RECOMMENDATIONS

Based on this Report Card, a number of programmatic, policy and funding actions could be recommended to enhance HIV prevention for girls and young women in Thailand. These are that key stakeholders – including government, relevant intergovernmental and non-governmental organisations, and donors – should consider:

1. The government of Thailand should sign the **Convention on Consent Marriage, Minimum Age of Marriage** and **Registration of Marriages.**
2. Review and strengthen Thailand's action in the light of the aspects of the **Political Declaration on HIV/AIDS** from the 2 June 2006 High-Level Meeting (to follow up on UNGASS) that particularly relate to HIV prevention for girls and young women. These include sections: 7, 8, 11, 15, 21, 22, 26, 27, 29, 30, 31 and 34.
3. Address the health impact of **unsafe abortion** as a major public health concern, and reduce the recourse to abortion through expanded and improved family-planning services. Ensure that a women's HIV positive status does not cause her to be pressured to seek an abortion against her will. Note that any abortion related changes within the health system can only be determined at the national or local level according to the national legislative process.
4. Undertake **a national awareness raising campaign with HIV prevention messages** for the broader community, and in particular aimed at reducing HIV prevalence among young women and men, sex workers and injecting drug users. This should build upon existing campaigns and use key messages **developed in collaboration with the target audience**.
5. Increase the focus on prevention within the **work of the National Health Security Office (NHSO)**. In doing so, expand young peoples' access to a broader range of information and commodities, including male and female contraception.
6. Increase the **scale and breadth of HIV prevention programmes** for girls and young women in the general population. Ensure that such efforts:
   - Build **awareness and action on equitable gender relations**, for example by addressing harmful gender 'norms' that contribute to girls' and young women's vulnerability.
   - Promote **income generating activities** and **building practical skills**, particularly for sex workers.
   - Include the **involvement of boys/young men** and create an enabling dialogue about sex and HIV and AIDS between them and girls/young women.
   - Target **men who have sex with men**, who may also be married.
   - Focus on the **promotion of positive prevention** (i.e. the need for HIV prevention to be for, and with, people living with HIV) and **positive attitudes to safe sex** and sexuality.
7. **Expand youth-friendly, and integrated, HIV and sexual and reproductive services**, particularly for young women living with HIV, to all major district health outlets within countries. Also **address some of the barriers** to the use of such services, for example by more systematically incorporating youth-friendly and confidential approaches into the training of government health staff.
8. More aggressively **promote a positive model of voluntary counselling and testing** – one that emphasises the benefits of knowing your HIV status within a safe and supportive environment, guarantees confidentiality and helps girls and young women cope with the aftermath, for example in terms of notifying their families and partners.
9. Promote **universal access to antiretroviral therapy**. Ensure that girls and young women living with HIV, including those who are poor and in rural areas can receive treatment in an environment that not only addresses their HIV status, but recognises their needs relating to their gender and age.
10. Rapidly move to implement **comprehensive health services and HIV/AIDS programs for migrants, hill tribes and other ethnic minorities**, in particular women and girls. It is essential to expand HIV prevention, voluntary testing and counselling services and condom availability, and to make anti-retroviral therapy available to foreign resident migrants, minorities and members of hill tribes on an equal basis with Thais.
11. Significantly **scale up the pilot HIV prevention programmes for vulnerable groups of girls and young women**, such as those involved in sex work or injecting drug use. Ensure that such initiatives are carried out within a supportive environment that is non-coercive, non discriminatory and promotes participants' rights.
12. Complement existing programmes for vulnerable groups by **developing models to reach other types of marginalised girls and young women**, such as those who live in border areas, are migrant workers and/or victims of gender-based violence.
13. Strong commitment to **support comprehensive sex education programs** at a local and national level is needed to integrate of sex education in school curriculum in all schools including the rural schools. In addition: enable condom distribution in schools; ensure that peer educators are equipped to provide referrals to services in the community; and ensure that teachers receive adequate training and support to put any life skills education provided into effective practice.
14. The national response to HIV and AIDS needs a **stronger 'right-based' approach**. Some rights of people living with HIV are still being violated and discriminated especially their rights to conceive or terminate pregnancies, because doctors don't want to get involved.
15. **Work with boys and men** to improve their health seeking behaviour, challenge their attitudes toward sex (to *inter alia* address demand for sex workers), and to reduce the transmission of HIV and STIs to their regular partners.

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REPORT CARD
HIV PREVENTION FOR GIRLS AND YOUNG WOMEN

THAILAND

COUNTRY CONTEXT:

Size of population:	**62,418,054**[1]
Life expectancy at birth:	**72.75 Years**[2]
Percentage of population under 15 years:	**22%**[3]
Population below income poverty line of $1 per day:	**10%**[4]
Female youth literacy rate (ages 15-24):	**97.8%**[5]
Youth literacy rate (female rate as % of male rate, ages 15-24)[i] between 1995-1999:	**100%**[6]
Median age at first marriage for women (ages 15-49) in 2006:	**21.2 Years**[7]
Median age at first sex among females (ages 15-49)[ii] in 2004:	**20 Years**[8]
Median age at first sex among males (ages 15-49) in 2004:	**19 Years**[9]
Health expenditure per capita per year:	**$321**[10]
Contraceptive prevalence rate[iii]:	**81.1%**[11]
Maternal mortality rate per 100,000 live births:	**36**[12]
Main ethnic groups: Thai 75% | Chinese 14% | other 11%[13]	
Main religions: Buddhist 94.6% | Muslim 4.6% | Christian 0.7% | other 0.1%[14]	
Main languages: Thai | English (secondary language of the elite) | ethnic and regional dialects[15]	

AIDS CONTEXT:

Number of women aged 15 and over living with HIV:	**220,000**[16]
Number of adults aged 15 and over living with HIV:	**560,000**[17]
HIV prevalence among pregnant woman in 2005:	**1.01%** [18]
HIV prevalence among brothel based sex workers in 2005:	**6.8%**[19]
HIV prevalence among injecting drug users in 2005:	**37.6%**[20]
Number of deaths due to AIDS in 2005:	**21,000**[21]

HIV PREVENTION FOR GIRLS AND YOUNG WOMEN CONTEXT:

Girls and young women in Thailand are particularly vulnerable to HIV infection in a number of ways, particularly through sex work and the increasing prevalence rates among married women.[22] In addition, social and cultural factors affecting gender roles mean that women have less negotiating power in sexual relationships.[23]

The economic activity rate of females in the age group 15 years and over in Thailand was 73.1 percent in 2001, approximately 85 percent of the male rate. Although the economic activity rate of women is very high, many women continue to be unpaid or 'contributing family workers'.[24] The rates of casual sex without condoms are also found to be equally high among both males and females. In addition, there is a high population mobility of both Thai citizens and cross-border migrants which also increases risk and vulnerability to HIV infection, particularly for women and young girls.[25]

Girls and young women in Thailand have made progress in the area of reproductive health, yet more needs to be done to strengthen women's reproductive rights as significant gender gaps continue to exist. In addition, access to comprehensive sexual and reproductive health services, including HIV prevention, treatment and care, remains uneven across the country.[26] Finally, barriers still exist to womens' access to, and protection from, the legal system.[27]

INTRODUCTION

THIS REPORT CARD AIMS TO PROVIDE A SUMMARY OF HIV PREVENTION FOR GIRLS AND YOUNG WOMEN IN THAILAND.

This Report Card is one in a series produced by the International Planned Parenthood Federation (IPPF), under the umbrella of the Global Coalition on Women and AIDS, and with the support of the United Nations Population Fund (UNFPA) and Young Positives.

The Report Card is an **advocacy tool**. It aims to increase and improve the programmatic, policy and funding actions taken on HIV prevention for girls and young women in Thailand. Its key audiences are **national, regional and international policy and decision-makers, and service providers**. It builds on global policy commitments, particularly those outlined in the Political Declaration on HIV/AIDS from the 2 June 2006 High-Level Meeting, to follow up on the United Nations General Assembly Special Session on AIDS (UNGASS).

The Report Card summarises the **current situation of HIV prevention strategies and services for girls and young women ages 15-24 years in Thailand**. It contains an analysis of five key components that influence HIV prevention, namely:

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

It also provides **recommendations** for key stakeholders to enhance action on HIV prevention strategies and services for girls and young women in Thailand.

The Report Card is the basis of extensive research carried out during 2006 by IPPF, involving both desk research on published data and reports, and in-country research in Thailand to provide more qualitative information. This research is detailed in full within a 'Research Dossier on HIV Prevention for Girls and Young Women in Thailand (available on request from IPPF).

1» PREVENTION COMPONENT 1
LEGAL PROVISION (NATIONAL LAWS, REGULATIONS, ETC)

KEY POINTS:

- For both women and men, the **Minimum Legal Age for Marriage** is 17 with parental consent, and 20 without parental consent.[28]
- The minimum age for having an **HIV test** without **parental and partner consent** is 18.[29]
- **HIV Testing is not mandatory** for any population group in Thailand. A number of key groups are tested for HIV as part of the annual HIV sero-sentinel surveillance, including military recruits, migrant workers, sex workers and injecting drug users. Sex workers are also regularly tested by the brothel owners. Neither of these processes are, however, government operated mandatory testing systems.[30]
- **Abortion** is legal only where pregnancy would be life threatening to the woman, or in the case that the pregnancy was caused by rape.[31] Studies suggest, however, that 66.6% of women with unplanned pregnancies seek abortion services from abortionists who are non medical-professionals. There are also concerns about women and girls living with HIV being **pressured to have an abortion and seek sterilization**.[32]
- **Sex work is illegal in Thailand**. The National Program on HIV Prevention decided, however, that it was more effective to work with those involved, than to pursue enforcement actions that would make sex workers less accessible for prevention strategies.[33]
- Injecting drug use is illegal and the **government is not supportive of promoting needle exchange**.[34] A drug treatment program is provided in most hospitals as a substitution therapy. Methadone maintenance therapy is available only in Bangkok Metropolitan Administration clinics and a few regional drug treatment centers.[34a]
- Health legislation gives all Thai people 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.[35]
- Children, youth and family members have the right to be protected by the State **against violence** and unfair treatment. These groups also have the **right to health and education**.[36]

QUOTES AND ISSUES:

- "A **mandatory HIV test** is required by many service establishments despite the provisions to protect people's right to confidentiality. Occasionally doctors violate People with HIV and AIDS (PHAs) rights by conducting HIV test without their consent." (Interview, Executive, Local NGO)
- *"Policemen perceived that finding it [a condom] is **evidence of the sale of sexual services**. If a woman has 3 condoms in possession, she will be charged with providing sex services. If she has 5 condoms then she will be charged with operating a sex business."* (Interview, Peer Educator, Local NGO)
- "It doesn't look good if we carry condoms. **Men are the ones who use condoms**, so they should carry them". (Focus group Discussion: 15-19 year olds)
- *"The Prevention and Suppression of the Sale of Sexual Services should be abolished to legalize sex work".* (Interview, Senior Representative PLHA group)
- "Legalization of sex work does not ensure safe sex. Some clients may refuse to use condoms and, in practice, **enforcement can be difficult**. Sex work will flourish and more girls and young women from neighbouring countries might be drawn into the sex trade." (Focus Group Discussion: 20-24 year olds)
- *"We have laws to prevent underage sex, forced sex, violence, etc. These laws are meaningless, if our **gender biased social values** (treasure virginity) do not change." 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 their parents' consent."* (Interview, Youth coordinator)
- "**Laws cannot guarantee safe sex**. Drug stores and convenient store staff tend to have negative attitudes towards female condom-customers. Requirement of parents' consent for less than 18 years old girls **reduces their chances of access to proper Sexual and Reproductive Health (SRH) services**. Most parents will be furious if they see condoms in their daughters' purses. It's the parents' attitude problem." (Interview, Youth coordinator)
- *"SRH services and Voluntary Counselling and Testing (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 an illegal abortion, or take some drugs to terminate a pregnancy, rather than consulting their parents."* (Doctor, SRH Unit)

2» PREVENTION COMPONENT 2
POLICY PROVISION (NATIONAL POLICIES, PROTOCOLS, GUIDELINES, ETC)

KEY POINTS:

- 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.[37]
- The **National Plan for the Prevention and Alleviation** of HIV/AIDS in Thailand 2002-2006 is a **multi-sectoral framework** for integrating the prevention and alleviation efforts of all relevant parties.[38] The plan's strategies include establishing health and social welfare services, developing knowledge and research and developing a holistic programme management system to integrate the tasks of HIV/AIDS prevention and alleviation. The plan also contains a **target to reduce HIV/AIDS infection among women** by 20%.[39]
- The **target groups in the National Plan** include general target groups, such as populations of reproductive age and young people in and out of the educational system. There are also a number of **specific target groups, including**:
  - The underprivileged and difficult to access such as street children, labourers, prisoners, and youth in juvenile detention centres;
  - Intravenous drug users, and sex workers;
  - Internal migrants, cross border migrants;
  - Workers in factories.[40]
- The National Plan addresses the needs of people living with HIV/AIDS stating that "At least eighty percent of **persons living with HIV/AIDS** and affected individuals will have **access to, and be receiving, appropriate care and support"**[41]
- Schools are expected to **provide students with information about HIV/AIDS in the classroom**. In addition, youth education and HIV prevention is a component of the Global Fund programme to strengthen HIV prevention and care in Thailand. It is not known, however, how many education institutions have introduced HIV prevention and life skills programming and whether those that did, have sustained the effort.[42]
- Since 1995, HIV transmission from mother to child has decreased from 25.5% to 8-9%. The policy on PMTCT encourages health care facilities to **provide Voluntary Confidential Counselling and Testing (VCCT) to all pregnant women**, and to provide **ARV drugs** to HIV positive pregnant women for PMTCT, and replacement feeding to all babies born to HIV infected mothers.[43]

QUOTES AND ISSUES:

- "They [Ministry of Public Health] **cut the condom budget**. Moreover, the available size (49) is not usable. All of our condoms are from international agencies. Sex workers often buy their own condoms." (Interview, Peer Educator, Local NGO)
- *"The condom supply has been depleted. The AIDS Bureau have requested additional budget from the National Health Security Office (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**."* (Project Officer, international agency)
- "**Social marketing** of condoms has not been very successful" (Representative, International Agency)
- *"The policy on **Voluntary Counselling and Testing (VCT)** is clearly stated in the National AIDS Plan. However, the quality of **pre- and post- counselling needs improvement**. The antenatal protocol recommends a mandatory blood test, including HIV test. The voluntary policy is there, but in practice it is mandatory."* (Interview, Executive, Local NGO)
- "We learnt **sex education** when we were young and inexperienced. It was only theory without practice. Life skills can be developed only through practice" (Focus group Discussion: 15-19 year olds)
- *"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."* (Doctor, SRH Unit)
- "They taught us about female reproductive organs and contraceptive methods. But, they don't demonstrate **proper condom use**. We were not shown contraceptive pills." (Focus Group Discussion: 20-24 year olds)
- *"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."* (Project Officer, international agency)

3» PREVENTION COMPONENT 3
AVAILABILITY OF SERVICES (NUMBER OF PROGRAMMES, SCALE, RANGE, ETC)

KEY POINTS:

- Thailand has an extensive health infrastructure, which has greatly facilitated the national response to HIV and AIDS. For example,**Voluntary Counselling and Testing (VCT) 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.[44]
- **Coverage of antiretrovirals** has expanded to 908 health service institutions in every province. Cumulative enrollment to the ARV program as of August 2006 was 103,861, with 82,340 patients still enrolled in the program.[45]
- While some hospitals can and do **provide systematic and appropriate services** (including pre- and post- test 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.[46]
- Drop-in centres for youth have been introduced in almost all the 76 provinces to **enhance accessibility of reproductive health information and services to youth at affordable costs**. At drop-in centres, young people have informal group discussions and seek counselling on health and sexuality issues.[47]
- There is a strong history of condom promotion in Thailand, and, **condom distribution** has been recognised as a good tool for helping to prevent the spread of HIV/AIDS. There is a need, however, to provide **more convenient and accessible condom outlets** so that people can buy condoms at a lower price (e.g. by installing condom automatic vending machines in public places).[48]
- **The government launched a highly successful nationwide "100% condom use programme"** for sex workers 10 years ago. Due, however, to the elimination of specialised STD clinics and less effective condom promotion, this programme no longer has its previous reach and impact.[48a]
- **No mass public prevention campaigns** have been carried out in Thailand for over a decade. Awareness has decreased and unsafe sexual behaviour may have increased.[49]
- There is a need to enable a more **positive environment for safe sex behaviour** in Thai society. This includes greater HIV/AIDS awareness raising among Thai people of reproductive age, and key target populations. It is also necessary to encourage adoption of correct and positive attitudes to safe sex and to implement **sustainable preventive behaviour in youth**.[50]
- Some programmes exist which discuss possibilities for **men's greater responsibility** in sexual and reproductive health and HIV prevention. These are reported to be important in encouraging male condom use, particularly among those having sex with sex workers or who are **married and also have sex with other men** (often without a condom). Generally, however, these programmes are not mainstreamed.[51]

QUOTES AND ISSUES:

- "**Attitudes towards Voluntary Counselling and Testing (VCT) have improved significantly**. Nowadays PHAs tend to reveal their HIV positive status, because they will be entitled to the ARV therapy from the National Health Security Office (NHSO). Moreover, stigmatisation towards People living with HIV and AIDS (PHAs) has lessened due to 20 years of extensive HIV/AIDS work in Thailand." (Project Officer, international agency)
- *"The availability of the **female condom is very limited**. It is too expensive, noisy and difficult to use. Only Sex Workers know about this contraceptive option. Housewives are not aware of the female condom."* (Interview, Peer Educator, Local NGO)
- "Sexual Transmitted Infections (STIs) and HIV/AIDS **prevention programs suffered** during the past 5 years because the previous government drastically cut the prevention budget." (Interview, Executive, Local NGO)
- *"**Free condoms** are available in limited hospitals and health centres. It is insufficient. Some conservative groups prefer getting condoms from health centres. They do not feel comfortable buying condoms from convenience stores."* (Interview, Executive, Local NGO)
- "If we hand out **condoms**, only a 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." (Focus Group Discussion: 20-24 year olds)
- *"**Mobile clinics** nowadays focus only on screening for cervical cancer. Safe sex and family planning information no longer exists."* (Focus Group Discussion: 20-24 year olds)
- "**Rural women may have to travel long distances** 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." (Doctor, SRH Unit)
- *"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."* (Project Officer, international agency)
- "If the services focus only on treatment, it will never work for youths….however other services that girls and young women need including **counselling and partnership relations may not be available**." (Project Officer, international agency)

4» PREVENTION COMPONENT 4
ACCESSIBILITY OF SERVICES (LOCATION, USER-FRIENDLINESS, AFFORDABILITY, ETC)

KEY POINTS:

- The Open-minded Talk for Safe Sex Project, a collaborative project of the Bureau of AIDS, Tuberculosis (TB) and Sexual Transmitted Infections ((STIs), Thai Business Coalition on AIDS (TBCA), Thai NGO Coalition on AIDS (TNCA) and Program for Appropriate Technology in Health (PATH), funded by the Global Fund, produced television spots, radio spots and print ads to **promote sex communication within Thai families**. One television spot focused on a girl and her mother.[52]
- **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.[53]
- School health services, consisting of only general health care and vaccination programmes, tend to be inadequate because they do not provide **counselling and contraceptive services**.[54]
- A **lack of confidentiality**, judgemental parents, teachers and service providers, a lack of affordability and inconvenient clinic hours are some of the **barriers** that have prevented adolescents from seeking sexual and reproductive health services.[55]
- 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 drug store proprietors.[56]
- 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 are often unable to access any state services, including health care. The Thai Government does not, however, deny stateless women access to PMTCT services.[57] Nevertheless, where these people can access services, they often face stigma and discrimination, and poor patient care.
- **The government recently decided to fully subsidize all care under its previous '30 baht health care scheme'.** This scheme, which forms part of the Universal Health Security Plan, now provides all Thai citizens with the right to receive standard health services for free. This right is particularly important for poor and underprivileged citizens, and in improving access to health promotion, and disease prevention and control services (including antenatal care, family planning, and immunisation).[58]

QUOTES AND ISSUES:

- "The **health centre in my community is very small**; there are only 2 members of staff. I have to seek antenatal care from a hospital." (Focus Group Discussion: 20-24 year olds)
- *"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 the workplace, inconvenient service hours and a lack of privacy."* (Interview, Peer Educator, Local NGO)
- "The **cost of services is often a problem for underprivileged groups**. They have to use public hospitals and the queue for SRH services is very long." (Doctor, SRH Unit)
- *"Confidentiality of the service is no longer a problem because most hospitals have developed an **anonymous system** using ID numbers instead of names."* (Interview, Senior Representative PLHA group)
- "Highest on the priority list is **youth friendly services** that address their [young people's] real needs. The second priority is programs that can **motivate active participation of youth** in HIV prevention." (Representative, International Agency)
- *"**Ethnic people** are not equally treated. We usually receive inferior health services. They [health professionals] are not willing to provide services to ethnic people."* (Focus Group Discussion: 15-19 year olds)

5» PREVENTION COMPONENT 5
PARTICIPATION AND RIGHTS (HUMAN RIGHTS, REPRESENTATION, ADVOCACY, PARTICIPATION IN DECISION-MAKING, ETC)

KEY POINTS:

- Thailand has signed both the **Convention on the Rights of the Child** and the **Convention on the Elimination of all Forms of Discrimination against Women** in 1992[59]. It has not signed the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages.[60]
- The **National AIDS Prevention and Control Committee** coordinates HIV/AIDS prevention and alleviation efforts in Thailand. Government agencies, non-government organisations, the business sector, community-based organisations and groups of people living with HIV/AIDS have administered and implemented prevention and alleviation programs.[61]
- The **Thai Network of People Living with HIV/AIDS (TNP+)** currently supports 7 regional networks comprised of over 900 PHA groups and has over 90,000 members. TNP+ is heavily involved in issues of advocacy and education and is represented in the National AIDS Committee.[62]
- There are at least one million Burmese in Thailand, the vast majority undocumented migrants. Once in Thailand and without work or residency documentation, Burmese women and **girls lack the most basic rights and access to services**, face acute discrimination and are subject to the threat of deportation to Burma.[63]
- **Non Governmental Organisations (NGOs) and community-based groups** are often best placed to **reach marginalised populations**. However, the share of the overall AIDS budget going to civil society groups in Thailand remains small (about 6-7 percent) compared to many other countries.[64]
- The **Thai Women and AIDS Task Force** was formed in 2002 and is aimed at empowering women and creating a forum for collective action against HIV/AIDS with **women's and gender perspective**.[65]

QUOTES AND ISSUES:

- "Girls, **young women and Sex Workers are represented** in the National AIDS Committee and many other committees. They also serve as board members in some Global Fund projects." (Interview, Peer Educator, Local NGO)
- *"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."* (Interview, Senior Representative PLHA group)
- "Most people do not have days off. They have to **work everyday to earn enough income**. To encourage their involvement, we need financial incentives." (Focus Group Discussion: 20-24 year olds)
- *"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."* (Representative, International Agency)
- "Within the national response to AIDS, the '**right-based' elements need improvement**. Some PHAs' rights are still being violated. PHAs cannot get pregnancy termination because doctors don't want to get involved. Many employers still discriminate against PHAs." (Doctor, SRH Unit)

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[iii]. The percentage of married women in union) ages 15-49 who are using, or whose partners are using, any form of contraception, whether modern or traditional

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