A Review of Sexuality and Reproductive Health and Rights in Thailand

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Siriporn Yongpanichkul, consultant based in Bangkok, Thailand, wrote this report for the Sexuality and Reproductive Health program of the Ford Foundation office for Vietnam and Thailand, in Hanoi Vietnam. The report was written May - August 2006 and finalized in May 2007.

Martha Ann Overland, journalist and editor, based in Hanoi, Vietnam, edited the report.

Susan Y. Wood, Program Officer for Sexuality and Reproductive Health, the Ford Foundation, Hanoi, provided oversight and editorial support.

The Ford Foundation Office for Vietnam and Thailand
Pacific Place
83B Ly Thuong Kiet Street, 14th floor
Hanoi, Vietnam
Tel.: (844) 946-1428 or 946-1418
Fax: (844) 946-1417
Email: ford-hanoi@fordfound.org

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Abbreviations

ARROW	Asian-Pacific Resource & Research Centre for Women
ART	Antiretroviral therapy
ARV	Antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CBOs	Community-based organizations
CUP	100 % Condom Use Program
GBV	Gender-based violence
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
ICPD	International Conference on Population and Development
INGOs	International non-governmental organizations
IDUs	Injecting drug users
MCH	Maternal and child health
MDG	Millennium Development Goals
MOPH	Ministry of Public Health
MSF	Medecins San Frontieres (Doctors without Borders)
MSM	Men who have sex with men
NGOs	Non-governmental organizations
OSCC	One-Stop Crisis Center
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PPAT	Planned Parenthood Association of Thailand
PPFA-I	Planned Parenthood Federation of America - International
RH	Reproductive health
SRH	Sexuality and reproductive health
STIs	Sexually transmitted infections
TNCA	Thai NGOs Coalition on AIDS
TNP+	Thai Network of People Living with HIV/AIDS
TWAT	Thai Women against AIDS Taskforce
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
VCT	Voluntary counseling and testing
WHAF	Women's Health Advocacy Foundation
WHO SEARO	World Health Organization, South East Asia Regional Office

I. Executive Summary and Introduction

Background

The Ford Foundation office for Vietnam and Thailand has been making grants in the fields of sexual and reproductive health (SRH) and rights in Thailand for over 40 years. The Foundation was one of the first non-governmental organizations (NGOs) to work on these issues in Southeast Asia and its commitment remains strong. In the ten years from 1998 through 2007, the Foundation committed at total of some $3.8 million in grants for sexual and reproductive health and rights in Thailand, plus additional funding for travel and study.

In order to maximize the strategic effectiveness of limited funding, the Foundation commissioned an assessment of the current state of sexuality and reproductive health in the country. This report is the product of that assessment. It reviews the current status of the principal issues addressed by the Ford Foundation Sexuality and Reproductive Health program and identifies realistic opportunities for the Foundation and other funders to maximize their future commitments in order to improve the lives of vulnerable and underserved groups in Thailand.

This report is not intended to be a statement of Ford Foundation priorities or grantmaking commitments, but rather used as a background document for those who would like to contribute to improving sexual and reproductive health and rights in Thailand.

Successes and Shortcomings of Sexual and Reproductive Health and Rights Programs in Thailand

In the past few decades, Thailand has made remarkable progress in improving its reproductive health service programs. Under the "30-Baht Scheme," Thai people can access healthcare, including reproductive health services and obstetrical care, for about US $0.80 per visit.[1] Yet the quality of reproductive and sexual health care offered in hospitals is often poor and young or unmarried people face barriers to accessing services and information.

Successful pilot programs in many areas of SRH have served as powerful arguments for expansion. But such models have not yet been replicated nationwide because of budget constraints, problems with resource allocation, management issues, a lack of understanding on the part of health personnel and, in particular, a lack of commitment at the policy-making level. In addition, the segmented distribution of authority and responsibility that occurs within government agencies often makes it difficult to implement SRH programs.

A diversity of women's health advocacy groups, NGOs and academics, however, have improved reproductive health rights and services, as well as helped shape national

[1] The 30-Baht program was started by the Thaksin government in 2001. After the coup in September 2006, the program was no longer officially in force, but universal access to subsidized healthcare has continued.

policy. For the first time in the country's history, Thailand had begun development of a reproductive health law to protect sexual and reproductive rights, but progress on the law was halted due to the political stalemate throughout 2006.

At the same time, HIV/AIDS transmission has increased due to unprotected sexual intercourse, largely through commercial sex and casual sex with regular partners. Thailand is widely praised for its HIV/AIDS prevention campaign. Yet problems in AIDS prevention, treatment and care persist, and laws to protect the rights of the HIV-infected persons need to be strengthened.

Thai adolescents are now more aware of the risks of unsafe sex but many are not ready to adopt a safe sex life. Reproductive health education has been introduced and encouraged in Thailand for the past 10 years. Thai adolescents, however, still appear to be shy about the subject and prefer to receive the information in private.

Abortion is currently legally-restricted in Thailand. Providing or self-inducing an abortion is prohibited unless it is carried out in consideration of a woman's health or the woman has been raped or is a victim of incest. Illegal and medically unregulated abortions pose risks to women's health. Hence, the government's Department of Health has worked very closely with the Thai Medical Council and other key organizations to improve services to women who would qualify under the law and to offer guidelines to physicians to define what would be a negative effect on health.

The problem of gender-based violence (GBV) persists. The majority of women in Thailand who suffer injuries from their spouses do not seek medical assistance or help from social services. Consequently, the Ministry of Public Health (MOPH) commenced a pilot program for One-Stop Crisis Centers (OSCCs), funded by the Ford Foundation, to assist victims of domestic violence. The program was carried out in several provinces following the success of the pilot project. The government has also tried to incorporate sexual and reproductive rights into the law, and make women feel more comfortable approaching police officers to report abuses. While expansion of the OSCC has been impressive, quality has suffered in many sites.

Undocumented immigrant workers and women who are members of the minority hill tribes in Thailand are not protected by the laws, nor do they have good access to healthcare schemes. Moreover, in Southern Thailand, many medical centers have reduced their operating hours due to the fear of violence, thereby limiting women's access to services, especially for Muslim women who may be more hesitant to use government services even when available.

Challenges and Opportunities

Despite progress in the areas of sexuality and reproductive health, there is still much to do. Unsustainable capacity development and a lack of funding for SRH programs is a major concern. There continues to be a gap between sexual and reproductive rights in policy and those in practice. Government agencies often lack a sense of commitment to SRH programs and the failure to integrate them remains a problem. It is also evident that many target groups remain uninvolved. And accurate and unbiased reports by the media are few and far between.

Fortunately, plenty of opportunities to improve the current situation do exist. Strong networks of NGOs and women's health advocacy groups have laid the groundwork for change. A powerful movement to stop the transmission of HIV/AIDS is already in place. Thailand also has a well-organized public health service. And the government and legal system appear open to reform.

The implementation of SRH programs in Thailand will require continued funding in order to deliver sustainable outcomes for the well being of the Thai people. Effective programming should focus on capacity building for NGO and government workers; empowering women in SRH programs; increasing male involvement in SRH activities; supporting further program research; and providing grant assistance to small organizations outside Bangkok. Other key areas to focus on include gender-based violence, safe induced abortion, reproductive rights and health services, adolescent sexuality, marginalized groups and the unmet needs of groups with diverse sexual orientations and gender identities.

AUTHOR'S NOTE ON METHODOLOGY:

This study was written based on the review and analysis of the current academic research available on sexuality and reproductive health in Thailand. The author also used advocacy materials and government documents to prepare the report. In addition, interviews were conducted with key informants, including past and current Ford Foundation grantees and non-grantee organizations working in the field, such as international donors, researchers and advocates.

II. Successes and shortcomings of Sexuality and Reproductive Health Programs in Thailand

1. Overview

Thailand's programs for women's sexual and reproductive health is recognized as outstanding in the international arena, specifically in mortality and fertility reduction, family planning coverage and safe motherhood. After the Thai government signed on to the goals of the International Conference on Population and Development (ICPD) in 1994, the MOPH declared a national policy on reproductive health. This new policy expanded the definition and coverage of reproductive health to include adolescent health, safe abortion, sex education, HIV/AIDS, infertility, reproductive tract infections and post-reproductive age care. When it was discovered that high incidences of violence against women were being reported, gender-based violence (GBV) was added to the list. The Thai government also ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1985 (UNFPA, 2005).

As new concepts and areas in sexual and reproductive health developed, Thailand launched initiatives in order to maintain compliance with the ICPD program of action. The MOPH studied and developed programs to improve the quality of services provided to clients in hospitals and healthcare centers, as well as to meet the needs of previously underserved groups through integrated reproductive health services in family planning clinics. The programs also promoted male responsibility and participation in women's reproductive health and focused on improving adolescent reproductive health services (Reproductive Health Division, MOPH, 2003). Successful pilot models and projects became powerful arguments for expanding these programs nationwide. However, evidence shows that few programs have been replicated across the country. Reasons given for this lack of expansion are budget constraints, problems with resource allocation, management issues, a lack of understanding on the part of health personnel and, in particular, a lack of commitment at the policy level.

Compartmentalized government administration has seriously slowed the implementation of reproductive health programs. Within the MOPH, for example, the program of integrated reproductive health services falls within the purview of the Division of Reproductive Health in the Department of Health. At the level of macro-implementation, management responsibility is under the Bureau of Health Service System Development in the Office of the Permanent Secretary. Only recently, in order to be able to sign on to international agreements, the MOPH appointed a high-ranking technical person, though not yet a formalized body, to follow up on social issues related to reproductive health (i.e., gender and sexuality). Meanwhile, social and legal issues related to reproductive health are still the main responsibility of the Office of Women's Affairs and Family Development in the newly established Ministry of Social Development and Human Security. As a result of this fragmented distribution of authority and responsibility, it has been difficult to coordinate the government's initiatives.

Despite these hurdles, academics, NGO networks and women's health advocacy groups have made great strides in improving reproductive health services in Thailand. HIV/AIDS NGOs and People Living With HIV/AIDS (PLWHA) networks have raised

awareness about issues of gender, sexuality and reproductive health rights. Continued capacity building, skills training and education in these areas are still crucial to the success of such organizations. On the other hand, healthcare providers are still poorly-equipped to deal with issues of gender and sexuality and, for the most part, are not yet aware of the reproductive rights of PLWHA, as well as the rights of their clientele at-large.

One significant sign of progress for the reproductive health advocacy movement is the development of a reproductive health law, which was initially drafted in 2003, and completed in 2004. Unfortunately, due to the dissolution of Parliament in March 2006, the law has not yet been enacted.

2. Reproductive health service programs

Thailand has shown remarkable progress in the field of reproductive health in recent decades. The birth rate has declined steadily over the past 30 years and contraceptive use has jumped to 79.2 percent in 2001 (UNFPA, 2005). A 2005 report by the United Nations Population Fund (UNFPA) on Thai women's reproductive health, notes that Thailand made so much progress because this issue has been mainstreamed into sustainable development policies and programs. According to the UNFPA report, many new programs related to reproductive health were started up over the past 10 years, such as pilot programs for adolescents, sex education programs and prevention of mother-to-child transmission of HIV/AIDS. In addition, all essential obstetric services are covered under the relatively new "30-Baht Scheme," which provides health services to all Thais for only about US $0.80 per visit (Tangcharoensathien et. al., 2002).

Unfortunately, while reproductive health services can generally be addressed in public hospitals, this is often at the expense of offering quality services. A study of eight hospitals indicated that all were lacking an integrated scheme for reproductive health services. In these hospitals, family planning and obstetrics/gynecology departments were the main focal points for reproductive health, with services for adolescents either extremely limited or non-existent. Furthermore, one of the major problems with reproductive health services in Thailand is that they are geared toward married women, and this is particularly true of family planning services (Sirirassamee, Sethaput, and Yodumnern-Attig, 2003). By focusing on the reproductive health needs of married women, the Thai government exacerbates the problem of ignorance among the young and/or single people by indirectly encouraging them to seek reproductive health information and services from unreliable sources, such as their peers or pharmacists (who have been shown to provide incorrect information regarding contraceptive use) (Boonmongkon, Jaranasri, Linsumphan, and Thanaisawanyangkoon, 2000). Healthcare providers have also been found to be ill-informed or poorly-equipped to answer questions about reproductive health and rights.

The 2005 UNFPA report also points out that access to reproductive health services differ regionally, and that women in Thailand's southernmost provinces tend to use contraceptives less frequently and report more unplanned pregnancies than women in the rest of the country. Some critiques of the "30-Baht Scheme" also suggest that patients' opportunities to receive healthcare can be limited in some areas because they are required to register with a local hospital or clinic in order to receive services under the scheme. Thus, in cases where a woman is not comfortable going to her local clinic

(which seemed to be a problem mainly with adolescents), she may be discouraged from seeking treatment elsewhere due to finances.

3. HIV/AIDS and Sexually Transmitted Infections

Unprotected sex is the major cause of HIV/AIDS transmission in Thailand. In 2004, more than 85 percent of reported cases were transmitted through sexual intercourse and 38 percent of those infected were females. The main routes of transmission are changing. During the 1990s, HIV transmission occurred primarily through commercial sex. Now half of the newly identified infections occur among the wives and sexual partners of men who became infected several years ago. (The 100% Condom Use Program (CUP), which promoted consistent condom use during all commercial and casual sex, has not had much effect on the slow but steady transmission of HIV from the infected male clients of female sex workers, and from infected male injecting drug users (IDUs), to their regular sex partners.) Currently, there is widespread concern about HIV transmission rates among young people who are increasingly engaging in unsafe sexual behavior. The Ministry of Public Health noted that in 2002 the rate of HIV infections among teenagers rose to 17 percent from 11 percent in the previous year. It is estimated that less than 50 percent of sexually active teenagers use condoms.

Thailand is still heralded for its success in keeping the AIDS epidemic in check by organizations such as the United Nations, which also recognizes the country's efforts at promoting care and support of PLWHA (UNESCO, 2002). Thailand started up its program of medical care for HIV/AIDS patients in 1992. It improved upon this program when it created the HIV/AIDS Clinical Research Network (CRN) in 1997 to broaden the scope of health services and also to reach more patients. Since 2001, the national health plan covers the treatment and prophylaxis of common opportunistic infections. More than 60 percent of those needing treatment have access to publically-funded antiretroviral therapy (ART) programs – some 60 percent of the need, compared to only 1.8 percent that had access to ART in 1997 (Thai Ministry of Public Health and the World Bank, [no date]). The number of people estimated to be living with HIV/AIDS in Thailand was estimated to be 580,000 at the end of 2005.

The MOPH has further improved upon its services by making voluntary counseling and testing available at all provincial and community hospitals, and making new efforts at harm reduction for IDUs (Thai Ministry of Public Health, 2003), albeit insufficient. Thailand also became the first country in the developing world to implement a program to prevent the transmission of HIV/AIDS from mother-to-child. The program includes counseling and testing at antenatal clinics, and the provision of infant formula for new HIV-positive mothers (UNFPA, 2005). These recent improvements fall within the scope of the country's five-year National Plan for Prevention and Alleviation of HIV/AIDS, which was implemented in 2002. This plan aims to cover both treatment and prevention of HIV/AIDS with an approach that integrates all sectors of Thai society by establishing social welfare services and developing community potential to combat the virus (Thai Ministry of Public Health, 2003).

There is still much room for improvement in HIV/AIDS treatment and care. In a report supported by the Ford Foundation and the Joint United Nations Programme on

HIV/AIDS (UNAIDS), a group of HIV-positive women from three different regions in Thailand reported dissatisfaction with HIV/AIDS-related healthcare. According to these women, they did not feel as though their doctors treated them sensitively or provided them with enough information regarding their medical conditions. Furthermore, these women requested that clinics be opened specifically to treat PLWHA and that antiretroviral drugs be provided free-of-charge through the healthcare system (Yodumnern-Attig et. al., [2006]). Because the Thai government's "30-Baht Scheme" does not cover expensive antiretroviral medications, these treatments remain out of reach of patients who do not have the financial means to pay for them.

STI prevalence in Thailand has been in decline since the late 1980s (Thai Ministry of Public Health, 2003). The decline is credited to aggressive condom promotion by the Thai government, specifically the widely recognized 100% Condom Use Program, which was initiated to curb the rise in HIV transmission. One of the shortcomings of this program, though, is that it emphasized condom use with sex workers. Therefore, condom use came to be associated specifically with commercial sex. In a 2003 report on reproductive health in Thailand, the MOPH notes that the country is still at risk for an increase in the number of HIV/AIDS cases because, while condom use during commercial sex is reported at 60 percent, condom use during casual sex is still only about 30-40 percent. It comes as no surprise then that adolescents make up approximately one-third of STI cases (Reproductive Health Division, the MOPH, 2003).

Outside the government sphere, NGOs in Thailand are also extremely active in a range of HIV/AIDS activities, from educating young people about condom use to promoting harm reduction for injecting drug users. As reported by the MOPH, the Thai NGO Coalition on AIDS (TNCA) represents over 300 NGOs that conduct AIDS and sexual health awareness work throughout the country. The Thai Network of People Living with HIV (TNP+) also represents about 300 PLWHA organizations operating in Thailand (Thai Ministry of Public Health, 2003). These two networks focus on policy development at the macro-level, addressing issues of capacity building and incorporating the perspectives of PLWHA into the public and corporate sectors (UNFPA, 2005).

In terms of government policy, a 2005 report by the Asian-Pacific Resource & Research Centre for Women (ARROW) and the Center for Reproductive Rights notes that there are no specific laws in Thailand that protect the rights of PLWHA, and that in some cases discrimination based on HIV status has been permitted by the Thai legal system. Furthermore, some government policies have indirectly infringed on the rights of other at-risk populations who need prevention information and treatment care. For example, when Thaksin Shinawatra became Prime Minister in 2001, his government declared a war on drugs as a top priority. The subsequent very public and aggressive campaign shut down programs, such as needle exchanges that have been proven to reduce HIV transmission among IDUs. Users were driven away from facilities and programs where they were previously able to receive information and counseling on HIV. According to Human Rights Watch, the crackdown on drug users has led to a rise in unsafe needle sharing practices and increased drug use in Thai prisons, resulting in a higher risk for HIV/AIDS (Human Rights Watch, 2004).

The rights of people living with HIV

The budget allocations from both the Thai government and international donors for HIV/AIDS programs have shifted over time. Most funding has been channeled into

programs for the provision of antiretrovirals (ARV) and other forms of treatment. While focusing financial resources on treatment has been critically important, the Thai government has left prevention programs with dwindling financial support.

The emphasis on HIV treatment, however, has had positive effects. With the help of ARV treatments, HIV-positive people can lead relatively normal lives, and many of them are able to marry and/or have children. Unfortunately, there are reports that the rights of positive women are still being violated when they seek healthcare services, particularly antenatal care (Yodumnern-Attig et al, [2006]). It was evident from both the literature review and interviews that doctors and healthcare providers remain largely unaware of both the reproductive and human rights of HIV-positive people. They were often judgmental concerning their patients' sexuality. Moreover, the information that staff members conveyed to their patients about contraception was found to be inadequate. Gender-sensitive counseling was also deemed unsatisfactory.

This situation has prompted NGOs to address the issue of rights for positive people. Since reproductive health, gender and sexuality issues are still relatively new in the field of HIV/AIDS work, efforts to promote such rights have progressed slowly. TNP+ is currently focusing on strengthening PLWHA networks and universal access to antiretroviral treatment, but with little emphasis on issues of women's health or reproductive health and rights. AIDS NGOs have recently formed Thai Women against AIDS Taskforce (TWAT) to advocate for women's interests and reproductive rights for positive people. However, this group is still relatively new and it has only limited capacity to effect change at this point in time.

4. Adolescent sexual and reproductive health

The way in which Thai adolescents view sexual and reproductive health has changed dramatically since the outbreak of AIDS. While young men were once initiated into sex by visiting a brothel with friends, this trend is shifting for two major reasons. The first reason is that since the outbreak of AIDS and the ensuing government campaigns to educate the public about safe sex, young men are much more reluctant to visit commercial sex workers. Secondly, the "need" for young men to visit sex workers is decreasing, as changing social and cultural mores are allowing more young women to engage in premarital sex. It is increasingly common for young men to have their first sexual experience with a girlfriend or classmate, as opposed to a sex worker (VanLandingham and Trujillo, 2002).

Just because Thai adolescents are now more aware of the risks of unsafe sex, however, does not mean that they all can put that knowledge into practice in their sexual and reproductive health decision-making or behaviors. Studies conducted among adolescents suggest that girls are often unprepared for their first sexual experience and thus do not take appropriate contraceptive precautions, nor encourage their partners to do so (Center for Reproductive Rights, 2006). Also, girls tend to be ill- or misinformed regarding contraceptive use, particularly emergency contraception (Naravage and Yongpanichkul, 2003; Sirirassamee, Sethaput and Yodumnern-Attig, 2003; Boonmongkon, Jaranasri, Linsumphan and Thanaisawanyangkoon, 2000; UNFPA, 2005). Due to a lack of information, as well as because they rarely have much bargaining power in their relationships, girls are often unable to ask their partner to use contraception.

Since 1997, there have been a number of pilot projects and activities developed by both the government and NGOs to address the unmet needs of adolescents. The major findings of these projects surrounding adolescent sexual and reproductive health are 1) embarrassment regarding the topic and 2) a desire to receive information and health services specifically tailored to adolescents. In one study conducted in Nakhon Sri-Thammarat province, adolescents were interviewed about the way in which they would prefer to receive these services. The study ultimately concluded that both healthcare and information should be available in one place that is easily accessible, respects adolescents' privacy and provides friendly service with same-sex staff.

> Following a study in Nakhon Sri-Thammarat province to ascertain how to best offer sexual health information to adolescents, a pilot program was initiated to try to meet those needs. An adolescent-friendly center was set up adjoining the provincial hospital (Poonkhum, [No Date]). However, the center ultimately failed due to its proximity to the hospital. Adolescents felt too conspicuous going to the center, and reported that they would have liked a place with even more privacy. The reason why this location was originally chosen, though, was because the MOPH could not afford another space.

In an effort to improve services for adolescents, the Division of Reproductive Health under the Department of Health initiated an adolescent-friendly service center, called "Friends' Corner." Fifty of these centers were then established nationwide. Budget constraints have limited the possibility of further expansion and strengthening of the adolescent service program. Currently, the Division of Reproductive Health is researching hospital-based adolescent health service models.

More than 10 years ago, the government and NGOs introduced a sex education program for adolescents in Thailand. Most school-based sex education programs, however, have been small scale and it has been difficult to replicate them nationwide. At the moment, the international NGO PATH, with grant assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria, is undertaking a project to expand and improve sex education for both in-school and out-of-school adolescents. The Division of Reproductive Health has also initiated a small-scale reproductive health education program for students at Rajabhat University in Bangkok. Aims of this project are to educate and equip future teachers with reproductive health knowledge and counseling skills.

5. Safe abortion

Abortion data in Thailand remain very limited due to legal restrictions and cultural factors. Abortion is currently legally-restricted in Thailand. Doctors can perform an abortion only in consideration of a woman's health or in the case of rape. Hence, a large number of women seek to terminate pregnancies outside of licensed hospitals and clinics (Whittaker, 2002; Warakamin, Boonthai, and Tangcharoensathien,

2004). Abortions obtained illegally often pose a risk to a woman's health. Non-authorized clinics need not abide by Thai medical regulations, increasing the chances that abortions are performed using improper methods under unsanitary conditions. The result is that there is a far higher rate of post-abortion complications among women who seek clandestine treatment (Warakamin, Boonthai, and Tangcharoensathien, 2004). Nearly 30 percent of the women who had abortions reported experiencing serious complications.

The campaign to remove the legal restrictions on abortion still faces strong opposition among Thais, since it is viewed to be a sin under the main tenets of Buddhism. Despite this, a group of journalists, public health workers and NGOs headed by the Foundation for Women are pushing for legal reforms in order to loosen the restrictions on abortion (Whittaker, 2002). Within the past 10 years, the Thai government has also started up a program to provide post-abortion care.

The MOPH's Department of Health has worked closely with the Thai Medical Council and other key organizations to address the issue of unsafe abortion. The Thai Medical Council helped to draft an amendment to the Thai Criminal Law, Article 305, which would enable a physician to terminate a pregnancy in the case of a negative effect on the physical and mental health of the mother, or in the case of severe fetal abnormalities. The Criminal Law Amendment Committee of the Office of the Council of State approved the draft of Criminal Law, Article 305, but final approval from the cabinet was put on hold when the parliament was dissolved in March 2006.

Because of the delay in amending the Criminal Code, the Department of Health continued to develop measures for improving abortion services at healthcare facilities so that a Medical Practice Rule regarding abortion services could be effectively implemented. [Please see Box.] In 2005, the Department of Health, in collaboration with the Royal Thai College of Obstetricians and Gynecologists, developed a comprehensive manual for abortion care, as well as an instructional manual for the training of trainers. In late 2005, three training workshops were held for medical doctors and healthcare personnel and nine training centers were set up nationwide. Among these core training centers only five (the centers at Chiangrai, Nakorn Sawan, Haad Yai, Khon Kaen and Ramathibodee Hospital in Bangkok), however, are functionally active, according to the Department of Health.

PROFESSIONAL MEDICAL GUIDELINES

The Medical Council drafted the "Medical Practice Rule on Preservation of Professional Practice Ethics" regarding the termination of pregnancy under Criminal Law, Article 305. The Medical Practice Rule is meant to provide a guideline for practicing physicians, as well as a reference point for lawyers dealing with cases related to this particular law. It aims to clarify Criminal Law, Article 305, by providing a more comprehensive definition of "health" to include mental health of the woman, thereby enabling physicians to conduct safe abortion services, as well as controlling the ethics of professional practices. After five years of effort, the Medical Practice Rule was finally released and officially declared in the government gazette in December 2005. Before the Medical Practice Rule was drafted and declared, there had never before been a standardized guideline for physicians regarding the practice of abortion in Thailand.

In the future, the MOPH plans to build capacity and provide skills training for medical providers at public hospitals nationwide in order to improve the quality of abortion care and bring them into line with the new Medical Practice Rule. They also would like to do advocacy for safe abortion provision with other stakeholders, such as lawyers and the police. Whether or not plans for expanding the training program nationwide come to fruition depends heavily on external funding, since budget allocations from the government might not be adequate.

6. Gender-based violence (GBV)

In an article in the *Journal of the Medical Association of Thailand*, Siriwan Grisurapong cites statistics from a 2003 report on intimate partner violence in Thailand prepared by the WHO. According to this report, 41 percent of women between the ages of 15 and 49 who live in Bangkok have experienced some form of physical or sexual violence from a spouse. Despite the fact that they had suffered injuries, one-third of these women did not seek medical assistance or social services and nor did they know such services exist. Furthermore, a 2005 report on GBV issued by the WHO indicates that urban Thai women who reported partner violence were "significantly less likely to have received postnatal care for their most recent live birth than women who did not report partner violence."

Rising rates of violence against women and children led to a 1999 cabinet resolution establishing comprehensive health services for victims of abuse in private and public hospitals. That same year the Thai Ministry of Public Health, with financial backing from the Ford Foundation, opened a pilot One-Stop Crisis Center (OSCC) in Khon Kaen Hospital in northeastern Thailand. In 2001, the MOPH supported the extension of the OSCC program to 20 provincial hospitals throughout the country, as well as the distribution of manuals to a number of hospitals on how to properly care for victims of abuse (Grisurapong, 2004). According to Grisurapong, tests given to staff members at hospitals with OSCC programs, when compared with test results from staff members at non-OSCC hospitals, revealed increased knowledge of how to deal with abuse victims. However, this same test revealed that staff members' attitudes toward victims had not changed. This suggests that OSCC programs still have a long way to go toward achieving optimal care for victims of domestic violence.

Although the MOPH expanded the OSCC program to 20 provincial hospitals in 2001, an assessment conducted in 2003 showed that few hospitals actually had well-established programs. Those hospitals that *have* run successful programs include hospitals in Khon Kaen, Saraburi, Rayong and Chiangrai. The provincial hospital at Chumporn also has developed commenced services for domestic violence, with support from UNIFEM. A service protocol for OSCC programs has been developed based on the model of the successful programs listed above.

In honor of the Queen's 72nd birthday in 2004, the MOPH announced the expansion of the OSCC program to 94 hospitals. It was recently expanded further to cover 104 hospitals, including military and police hospitals. In 2004, the OSCC program was renamed "Soon Phung Dai" (or "Dependable Center" in Thai) for public relations purposes. Currently, the Bureau of Health Service System Development under the MOPH's Permanent Secretary Office is responsible for nationwide implementation of

the program. According to staff from this bureau, the MOPH plans to expand the program to about 700 community (district) hospitals in the near future, while also strengthening the capacities of participating hospitals.

One very positive step is the incorporation of sexual and reproductive rights into the law and in the country's penal code. A person convicted of committing a rape, for example, can be fined and imprisoned up to 10 years. While the MOPH has been working to improve health services for women who are victims of violence, Thai law provides little protection for these women. Thailand also does not have legislation that deals with marital rape, and a proposal for such legislation put forth in 2000 was rejected.

While domestic violence is addressed under the law, it only appears indirectly. Under the Thai constitution, "children, youth and family members" are meant to be protected by the state from violence and unfair treatment. However, there is no specific provision concerning domestic violence. Most cases go unreported, and therefore stay outside the reach of the Thai legal system (ARROW, 2005).

Nonetheless, the government is making efforts to stem the tide of domestic violence in Thailand. Since few victims actually report abuse to officials, the Bangkok police force has begun to recruit more female officers so that women feel more comfortable approaching the police. The Policy and Plan on Elimination of Violence against Children and Women was adopted by the cabinet in 2002. It specifically addresses issues of domestic violence by joining government and NGO efforts. Yet it is not clear if this plan was ever implemented. (ARROW, 2005). The issue of domestic violence is being addressed, however, by NGOs who advocate for women's rights, such as the Association for the Promotion of the Status of Women.

The establishment of GBV services for women and children has been largely successful in terms of the number of new service facilities opened in the past few years. However, some of those interviewed felt that implementation of OSCC programs throughout the country is limited. The constraints and limitations include:

- Services in most hospitals are limited to treatment for injuries and patient consultations, which means there is a lack of follow-up, few home visits and little emphasis on holistic care for victims. In most areas, support networks or networking mechanisms with relevant agencies are not yet well established.

- Constraints persist on the provision of reproductive health services to rape victims. For example, whether or not a rape victim would be provided an abortion if she is pregnant differed between hospitals, depending on the views of the hospital committees. However, the decision to grant an abortion in such cases should not be conditional, since it is legal for rape victims to terminate their pregnancies.

- Capacity building for care providers is limited both in scope and the amount of time during which it is carried out. Generally, care providers are found to pay little attention to patients' rights, but nothing can be done to change this if capacity building is not expanded and sustained.

- Although the MOPH developed a clear policy to expand the OSCC program nationally, they have not provided sufficient funding or the necessary human resources. The total budget for the program is only $7,500 per annum for hospitals nationwide.

- Communities, particularly women, do not participate actively and few OSCC programs reach out to communities by recruiting among NGOs, community based organizations (CBOs) and grassroots groups to sit on committee boards.

- While most abuse occurs at the village level, for the most part services have not expanded to district hospitals and community health centers. Since OSCC programs are only operating at major hospitals, there are probably a large number of GBV victims whose needs are not being met.

- Few public relations campaigns have been conducted to promote the program at the community level, so that many women are still not aware that such services exist.

7. Reproductive and sexual health of migrant women and other vulnerable groups

The Thai government allows migrant workers from neighboring countries to work officially in the country. Those that register with the government enjoy the same rights as ethnic Thais in the workplace. But in an article on Burmese migrants working in Thailand, Darunee Paisanpanichkul notes that when it comes to Thailand's labor laws, policy and practice do not always come together. Paisanpanichkul writes that while there are policies that regulate migrant labor, the most important relationship for a migrant worker is with her/his employer. In many cases it is easy for employers to exploit this relationship to their advantage. Also, despite the fact that they have the option to register as legal migrants in Thailand, many migrant workers fail to do so. By not registering, these workers are placed outside the protection of the law and cannot access government healthcare schemes (Lao Liang Won, 2006).

Many women migrant workers come to Thailand not knowing that they may end up in deplorable conditions. Agents in other countries promise women a way to make money, which often ends up being a sort of debt bondage. Some enter this situation of their own accord, while others are sold by their families. But rarely do the women or their families know that they are being signed into forced prostitution or manual labor (Chaiyanukij, 2004). Many migrant women working in Thailand are at a further disadvantage because they do not speak Thai and, in many cases, have not entered the country legally. Their illegal status puts them at risk of being exploited in the workplace, since they have no recourse under the law (Chaiyanukij, 2004). The UNFPA's 2005 report on women in Thailand also notes that many of these women are enticed into sex work, an industry that is already exploitative. Due to language barriers, it is difficult for these women to ask clients to use condoms during sex, which puts them both at risk of spreading HIV/AIDS and other STIs. Chaiyanukij notes, however, that a number of NGOs and intergovernmental organizations in Thailand are already addressing the needs of migrant women.

Women who are members of hill tribes in Thailand face similar issues of discrimination and lack of care in the Thai healthcare system because they are not

considered Thai citizens. It is not uncommon for these women to be driven out of their villages due to loss of land or financial hardship. Furthermore, these women do not have access to the "30-Baht Scheme" and so obtaining healthcare is both difficult and prohibitively expensive (Physicians for Human Rights, 2004).

Muslim women in Thailand also face obstacles when seeking healthcare. This is due in part to their religious beliefs and, for those women who live in the Muslim-majority provinces of the south, because of localized violence. A research study on Muslim women's health in Thailand reveals that religion influences their medical decisions (Carpio, et. al., 2001). According to this study, both the promotion of family planning in local hospitals, as well as revealing hospital dress, were factors that prompted Muslim women to give birth at home. Furthermore, according to a 2005 report by the NGO Medecins San Frontieres (MSF), both maternal and child mortality in the southern Muslim-majority provinces of Yala, Pattani, and Narathiwat are disproportionately higher than they are throughout the rest of the country. Compounding this problem, increasing civil unrest in this region is making it more difficult to access primary healthcare services. While some NGOs, such as MSF, are operating in the region to promote access to healthcare, this is still a difficult task, since many health centers now operate on limited hours due to the fear of violence (MSF, 2005).

Ethnic Thai women who enter into sex work are also considered a vulnerable population by virtue of the nature of their work. Since sex work is technically illegal in Thailand, they can be easily exploited. Also, the type of work that these women do naturally puts them at greater risk for contracting STIs as well as becoming pregnant unintentionally. Since abortion is legally-restricted in Thailand, these unplanned pregnancies can easily lead to clandestine abortions that can endanger a woman's health (UNFPA, 2005). The 2005 UNFPA report also notes that sex workers face a higher risk of developing reproductive cancers because of their multiple partners. This risk is compounded if they start using injectable contraceptives at a young age. Fortunately, a number of NGOs, such as EMPOWER and Population Services International, work specifically with sex workers to promote condom use and general reproductive health care.

III. Challenges and Opportunities in Sexual and Reproductive Health Program Implementation

1. Opportunities:

- **Available government health policies and services**. The Thai government provides public health services and healthcare facilities in each of the country's sub-districts and in more than 69,331 community health centers. Poor and vulnerable groups have access to affordable healthcare for 30-baht per visit under the Universal Health Insurance Scheme. Currently, ministries other than the MOPH play major roles and take responsibility for program implementation in the areas of gender and reproductive health and rights. The Ministry of Social Development and Human Security, for example, has become a focal point in addressing the issues of reproductive health rights and gender equity.

- **An emerging NGO movement.** A loose network of NGOs and women's health advocacy groups has recently emerged in Thailand, encouraging collaboration between members of civil society and multi-stakeholders. These civil society organizations are committed to improving sexual and reproductive health and rights. Most recently, women parliamentarians have organized in order to legislate with women's interests in mind and most notably advocate for a law against gender-based violence.

- **A powerful HIV/AIDS movement.** In the 1990s, HIV/AIDS became one of the most significant socio-economic issues facing Thailand. The Thai government and international donors worked with NGOs, community-based organizations and a network of PLWHA support groups to develop their capacities to confront the growing HIV/AIDS problem. This strategy has enabled the continued growth and development of Thai AIDS organizations and networks. Today, these networks continue to work actively to hold the healthcare and social welfare bureaucracies accountable and to address social issues related to HIV/AIDS.

- **Access to antiretroviral treatment for PLWHA.** The Thai government began offering the triple combination antiretroviral therapy in 2000. Over the next couple of years, the price of ARVs declined significantly when generic drugs became available. At the beginning of 2003, the Global Fund awarded Thailand US $209 million over a five-year period to help fund the antiretroviral treatment program. It was estimated that 72,000-91,000 people were receiving ARVs at the end of 2005, including those using private sector suppliers (the MOPH and World Bank [no date]).[2]

[2] In fall of 2006 and early 2007, Thailand invoked "compulsory licensing," for two AIDS drugs – efavirenz (Stocrin) and lopinavir+ritonavir (Kaletra) – and a drug for heart disease. This is allowed under international trade law because of the 2001 Doha agreement of the World Trade Organization, which makes clear that a country may issues a compulsory license for a drug that treats a disease causing a severe health emergency in that country.

2. *Challenges:*

- **Unsustainable capacity and inadequate funding from the government**. Thailand still lacks sustainable capacity in all implementing sectors and involved agencies concerned with the issues of gender, sexuality, and reproductive health and rights. Most SRH programs and research rely heavily on international contributions because the Thai government often is unable to allocate money for nationwide implementation of successful pilot programs. (The OSCC program is a good example of such limitations.) Furthermore, financial assistance for pilot programs/projects is usually short-term. In some cases, grant programs are highly competitive and unable to reach grassroots organizations or small NGOs. Many donors define their areas of interest narrowly and focus on only one or two populations in need, thereby overlooking others just as vulnerable.

- **Unmet needs for particular groups.** Public health facilities still come up short when it comes to adequately meeting the reproductive health needs of all Thais. A small number of successful programs have been set up for adolescents and single women, for example, but unfortunately they have not been widely replicated across the country.

- **Limited participation from affected groups.** There continues to be a lack of participation from women and adolescents and other affected populations in SRH programs both at the ground level and at the level of policy development.

- **Gaps between policy and practice and limited awareness of policy-makers and service providers**. While reproductive health laws have been successfully drafted with strong involvement from politicians and parliamentarians, these policies have yet to be implemented, let alone making any real difference on the ground. Marginalized groups such as PLWHA, poor women, migrants and sexual minorities, continue to face violations of their sexual and reproductive rights. Most government workers at the administrative and policymaking levels, as well as the politicians, remain relatively unaware of the issues surrounding SRH and related rights.

- **Poor integration of SRH program implementation among pertinent government departments.** The lack of coordination among different agencies is the result of the compartmentalized structure of government administration. Although there has been an attempt to increase collaboration between different departments/ministries, the efforts have failed to generate a strong sense of partnership within government agencies. This problem is exacerbated by the fact that each department must follow its individual ministerial work plan and adhere to individual performance indicators.

- **Lack of a pro-active media.** Members of the media could play a vital role in educating the public on SRH and rights if they were equipped with a better understanding of the issues. Unfortunately, the Thai media is often insensitive when it comes to issues of gender and sexuality and it continues to portray women as sexual objects. Few training programs for journalists have been conducted to correct this problem.

3. Funding for SRH and Rights in Thailand

In the past, contributions and funding for SRH program initiatives and development in Thailand came almost entirely from international donors. This assessment identified some sources of financial assistance for SRH work, in addition to the Ford Foundation. One is a government fund and the others are international donors. They include:

- *The Thai Health Promotion Foundation*

With the Health Promotion Foundation Act of 2001, the government created the Thai Health Promotion Foundation (or ThaiHealth), which placed the Foundation outside regular government administration. The Act gives ThaiHealth about US $35 million annually -- monies that come from a 2 percent excise tax placed on tobacco and alcohol.

ThaiHealth has recently decided to expand its regular program to include a focus on healthy sexuality. The Women's Health Advocacy Foundation (WHAF), a sub-contractor for the program, reports that the new healthy sexuality program will focus on four strategies in its implementation: policy advocacy; improving gender, sexuality and human rights knowledge; public campaigning; and networking. Many stakeholders, i.e., government agencies, NGOs, academics, international donors and women's advocacy groups, have eagerly participated in the development of program strategies. The program also has attracted attention from UN agencies, such as UNAIDS and UNFPA. These agencies have shown an interest in providing future financial contributions, or even co-funding the program. For the time being, 49 million baht (US $1.3 million) has been allocated by ThaiHealth to fund the new program for two years, which makes the healthy sexuality program the first program on sexuality ever to be funded by the Thai government.

- *United Nations Population Fund (UNFPA)*

The UNFPA is currently in the final year of its 8th consecutive five-year grant program supporting reproductive health programs in Thailand. Strategic planning for the 9th grant cycle of US $5 million will take place soon. Recently, the UNFPA has provided funding for several RH projects run by MOPH, Planned Parenthood Association of Thailand (PPAT) and World Vision/Thailand. These projects have focused on adolescent health, immigrants' health, the elderly and RH research/capacity building. In the future, the UNFPA may also fund projects in RH information system development and linkages.

- *United Nations Development Fund for Women (UNIFEM)*

UNIFEM's Thailand program has focused mainly on four key areas in women's health and rights: the reduction of poverty, eradicating violence against women, reversing the spread of HIV/AIDS and democratic governance. In the area of HIV/AIDS, UNIFEM has just completed the first phase of a program aimed at mainstreaming gender concerns into the national AIDS plan. The program also facilitated the formation of networks for HIV-positive women through organizations

such as UNAIDS and other stakeholders. In its second phase, the program will address violence against women with HIV/AIDS, with a focus on married women and young girls, as well as the power dynamics between men and women.

In the first phase of a program to eradicate violence against women that was recently completed, UNIFEM contributed support for an OSCC program in Chumporn province. The second phase of this program will support advocacy work for new legislation, as well as working with men through social clubs and professional organizations.

- *The Rockefeller Foundation*

The Rockefeller Foundation has funded projects focused on issues of cross-border health in the Greater Mekong sub-region, which included programs on gender, sexuality, HIV/AIDS and reproductive health. These programs specifically targeted migrant populations and ethnic minorities. Rockefeller has provided grants to a number of NGOs and academic institutions in Thailand for work addressing cross-border health challenges. However, the final funding cycle for the Rockefeller projects is near completion, and new plans for funding opportunities have not yet been announced.

IV. Looking forward

This assessment identified many challenges remaining in the field of SRH in Thailand, but many opportunities as well. Unfortunately, several international donors are now withdrawing the financial support that is so crucial to making Thailand's SRH programs both successful and sustainable. The Ford Foundation and a handful of other donors have contributed significantly to SRH, HIV/AIDS and development work in Thailand over a long period of time and they have the opportunity to continue this support at a time when it can truly play a vital role in both sustaining and enhancing SRH initiatives, research and capacity building in Thailand.

This assessment has identified priority SRH issues for future funding from donors. Efforts in some of these areas are in fact already being funded by donors, including the Ford Foundation, but continued support is essential to the success of the programs. Some reflections and recommendations for future donor funding in Thailand are as follows:

1. Recommended SRH issues to be addressed

- *Gender-based violence (GBV)*

Gender-based violence is an area in which the Ford Foundation has already provided long-term funding for programs in Thailand. However, continuing and future support for GBV programs remains crucial. Although GBV works/programs have been adopted into national policy by the Thai government, many challenges arise when launching them. For one, it is difficult to garner participation from all sectors of society in order to create services that are both high quality and diverse. Also, support is needed to continue programs already in place, such as the One-Stop Crisis Center program. At the same time, new issues, such as sexual violence and sexual harassment, have not yet been fully addressed and need to be considered for both research and intervention programs. Another challenge is the lack of male participation, which limits the effectiveness of the programs. Many groups are now encouraging more male involvement in GBV programs, but progress is slow. Furthermore, these programs should be expanded to address issues of sexual violence, which is an area of GBV that has been largely ignored in program development.

The MOPH has already announced it will expand the OSCC program to public hospitals nationwide, which means that more healthcare facilities are currently being recruited into the program. This expansion will provide increased access to services designed specifically for battered women and abused children. However, limited budget allocations for participating hospitals will surely weaken the quality of already shaky services. OSCC programs need improvement in the areas of skills training for service providers, creating networks of diverse services for women, and raising GBV awareness in all sectors.

Key strategies recommended for future OSCC programming include capacity building programs for all relevant sectors (i.e., the police, lawyers, health providers, and grassroots community groups). The program should also focus on strengthening coordination among relevant organizations and government agencies, particularly at the

provincial and community levels. Participation of community-based women's groups, including abused women themselves, would strengthen outreach and effectiveness. Furthermore, it is very important that interventions raise awareness among males and encourage their participation in the intervention programs.

Key players that may be important to include in OSCC program expansion are:

1) Hospitals where the OSCC program has been established.

2) NGOs and groups that are either community-based or have grassroots origins, which can provide influential partnerships to achieve the success of the OSCC program at the community level.

3) The Bureau of Health Service System Development, MOPH. This is a key agency at the central level responsible for OSCC program implementation, budgeting, technical support and capacity development in participating hospitals nationwide.

4) Sectors outside the healthcare field, such as the police, lawyers and social workers.

- *Unplanned pregnancy/safe abortion*

A lack of access to safe abortion services is another obstacle on the road to good reproductive health for women in Thailand. (The death rate due to complications from induced abortions is believed to be high in Thailand, although no national statistics have been reported by the MOPH.) One promising step forward in the efforts to provide safe abortions is the implementation of the Medical Practice Rule. Work is still needed to raise awareness about abortion care among healthcare workers. Medical staff need to be provided with educational and training programs to ensure a minimum standard of practice. Such measures will reduce the number of complications from unsafe abortions, and also provide women with the option to safely terminate a pregnancy. Furthermore, strengthening hospital programs will create opportunities for health providers to incorporate to go beyond their focus on biomedical sciences, to increase their understanding of issues such as gender, sexuality and reproductive rights, which could improve sexual and reproductive health care overall.

Since abortion is a highly controversial topic in Thailand it will be difficult to promote programs for quality abortion care in the public sphere. Broadening the program strategy to focus on unplanned pregnancies could potentially attract more public support for the program. Moreover, programs addressing unplanned pregnancies can also be integrated into programs on adolescent sexuality and reproductive health, as well as GBV.

One recommended strategy for immediate action is to provide Thailand's doctors (particularly gynecologists) with a broader education on safe abortion that addresses reproductive health rights issues. Along with improvements in healthcare services for cases of unplanned pregnancies, these programs should also focus on advocacy for gender, sexuality and reproductive rights through various stakeholders, such as the government sector, NGOs, community-based groups and the media.

- *Reproductive and sexual rights of PLWHA*

At this point in time, discrimination against PLWHA is not prohibited by Thai law and many people with HIV/AIDS report receiving inadequate and insensitive healthcare. Furthermore, since ARV treatments are helping HIV-positive people to live longer, they are facing new discrimination in areas such as reproductive rights and the rights of positive children. Due to the fact that these issues are so new, they have yet to be adequately addressed by PLWHA organizations and advocates.

Advocates for the rights of PLWHA seem to be making steady progress. In this area too, though, much work remains to be done. The assessment revealed that many healthcare providers have not been well trained to address the needs of PLWHA patients. However, these healthcare providers did show familiarity with patients' basic rights, as declared by the Thai government in 1998. Provider education could affirm that PLWHA have the same basic rights as others and legal reforms should ensure patient protection in the event these rights are violated.

Positive women need empowerment programs so that they can advocate for their own rights. They should be encouraged to actively participate in programs that would benefit them and also benefit from their participation, such as the Prevention of Mother-to-Child Transmission (PMTCT), family planning, and maternal and child health (MCH). The Thai Network of People Living with HIV/AIDS (TNP+) is a very active PLWHA organization that has a large number of members nationwide and has the potential to truly effect change by getting more women involved and placing more of an emphasis on addressing women's health and rights issues.

Strategies for addressing reproductive rights and the rights of PLWHA in Thailand should aim to strengthen the capacity of PLWHA networks. Emphasis should be placed specifically on empowering networks of positive women and enabling them to advocate for their own rights at program and policy levels. Strengthening the capacities of these women can encourage them to speak out amongst their peers, which will in turn raise awareness and promote positive women's rights among nationwide PLWHA networks. Another option is to create a network of positive women that functions independently, but is also part of a national network. This too would promote advocacy and policy reform on a nationwide scale.

- *Adolescent sexuality and reproductive health*

Adolescents and young people are considered to be a high-risk group for HIV/AIDS, and so they are treated as a high priority group by the Thai government. However, HIV/AIDS prevention programs currently in place rarely go beyond a basic discussion of the disease and condom promotion. Many government sectors agree that better sexuality education programs in schools are needed, but implementation of comprehensive sexuality education has been limited thus far.

An increasing number of young people are engaging in premarital sex in Thailand and not all are taking measures to protect themselves. Since the sexual and reproductive health needs of this segment of the population are not being met and young people are practicing risky sexual behavior, this population is at risk for unwanted

pregnancy, STIs and HIV/AIDS. Although some program initiatives, both in service and education, have already been launched to meet adolescents' needs, they have made little headway because of the government's budget constraints and of limited commitments from policymakers. Funding organizations should therefore focus on expanding upon and improving services for this population.

At this time, the ThaiHealth program on healthy sexuality is getting underway. This may be a good opportunity for donors to contribute to a new sexual health program in Thailand that will benefit adolescents. Specific areas for donors to focus on in conjunction with this program would be either to enhance the program already developed, or to address other dimensions of sexuality that are complementary to ThaiHealth's program.

- *Integrated sexual and reproductive health services for women.*

Most existing MCH and family planning programs offer a range of sexual and reproductive health services, but they continue to target married women. Health services offered to adolescents, single women and post-reproductive women do not include comprehensive sexual and reproductive health care. Moreover, the quality of SRH services is still often poor.

Although many women are aware of their reproductive health *needs,* they tend to be unaware of their reproductive *rights.* On a positive note, progress has been made in the development of reproductive health law. But it still falls short of effectively addressing all aspects of reproductive rights, making this an area that should receive more attention from both programming and funding organizations.

- *Unmet needs of groups with diverse sexualities and gender identities.*

The assessment found that efforts that target people with diverse sexual orientations or gender identities tend to focus exclusively on MSM. They often exclude groups such as women who have sex with women and transgenders. It is important that programs be created to address the sexual and reproductive health and rights of all marginalized populations. In addition, Thailand lacks a good understanding of sexual diversity and additional research on the sexual and reproductive health needs and rights of sexual minorities is needed.

- *Priority populations/groups.*

The assessment found that adolescents and young people, poor women and children, migrant populations and ethnic minorities often face the largest obstacles to accessing SRH services and programs. These populations need priority attention so that their reproductive and sexual health and rights can be strengthened. Some people interviewed also recommended targeting the post-reproductive age groups and the elderly, who are now increasing in number and account for 32 percent of Thailand's total population.

2. Possible strategies and approaches:

- *Training for service providers, government officials and NGO workers*, as well as civil society as a whole. One specific recommendation is to revise university curriculum to include a compulsory SRH course for health sciences, biomedical and nursing students.

- *Empower women* to actively participate in SRH programs and projects. Create alternatives to allow them to make choices, become visible and play a central role in addressing their sexual and reproductive rights and negotiate with the policy makers and bureaucracies when it comes to their SRH needs and services. Clearly women play a significant role in the country's economic and public life, yet a limited number of women reach leadership positions. Social norms about women's roles, as well as constraints of time and opportunity, prevent many women from participation in the public sphere.

- *Increase male involvement* in SRH activities by working with men through male social clubs, professional association, etc. Involving men in SRH programs is still very challenging, particularly in countries whose culturally defined gender roles may hinder their participation. SRH programs should target men specifically and involve them in long-term program planning. One possible strategy is to emphasize the participation of men by reaching them at a younger age and providing sex and gender education so that they can develop a positive image of themselves and of masculinity that encourages shared responsibility for sexual and reproductive health and respect for the rights of girls, women and people of different sexual orientations.

- *Gender awareness in HIV/AIDS programs*. Many PLWHA groups and HIV/AIDS advocacy groups in Thailand remain dominated by men, leaving little room for women to voice their views and articulate their specific needs. It is important to start incorporating issues of gender into all works related to HIV/AIDS in order to promote awareness and also to meet the unique needs of HIV-positive women.

- *Supporting research and evaluation* in SRH. In the past, the Ford Foundation and a few other donors have made grants to Thailand in the area of SRH research, providing rare opportunities for Thai social scientists to conduct rigorous studies on reproductive health and rights-related issues – issues that generally receive little attention from researchers. The assessment confirmed a need for continued funding for reproductive and sexual health research. With extended funding, Thai researchers can expand upon much-needed knowledge in the areas of sexual violence, sexual harassment, sexual and reproductive rights, diverse sexualities and gender identities, and the sexual and reproductive health of the elderly.

- Providing grant assistance to *organizations outside Bangkok*. Our research revealed that most organizations currently receiving funding from donors are medium- or large-sized NGOs and academic institutions concentrated in and around Bangkok. Donors should consider funding women's health programs outside of the city and at the grassroots level in order to build capacity and promote participation at the community level.

Thai Reproductive and Sexual Health Data

Fertility rate (2003)	1.7%
Family planning (2000)	
Contraceptive prevalence rate (CPR)	79.2%
Maternal and child health	
Rate of complete antenatal care (2000)	91.8%
Rate of deliveries attended by health personnel (2000)	98.1%
Rate of complete postnatal care (2000)	56.8%
Rate of low birth weight (20001)	8.8%
Infant mortality rate (2003)	20.0 : 1,000 live births
Perinatal mortality rate (2002)	9.4: 1,000 live births
Maternal mortality rate (2002)	23.9: 100,000 live births
HIV/AIDS	
Prevalence rate of HIV infection in pregnant women	1.37%
Reproductive tract infections (2002)	
Sexually transmitted diseases morbidity rate	21.9: 100,000 population
Syphilis morbidity rate in pregnant women	0.3%
Abortion (1999)	
Induced abortion rate	19.5: 1,000 live births
Infertility	
Rate of women aged 20-44 years who experience infertility	
Primary infertility	2.5%
Secondary infertility	9.9%
Adolescent reproductive health	
Sexually transmitted disease morbidity rate in adolescents (2002)	37.6% of total cases
Rate of women aged less than 20 years having deliveries (2001)	9.0% of total births
Rate of adolescents aged less than 20 years who were admitted to hospital for abortion complication treatment (1999)	30% of total cases
Rate of AIDS in adolescents (2001)	7.9% of total AIDS cases

Source: Reproductive Health Division, the MOPH, 2003.

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Attachment 1

The study background

The Ford Foundation office in Bangkok closed in 1998, but the Foundation decided to retain the Sexuality and Reproductive Health (SRH) field as an area for continuing grant making in Thailand.

The SRH program for Vietnam and Thailand is currently building upon the past work of the Foundation, while sharpening its focus on gender, sexuality and rights. This program makes grants under two initiatives:

- Initiative 1: Increase access to gender-sensitive, rights-based sexual and reproductive health programs and services for young people and other vulnerable groups.

- Initiative 2: Expand awareness of gender-based violence and develop programmatic and policy responses.

While most of the grant making is done in Vietnam, the Ford Foundation is committed to maintain work in Thailand at the level averaging $250,000 - $450,000 a year, plus some additional funding for travel and study. With this very limited amount of money, the Foundation seeks to be strategic in its use of resources. This purpose of this review was to provide updated information that the Ford Foundation could use to strengthen work in Thailand that can link to and strengthen its work in both Vietnam and in the region as a whole.

2. Scope of the study

The Ford Foundation hired a consultant, Siriporn Yongpanichkul, to conduct a succinct but thorough assessment of SRH in Thailand during the months of April – July 2006. The goals of the assessment were to:

1) Provide an overview of the most pressing SRH and rights issues in Thailand;
2) Review and characterize the current and prospective programs of other major donors and actors in the SRH and rights fields in relation to current and prospective Ford SRH programming;
3) Review and characterize the public environment and the government of Thailand, focusing on approaches and opportunities for SRH work from a rights perspective;
4) Identify important gaps in funding and opportunities for the Ford Foundation and other donors to make a contribution. These gaps will be determined according to an analysis of other donors' priorities, as well as the priorities of the Thai government;
5) Prepare a written report that presents the above findings, draws out implications for future work, and recommends ways to orient the SRH with respect to future needs and opportunities within the SRH field (both in Thailand and keeping in mind possible linkages to work in Vietnam).

Two main methods for the assessment included: 1) review of current research, and analysis of SRH and rights in Thailand in academic journals, advocacy materials, as

well as other sources; and 2) interviews with key informants working in the field, such as other donors, researchers and advocates.

Based on the past and current interests of the Ford Foundation a few specific SRH issues or fields were given special attention in this assessment study, namely, sexual and reproductive health services and rights, HIV/AIDS, adolescent sexuality, safe abortion and gender-based violence. A number of key informants with various areas of expertise were selected for interviews, so that many different issues and perspectives could be included in the report. In the end, 19 informants were interviewed in depth. The group was comprised of seven individuals from NGOs, four from international NGOs, three from government organizations and three from academia. One respondent from an NGO was unable to participate in a face-to-face interview, but sent in responses via e-mail instead. In most cases individual interviews were done with key informants, although, in a few cases small group interviews were conducted with 2-3 people.