sure that the rights of people living with HIV/AIDS and individuals affected by the disease are respected when disseminating information on HIV/AIDS infection status.” (National AIDS Prevention and Alleviation Committee (2001) National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006, pp. 31-2)

Do key decision-making bodies (e.g. the Country Coordinating Mechanism of the Global Fund to Fight AIDS, TB and Malaria) have a set number of seats for civil society? Are any of them specifically for representatives of girls and young women or people living with HIV/AIDS?


Are HIV prevention programmes generally developed ‘for’ or ‘with’ girls and young women, including those who are marginalised and vulnerable? Are girls and young women seen as ‘implementers’ as well as ‘receivers’ of services?

To what extent are girls and young women aware of decision-making processes? Are they encouraged to have a voice? Are they seen as an important constituency within committees, management groups, etc?

How high are issues relating to HIV prevention for girls and young women (e.g. early marriage and stigma) on the agendas of local leaders and decision-making groups (e.g. district AIDS committees)? To what extent do girls and young women participate in those type of bodies?

To what extent are people living with HIV/AIDS organised, for example in networks? Are girls and young women involved in those bodies?

The Thai Network for People Living With HIV/AIDS (TNP+) was formed in 1998 in order to coordinate the activities of PLHIV groups, which were isolated and lacked the ability to push for change. Before 1998, PLHIV had not been active on health care issues.

http://www.who.int/hiv/pub/prev_care/en/thailand.pdf (Date accessed 18/11/06))

The first large scale gathering of PLHIVs occurred on October 8-10, 1997 in the First PLHIVs Forum at Ratanakosin Hotel. This event led to the formation of the Thai Network for People Living With HIV/AIDS (TNP+). Previously there were 3 regional PHLA networks, in Upper North, Lower North and Northeast, respectively. During the forum, the mission of TNP+ was drafted, and the national committee was appointed, comprising representatives from every region of the country.

http://thaiplus.net/page01.html (Date accessed 18/11/06))

How are issues of participation affected by stigma? For example, is it safe for people living with HIV to speak openly about their HIV status?

“In government we treat people living with HIV/AIDS as partners…they have a very important role in educating people and communities, helping to diminish stigma and discrimination, and giving mutual support. They are very important in some of our decision-making. We recognize their outstanding work.” Dr. Sombat Thanprasertsuk,
Overall, how are participation and rights applied in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?

How do the effects of participation and rights vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

Prime Minister Surayud Chulanont yesterday voiced his strong intention of ensuring that no one will be abandoned in his fight for a better society.

"Now, 7.5 million Thais are poor, and many more who are stateless, HIV-positive and disadvantaged are being abandoned. If the 60-million-population holds on to its generosity and the principle of not neglecting one another, Thai society will be full of peace and harmony," he said.

The prime minister was talking to hundreds of academics, non-governmental organisation representatives and state officials attending the national social strategic development forum at Government House.

The forum was spearheaded by the Ministry of Social Development and Human Security to gather opinions and suggestions from all sectors to map out an effective implementation plan to achieve a decent and happy society.

A society where no one was abandoned is one of the government’s three social strategies to achieve this goal. The other two strategies were to develop a society with both strength and morals.

Social Development and Human Security Minister Paiboon Wattanasiritham raised his concerns for the many vulnerable groups in society, including the poor, more than 5,000 homeless people, more than 500,000 stateless people, more than 300,000 HIV-positive people, more than two million migrant workers, more than a million disabled people, and about 70,000 former convicts. These people, Mr Paiboon said, should not be left unattended.

http://www.bangkokpost.com/News/18Nov2006_news11.php (Date accessed 18/11/06)
PART 2:
IN-COUNTRY RESEARCH
Focus group discussion: 15-19 year olds

Age group: 15-19 years
Number of participants: 12
Profile of participants: included some girls and young women who are: in-school; out-of-school; peer educator; from urban areas; from suburban areas; or PLHIVs; ethnic people; sex workers; living with HIV; and unmarried.
Place: Chiangmai

Prevention component 1: Legal provision

What do you know about laws in Thailand that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?

Participants had limited knowledge on relevant legislations. They did not perceive that existing laws hindered HIV prevention efforts. Most participants opposed legalization of sex and supported requirement of parental consent for SRH services.

"Legalization of sex will promote sex trade, making it easier for both clients and SWs."
"Parents should know about their children’s sexual behaviours. They can advise us in time of crisis."

Prevention component 2: Policy provision:

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

Sex education covers sexual development, STIs and HIV/AIDS, responsible relationships, life skills including assertiveness, etc. However, students don’t have sufficient opportunity to practice relevant skills in class. In real life situations, they cannot recall most of the lessons learnt.

To ensure that target groups adopt safe sex practice, sex education must be a life-long learning program.

"Every student in my school must learn sex education."
"We learnt sex education in schools, but we cannot remember what was taught."
"The course covers many aspects including relationships, but the knowledge and skills gained from the course are not sufficient to ensure safe sex."
"We learnt sex education when we were young and inexperienced. It was only theory without practice. Life skills can be developed only through practice."

What could the government of Thailand do to fight fear about AIDS in your community?

Stigmatization of PLHIVs and AIDS patients still occurs in Chiangmai, but the situations have significantly improved because of in-school sex education program and high number of PLHIVs. All participants said that they can live in the same house and have meals with PLHIVs.

"We learnt from school that HIV is not highly contagious. We cannot get HIV from sharing a meal with PLHIVs."
"PLHIVs and AIDS patients have never bothered or harmed us. They lead normal lives like everyone else."
"HIV/AIDS affected children can enrol in any school."
"Some older people may find it hard to accept PLHIVs, but we have to give them more HIV/AIDS information and time to change their attitudes."

Mass media campaign through radio and television advertising is the channel to reach this resilient group.
"Suitable media are television and radio."
Prevention component 3: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? an HIV test?

Only a few participants visited health centres and hospitals for SRH services. They have limited knowledge on available services and prefer buying condoms and contraceptive pills from drugstores. (This finding correlates with previous studies on the important role of drugstores in the Thai health system. Most Thais will not seek medical consultation for minor illnesses and contraception. They prefer to buy medications from drugstores to avoid doctors’ fee.)

Condoms are widely available in Chiangmai. Free condoms are available in limited health centres. Pay condoms are available in drugstores, convenient stores and vending machines near the hospitals.

“It’s more convenient to buy them (contraceptive pills and condoms) from drugstores.”

Condom acceptance among this group of participants is lower than the 20-24 group. Only one out of twelve participants said that she could carry condoms and ask her partner to use condom.

“It doesn’t look good if we carry condoms.” “Men are the ones who use condoms, so they should carry them.”

“VCTs are available in hospitals and specialized clinics. Health centers do not have this service.”

Brochures on STIs are available in health centers, specialized clinics and hospitals. Other sources of STIs information are the internet and YMCA’s community programs on family planning and HIV prevention.

Participants do not know where to access ARV and PMTCT. (The participant who is a PLHIV is not on ARV. One requirement for ARV enrollment is the CD4 level of <200)

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

Boys and young men know about HIV prevention, probably more than girls and young women because they learn sex education in schools and they have other information sources, including peer groups, printed and electronic media and the internet. However, their role in supporting HIV prevention for girls and young women is still limited. Only one participant received information on condom use and condoms from her brother.

What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

Most participants would like to have VCTs, counseling services and condom vending machines in their neighborhood.

Prevention component 4: Accessibility of services

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

None of the participants has used HIV prevention services, including condom, VCT, ARV and PMTCT; SRH services including gynecological examination and antenatal services in health centres and hospitals in their communities. However, they have had blood test (to determine blood group) and other minor treatments. The only problem encountered was long queue at the hospitals.

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?

Cost is the main barrier in private hospitals and clinics. Barriers encountered in public hospitals and health centers include limited service hours, attitudes of service providers (nurses) and limited counselling. Privacy is not a barrier because the diagnosis room is separated from the waiting area.
In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

Married girls and women, PLHIVs, pregnant women, orphans, SWs and out-of-school have equal access to SRH and HIV prevention services. Unmarried girls may find it harder to get the service because of timidity. It is more difficult for ethnic people and migrants to get health (including SRH and HIV prevention) services.

“Doctors and nurses may treat clients equally, but we are too shy, we do not have the courage to access the service.

“……hospital has separate wards for PLHIVs and pregnant women, so they get equal access to SRH and HIV prevention services.”

I don’t think that’s the case (equal service, regardless of race). Ethnic people are not equally treated. We usually receive inferior health services. They (health professionals) are not willing to provide services to ethnic people.”

“Migrants and ethnic groups also have the language problem.”

“We (SWs) do not have any problem accessing health services. There’s no need to tell them about our occupation and they rarely ask about it.”

**Prevention component 5: Participation and rights**

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

YMCA has an outreach program on family planning and HIV prevention in remote villages. Participants, including ethnic adults and children, learn about HIV infection, contraceptive methods and proper condom use. There are safe sex campaigns and sex education programs in schools. Participants have no information about peer groups that focuses on HIV prevention for girls and young women, but there is a program by M+ group for MSMs. PLHIV networks occasionally have campaign activities in many communities. Activities include medical consultations by foreign doctors and dissemination of medications.

What would encourage you to get more involved in HIV prevention in your community?

Advocacy campaign to promote HIV prevention must be innovative and address issues that are of interests to girls and young women. Appointment of celebrity role models and study trip for rural-based youth would encourage participation of youth in HIV prevention. Moreover, support for activities should be continuous. An annual HIV prevention campaign is insufficient to generate behavioral change and adoption of safe sex practice.

“Incentives, like study trips, will do.”

**Summary**

What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in Thailand to protect themselves from HIV?

HIV prevention should be integrated in youths’ way of life. Advocacy campaigns have to be frequent and continuous to induce attitude and behavioural changes. Sex education curriculum has to be comprehensive. Parents should get involved in sex education. Counseling hotlines for youth is more useful than one-to-one counseling. Access to VCT should be improved and advocacy campaigns to inform about service points and benefits of VCT are necessary.

Recommendations to promote condom use include installing more condom vending machines in easy access areas, subsidizing condom costs, and implementing advocacy campaign to promote condom acceptance.

“Parents have limited role in sex education, they are not invited to participate in school activities.”

“I’ll prefer counseling hotlines to counseling service in hospitals and health centres.”

“It’s difficult to get VCT; we do not know where to access the service.”

“Condoms at…..stores are too expensive, the ones in vending machines are OK.”
Focus group discussion: 20-24 year olds

Age group: 20-24 years
Number of participants: 7
Profile of participants: included some girls and young women who are: in-school; out-of-school; peer educators from urban area; pregnant; with children from rural area; living with HIV; ethnic people and unmarried.
Place: Chiangmai

Prevention component 1: Legal provision

What do you know about laws in Thailand that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?
Participants divided into 2 groups on the legalization of sex. Participants who supported legalization said that it will enable effective control of HIV prevention because necessary regulations will be available and SWs will be entitled to better SRH health services. However, most participants who opposed legalization said that it will promote sex business and human trafficking.
Requirement of parental or spouse consents for SRH services is not a barrier to accessing SRH services.
The law that prevents marriage with minors is rarely enforced. Girls and young women can avoid that by having de facto relationships.
“Rules that require condom use can be enforced.”
“Legalization of sex does not ensure safe sex. Some clients may refuse to use condoms and, in practice, enforcement can be difficult. Sex will flourish and more girls and young women from neighboring countries might be drawn into the sex trade.”
“We can ask our peer’s parents to sign it, or in most desperate case, we can forge the signature.”

Prevention component 2: Policy provision:

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?
Every participant has received health education (not sex education), containing some information on sexual development and family planning. Health education curriculum does not cover relationships and lifeskills development.
“They taught us about female reproductive organs and contraceptive methods. But, they don’t demonstrate proper condom use. We were not shown contraceptive pills.”

What could the government of Thailand do to fight fear about AIDS in your community?
MOPH should support advocacy campaign to inform and educate the general public that the appearances of PLHIVs are no different from healthy individuals, HIV/AIDS is similar to other chronic illnesses and HIV cannot survive well in the environment. Other options include encouraging participation of PLHIVs in HIV prevention, providing incentives for business owners who employ PLHIVs and information on PLHIVs rights should be included in in-school curriculum.
“The general public still has wrong perceptions about PLHIVs. They have not seen good looking PLHIVs or nice photographs of PLHIVs. The horrible photographs of dying HIV/AIDS patients shown during the early days of HIV/AIDS in Thailand still haunt them.”
Prevention component 3: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? an HIV test?

The health care system reform has significant effect on HIV prevention services. The system aims to strengthen capacities of health centres, enabling them to provide primary health care to clients. Only cases that require secondary or tertiary health care services will be referred to hospitals.

However, all participants bypass health centres for 2 main reasons: health centres have limited capacities (no VCT, ARV and PMTCT services) and clients are concerned about the confidentiality of SRH services.

Comprehensive SRH services, with the exception of free condom, are available in community and regional hospitals, The Royal Thai Red Cross anonymous clinic and in selected SRH clinics.

Private hospitals and clinics focus mostly on STIs and HIV/AIDS treatment and care. They provide limited counseling service and STIs information.

Condoms are widely available in Chiangmai, pay condoms are available in drugstores, convenient stores and vending machines. Limited free condoms are available in few health centres and offices of NGOs and CBOs focusing on HIV/AIDS prevention. OOP (Our Option for a Positive Lifestyle) condom promotion campaign provides a small number of free condoms in participating schools and universities. TDN (Thai Drug Users Network) occasionally distributes condoms to members during advocacy campaign.

Condom acceptance is low. Girls and young women, especially the unmarried group, feel uncomfortable to ask for condoms from service providers or being seen with condoms.

“We prefer buying condoms at drug and convenient stores. The staffs do not ask questions and they do not know us.” (About half of the participants admitted that they were too timid to request for condoms from health service providers)

“If we hand out condoms, only few girls will take them. However, when we leave some on the desk and turn our back. They will be gone in a few seconds.”

STIs and HIV/AIDS brochures are available in anonymous clinic, TNP+ and NGOs including PPAT, hospitals, health centers and some specialized clinics.

The Tumbol Administrative Offices (TAO) sometimes publishes and disseminates HIV/AIDS leaflets to rural villagers.

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

Boys and young men learn about HIV prevention from media, peers and in-school health education. Some play a key role as peer educators. However, most are not keen to participate in HIV prevention.

“Boys and young men do not pay attention to SRH, HIV/AIDS and health issues. They tend to think that we all die one day, regardless of HIV infection.”

What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

Clearly the HIV prevention service needs of different types of girls and young women are different. While married girls prefer strengthening capacities of health centres, unmarried (urban and ethnic) group prefer better access to public hospitals’ services.

Health centres should be upgraded to be able to provide free VCT, ARV and PMTCT.

MOPH should reinstate the condom budget and distributed free condoms in remote areas. The quality of counselling service should be improved.

“We have to pay for VCT. It is expensive in private hospitals. However, if we do not want to pay, we just tell the nurse that we’d like to donate some blood.”

“Mobile clinics nowadays focus only on screening for cervical cancer. Safe sex and family planning campaign no longer exists.”

“The counseling service is available in some health centers, but the person in charge is not keen to help clients.”
Prevention component 4: Accessibility of services

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?
Health centres have limited capacity and personnel. Health service professionals at some public hospitals have double standards for regular (using the national universal health coverage) and privileged clients.
The quality of VCT counselling is inconsistent. The anonymous clinic of the Royal Thai Red Cross provides both pre- and post-counselling. However, some public hospitals do not provide post-counselling, informing about the window period, or recommending another test to negative cases.
"The health centre in my community is very small; there are only 2 staffs. I have to seek antenatal care from a hospital."
"They won’t take good care of regular antenatal clients. We have to enroll in special antenatal care at the doctor’s clinic and pay extra doctor fee; although the delivery takes place at the public hospital."

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?
Clients are satisfied with existing HIV prevention service. However, language barrier, cost of services and the service hours are the main barriers for some clients. Other minor barriers are attitudes of some health service providers and the language that they use.
"Some have negative attitudes towards ethnic people."
"Some nurses use inappropriate language."

In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?
Language and negative attitudes of some health service providers towards migrants and ethnic girls and young women make accessing SRH services more difficult. SWs and PLHIVs have equal access; however, AIDS patients may have difficulties accessing services.
"They are not willing to provide service, requesting identification cards, migrant registration cards, etc.
"Health care professionals may be reluctant to service AIDS patients, but PLHIVs do not have any difficulties accessing services."
"The examination was very quick. They just prescribed the medications and sent us home. They didn’t explain about appropriate care."

Prevention component 5: Participation and rights

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?
Five years ago there were many projects on HIV prevention in Chiangmai implemented by both GOs and NGOs. However, most were discontinued. Mae Rim District organized one-day mobile training in HIV prevention to ethnic people last year. Some TAO has allocated budget for HIV prevention camp. T.Y.A.P. Foundation (previously Thai Youth AIDS Prevention Project) is one of few NGOs that are still active. Their recent campaigns are for condom promotion and out-reach sex education in both urban and rural areas. Harm Reduction Center by Thai Drug Users Networks has some on-going activities in Chiangmai. PPAT has outreach PORT program in rural Chiangmai and PLHIVyaoprovinces.

What would encourage you to get more involved in HIV prevention in your community?
To encourage participation of girls and young women in community activities, MOPH and donor agencies have to provide continuous technical and financial supports, strengthen the management of NGOs and CBOs support fund, develop youth centers, provide financial incentives to some underprivileged groups and combine some entertainment programs in the HIV prevention campaign.
“The fund was poorly managed. Several PLHIVs were ready to join the advocacy campaign, but fund transfer was delayed. They could not wait so they went their ways. Finally when the fund arrived, we could not locate most of them.”
“Chiangmai does not have any youth centre, a place where we could meet and join in community activities.”
“Most people do not have days off. They have to work everyday to earn enough income. To encourage their involvement, we need financial incentives.”

**Summary**

**What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in Thailand to protect themselves from HIV?**

Establish youth friendly clinics cum activity centres, providing counselling, internet services, aerobic classes, music classes, juice bar, etc. The service should be easy to access in department stores or trendy places where youths like to hang out after class. Establish SRH counselling hotlines for youths and promote them in youth friendly media, e.g. teen magazine, websites and bulletin boards in coffee shops/ juice bars. Other options include supporting advocacy campaign to promote condom acceptance, educating the general public on proper condom use, subsidizing condom costs for underprivileged groups and improving the packaging of condoms.

“If it is a stand alone youth friendly clinic, nobody will use it.”

“I go to hospitals/clinics for treatment of illness only. I’ve never received counselling service there. I feel more comfortable discussing SRH and relationship issues with my friends.”

“I prefer telephone counselling to one-to-one counselling because I can say whatever I want. I am too shy to talk (face to face) to someone, whom I don’t know well.”

“The packaging (of condoms) should be attractive and not too revealing so girls can carry it with confidence.”

The suitable channel to reach ethnic groups and rural-based communities is through village heads because they are true opinion leaders, commanding high respect from community members.

“Villagers believe in his words.”

**General**

**What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse ... and why?**

Epidemiological statistics that clearly indicate worsening situation of HIV prevention for girls and young women in Thailand is not yet available. However, other indicators including increasing rate of STIs, number of unwanted pregnancy and abortion cases may indicate high HIV risk from unsafe sex among girls and young women.

“Although the increasing trend of HIV incidence among girls and young women is not yet clear, rate of STIs increases in some provinces. Moreover, the rate of safe sex is still unsatisfactory; the number of unwanted pregnancy and abortion cases has increased.”

**Prevention component 1: Legal provision**

In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?

Legislation including the Prostitution Prevention and Suppression Act, sections that deal with abortion in the Criminal Law and requirement of parental consent for SRH services has minimal effect on HIV prevention for girls and young women in Thailand.

“Legализation of sex and abortion won’t have any effect. Sex was previously legal and then made illegal. The conditions for abortion have been expanded but illegal abortion still exists.”
“Legislation without enforcement and social awareness will not improve the situation of HIV prevention.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?
N/A

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
“We have to be more specific. For example, the proposed SRH law, we have to consider the Thai context and identify key issues that are legally enforceable.”

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?
The inclusion of HIV/AIDS treatment and care, including ARV in the national universal health care program in October 2005 had affected the availability of condom because most of the allocated funds were used to increase GPO-VIR production.
“There’s a gap, and we’ve proposed for HIV prevention budget increase in the National Plan for the Prevention and Alleviation of AIDS in Thailand 2007-2011. However, the plan has not been endorsed because the government has not appointed a new Committee on AIDS Prevention and Alleviation.”
“The policy needs revision. There’s a question of sustainability. Moreover social marketing of condom has not been very successful.”
“The condom supply has been depleted. The AIDS Bureau have requested additional budget from NHSO to expand the condom service until the end of this year. However, NHSO’s main focus is on treatment and care not on HIV prevention.”

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?
Sex education is available in some schools. There are many curricula, including Ministry of Education’s, Department of Health’s and PATH’s. However, the Ministry of Education has not made a strong commitment to the support program.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
Stakeholders of sex education should lobby for more commitment from MOE and integration of sex education in school curriculum. Meanwhile, they have to use natural entry points to reach diverse groups of young people.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in Thailand?
The launch of National Universal Health Coverage has limited the access to SRH services, including STIs information, VCT, counselling, etc. among young people and SWs because youth-friendly services and STIs clinics were closed down.
“Girls and young women would not use the service because they have to use the same health service institutions as other adult clients. SWs’ workplaces are usually far from their hometown so they cannot use the universal health care scheme.”
“Assessment of friends’ corner or youth-friendly clinics indicated limited success.”
What type and scale of HIV prevention services are available for particular types of girls and young women? For example, what services are there for those who are: Unmarried? Out of school? Involved in sex work? Or PLHIVned? Injecting drug users? Migrants? Refugees? HIV positive?

Availability of HIV prevention services vary from place to place. Migrants, ethnic minority groups have more access than the general population in some areas where there are ongoing projects.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Boys and young men have equal access to HIV prevention services and information in schools. Sex education curriculum aims to promote mutual responsibility in adopting safe sex practice. However, it is unclear whether boys and young men have any influence in HIV prevention for girls and young women.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

The pilot youth friendly service model in Payao should be expanded to other provinces. “Youth friendly service is a difficult task because youth are normally healthy. They usually do not seek health services. We have to develop other activities to encourage their usage.”

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in Thailand?

Main barriers include the lack of prevention services, privacy of service, breach of confidentiality, attitudes of service providers and language use by service providers.

“Cost is not the main barrier, because treatment and care of STIs and HIV/AIDS are covered by the national universal health coverage. However, HIV prevention services that girls and young women need, including counseling, partnership relations may not be available.”

“If the services focus only on treatment, it will never work for youths.”

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

The lack of youth friendly prevention services apply to all types of girls.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

The role of boys and young men in this regard is not clear.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Highest on the priority list is youth friendly services that address their real needs. The second priority is programs that can motivate active participation of youth in HIV prevention.

“We need more information on their social spaces to be able to identify their natural entry points.”

“We have to encourage participation of girls and young women in HIV prevention. This may start from small clubs in schools.”

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?

International commitments have minimal effect on HIV prevention for girls and young women.

“Very few people at the implementation level know details of these conventions. There is no clear national agenda and facilitator. Responsible agencies are in different governmental units.”
To what extent is the national response to AIDS ‘rights-based’?
National response to AIDS ‘right-based’ can be improved.
“Most people do not know about their rights. It’s the nature of Thai people. We usually do not defend our rights. This is not limited to AIDS rights.”
“A female PLHIV wants to terminate pregnancy but service providers convince her to enroll in the PMTCT instead.”
“What’s lacking is complete information to enable the person to make sound decision.”

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?
Representatives of youth and PLHIV networks are actively involved in the national AIDS plan.
“Thailand has strong youth and PLHIV networks from 10-15 years of intense HIV/AIDS programs.”

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?
Develop linkage between HIV/AIDS groups and youth or women groups.
“Most of women group do not touch on HIV/AIDS or sex. We have to integrate HIV/AIDS issues in their activities, developing more linkage between HIV/AIDS groups and women groups.”

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?
Dialogue and sharing of information between groups will bridge existing gaps and lead to innovative HIV/AIDS programs. Leadership with strong commitment towards HIV/AIDS prevention and development of youth friendly SRH service model will enable girls and young women to get better access to HIV prevention service.
“We’ve done extensive work on HIV/AIDS. However, we have not done enough to synthesize new knowledge or document lessons-learned. So we end up repeating what has been done in another area. There’s no innovation.”
“We’ve formed small taskforces to tackle specific issues i.e. SWs, migrant workers, etc. Key players get together and discuss potential collaborative approach.”

One-to-one interview: Doctor (male)
Sexual Reproductive Health and Family Planning Unit

General

What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse … and why?
AIDS Bureau reports higher incidence of HIV/AIDS among teens and young people. The median age of first sex has dropped and teens are more sexually active. Approximately 10% of students have sex experience and most of them do not use condom. Some schools are not receptive to sex education and condom vending machine in the school premise.

Prevention component 1: Legal provision

In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?
The Prostitution Prevention and Suppression Act has severe adverse effect on HIV prevention but the effect of abortion law and parental consent (for RSH services and marriage) is minimal.
“Registration of SWs has many benefits; we can provide STIs information and SRH services to them. And from epidemiological standpoint, we can trace SWs’ clients and recommend suitable treatment and care.”
“Existing law has a clause which allows physician to terminate pregnancy if it poses health risk for the mother. It depends on the definition of the term health risk, whether it covers only physical health or includes other aspects, such as mental or social health etc. The Thai Medical Council has expanded the definition of mother’s health risk. And, if we use WHO’s definition, pregnancy termination can be performed.”

“SRH services and VCT requires parental consent if the client is a minor. However, this has little impact on access to SRH services. The main barrier is probably the nature of teenagers; they listen to their peers more than their parents. They would seek illegal abortion or take some drugs to terminate pregnancy rather than consulting their parents.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?
Single girls and young women may have difficulties accessing some SRH (pregnancy termination) services.
“Some hospitals require spouse consent from single clients to avoid potential lawsuit.”

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
The Prostitution Prevention and Suppression Act should be abolished to legalize sex.
“Legalization of sex in some developed countries has proven to be beneficial not only to SWs but also to the society. Registered SWs are entitled to welfare, better benefits and health care. The government can effectively control STIs and earn additional income from tax paid by the sex trade.”

Prevention component 2: Policy provision
What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?
The antenatal protocol recommends blood tests which include HIV test. Clients normally receive pre-counseling from nurses. However, very few clients who refuse to take blood test still receive antenatal care services.
MOPH has limited budget for condom. The National Family Planning Program used to provide free condom to clients. However, this program was discontinued when MOPH launched the national universal health coverage.
“It’s about time; clients should absorb the contraception and STI prevention cost so we can use limited health budget for other purposes.”

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?
Sex education is available in some schools, but the curriculum is outdated. It does not reflect current situations and does not address youth’s needs.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
The government should strengthen social policies and improve existing sex education curriculum.
“Social programs to develop family value are needed because they will solve both STI and drug problems. Parents have to spend more quality time with their children. Parent and teachers have to teach life skills and necessary SRH to enable children to cope with the rapidly changing environments.”

Prevention component 3: Availability of services
What type and scale of HIV prevention services are available for girls and young women in Thailand?
Female condom is not available in Thailand. The budget for male condoms has been drastically reduced. Free condoms are no longer available in family planning clinics. STIs
information is widely available in medical and in teen websites. VCTs are available in every hospital, but not in health centers. PMTCT is available in every regional and large hospital. ARV is available in most hospitals but the coverage of ARV is not yet 100%, due to limited budget.

“Girls rarely seek VCT. Most of the VCT cases in our hospital are married women, who doubt about their HIV statuses, and single women, who seek premarital blood test.”

“To avoid breaching of confidentiality, clients usually do not go to health centers in their communities for gynecological examination and VCTs. Some travel to other provinces to receive these services.”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? OrPLHIVned? Injecting drug users? Migrants? Refugees? HIV positive?

Single, out of school, or PLHIV girls and SWs do not have problems accessing SRH and HIV prevention services. However, rural women may have to travel long distance to get VCTs, ARVs and PMTCT. Muslim women in the remote south may be the most vulnerable group because of limited services and their religious beliefs.

“We often don’t ask clients about their occupation, so SWs can get access to our services just like any client.”

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Girls and boys have equal access to STI information and HIV prevention services. Boys and young men do not have any significant role in improving female’s SRH and HIV prevention.

“I am not sure whether boys and young men have any influence on contraception or STI prevention options. Unwanted pregnancy is not their problem. They do not have to suffer the consequences of unwanted pregnancy.”

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Existing services are fine, although some services are still limited in rural areas. Target groups should voice their needs and lobby key decision-makers for more SRH and HIV prevention budget.

“The best prevention starts at home and at community level. We have to empower people to be able to think and choose the best option for themselves. They should help themselves first by teaching their children about safe sex. Then get involved in community works and lobby for any type of service that are still lacking. People in the communities know their problems and needs. Health policies are usually developed by health administrators in Bangkok, using the top-down approach. We should promote the bottom-up approach, encouraging more community participation.”

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in Thailand?

Main barriers are cultural norms, the language that the services use, the attitude of service providers, service hours, long-waiting period and cost of services. The lack of privacy was not a problem because the diagnosis room is separated from the waiting area.

“Our society still perceives that girls who use condoms and contraceptive pills are promiscuous.”

“We’ve received many anonymous letters complaining about long queue, the attitudes of service providers and improper language that they use.”

“Cost of service is a problem for underprivileged groups. They have to use public hospitals and the queue for SRH services is very long.”
Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?
Single young women may have some difficulties accessing some SRH services. However, in-school or out of school girls and PLHIVs get equal access to SRH services.
“Underprivileged groups get equal access to services because of the national universal health coverage. Affluent people may use private hospitals for short-term treatments, but if the illnesses are chronic they will refer the cases to public hospitals.”

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?
Boys and young men have limited role in this regard.
“Our record indicates that most healthy men abandon their wives if they are HIV positive. However, healthy women tend to take good care of their HIV positive husbands.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?
Assess real needs of girls and young women and formulate policies that address their needs. Meanwhile promote morally-just society by instilling sufficiency principle and invest more on youth and family programs.
“Improving HIV prevention services alone won’t do any good. Our social problems have long been neglected. Girls and young women are more materialistic nowadays. They sell sex to get quick cash and material wealth. We cannot keep up the services, if we do not look at the root cause of the problem.”

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?
The interviewee did not respond to this question.

To what extent is the national response to AIDS ‘rights-based’?
The national response to AIDS ‘right-based’ need improvement. Some PLHIVs’ rights are still being violated. PLHIVs cannot get pregnancy termination because doctors don’t want to get involved. Many employers still discriminate against PLHIVs.
“Doctors won’t provide abortion service to female PLHIVs, not because of legal implications but because of their religious beliefs. In Buddhism, termination of pregnancy is a sin.”
“Many employers still impose mandatory HIV screening for job applicants. One of my students applied for a job at a national company (name withheld). They still screen applicants for HIV.”

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?
Participation of girls and young women is still limited.
“Girls and young women still have limited role. Just look at our women groups. They are not very strong. They need to do more to defend their rights. An example is pregnancy termination. They should campaign aggressively to abolish the law and promote social recognition.”

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?
Sex education to promote self-esteem among girls and young women is urgently needed. The Women’s Affairs and Family Development and the Ministry of Social Development and Human Security must work harder to encourage participation of women in every level. Finally, women groups have to campaign to change outdated gender-biased norms.
Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?

To improve HIV prevention for girls and young women in Thailand, the AIDS Bureau must assess SRH and HIV prevention needs in different settings and formulate policies that address the needs. They must encourage involvement of community based groups in every process of The National Plan for the Prevention and Alleviation of AIDS. Finally, policy-makers must have the courage to fight conservative and gender-biased cultural norms. They must be firm and push for necessary changes.

“Several years ago the Office of the Prime Minister published a sex education booklet for teens. The book was later recalled because some conservative groups felt that the language used was too explicit. It was, in fact, a very good book. The content and language used were appropriate for teens. And they like it.”

One-to-one interview: Youth Coordinator (female)
An international NGO working on sexual education, HIV/AIDS

General

What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse ... and why?

Latest statistics show rising rate of STIs among teenage and young people. Attitudes towards sex improve, but they still do not practice safe sex. Girls and young women are more vulnerable than boys and young men because they get less access to SRH information and services due to our patriarchal society. Most women in Thailand still lack the power to control their own body, sexuality and sexual life.

Prevention component 1: Legal provision

In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?

Abortion and sex work are illegal, making it more difficult for SWs and young single women to get access to SRH services.

Requirement of parents’ consent for less than 18 years old girls reduces their chances of proper SRH service.

”Most parents will be furious if they see condoms in their daughters’ purses. It’s the parents’ attitude problem.”

”Laws cannot guarantee safe sex. We have laws to prevent underage sex, force sex, violence, etc. These laws are meaningless; if our gender biased social values (treasure virginity) do not change.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?

Our society expects female students to practice abstinence. It is very difficult for underage girls to get access to condoms from health service providers without parents’ consent. Drug store and convenient store staff tend to have negative attitudes towards female condom-customers. Rural girls and young women have limited choices for safe pregnancy termination. They often get illegal sub-standard abortion service from unqualified persons in other provinces because there is a tendency to violate the rights to confidentiality in rural area. Out of school, street children, migrants, ethnic minorities are most vulnerable because they cannot communicate well. Moreover, without identification cards they cannot get access to the national universal health coverage. Illegal migrants are probably the most difficult to reach group because they are often arrested by policemen and immigration officers. Public health service providers cannot visit their workplace because their employers do not trust government officials.
Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Laws should be more flexible, providing more options. Women must be able to choose whether they want to continue or to terminate the pregnancy. At present doctors can terminate pregnancy only if it threatens the mother's health. This should be expanded to cover economic problem.

“Legalization of sex work would benefit HIV and STIs prevention but registration of SWs may stigmatize them.”

“Legal provision alone cannot ensure better SRH for girls and young women. Attitude change is very important. Our society has to be more open-minded.”

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?

Girls and young women rarely seek SRH from community health centers because they fear that confidentiality will be breached by health service providers. They know that condoms are available in health centers but they prefer to buy condoms from drugstores out of town. Similarly, if girls/young women want to terminate pregnancy, they do not seek counseling or antenatal service from health centers. This hinders HIV prevention effort because they do not get sufficient access to HIV/AIDS and STIs information.

Attitudes towards VCT have improved significantly. Nowadays PLHIVs tend to reveal their HIV positive status, because they will be entitled to the ARV therapy from the National Health Security Office (NHSO). Moreover, stigmatization towards PLHIVs has lessened due to 20 years of extensive HIV/AIDS work in Thailand.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

Ministry of Education (MOE) has endorsed sex education in school, but the coverage is still low and the quality of sex education varies from school to school. There are many curricula, with different objectives from promoting abstinence to comprehensive sex education. Consensual indicators for successful sex education have yet to be developed.

“Just look at the MOE’s curriculum, they cut and paste information from existing curricula, publish 6 manuals and disseminate them to schools. Each school receives the budget of $500 to implement sex education, but there is no capacity building program for teachers at all.”

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Existing policies and protocols are fine, but implementation of policies and protocols need improvement.

“We have good policies and protocols but no commitment and action. Our policy on sex education is comprehensive; but MOE’s support is very limited, both in terms of budget and human resource development.”

“MOPH’s policy is to ensure availability of condom for all, but the budget for condom is insufficient. It’s been declining in recent years.”

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in Thailand?

Female condom is not available in Thailand. Male condoms are available only to high risk groups and target groups of some projects. MOPH is adopting a social marketing program, encouraging people to pay for condoms.
“The social marketing policy was developed by middle-class health service providers. They do not understand that minimum wage earners cannot afford condoms. They don’t earn enough to make a living.”

SRH service providers do not have up-to-date information on HIV/AIDS and STIs.

“Young generation of SRH service providers still preaches the same HIV/AIDS information that we had 10 years ago. Some PLHIVs are more knowledgeable than they are.”

Antiretroviral drugs are available under the national universal health coverage, but some PLHIVs in remote areas may not know about this program.

PMTCT and voluntary counseling and testing are available at every hospital but the quality of counseling needs improvement. There are cases of HIV blood test without clients’ consent.

“We need to campaign harder to promote VCT. This will benefit both HIV prevention and the PLHIVs.”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Or PLHIVned? Injecting drug users? Migrants? Refugees? HIV positive?

Due to budget constraint, the services tend to focus risk groups. SWs, PLHIVs and migrants have better access to condom services. However, this is not the case for IDUs in the ARV program. IDUs cannot enroll in the ARV program unless they quit drugs.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

They are entitled to similar services and information, but boys and young men have better access. They do not have the cultural barriers that women do.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Sex education in schools should be expanded and youth friendly clinics should be re-established. Girls and young women should get better access to condoms and counseling. Other necessary services are assistance for sexual harassment victims, emergency homes for girls and young women in every province.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in Thailand?

Youth friendly clinics/friend corners were closed down due to budget constraint. The first priority is to make youth friendly service available to girls and young women. Then improve the quality of service, making it more affordable, convenient and client-centered.

“The quality of service is a minor issue; the lack of service should be tackled first.”

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

Risk groups (SWs, MSMs, IDUs, PLHIVs) have better access to HIV prevention services. Single girls and young women are most vulnerable because of social value and MOPH’s policy which focuses on risk groups.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

They have limited role in making prevention services easier and better for girls and young women. Boys and girls rarely communicate. Most boys would not take any responsibility when SRH problems arise. Our curriculum is trying to overcome this problem by educating boys about relationship and mutual responsibility and promoting girls’ self-esteem.
Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?
Establish youth friendly services and campaign to make people aware of their SRH rights. Girls and young women should be aware of available alternatives, condoms, contraceptive options, counseling, treatment and care, etc. They should protect their own rights.
“Even leaders of our youth network are not proactive enough. They just follow MOE’s and MOPH’s initiatives. They lead campaigns on condom/safe sex upon request, but they never question MOPH’s SRH policy nor demand better SRH services.”

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?
International commitments have little impact on SRH rights in Thailand.
“I have not witnessed any agency’s action towards CEDAW and other relevant conventions.”

To what extent is the national response to AIDS ‘rights-based’?
Situations of AIDS rights have improved significantly, due to more comprehensive National AIDS Policy and active campaign by NGOs and PLHIV networks.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?
At least 3 youth networks under Teenpath have collaborated with the national youth network (Youthnet) in the national forums. They have representatives in National Plan for the Prevention and Alleviation of AIDS in Thailand 2002-2006. One of Teenpath advisory boards, under the Global Fund to Fight AIDS, Tuberculosis and Malaria, comprises girls and young women. They participate in strategic plan development and make recommendations on project implementation.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?
Most of Teenpath’s advisory board members are girls and young women. Key leaders of Youthnet are mostly women.
“Girls and young women actively participate in SRH projects because it is their problems. On the contrary, we should promote more involvement of boys and young men in SRH programs.”

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?
The government should clarify the policies on comprehensive sex education and SRH services and rights to stakeholders, develop mechanisms to implement the policies and provide continuous support to stakeholders.

One-to-one interview: Peer educator (female)
An local NGO working on HIV/AIDS

General

What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse … and why?
HIV incidence has declined in SWs but increased among teenage, young people and housewives.
“SWs are professionals and they use condoms. They have more negotiating skills and power. They can refuse to service clients if they don’t use condoms. Most teenagers do not have life skills and alcohol use makes them more vulnerable.”
“SWs are not intimidated by drugstore or convenient store staff; but housewives, girls and young women are.”

**Prevention component 1: Legal provision**

In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?
The Prostitution Prevention and Suppression Act has adverse effects on HIV prevention because policemen often arrest girls and young women who carry condoms.
“Condom is a medical equipment, but policemen perceived that it is the evidence of sex crime. If a woman has 3 condoms in possession, she will be charged with sex service. If she has 5 condoms then she will be charged with operating sex business.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?
The law affects all girls and young women.
Illegal migrants are most vulnerable because they will be charged with both the Prostitution Prevention and Suppression Act and the immigration law, limiting their access to SRH services.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
Abolish the Prostitution Prevention and Suppression Act and some sections of the Criminal Law relevant to sex, but do not legalize sex trade. (Legalize sex trade might lead to registration and stigmatization of SWs.)

**Prevention component 2: Policy provision**

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?
Despite clear voluntary basis of the VCT protocol, mandatory blood test still exists. The “condom” policy is poorly implemented.
“The rights issue was discussed extensively at the Toronto HIV/AIDS Conference; however, mandatory blood test is still common in Thailand.”
“They (MOPH) cut the condom budget. Moreover, the available size (49) is not usable. All of our condoms are from international agencies. SWs often buy their own condoms. You should not trust government officials. They are very good at developing proposals and protocols, but they are not good at implementing them.”

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?
Sex education curricula are incomprehensible. Teachers are not well informed and lack sex communication skills.
“In my opinion, all teachers are too conservatives… They expect girls to be virgins. They are too shy to talk openly about sexual development and safe sex…They should at least teach proper condom use, safe sex and provide counseling service to school children.”

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
MOPH should focus on existing condom policy, improve the service, increase the condom budget and launch campaigns to promote condom acceptance. The second priority is to provide comprehensive sex education to girls and young women.
“Condom use can prevent both STIs and unwanted pregnancy; relevant problems will be solved if people accept condom use.”
Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in Thailand?

Availability of female condom is very limited. It is too expensive, noisy and difficult to use. Only SWs know about this contraceptive option. Housewives are not aware of female condom. Male condom is widely available at reasonable price. Information on STIs is widely available, especially to Global Fund’s target groups including SWs, MSMs, underprivileged population, clients of anonymous clinics, students etc. However, the service is limited in remote areas and in some regions. Condom use among students and young women is still low because they perceive that they are not HIV risk groups.

VCT is widely available, but girls and young women are too shy to use the service. First-line ARV is available to qualified PLHIVs. PTMCT has improved in recent years. PLHIVs have more alternatives because the PMTCT program has reduced transmission rate.

“We have 7 centers to disseminate information on SRH and STIs to SWs nationwide, and we have community radio programs, Bad Girls magazine, brochures on safe condom use. However, the service in southern Thailand is limited because of the local (Muslim) culture.”

“FTA between United States and Thailand will worsen the situation, making patented drugs too expensive for most PLHIVs.”

“Many AIDS drug trials are conducted in Thailand, but we have not benefited from these trials. We have to pay exorbitant prices for AIDS drugs….The welfare and compensations for the participants of these trials are very little.”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive? SWs get better access to SRH services than other groups of girls and young women because they can afford top-quality services at leading private hospitals. Moreover, they are aware of their potential health risks.

“People tend to think that we are the vulnerable group. That’s not true. We can afford expensive services. We won’t use public hospital or the social security scheme. sex is our profession so we have to take care of our SRH.”

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

HIV prevention services and information are available for boys and young men. They have better access, but whether this affects the situation for girls and young women is unclear.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

The first priority is availability and acceptance of condoms, followed by sex education and improved counseling service for VCT clients.

“We are pushing the MOPH for a condom campaign, encouraging people to perceive that condoms are household items like toothbrushes, combs, etc.”

“We’ve proposed (to MOPH) that lubricating gel and condoms, in all sizes, should be available to all SWs.”

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in Thailand?

The main barrier is the negative attitudes of doctors and nurses towards SRH and STIs clients. The language that they use is inappropriate. Other barriers are distance from SWs’
workplace, inconvenient service hour and the lack of privacy, respectively. However, the cost of service is not the barrier.

"Public health centers and clinics open during 8:30 a.m. - 4:30 p.m., but a normal SWs’ day starts around 3:00 p.m. Consequently we often use private hospitals."

"Some sex operators have contracts with private clinics. SWs have to submit monthly gynecological examination and quarterly blood test results to their employers. It may violate SWs’ rights, but SWs should be entitled to this health care service."

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

Both single and married women do not have easy access to free condoms because of health service providers’ negative attitude.

“They would question why you need condoms. If you are single, you should practice abstinence, so you don’t need condoms. Similarly, why should you need condom, if you’re having sex with your spouse?”

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Boys and men have limited role in HIV prevention in SW group. They even make HIV prevention more difficult in other groups (girls, young women and housewives), demanding unprotected sex because they do not like the feel of condoms.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Campaign to promote condom acceptance is the first priority followed by education on safe sex and HIV prevention among journalists and production of communication tools including TV spots and print ads, respectively. Others include awareness campaign to create supportive environment for sex education and acceptance of condom vending machine in schools and workplaces.

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?

The interviewee did not respond to this question.

To what extent is the national response to AIDS ‘rights-based’?

This is an area that needs immediate improvement. The general public still perceives that SWs are the culprits of HIV epidemic in Thailand and are the HIV high risk groups because the National Plan for the Prevention and Alleviation of AIDS stated so.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?

Girls, young women and SWs are represented in the National AIDS Committee and many other committees. They also serve as board members in some Global Fund projects. Our organization has been actively involved in the Thai Labour Relations Committee, lobbying for better benefits and health care for SWs.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Participation of stakeholders in national level decision-making about AIDS is already high. Thailand has extensive networks of active PLHIVs, community groups, youth groups and NGOs focusing on AIDS. There are many channels to participate in national level including participating directly in the AIDS committee, through AIDS NGO networks, through the Thai Labour Relations Committee, the National Human Rights Commission, etc. The only limitation is the budget constraint.
Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?

Government and donors should pay more attention to HIV prevention, providing continuous technical and financial support to NGOs, community groups and PLHIV networks. They should develop strategic plans based on target groups needs.

One-to-one interview: Executive (male)
Thai network of PLHIVs

General

What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse … and why?

Incidence of HIV in teenage and young people has increased in recent years. Girls and young women are more vulnerable to HIV infection because of their physiology. Other factors include the gender biased Thai culture, limited SRH information, limited availability of condoms and negative attitudes towards condom use.

“Most Thais still perceive that SRH is a taboo that we should not discuss with our children.”

“Condom vending machines are placed in difficult to reach areas…government offices and workplaces, which are closed after hours. Condoms that are sold in convenient stores are much more expensive than condoms in the vending machines.”

Prevention component 1: Legal provision

In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?

Existing Thai laws to prevent underage sex are fine but enforcement of the laws is lagging. The Prostitution Prevention and Suppression Act has reduced access to proper SRH services for some indirect SWs.

Requirement of parental consent for minors may hinder HIV prevention effort.

“We’ve jointly drafted a proposal to make HIV/AIDS a national agenda. One of the issues deals with legalizing sex. SWs should be entitled to similar welfare benefits and social security coverage as other professions.”

“Negative perception and attitude towards sex in some conservative families may prevent girls from receiving SRH services.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?

These laws affect all types of girls and women similarly. Indirect SWs, who are students, may have more difficulties getting SRH services because Thai society has high expectations towards well-educated group.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

The Prostitution Prevention and Suppression Act should be abolished to legalize sex. Requirement of parental consent for having HIV test for 18 years old and younger should also be abolished to improve HIV prevention for girls.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?

Mandatory HIV test still exists in some antenatal clinics. MOPH has the policy to provide free condoms to risk groups including SWs, MSMs and PLHIVs; but the budget was too small. The
National Health Security Office has developed a guideline for HIV counseling. Counselors have to provide condoms to clients with HIV risk.

“Public hospitals adhere to the VCT protocols. They have well-trained counselors. However, private hospitals and clinics usually do not have the counseling service.”

“We need at least 80,000,000 condoms to reduce new HIV infection. Free condoms are available only in hospitals and some urban health service institutions. Few rural health centers have this service.”

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

In-school sex education is available, but the coverage is still small. Comprehensive curriculum for Grade 1-3 children is not yet available.

“Global Fund sex education project focuses on teenage and young people. The median age of first sex is decreasing; we have to catch them while they are young.”

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

MOE should formulate clear policy on sex education and develop comprehensive curricula for different age groups. MOPH should campaign to promote condom acceptance.

“The practical approach for Thailand is CBA, not ABC.”

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in Thailand?

Female condom is not available in Thailand. Girls and young women have limited access to male condoms because of conservative Thai cultural norms.

Information on STIs is limited because some STI centers were closed down, the number of existing STI specialists is not sufficient to cope with the high number of patients. VCT is available in every public hospital, but only a few health centers and private clinics have this service. The cost of VCT in private hospitals is high and the quality of the service is inferior to public hospitals.

Pediatric ARV program needs improvement because suitable dose for children is not available. First-line ARVs are sufficient but availability of second-line ARVs for both children and adults are still limited.

PMTCT and ARVs for newborns are available in every public hospital, but the budget for baby formula for PLHIVs’ children is insufficient.

“Girls are too shy to request for or buy condoms. We have to change our social biased society; girls and boys should have equal access to condoms.”

“STIs and HIV/AIDS prevention programs suffered during the past 5 years because the previous government drastically cut the prevention budget.”

“Most private hospitals and clinics do not have trained HIV/AIDS counselors. The doctors are too busy to provide proper counseling service.”

“We’ve proposed to the NHSO to expand the service to health centers and to promote participation of PLHIVs in the counseling process.”

“The quota of second-line ARVs is limited to 1,600 patients nationwide.”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Or PLHIVned? Injecting drug users? Migrants? Refugees? HIV positive?*

Legal aliens are covered by the social security scheme and are entitled to basic SRH services, but illegal aliens are not. SWs who are illegal aliens are the most vulnerable groups. Besides illegal status they also have language barrier. Ethnic groups and street children are difficult to reach groups. Single, married women and PLHIVs get equal access to SRH service. IDUs are stigmatized by health service providers. They cannot enroll in the ARV program unless they quit drugs.

“Nowadays doctors and nurses are more open-minded. They normally do not ask patients about their marital or HIV status when they seek health services.”
What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

They have better access to SRH services. The sex education curriculum developed by NGOs and PLHIV networks (Teenpath Curriculum) focuses on promoting boys and young men’s role in safe sex. Better understanding and active participation of boys and young men will improve HIV prevention efforts for girls and young women.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Highest on the priority list is the improvement of existing condom service. MOPH has to increase the condom budget and develop public campaign programs to promote condom acceptance. Sex education to teach children about safe sex, STIs prevention and contraception should be expanded to cover every school nationwide.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in Thailand?

Aside from negative attitude towards SRH of some parents, there is no other barrier to HIV prevention services. Confidentiality of the service is no longer a problem because most hospitals have developed anonymous system using ID numbers instead of names. Attitudes of doctors and nurses towards PLHIVs have improved significantly in recent years. Cost of services is not a problem in Thailand because patients are entitled to free service under the universal health coverage.

“I’m proud to be a Thai, there’s no better service elsewhere. If the service is not covered by the NHSO, we can lobby relevant subcommittees to include it in the health coverage in the future.”

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

PLHIVs do not have difficulties accessing HIV prevention services. There are peer groups and counselors in every hospital.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Male youth leaders in Teenpath project are active in many schools, educating SRH, STIs information and HIV prevention to their peers, school children and their parents.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Existing services are fine. Girls and young women have to be open-minded. They should have the courage to seek assistance from numerous peer groups and counselors at any hospital.

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?

Ratification of international conventions might be beneficial in some aspects, but it can cause hardship among the target groups.

“I doubt whether it’s better or worse. Some HIV/AIDS or PLHIVs have to work because their parents are gone and their grandparents are too old to support them.”

“Some countries use these conventions as the non-tariff barrier for Thailand’s products.”

To what extent is the national response to AIDS ‘rights-based’?

The National Plan for the Prevention and Alleviation of AIDS in Thailand 2007-2011, now being drafted, does not meet the needs of PLHIVs.
“We were invited to participate in the formulation of the National Plan for the Prevention and Alleviation of AIDS in Thailand 2007-2011, but we declined the invitation. Formulation of the plan was not based on participatory approach. They have developed rigid frameworks that do not meet our needs. We prefer our Civil HIV/AIDS Agenda.”
“The government should give tax incentive to employers of PLHIVs; this is an issue that we have raised in the Thai Social Forum.”
“We need to campaign harder on PLHIVs’ rights, especially the rights to have children.”

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?
PLHIV networks and youth groups are well represented in many committees including the NHSO board and budget committee. Youth groups have representatives in the committee to formulate National Plan for the Prevention and Alleviation of AIDS in Thailand 2007-2011.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?
Girls and young women are well represented at in the national level decision-making about AIDS, but policy-makers have to be more receptive to their ideas. They should develop policies that truly address girls and young women’s needs.

Summary
In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?
The government should develop youth-friendly services, launch public campaigns to change negative attitudes of the general public on SRH, develop capacity building program for health service providers and provide more financial and technical support to PLHIV networks.
“MOPH should increase the number of SRH specialists and nurses, improve existing SRH services and make a commitment to support HIV prevention.”
“The NGO fund has been cut drastically. The grant that we got from the AIDS Bureau was so small ($2,500) and we had to revise our proposal so many times…. The payment was late. It was not worth the effort.”

One-to-one interview: Executive (male)
A local NGO working on SRH, family planning and HIV/AIDS

General
What is your impression about the general situation of HIV prevention for girls and young women in Thailand? Are things getting better or worse … and why?
HIV prevention for girls and young women in Thailand has worsened in recent years due to sexual behavior and low percentage of condom use.
“Our female clients have sex at a younger age and they have many partners. Some in-school girls are involved in sex. The rate of condom use among young people is low. The increased rate of unwanted pregnancy may signify that they are more socially active and they do not practice safe sex.”

Prevention component 1: Legal provision
In your opinion, what laws in Thailand are making HIV prevention for girls and young women better or worse?
Requirement of parental consent makes it difficult for girls to get VCT and SRH services. This has worsened STIs and HIV prevention because they may spread the virus to their partners. Most people still understand that abortion is illegal; although the Thai Medical Council and the Ministry of Health have drafted new regulations expanding the conditions under which abortion may be performed under the current law.
The Prostitution Prevention and Suppression Act has worsened HIV prevention efforts. “Women who have pregnancy termination are criminals because relevant sections in the Criminal Law have not been abolished.”
“Luckily parental consent is not required for the use of contraceptive pills. In the South, Muslim women need their spouses’ consent for contraception. However, they can manage that by seeking the service in other districts.”
“Not knowing about their HIV statuses, girls can pass on the virus to their partners or clients if they sell sex.”
“Despite illegal status, sex still flourishes. Health service providers cannot access this target group because SWs are not in the open. Enrollment of SWs in the social security scheme cannot be done.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?
The laws affect all types of girls and young women. However, illegal migrants and ethnic groups (without identification cards) cannot access any type of health service. “Without identification cards, they cannot access the national universal health coverage and social security scheme.”

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
A law that clearly states that HIV test must be on a voluntary basis should be introduced. A Labour law that protects the rights of PLHIVs is still lacking. Sections of Criminal Law that deals with abortion should be amended and the requirement of parental consent for VCT and other SRH services should be abolished. Besides amendment of laws, campaign programs to change conservation cultural norms should be implemented. “Mandatory HIV test is required by many service establishments despite the provisions to protect the right to confidentiality… Occasionally doctors violate PLHIVs rights by conducting HIV test without their consents. Some health (antenatal) protocols require mandatory blood test and HIV test is included.”
“We encourage our colleagues to introduce the workplace policy on HIV.”

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counselling and testing – make HIV prevention for girls and young people in Thailand better or worse?
Improper implementation of antenatal care protocol has adversely effect on VCT. Discontinuation of contraception campaign affects condom budget and dissemination of SRH information.
“The policy on VCT is clearly stated in the National AIDS Plan. However, the quality of pre- and post- counselling needs improvement. The antenatal protocol recommends mandatory blood test, including HIV test. The voluntary policy is there, but in practice it is mandatory. That’s an infringement on our right to confidentiality.”
“The fertility rate is low. Consequently MOPH has discontinued the contraception campaign, and reduced the condom budget. A component of the contraception campaign is safe sex. SRH education thus suffers.”

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?
The coverage of sex education is still limited. Most teachers do not have capacity to teach comprehensive sex education. The curriculum for young children is not available. “This is a big problem; existing sex education are still pilot projects. The coverage is still small. Sex education is not available in Teachers’ Colleges. If MOE introduce sex education policy, we will have to train a large number of teachers to enable them to teach comprehensive sex education.”
“After a weeklong sex education training course, teacher still do not have sufficient confidence to teach sex education in class.”
Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

The government should improve protocols that deal with HIV stigmatization and support social campaigns to change the gender-biased cultural norms.

“If HIV stigmatization is eliminated, lobbying for HIV prevention, treatment and care is effortless.”

“Families have high expectations towards their daughters. They should not have pre-marital sex. Boys and young men do not have this pressure.”

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in Thailand?

Free condoms are available but the supply is limited. The coverage of VCT is still limited and the quality of existing VCT need improvement. ARV target has not been reached due to limited promotion budget. Moreover, the ARV policy, similar to HIV prevention policy, is based on risk groups. PMTCT is available to all antenatal clients in public hospitals. Availability of PMTCT service in rural settings is limited.

“Free condoms are available in limited hospitals and health centres. It is insufficient. Some conservative groups, i.e., farmers, fishermen and housewives prefer getting condoms from health centres. They do not feel comfortable buying condoms from convenient stores.”

“Social marketing of condom needs support from stakeholders, AIDS Bureau does not have the capacity. Just look at the HIV prevention budget. We have to request financial support from international agencies. How many organizations in Thailand have the capacity to develop proposals for international funding?”

“Some, not all PLHIVs have access to ARV. The number of PLHIVs seeking ARV is below target because there is no campaign to inform them about availability and benefits of the drug program.

“Some pregnant women may not have access to antenatal care and only some of antenatal clients in private clinic are enrolled in the PMTCT program.”

“From our experience in Narathiwas about half of pregnant mothers do not have access to antenatal care. There are at least 500 active midwives in the province.”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Or PLHIVned? Injecting drug users? Migrants? Refugees? HIV positive?

Unmarried women, SWs and legal aliens do not have difficulties accessing SRH and HIV prevention services. IDUs is the most difficult to reach group.

“Our previous government had the policy to eradicate drug use. The HIV component was not on the agenda. It was very difficult for community workers to reach IDUs.”

“Migrants are less vulnerable, we can reach them and we don’t need identification cards.”

“Stigmatization of HIV or PLHIVns still exists; some HIV positive children are still barred from schools.”

“Unmarried women and SWs do not have difficulties accessing SRH service.”

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Many NGOs have sex education programs that aim to promote responsible relationship and participation of boys and young men in HIV prevention.

“If boys and young men care, girls and young women will be safe. We have campaigns to change gender-biased social norms, but the coverage is still very low.”

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Quantity and quality of condom and VCT services need improvement. Moreover, the government has to support campaigns to change gender-biased value and negative attitudes towards condoms.

“We need to campaign aggressively to promote safe sex. If the attitudes towards safe sex improve, they will protect themselves by using condoms.”
"The policy is there, but the support is still lacking."

**Prevention component 4: Accessibility of services**

What are the main barriers to girls and young women using HIV prevention services in Thailand?
Attitudes of service providers, language use and cost of service are main barriers. Other barriers include shyness, breach of confidentiality, convenience and cost of service.

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?
All have equal access with the exception of marginalized people, i.e. migrants, ethnic groups, IDUs, etc.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?
Boys and young men have some, although limited, role in making HIV prevention services easier and better for girls and young women.
"There’s no role model at the national level. However, some of our male peer educators have been active in promoting HIV and STIs prevention."

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?
Both the service settings and quality of service should be improved. MOPH should develop capacity training program for health service providers.
"Improve existing service settings to ensure privacy. Service providers should be trained to change attitudes towards STIs and HIV/AIDS clients."

**Prevention component 5: Participation and rights**

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Thailand?
Implementation of both conventions is still very limited.

To what extent is the national response to AIDS ‘rights-based’?
The national response to AIDS ‘right-based’ has improved as evidenced by active participation of PLHIVs in all levels.
"More PLHIVs reveal about their HIV statuses. There are more PLHIV groups and networks in hospitals. This may signify less prejudice towards PLHIVs."

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?
Youths and PLHIVs are on the committee to develop the National Plan for the Prevention and Alleviation of AIDS in Thailand 2007-2011. However, it is still uncertain whether their suggestions and needs will be addressed in the plan.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?
The government should have a policy to encourage participation of girls and young women in every process of the AIDS plan. Guideline on the selection process should be developed to ensure fair representation.
"Youth forum exists, but I’m not sure about their nomination process. There are about 20 youths in our board member. Each peer group nominate a representative. They we select active youths from the list."
"Some girls and young women are already active in community works. We should promote their participation in HIV prevention. Parents/adults should support their activities."
Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Thailand?

NGOs, CBOs and PLHIV networks have to work together to lobby for AIDS budget increase and improved SRH services.

"The decreasing budget shows the level of commitment of the MOPH on AIDS policy and national plan."

"We need a government figure who has the political will to solve HIV/AIDS problems. Meanwhile, communities have to work together to lobby for change."