

2009

Policy Analysis
Report

on the HIV/AIDS

Response in Thailand:
A Civil Society
Perspective

2009 Policy Analysis Report on the HIV/AIDS Response in Thailand: A Civil Society Perspective

Researched and compiled relevant documents by Sutthida Malikaew

Written and Edited by Niwat Suwanphatthana

Translated by Pipob Udomittipong

English Edited by Constanze Ruprecht

Published by Policy Watch Group, Thai NGO Coalition on
AIDS (TNCA)

494 Soi NakornThai 11, Lard Prao 101, Klong Jan,
Bang Kaphi, Bangkok 10240

Telephone: 0-2377-5255

Fax: 0-2377-9719

www.tncathai.org

email: tncathai.org

Total Published 500 Copies

First Edition June 2010

Art work Umpa Buarapa

Printing Coordination Siriporn Raweeekoon

Published at Plan Printing Company Limited



Supported by


Ford Foundation




Preface

Two major goals of HIV/AIDS response include a reduction of new cases and enhancement of access to care and treatment as well as other relevant services. This should help PLHIV and AIDS patients to live their lives happily with others in society and attain a good quality of life. The UNAIDS has spelled out measures for achieving the goals including the promotion of access to comprehensive prevention, care and treatment or what is known as Universal Access (UA).

As a part of NGO network working on HIV/AIDS in Thailand, the Thai NGO Coalition on AIDS (TNCA) finds it important to encourage the Thai government to provide for policy and service delivery in accordance to the principle. In 2009, TNCA held meetings with 15 networks under its umbrella. It was agreed that in order to have the policy making and access to services in place, we have to give attention to the issues of Sexual rights and AIDS rights, both of which are human rights. The campaign was thus launched during the 2009 World AIDS Day under the slogan “Sexual Rights and AIDS Rights are Human Rights: Respect, Understand, safety and Happiness”. This is in line with the slogan on the UNAIDS’s World AIDS Day, “Universal Access and Human Rights”. In addition, TNCA agreed to set Sexual rights, AIDS rights are human rights as our advocacy issues for the years 2009-2010 as well.





In addition, TNCA sets up a Policy Watch group composed of veteran campaigners on HIV/AIDS policy in Thailand including Mr. Nimit Tienudom, Ms. Sureerat Treemanka, Mr. Niwat Suwanphatthana, and Ms. Kanjana Thalaengkit. Issues about key policy regarding HIV/AIDS during the year 2009 have been compiled and a number of meetings called to review the policy. Sexual rights and human rights based approaches are employed in the analysis. Representatives from civil society organizations working on HIV/AIDS countrywide have been asked to share their views and the proceeding has been printed as “The 2009 Analysis of Policy Response toward HIV/AIDS in Thailand: A civil society’s perspective”, the volume of which rests in your hands now.

Pursuant to the completion of this report, TNCA has developed a proposal to set up a subcommittee to monitor and follow up on the stigmatization and discrimination against people living with HIV/AIDS. It is supposed to enhance the implementation of strategies aiming to protect AIDS rights. The agenda is being proposed for discussion at the meeting of the National AIDS Prevention and Alleviation Committee (NAPAC)

Next, we shall monitor how concerned agencies respond to our proposal. Meanwhile, efforts shall be made to encourage civil society organizations and state agencies



to use Sexual rights and human rights based approaches to mobilize more effectively policy on HIV/AIDS and sexual health at all levels. We shall work through the Provincial Coordinating Mechanism (PCM) in order to enhance more effective policy on prevention, care and treatment and to reduce impact on all groups of population in Thailand.

In behalf of Thai NGO Coalition on AIDS (TNCA), I would like to thank Ford Foundation for making possible the publishing of this report and the 15 civil society networks which help to brainstorm and the Policy Watch group for giving us time and resources. Special thanks go to Ms. Sutthida Malikaew, for researching and compiling relevant documents and Mr. Niwat Suwanphatthana for writing the short version of the report which we enjoy to read. Our gratitude also goes to many other whose names cannot be mentioned here.

Last but not least, I hope everyone enjoy her or his good sexual health and consensual sex without the use of force. We all should stay free of STIs, unwanted pregnancy, have access to the information and be proud of one's gender identity which shall be respected, understood, safe and happiness.

Supatra Nacapew
Chairperson, Thai NGO Coalition on AIDS (TNCA)



Contents

Part A :	Introduction	7
Part B :	Recommendations for the enhancement of the protection of sexual and reproductive health rights	17
Part C:	Review and analysis of relevant policy	27
Part I	Health services policy and its implementation	29
Part II	Educational and public awareness policy	54
Part III	Human rights and respect for human dignity policy	65
Part IV	Structures and mechanisms for developing policy and implementation	87
Appendix		114

PART A



“Civil society believes that respect of sexual rights is key to helping people understand notions of biological sex, gender and sexuality beyond typical female and male sexual identities. This should lead to universal protection and respect for human dignity.”

Introduction

2009 Policy Analysis Report on the HIV/AIDS
Response in Thailand: A Civil Society Perspective
By the Thai NGO Coalition on AIDS (TNCA)

Thailand embarked on efforts to address HIV/AIDS more than 20 years ago. A number of civil society organizations have taken part in the HIV/AIDS response, including NGOs (non - governmental organizations), CBOs (community - based organizations) and individuals as well as working groups belonging to 15 - 18 networks coordinated by the Thai National Coalition on AIDS (TNCA). These groups have understood the need to advocate more intensively for policy change in order to address HIV/AIDS-related issues in Thailand more effectively.

Activism on HIV/AIDS in the past two decades has drawn on scientific knowledge and epidemiology to develop and

monitor both policy and the response to HIV/AIDS. It is agreed within the civil society sector that the national response to HIV/AIDS has to rely on different bodies of knowledge, including the field of socio - cultural studies and a rights-based approach. This will allow the national response to HIV/AIDS to integrate knowledge from the areas of pathology, socio-cultural studies and human rights.

One of the major modes of HIV transmission in Thai society is through sexual relationships. Meanwhile, the HIV/AIDS response in tends to adopt a segregated approach, focusing on different populations, which in the long run is not helpful in creating safe sexual health for everyone.

Epidemiological knowledge and tools are useful for estimation and surveillance purposes. They allow us to identify HIV transmission patterns among various groups of populations. However, finding appropriate solutions requires us to address sexual relationships in the context of biological sex, gender and sexuality. Awareness of these concepts has to be fostered in light of existing values as well as social and cultural definitions in order to address HIV/AIDS and promote sexual health that is both enjoyable and safe in the long term.

Representatives of civil society believe that respect of sexual rights is key to helping people understand notions of biological sex, gender and sexuality beyond typical female and male sexual identities. This should lead to universal protection and respect for human dignity. It would also contribute to reducing problems stemming from sexual inequality and developing effective, successful solutions in addressing HIV/AIDS.

Sexual rights include respect for the right to one's body, human dignity and respect for sexual rights. The concept covers three dimensions, including *biological sex*, inherited since birth and discernible by scientific knowledge; *gender*, defined by social and cultural roles, based on upbringing and socialization within fundamental institutions such as the family and social institutions such as one's nation, religion and education; and *sexuality, defining* one's sexual life and focusing on issues concerning the body, related beliefs and concepts, and how one conducts one's living in relation to biological sex and gender.

In 2009-2010, civil society campaign agendas that include [sexual and AIDS rights in which human rights are applied to foster mutual respect and understanding, safety, and happiness](#). These areas can be described as follows;

Human rights

These are the rights inherited since birth, enabling one to conduct one's life based on human dignity and equality.

Sexual rights

Almost all people are born with genitalia, but our sexual identity – that is, feelings, perceptions and sexual orientation – may be different from the genitals each one of us has at birth. Gender, femininity, masculinity and sexuality are constructed by social and, cultural values and beliefs, and are subject to the control of social institutions; this can produce diverse social relations and sexual orientations.

Sexual rights are a fundamental human right. They are concerned with the freedom to have choices related to sex, sexual orientation and sexual roles. These rights have to be respected and treated equally and universally.

Every person is entitled to learn about sex, his/her right to sexual health, and reproductive health and protection, in order to allow him/her to experience sexual relations without violence, in happiness and safety.

In other words, every individual, regardless of gender or sexuality, shall be accorded the rights explained above, equally and universally.

AIDS rights

Having HIV in our body is similar to suffering from a chronic disease. Every human being has the chance to become infected with the virus from having sexual relationships or sharing needles when using drugs with a person who is HIV-positive (or person living with HIV, PLHIV). A PLHIV is a human being whose rights need to be protected similar to other patients, including freedom from discrimination, labeling, stigmatization and other preferences due to the gender or sexuality of a PLHIV. Any other kind of treatment would be considered a violation of human rights.

The best prevention of HIV transmission is through the protection of sexual and AIDS rights.

Women are generally prohibited by social norms from talking or expressing interest in learning about sex. They are expected to be cautious and careful in their sex life, and thus many of them have received the virus from having sex only

with their sexual partners, the persons they trust and share their lives with.

Meanwhile, males are socially expected to take leadership and assume responsibility. They are supposed to be knowledgeable in sexual issues though much of the knowledge and beliefs they have are actually misconceptions about sex and sexual relations. Without the awareness that everyone should have an equal right in developing one's sexual relationship as one sees fit, it is the rights of women and sexual partners that are infringed upon. Many adults tend to think teenagers are too immature to discuss sex. As a result, no communication around sex takes place within families or the larger community. There is simply no safe space for youth to learn about and understand issues concerning their body, emotions, feelings, identity, and the desirable sexual orientation. People are forced to express themselves according to their "natural" sex (i.e. based on the genitalia they were born with, which impedes the search for sexual needs and satisfaction.

There are people with diverse sexualities who are able to express themselves, and show imagination as well as emotions and feelings. Some choose to have sexual relationships with

those of the same sex (homosexual). Unfortunately society fails to give these individuals the space to stand tall with dignity, without being condemned and discriminated against.

Under the current reproductive health system, women are not allowed to control their own pregnancies, pregnancy spacing, child rearing or the termination of pregnancy when they are not ready to bear children.

It is held as a common notion that a “perfect” family consists of a father, a mother and children, including both boys and girls; thus family life, especially the bearing of children, becomes regulated by social limitations. However, when PLHIV marry or live in a partnership, these same social “rules” are reversed and they are told to follow a different line. They are expected to not have children, fear HIV transmission and disclose their HIV status to their sexual partners.

This case reflects the diversity that exists within the context of sex and sexuality and allows us to see the problems arising from a stereotypical gender perspective dominated exclusively by male-female sexual relations, i.e. heterosexual relationships. The fact that individual human beings are denied the opportunity make their own decisions regarding sexuality

that break with traditional gender notions has led to sexual inequalities, a lack of respect for one's rights, sexual labeling and stigmatization, and the violation of sexual rights as well as HIV infection. This occurs when one has no power to choose and negotiate sexual matters.

Promoting communications around sexual rights can enhance self-awareness and understanding, and helps one to come to terms with causes that dominate gender notions based on social norms, beliefs, culture and customs. It enables one to choose one's preferred sex life. It is essential to challenge society to create more opportunities for openly discussing and communicating around sex, and to raise awareness of sexual rights. Broadening the safe space for diverse sex lives thus becomes a tool to protect sexual rights. Sexual diversity will be considered "normal" and can eventually sustain itself. All of this can make it possible for society to peacefully co-exist in

Respect The humanity of individuals from all genders, ages and classes

Understanding Sexual diversity, gender and sexuality

Safety

A safe space to enhance learning about sex, communication and to make possible equal sexual relationships

Happiness

The confidence to choose one's own sexual preference, to enjoy a safe sex life, and be happy with one's sexual identity



PART

B



“However, is why these different populations, despite knowing how infection occurs and receiving condoms, continue to perform unsafe sex with their hetero-homosexual relationships or in sex work. The answer may be related to the management of “power within sexual relations” which is uneven.”

Recommendations for the enhancement of the protection of sexual and reproductive health rights

The realm of HIV/AIDS has hitherto been confined mainly to the area of epidemiology, prevention of transmission, sickness, and medical treatment. All measures, implementation and policy have thus been guided by a medical approach.

Efforts have been made, however, to use the social dimension to understand the causes of unsafe sex and other conditions and factors that enable one to be able to choose and make decisions based on equality. It should help to address the vulnerabilities and risks that have brought about a lack of protection and self-care.

Nevertheless, the dominant approach to control HIV transmission tends to be based on reductionist views about human beings. It stresses the importance of knowledge in virology, infection and prevention by focusing on different body parts that are the channels for receiving and transmitting the virus. Social, cultural, economic and political factors that enable one to have choices, opportunities and bargaining power, which are the main causes of human rights and dignity violations, have been ignored.

Efforts to present an analysis of measures, law and policy by the state from a civil society perspective can help broaden the way we look at problems related to HIV transmission by bringing into the debate the issues of sex, rights and human dignity.

Civil society believes that respect for sexual rights is necessary and key to help us move beyond traditional views on sex, gender and sexuality. It will enable us to have access to equal protection and respect of human dignity, leading to a reduction in sexual inequalities. In addition, it can steer us toward more direct and effective solutions in addressing HIV /AIDS.

Civil society has prepared legal and policy recommendations regarding sexual and reproductive health rights which aim to solve existing problems and can lead to successful outcomes, including:

- A subcommittee should be set up to monitor and follow up on efforts to eradicate stigmatization and discrimination against PLHIVs and AIDS patients. It should become a part of the overall structure in the response to HIV/AIDS at the national level and should be mandated to monitor and follow up on problems and impacts as a result of labeling and discrimination concerning sex and HIV/AIDS.

- Policy and action plans developed in response to HIV/AIDS should encompass all aspects of sexual and reproductive health, respect for sexual rights and human dignity concerning the diversity of sex, gender and sexuality. They should be regarded as a fundamental human right and be integrated into the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation.

● Policy, measures and action plans developed in response to HIV/AIDS should be developed in light of other policies and laws that may help to enhance the protection and promotion of sexual rights and respect for human dignity.

● The National AIDS Prevention and Alleviation Committee (NAPAC), which is a main conduit for policy implementation, along with other mechanisms should work toward monitoring and supervising efforts to ensure the enforcement of obligations in accordance with various international instruments. They should also promote the reform of laws and policies that may impede efforts to ensure these rights.

● The “risk group” and “extreme risk group” categorization should be abandoned since it has led to the assumption that it is these groups that transmit the virus and are therefore social problems. Instead, efforts should be made to enhance the understanding about factors and conditions as well as social structure, culture, religion, unequal economic and political status, which have made certain groups in society vulnerable,

unequal, subject to hate and discrimination, and unable to make their own decision to live a safe life like other groups in society.

- Any act which tends to promote social labeling, isolation, discrimination and criminalization should be stopped, including other, similar regulations, rules or traditions. This will help to promote the right to access and receive health services to ensure that various groups of people are able to look after and protect themselves as much as other people and groups.

- Members of these groups of people should be empowered to gain access to the right to health, education, housing and work in equal measure with other groups in society.

- The delivery of health services should incorporate greater respect for rights and human dignity and an acknowledgement of the diversity of sex, gender and sexuality, including the fact that these do not encompass the male and female sex, or

masculinity and femininity only. There is nothing wrong with the decision to follow one's personal preferences in the areas of sex, gender and sexuality, and this does not lead to the decrease of human dignity among those who decide to do so. In addition, the criminalization of such decisions should be avoided to prevent people who opt for a different sex life from being treated as offenders or being subject to disgust or isolation. On the contrary, they should be given access to services and the ability to live in society in safety and on equal footing with others.

- Service providers and those working on HIV/AIDS and related individuals should be receive the opportunity to learn more about sexual rights, AIDS rights, human rights, sexual diversity, gender and sexuality. Implementation and service delivery should be based on respect for these rights and human dignity. Based on reviews of existing knowledge, tools should be developed to design training courses organized by TNCA, the Thai National Network of People Living with HIV/AIDS (TNP+) and the Foundation for AIDS Rights (FAR).

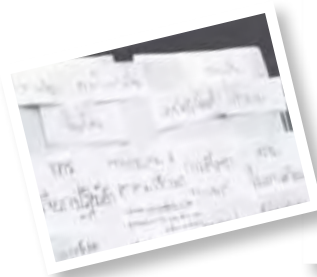
● Efforts must be made to support and promote a “comprehensive sex education process” which shall be replicated to cover both formal and non-formal education systems. Resources have to be invested to improve attitudes and potential of instructors. The National AIDS Prevention and Alleviation Committee should ask the Subcommittee for Advancing the Prevention Program Effort and to steer the attempts to develop concepts on human dignity, human rights and sexual rights among youth who will be taught based on the comprehensive sex education curriculum. The Ministry of Education should take the lead in coordinating and promoting the participation of youth and teachers’ organizations or associations across the country. They will form an important partnership as they mobilize the work in cooperation with other concerned agencies and organizations.

● A one stop service system that provides friendly services to youth and women, and other services, guided by a gender sensitive approach should be developed to provide counseling, knowledge, information, and spiritual and physical refuge to

youth. This service shall function as an immediate referral point for young people and the problems they identify, and to help parents and the general public understand the needs of youth. The Department of Health together with NGOs working on sex education, councils focusing on children and youth, and youth groups/networks should be part of the working team to mobilize the pilot efforts. Lessons are to be reviewed before further replication.

- Comprehensive sex awareness must be promoted, though not regarded as the promotion of immoral activities. Instead it should be viewed as an effort to instill among youth awareness about their rights to have a sex life which suits their personal needs as well as social, cultural and economic change. State agencies under the Ministry of Public Health (MoPH), who are Principal Recipient (PR) of the Global Fund, and Principal Recipient and Sub Recipient (SR) NGOs should conduct activities with youth and other groups to advance this awareness. Work that has been implementation in the past five years should be developed into social policies.

The “comprehensive sex education process” must be promoted to enhance the protection of reproductive health rights.



PART C



“Civil society has prepared legal and policy recommendations regarding sexual and reproductive health rights which aim to solve existing problems and can lead to successful outcomes.”

Review and analysis of relevant policy

This section deals with policy analysis and recommendations. The policy analysis can be divided into four parts:

Part I Health services policy and its implementation

Part II Educational and public awareness policy

Part III Human rights and respect of human dignity policy

Part IV Structures and mechanisms for developing policy and implementation

Part I

Health services policy and its implementation

As for health services policy and its implementation, three issues shall be explored including (1) Policy for halving the number of new HIV infection cases by 2011 (Half by 2011); (2) Enhancement of counseling services and provider-initiated counseling and testing (PICT); and (3) prevention of mother to child transmission (PMTCT). All three issues will have a significant impact on the implementation and delivery of HIV /AIDS-related health services, in particular in the area of HIV transmission prevention.

(1) Policy for halving the number of new HIV infection cases by 2011 (Half by 2011)

Since 2007 when the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007 - 2011 (2007 – 2011) was launched, efforts have been intensified to implement policy and enhance prevention. The Subcommittee for Advancing the Prevention Program Effort has been set up to work on the reduction of new cases by

half by 2011. Four populations were determined as the Most at Risk Populations (MARPs): Intravenous Drug Users (IDUs), Men who have Sex with Men (MSM), Sex Workers (SWs) and Migrant Workers (MWs). The plan's implementation has been made possible by funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, or Global Fund), from the continuation of the first, and the eighth rounds consecutively. Particularly, in the eighth round, direct funding has made possible working directly with the four target groups. It is clear how policy implementation is geared toward working with these groups.

Civil society claims that the development and implementation of the 'Half by 2011' policy has mostly been based on epidemiology, employing epidemiological tools and formats to calculate and estimate new cases. Emphasis was given to the channels through which the virus is transmitted, in order to highlight populations which feature high prevalence rates. The data is then classified and ranks risk groups and MARPs including the receiving and transmitting of HIV from these to other populations.

Findings derived from employing epidemiological tools and models include projected prevalence rates among various

populations, major conduits for HIV transmission and major populations affected, including: IDUs who share syringes and needles with PLHIVs; have unsafe sex with PLHIVs (both sex workers, MSM); and sex between heterosexual spouses. Based on these findings, preventive measures can be developed, including raising awareness about the infection of HIV, promoting the use of condoms and harm reduction.

It is deemed by civil society that such a policy has been developed hinging primarily on epidemiological knowledge and that preventive measures have then been determined according to different risk groups including the MARPs. Resources and cooperation can then be applied to reduce new cases, but only in the short term; prevention and alleviation efforts are not sustained in the long run.

What epidemiological tools fail to recognize are “sexual orientations that are diverse and mutable”, as expressed through gender and sexuality. The four populations thus constitute diverse sexual orientations which in themselves are diverse, mutable and not subject to biological sex or any fixed sexual orientation. In other words, MSM may not have sex exclusively with other men. They may also have sexual relationships with women and other genders. Meanwhile, sex

workers do not just adhere to one single sexual orientation or sexual relationship. They are also engaged in spousal and other types of sexual relationships.

The epidemiological domain tends to ignore or be less sensitive to the mutable and diverse nature inherent in sexual orientation/identity, and simply focus on promoting sex with condoms as the prevention for HIV infection. What the epidemiology fails to explain, however, is why these different populations, despite knowing how infection occurs and receiving condoms, continue to perform unsafe sex with their hetero-homosexual relationships or in sex work. The answer may be related to the management of “power within sexual relations” which is uneven. Whoever has this power determines whether to have sex or not, to have safe or unsafe sex, to have protected or unprotected sex, to have enjoyable or non-enjoyable sex, or to have forced sex/functional sex/desirable sex. Focusing simply on raising awareness about the causes of infection and distributing condoms will not make the four main populations engage in safe and proper sex.

In addition, the epidemiological approach also fails to address social stigmatization and discrimination as a result of the existing policy and implementation. Those people classified

as most at risk are blamed for HIV transmission. This approach helps reinforce negative attitudes and bias against those who are different from us and simply complicates access to services, and decreasing respect for rights and status.

The policy and solutions concerning prevention should be developed based on broader realms of knowledge covering socio-cultural dimensions and be informed by a rights-based approach. Social and cultural vulnerabilities should be taken into account since they are related to the violation of sexual rights and human dignity as a result of bias and rejection, a lack of respect for diverse sexual orientations, and a lack of power to manage sexual matters. Also, stigmatization, discrimination, isolation and sexual discrimination have made people feel powerless and unable to access the prevention, care and treatment services, making them more vulnerable to infection.

The sexual identities of MSM are not socially recognized. They are largely determined by fixed stereotypical views closely influenced by biological sexual identity. Thus, manifesting sexual differences is not respected and is even used as an excuse to promote dehumanization.

Sex workers find themselves vulnerable in the context of managing their own sex life. This is due to their

marginalized economic power, a lack of safety/security and social welfare from their work and the fixed perception of their sexual identities related to the work they do. As a result, sex workers' sexual identities as well as social status have been ignored, with few attempts made to enable them to have more choices and become stronger.

Migrant workers and IDUs are similarly subject to these fixed and stereotypical attitudes regarding the main causes for HIV transmission, which here too, stems from the exclusive reliance on a medical point of view and a disregard for their diverse sexual orientations/identities.

Such a static view and attitude has been applied with the MARPs, causing them to become more vulnerable. A lack of dynamism and the process of lexicalization have made the identities of IDUs, MWs, MSM, and SWs subject to stigmatization and social discrimination, with the situation deteriorating.

Civil society would like to propose the following recommendations concerning the Half by 2011 policy:

- The state should promote efforts to foster greater understanding for the way of life individuals in each group

have chosen. Their life style choices should be regarded holistically – including their sex life as it relates to culture, tradition, and beliefs – in order to further develop knowledge that can then be applied while working to reduce stigmatization in the areas of prevention, care and treatment. This work should be based on a multidisciplinary approach that covers aspects of epidemiology, social-cultural perspectives and human rights.

- The state should focus on raising public awareness about risk and prevention of risk without pointing to any particular populations, while at the same time it is necessary to work with the different groups in the context of each individual's way of life. In particular, attention should be paid to sexual diversity and respect for human dignity in order to allow everyone to feel safe and lead a happy life in society.

- The state should help civil society work more effectively by adjusting existing laws to allow all individuals and groups to gain access to prevention, care and treatment services. The laws should be reformed to better reflect the concept of human rights, to help promote the decriminalization of drug users, to minimize harassment by state officials of sex workers, and to

remove the perception that love and sex between people of the same sex are abnormal and dangerous.

- Current policy and prevention measures tend to focus on power, sexual inequalities and the eradication of discrimination based on differences in sexuality, gender and ways of leading one's life. Though sexual and reproductive health rights are incorporated, the above-mentioned individuals are still perceived as one of the 'issues' contributing to the perpetuation of HIV transmission, rather than being viewed as human beings whose rights and human dignity must be respected.

- Respect of sexual rights and human dignity should be promoted to enhance sexual health in a way which is safe and suitable to the gender and sexuality chosen freely by each individual.

- Efforts to help various groups and couples practice safe, protected sex, and enjoy sexual health should therefore be based on the notion of "mutable and diverse sexual orientation/identity" and the management of the uneven "power within sexual relations". In other words, "sexual rights" must be respected.

- Funding support should be allocated to promote networking, the strengthening of working potential and greater coordination among working groups. Proposals submitted by the target groups should include the request for funding to provide for capacity building and networking to enhance the dignity of affected groups who themselves would prefer to live a life free of HIV/AIDS like anyone else in society.

(2) Enhancement of counseling services and Provider Initiated Counseling and Testing (PICT)

The promotion of (Voluntary Counseling and Testing) VCT has intensified again after the expansion of anti-retroviral (ARV) treatment in Thailand. It has been implied that VCT shall be promoted to enable PLHIVs and AIDS patients to know of their status sooner and be able to have faster access to care and treatment, as well as to enhance overall prevention of HIV transmission.

VCT services have been developed and implemented in various forms by different actors to achieve better efficiency including mobile VCT and more recently the inclusion of VCT in the country's universal health care package and the

expansion of training in basic counseling among nurses in public hospitals.

Nevertheless, it was found that very few people decide to access VCT services. Thus, another form of VCT called Provider Initiated Counseling and Testing (PICT) has been promoted. In this format, service providers are supposed to convince or persuade clients to request counseling and blood testing. This kind of a practice could have been initiated before.

Promotion of PICT seems to have intensified at the policy level. This is based on the assumption that if many people decide to undergo testing, it would help to speed up the screening process and allow us to discover greater numbers of PLHIVs and AIDS patients. In the context of the goal to identify more people living with HIV, this would increase the efficiency and success rates of medical, treatment and prevention interventions.

In the few years, a study titled “The Potential of Provider - Initiated Voluntary Counseling and Testing in Health Care Setting in Thailand” was published. It was conducted by the Health Intervention and Technology Assessment Program (HITAP) with funding support from the Global Development Network, the Thai Health Promotion Foundation and Health

System Research Institute (HSRI). The study helps to prove that PI(V)CT is successful in significantly increasing the number of those applying for testing. There has been a 50 - time increase of the counseling and testing. It was also found that PI(V)CT makes the per head investment most economical (Yot Triwattananond, 2010). Findings of the study have been presented to policy makers including the National Health Security Office (NHSO).

Reviewing the approaches taken by VCT, VCCT, PIVCT, or PICT, one may find that all these measures or models share similar objectives/needs, including the intent to develop a more accessible, speedy format/channel that helps people use the service and learn about their HIV status sooner so they can prevent further transmission and gain prompt access to treatment. This would enhance the treatment efficiency and reduce mortality rate.

Their differences probably lie in the hidden agenda behind the need to develop various approaches, evolving from VCT to PIVCT and/or PICT, and how the different tools have been used to serve different purposes. If the purpose is to identify PLHIVs and AIDS patients sooner in order to improve control and prevention, PICT should be used. Yet this approach

could also potentially distort the basic aim of VCCT. In other words, the aim may shift in the direction of CCTV (closed circuit television), which strives to monitor and identify those who have HIV/AIDS in order to screen them out. This is similar to recent attempts by the state to screen out those having new strains of flu, with implications of increased labeling, stigmatization, discrimination and prejudice against those found to have the virus and who are classified as clearly dangerous persons.

Though essentially PICT aims to give people choices in treatment and to promote safe behavior, it also aims to increase the number of people registering for blood testing in order to identify as many HIV-positive people as possible sooner. PICT has good intentions: preventing transmission and enabling people to have faster access to treatment.

Nevertheless, this approach may also inadvertently cause rights violations and infringement on an individual's human dignity. It may result in efforts that focus on forcing more people to get tested, simply to increase the number of those applying for testing and to meet the target numbers. This may subsequently affect the quality of counseling, become less sensitive to and take for granted the differences among clients, including their sexual identities and other aspects.

The expectation of having a large number of people getting tested may compel us to ignore the rights of clients to give informed consent and to maintain confidentiality. This is the case when PICT is provided as part of Prevention of Mother to Child Transmission (PMTCT) programs for pregnant women, where the focus is on persuading pregnant women to have their blood tested for HIV in order to get into the PMTCT. This has happened without concern for the pregnant woman's willingness or the consequent impact on her human dignity. The bodies and reproductive health systems of pregnant women who live with HIV/AIDS are simply viewed as a mechanism in the HIV transmission process, the implication of which shall be explained in further sections. Civil society also feels concerned with the purported effort to apply this testing with groups that have been identified by epidemiological means as the groups most at risk.

What is missing in the implementation is perhaps respect for clients' readiness and willingness as well as a genuine decision-making process. The service should be made available to provide for counseling and promoting access to information and knowledge, including the assessment of one's behaviors and chances in order to help individuals address the

vulnerabilities in their lives. They should be allowed to decide whether to undergo testing or not, and service providers should keep any information confidential, respecting the fundamental right of each client.

In order to make VCCT a tool to help clients come to terms with their own vulnerabilities and their risky behaviors, service providers have to develop positive and open attitudes. They should be ready to embrace the mutable and diverse sexual orientations/identities of their clients and understand the unequal power distribution within sexual relations. Services should be provided without stigmatization and discrimination. This will make VCT, VCCT, PIVCT, and PICT tools to effectively achieve the Half by 2011 policy based on the respect for rights and human dignity.

Another important issue is access to VCT among youth under 18 years old. Although VCT services have been included as part of the national universal health care scheme, the offer of such a service to people under 18 is still not possible since it violates the “Guidelines for Medical Persons Concerning HIV/AIDS” (Medical Council of Thailand, 2545). Section 2.4 (on keeping clients’ information confidential and disclosure) provides that should the client be a person who is: younger

than 18; not older than the legal age due to early marriage; of physical and mental disability and not able to understand and make his/her decision at different stages during the counseling prior to the testing, then the seeking of consent and the disclosure of results and counseling after testing must be a matter for his/her parents or custodians

A major challenge is therefore finding a way to improve current methods used to encourage youth to access HIV testing in order to receive subsequent services without breaking the law and serving the best interests of children and youth. Civil society organizations led by PATH have reviewed relevant laws and proposed to the subcommittee for drafting the guidelines concerning HIV/AIDS under the Medical Council of Thailand. The proposal is currently under consideration.

Another major challenge regarding VCT services is that ethnic minority groups and migrant workers still have no access to such services. It could be said that at present, no migrant workers have access to HIV testing.

Civil society would like to propose the following recommendations concerning VCCT policy:

- VCCT should be provided for and delivered alongside efforts to promote access to information, counseling and alternatives in prevention, care and treatment services based on a voluntary and confidential approach, rather than be applied with the goal to force people to get tested for HIV for the sake of prevention and control.
- The measure should not be applied among specific groups due to certain attitudes, stereotyping and bias. Instead, such a measure should be aimed at including all people equally and universally.
- Appropriate and friendly one-stop service systems should be set up and include counseling, condom distribution, reproductive health services, peer group support for PLHIVs and AIDS patients, ARV services, services for pregnant women, and more. VCCT services should be provided to all groups based on understanding of and sensitivity to culture, ways of life and sex life.
- In order to make VCCT accessible to all groups, efforts must be made to regularly provide information and offer

counseling within the community. In addition, more personnel should be recruited and receive training to provide counseling. The counselors do not need to always be governmental officials; outreach work can include civil society representatives, who would be empowered and could function as counselors as per standard counseling procedures. Also, PHAs who participate in the Comprehensive and Continuum of Care Centers (CCCs) in more than 500 hospitals throughout the country should be encouraged to perform VCCT with funding support provided.

- The services should be delivered in the languages or dialects used by migrant workers and ethnic minority groups. Any NGO volunteer or staff who trains as counselor should be considered service providers and they can then be asked to help provide friendly VCCT services among ethnic groups and migrant workers since they speak the same language as the workers and have proper understanding of their culture and society.

- The implementation of VCCT, VCT and PICT should be monitored and evaluated in order to review and adjust National

Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation including the reproductive health and rights protection plan to ensure effective results in decreasing the number of new cases and guaranteeing access to quality care and treatment services based on collaboration between state agencies and civil society.

(3) Prevention of Mother to Child Transmission (PMTCT)

Since 1999 the Department of Health has declared PMTCT part of the national agenda. Over the past ten years, it is deemed by civil society that this PMTCT policy has drawn exclusively on medical knowledge, making issues concerning the prevention of HIV transmission to newborns into a solely medical matter. This is visible in the program name itself, ‘PMTCT’, which only includes medical aspects while ignoring social and cultural impacts that pregnant women who live with HIV/AIDS experience and the stigmatization that they are the ones who pass HIV on to the newborns. It is suggested that the name should be changed from PMTCT to ‘prevention of the HIV transmission to newborns’. While medical aspects are retained, the new title helps to raise social and cultural

awareness and steer people away from condemning pregnant women who live with HIV/AIDS.

As this policy has been implemented along with the expansion of ART led by the Department of Disease Control which began almost simultaneously, we have found the implementation of policy and quality of service delivery unrelated to each other. Our findings reveal a huge gap between the services provided by the Department of Health for mothers and children and the services run by the Department of Disease Control to provide ART in clinics. As a result, a number of women who manage to maintain good health after child delivery and do not need ART, are not informed of ART services, though this information is useful for future planning of possible treatment needs. Though coordination has recently been enhanced, the gap in collaboration between the Departments of Disease Control and Health still exists.

Civil society holds that PMTCT still stresses the protection of the newborn while ignoring the importance of the health of pregnant women who live with HIV/AIDS. This can be observed in the context of the debate around and concern over pregnant women who live with HIV/AIDS, and are recruited into PMTCT programs in order to receive ARVs; some of them have developed resistance to the drug regimen.

Due to advocacy from civil society led by TNP+ and its alliances in 2009, NHSO and the Department of Health have agreed to change the regimen used in PMTCT to a triple-drug regimen to enhance the efficiency in preventing the HIV transmission to the newborn and to prevent drug resistance among pregnant women. The regimen has been incorporated into pilot programs and shall be made available countrywide in October 2010.

In addition, civil society believes that PMTCT fails to protect women's reproductive health rights, including the decision to carry to term or to terminate their pregnancies, to have new pregnancies and to choose the preferred number of children. The information and service delivery provided is still by and large subject to the discretion of medical doctors and nurses, while medical personnel maintain different views regarding HIV/AIDS and PLHIVs and AIDS patients. Some are biased against providing services and planning, the act of which may lead to the violation of sexual and reproductive health rights of women who live with HIV/AIDS and are married.

In addition, some services provided to pregnant women may cause violations of sexual rights, including their choice to conduct their sex life as they see fit, or to have new spouses.

Most of the pregnant women seeking the services are told to stop thinking about having new spouses. They are told that having new spouses is tantamount to committing a sin; this places great pressure on pregnant women who seek services from mother and child and ARV clinics.

Civil society believes that PMTCT policy should be implemented based on a respect for sexual and reproductive health rights and the decisions made by the women themselves. Pregnant women should be provided with voluntary counseling and blood testing and the information has to be kept confidential. Quality counseling should be developed to enable women to make decisions whether or not to be tested and other contingency plans, including:

- Should they find themselves infected, how can they continue living?
- Should they participate in the PMTCT programs?
- Should they disclose their status, and how can they disclose to their partners? Is it proper to take their partners to get tested?
- Should they find themselves not infected, how can they continue living?
- How can they reduce their risky behaviors and the

vulnerabilities to getting infected and also protect their partners?

The counseling service should also cover family planning, repeated pregnancies, and choices in the termination of pregnancy.

Civil society would like to propose the following recommendations concerning PMTCT:

- The title of this program should be changed from Preventing Mother-to-Child Transmission (PMTCT) to “minimizing the transmission to newborns” in the attempt to prevent labeling and discrimination.

- Let the services be delivered through the normal universal health care package, with PMTCT not placed under the care of the Department of Health, whereby;

- A triple drug regimen should be provided to pregnant women who live with HIV/AIDS All women seeking prenatal care should be given VCCT. However, neither they nor their husbands should be forced to have it.

● The VCCT service should be delivered while keeping potential clients fully informed, including risks related to pregnancy of each pregnant woman, information concerning ART, how to look after oneself after child delivery, and impacts on oneself and spousal life, etc. This information should be part of the required service provision, given before pregnant women decide to have the blood test or not and whether they are still pregnant or have already delivered the child.

● Along with information concerning VCCT, it should be mentioned that under the universal health care program pregnant women and their spouses are entitled to seek counseling and VCT twice a year free of charge. Mothers who live with HIV/AIDS should be treated similar to other mothers.

● Every woman living with HIV/AIDS has the right to reproductive health and sexual rights. They can decide about their sexual relationships, planning their pregnancy and/or its termination, and can access family planning while being kept informed of comprehensive news and information, for example, their right to access and seek services, news, information, health care, treatment and ART. It should be reiterated that

such a right also enables pregnant women who live with HIV /AIDS to decide whether or not to seek PMTCT.

- The different opportunities and choices pregnant women have due to their HIV status, marriage status, Thai nationality status or being illegal migrant workers or dependents should be taken into account. Due to these different choices, economic opportunities and livelihoods, each pregnant woman may seek a different kind of support and care.

- Officials should receive training to enhance their counseling skills, with a particular focus on highlighting the importance of gender and sexuality as well as human rights and reproductive health. This should enable officials to provide counseling, information and support to PLHIVs and AIDS patients. With an understanding of sexuality they shall be able to encourage more discussion on sexual relationships, violence and unsafe sex among PLHIVs and AIDS patients. Support should also be given to women who are unable to disclose their HIV status because they are victims of violence, so they can receive mental rehabilitation as well as social and legal assistance.

● Efforts should be made to promote collaboration with networks of women living with HIV/AIDS, TNP+ as well as other civil society networks. Their participation should be equal in the advocacy for pregnant women and mothers living HIV/AIDS to have access to services.

● Clear policy concerning safe termination of pregnancy should be promoted to make it suit the needs of women and women living with HIV/AIDS. At the very least service provision facilities that are safe and efficiently run should be set up.

● The Department of Health is encouraged to develop an action plan on reproductive health and work with people of all genders. It should stress awareness-raising on reproductive rights from a human rights perspective. In other words, people from all walks of life, all ages, genders and statuses, should be able to access knowledge and understanding around issues of sex, gender and sexuality which are the fundamental rights of all people. Services should be provided based on a voluntary basis and when women and men have the option to protect their own reproductive health rights.

Part II

Educational and public awareness policy

HIV transmission has increased among youth. It has been assumed that the reason for the transmission is due to a lack of comprehensive awareness of sex. Though the promotion of understanding of reproductive health has been included as part of both the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation and the reproductive health action plan of the Department of Health, it is not easy for Thailand to develop a balanced sex education curriculum that suits the local reality and aims to engender understanding.

Apart from a lack of critical understanding of sex, young people also encounter many other problems related to poor sex education, including unwanted pregnancies, sexually transmitted infections (STIs), or sexual violence. Therefore, well rounded sex education should help to promote and enhance the prevention of HIV transmission and to address related problems.

The Department of Health, MoPH, has reviewed the existing sex education curriculum and proposed ways to make it better-rounded. During the educational reform process, a curriculum was proposed to the Ministry of Education. It was later incorporated into the health and sports science curricula and officially used in 2002. According to this curriculum, six objectives are expected to also serve the purpose of teaching at home:

Human sexual development including understanding about physical growth, sexual development at different ages, and physical, mental, emotional and social development.

Interpersonal relations including how to initiate and maintain interpersonal relations in society, how to initiate and maintain relations with friends of the same or different sex, how to choose one's partner, preparation before marriage, family building, and relations between spouses, and parents and children.

Personal and communication skills including skills to deal with situations related to sex, such as communication skills, initiating and controlling relationships within a proper framework, how to refuse, how to ask for help, how to deal with

emotions, how to make decisions and how to solve problems related to sex.

Sexual behaviors including the expression of sexual behaviors or gender roles suitable to age and norms in society, how to avoid sexual risks, teen sex, unprotected sex, how to develop a proper sexual identity, gender equality, and balanced gender roles.

Sexual health including understanding and skills in health care suitable to one's age, such as how to look after sexual organs, reproductive health, observing changes and abnormalities in the functioning of sexual organs, how to avoid bruises and injuries, inflammation, infection and sexual harassment.

Society and culture – sexual values suitable to Thailand's society and culture, respect for the opposite sex, self-restriction, not getting engaged in sex easily, how to adapt to a changing society, in particular regarding obscene material and laws concerning sex.

The sex education curriculum adjusted by the Department of Health has become more progressive and comprehensive, also stimulating debate. For example, in objective 4, it mentions the concept of equality and how to

develop proper sexual orientation, though the definition of the term “proper” has not been explained in detail. Objective 2 is concerned with how to initiate and maintain sexual relations and objective 6 discusses sex values suitable to Thailand’s society and culture, which tends to encourage youth to refrain from having sexual relationships and to consider sexual relationships a rite of passage to spousal and family life. The contents would have become more progressive and well-rounded should there be discussion about sexual orientations which are diverse and mutable, diverse forms of sexual relationships and safe sex.

However, it was found that the 2002 curriculum has not been implemented effectively. The teaching of sex education in schools has failed to achieve the expected results due to a number of factors including teachers’ attitudes, experience and skills in imparting sex education, effective sex education, the policy and atmosphere in schools, and so on. (Health Counterparts Consulting, 2009)

Between 1999 and 2001 there was an attempt by PATH, a veteran NGO working on HIV/AIDS, to experiment with teaching well-rounded sex education in some pilot schools in Bangkok. Then in 2003, MoPH, supported by the Global Fund, chose PATH to be sub-grantee to carry out prevention

activities among youth in educational institutes.

Based on PATH's past experience and the situation among young people, including especially the lack of sex education, PATH initiated the "TEENPATH Project" aiming to promote sexual health among youth by instilling in them the knowledge, maturity and skills to strengthen relations and choose a safe sex life. This should help reduce problems including STIs like HIV/AIDS, unwanted pregnancies and sexual violence. Sex education has been promoted systematically in educational institutes, and youth have been supported to organize their learning process and to develop creative public communications on sex.

The TEENPATH Project's sex education curriculum shares similar contents with that of the Department of Health. Comprehensive understanding is priority, hinging on the six dimensions of sex as explained above, including sexual development, sexual relations, personal and communication skills, sexual behavior, sexual health, and society and culture. Three major components are included, namely, (1) sexuality, to create an understanding of all dimensions of sex in human life; (2) positive youth development, based on the belief in young people's potential to learn and decide for the good of

themselves; and (3) the child-centered education approach (Health Counterparts Consulting, 2009).

Five years of implementation by “TEENPATH Project” have paved the way for new ways of teaching sex education in the Thai educational system. The emphasis has been given to training sex education instructors, development of sex education teaching aids, implementing sex education in pilot schools and promoting sex education networks composed of teachers and core youth leaders. Positive definitions of sex education have been promoted beyond the stereotypical view of physicality. Viewing sexual desire from the looking glass of adults has been replaced by young people’s perspectives. Youth are shown respect and allowed to make their own decisions based on comprehensive information. In addition, sex is no longer confined to the medical realm. It also encompasses social, cultural, economic and historical dimensions.

Apart from producing this curriculum, the TEENPATH Project also helped to expose Thai society to sex education from diverse perspectives through activities including sex education camps, replication of sex education from schools to youth probation centers, organizing a public seminar on “Sex Education for Youth” and allowing the children to express

their views as to what “desirable sex” is for youth. Sex is no longer defined unilaterally by adults, but based on the reality youth are exposed to.

Another challenge is how to promote learning processes to incorporate comprehensive sex education in the long run. Such an education should be expanded from school to family and community as well. Though more opportunities and an enabling environment are currently available for sex education, attention should still be given to review its quality and to ensure its comprehensive contents. The learning process related to sex education should be developed from the positive point of view of youth and place youth at the center of the process. No efforts should be made to control, but instead to promote learning and prudent decision-making to allow young people to have a safe and enjoyable sex life.

Reviewing the curriculum used in 2008, one may find significant improvements in the sex education curriculum for schools. The contents are comprehensive and classified at different levels. However, according to surveys by groups working with youth, certain schools still teach sex education stressing just the physical aspects. Meanwhile, some schools have adopted the curriculum developed by TEENPATH Project.

The policy is quite enabling as far as the implementation of sex education in schools is concerned. In 2008, the curriculum was declared appropriate for use in all schools. But one obstacle found is at the practical level; some school administrations and teachers still fail to promote sex education effectively in their schools.

Key to the effective instruction of sex education is the teacher. And it depends on how much understanding the instructors themselves have. In a child-centered education system, more effort has to be invested and teachers' skills are very relevant. Though the curriculum is well-rounded and comprehensive, we have found the teachers still adopting traditional teaching methods with teacher at the center. This fails to enable the students to think for themselves and to exchange ideas. This may not help us to achieve the real objective of the sex education curriculum.

As for other civil society organizations, the Youth for Change or Youth Network on HIV/AIDS Thailand (Youthnet) has proposed the following recommendations concerning HIV/AIDS and sex education:

- The state should accelerate efforts to encourage adults and those responsible for youth-related policies to embrace differences and diversity and come to terms with the nature of youth. Nonjudgmental attitudes should be promoted in the attempt to help youth explore safe sex choices. Training should be given to relevant personnel and public campaigns launched using public media to enable youth along with their families and community to join the effort.

- Comprehensive sex education and information about HIV/AIDS should be seriously and continually given to children and youth inside and outside school guided by a clear sex education curriculum. Teachers and service providers should be helped to maintain an open mind and recognize the importance of communication on HIV/AIDS and sex education, and to have positive attitudes toward condoms as a means to help youth to perform safe and responsible sex.

- A service provision system friendly to children and youth should be developed and equipped with available tools including condoms, contraceptive pills, lubricants, clean syringes and needles for injecting drug users, and ART. It should be

made accessible to local children and youth who can also cooperate to run learning centers on HIV/AIDS and provide sex education in schools and the community. Services catering exclusively to youth should be made available as well, including clinics and hospitals. They can be arranged as special 'weekend clinics', as mobile services that include individual (one-on-one) counseling and other types, such as telephone counseling, outdoor meetings or counseling via the internet. Other services needed for teenage mothers and their children would include day-care centers, short-term foster care and adoption.

- The state should accelerate the development of a care and treatment system exclusively for youth living with HIV/AIDS. Special training should be given to medical personnel to enable them to work with underage individuals, separate from their work with adults. Working with youth requires a special kind of knowledge which is lacking in light of the immense need and problems youth face.

- The state should allocate more resources for work with youth on prevention, care and treatment including funds for activities, expert resource persons, up-to-date informa-

tion, related equipment such as condoms and syringes, and self-esteem enhancement activities like group therapy, skills training and confidence boosting sessions in preparation for surviving in society. .

- The state must provide for an enabling environment and mechanisms to support HIV/AIDS prevention. Human resources in the state sector should be empowered to broaden their understanding of youth, to adopt attitudes that facilitate outreach to children, advisory functions or home visits that demonstrate an understanding of youth, and attempts to encourage the enforcement of applicable laws and policy to tackle HIV/AIDS supported by ongoing monitoring and evaluation procedures.

- Efforts should be made to instill understanding about gender equality, reducing bias and labeling resulting from sex, age, ethnicity, and religion through ongoing and serious legal measures in order to prevent violations of AIDS rights, particularly the requirement of a blood test for job applications or enrollment in educational institutions.

Part III

Human rights and respect for human dignity policy

Based on civil society experience, one of the root causes of HIV transmission includes violence and sexual oppression. These occur due to gender inequality, unequal power structures within sexual relations, and a lack of respect for sexual and reproductive health rights. They take various forms including domestic violence, sex work and sexual exploitation. These three issues are closely linked to the occurrence of sexual violence in the context of HIV transmission and other related problems. Therefore, civil society has chosen to review certain relevant legal issues.

Following are applicable laws including the Domestic Violence Victim Protection Act B.E. 2550 (2007), the Anti-Trafficking in Persons Act B.E. 2551 (2008), and draft laws that will be enforced, including the Draft Reproductive Health Protection Act, the Draft Promotion of Gender Equality and Opportunity Act.

Domestic Violence Victim Protection Act B.E. 2550 (2007)

The Act is underpinned by the myth of the notion of “family” and the overwhelming emphasis on family values. This makes it difficult for victims of domestic violence, particularly women and children, to escape from the violence. Should they decide to report the cases against their own husbands or parents, they would be accused of disrespecting family “values”. As a result, instead of accessing solutions, the victims will simply be subject to criticism. In addition, such an approach paves the way for mediating attempts “essentially focused on upholding the family structure” regardless of how much pain the victims have to experience. And they may have to return to face the same domestic violence after going public in demanding justice.

It could be said that the Domestic Violence Victim Protection Act B.E. 2550 fails to protect the victims, but instead upholds the “family institution”. It fails to provide for the right to identity of women or victims of violence; the emphasis is merely on “making the family happy”.

Domestic violence can also contribute to the transmission of HIV, including the cases women who have no bargaining power when it comes to sexual relationships and cannot ask for safe sex.

The Foundation for Women has found examples of women who have been victims of violence inflicted on them by their HIV-positive husbands. As the women are not infected, they are subject to control and physical attacks, since the husbands fear they may leave them, though in reality, the wives usually do not consider leaving since they have children together. Upon learning about their husbands' HIV status, the wives also go for blood tests and though HIV-negative they do not receive any counseling as to how to arrange their lives without being infected by their husbands. No follow up has been made to help women who are at risk. Meanwhile, the husbands are often not aware of opportunities to participate in group activities with the PLHIVs and AIDS patients, facilitating an exchange and broadening their worldview as to how to continue their own lives.

It is possible that the violence perpetrated by husbands is caused by external pressure and feelings of desperation

given that they do not always find work. Yet their wives, apart from already being victims of domestic violence, are also made vulnerable to infection since they have no bargaining power and are expected to remain obedient.

Married women, regardless of their HIV status, risk becoming victims of domestic violence. Wives who are found to have HIV may be expelled from the family, looked down on and subject to both physical and mental abuse. Under these circumstances, legal protection for domestic violence victims alone is not enough. Other factors have to be incorporated in order to minimize the impact of violence and improve protection against violence, including the provision of quality counseling, helping victims identify solutions and choices, and so on. But all these options are not included in the protective measures listed in the Act.

Nevertheless, the notion of “family” can become an obstacle in the delivery of public health services. For example, in the attempt to persuade men to use condoms, if wives say their husbands refuse to do so, then that is the end of their options since they are unable to do anything else. Or if public health officers find out that wives are victims of violence perpetrated by their husbands, they cannot do much to help,

fearing that their intervention shall infringe upon the “sanctity of the family unit”. However, in cases where the Domestic Violence Victim Protection Act is applicable, those “competent officials” can intervene. As the name implies, these “competent officials” should also approach officials in other capacities relevant to victims of domestic violence, including public health, psychology and social work. This will happen when the competent officials no longer adopt the attitude that domestic violence is an individual matter. It will also help public health officials take on more in-depth roles, particularly in giving counseling, something which will lead to appropriate assistance and remedies in the longer term.

Given the aforementioned weaknesses, it could be claimed that the Domestic Violence Victim Protection Act, B.E. 2007 simply gives some guidelines as to how to address violence committed against individuals in the family and those closely related. However, since the law specifies clearly its intent for “the maintenance and protection of marital status and family unity” based on a rather conservative family concept, the Act is not effective enough to deal with all crimes arising from domestic violence that occurs due to male dominance. Therefore, the Act is simply a legal tool to address violence

in the family, but it cannot guarantee justice and gender equality. And without gender equality and the lack of protection for victims of domestic violence, the possibility to control the transmission of HIV/AIDS and the quality of care and treatment can also be compromised.

In sum, the constraints of the Act can be described as follows:

- The Act fails to provide effective protection to domestic violence victims, particularly;

In the context of victims of sexual violence committed by family members, since the emphasis is placed on upholding family unity, and when any sexual violence is committed within a family, it is supposed to be treated as a family matter or a matter between spouses.

Domestic violence in the context of parent-child relationships, where sexual violence is perpetrated against children or those under custodianship because it is regarded as a way to discipline or help the child.

In both cases, a legal process is generally not pursued, but mediation is often offered to uphold family unity. This tends

to ignore the fact that sexual violence stems from gender inequality, inequality inherent in power structures, and the disrespect of sexual rights. Such acts are in breach of the Yogyakarta Principles: (1) The Right to the Universal Enjoyment of Human Rights, (2) The Rights to Equality and Non - discrimination, including discrimination on the basis of sexual orientation or gender identity; (3) The Right to Recognition Before the Law; (5) The Right to Security of the Person; and (6) The Right to Privacy and the Declaration on Sexual Rights of Health, Empowerment, Rights, Accountability (HERA)¹ which affirms the right to live a sexual life without being subject to violence, discrimination and force based on the working guidelines of equality, respect and justice.

● The Act is found not to be sensitive to the issues of gender and sexuality, particularly regarding the respect of sexual rights. In the Act, only the right to prosecution is upheld. The focus is put on just the perpetrator and victim and universal

1. HERA (Health, Empowerment, Rights, Accountability) is an international group of well-known women's and human rights activists for which the International Women's Health Coalition (IWHC) served as the secretariat. The group worked to ensure implementation of the agreements reached at international conferences and compliance with international agreements with regard to sexual and reproductive health rights including the International Conference on Population and Development (ICPD) and the Beijing Declaration.

measures that do not consider gender differences and sexuality of the victim which may differ depending on each person.

- Enforcement of the Act lies initially at the discretion of law enforcement officers. Similar to other laws, enforcement is subject to the discretion and interpretation of the competent officials. But there are cases where certain officials are ignorant of and insensitive to issues of gender, sexuality and the respect for sexual rights. They tend to adhere to the notion of the family institution as the most important value, all of which may lead to discrimination within the law enforcement sector. In addition, the tendency to interpret and treat the matter as an private matter between spouses or parents and children may lead to attempts to mediate and compromise, letting perpetrators off the hook and thus allowing them to continue inflicting violence.

- Judiciary processes at the court level are no different from those occurring with the police, whereby parties involved are encouraged to reach a compromise. Essentially, the law tends to uphold the importance of the family institution at the expense of the protection of domestic violence victims. Although such

an approach could be viewed as a positive response since it avoids the use of punitive measures against the perpetrators of the violence and other measures including probation are used instead, in reality, it is found that post-trial period measures including proposed rehabilitation and the prevention of recurrence of the crime are not strictly implemented. As a result, violence continues to be committed, as reported widely in the media.

● There is a lack of safeguards against domestic violence. According to good practices and international standards, any law should include protective measures and safeguards, not just punitive measures. It needs to ensure and encourage campaigns for change and raise awareness about the available services. The Operational Center to Prevent Domestic Violence is mentioned in the Ministerial Regulation, but it does not clearly state the mandate and composition of the body, even though it should be given a vitally important role in awareness-raising at the community, provincial and national levels, in addition to mobilizing efforts within concerned sectors in society and community.

● Civil society emphasizes giving due respect to personal rights and liberty and states that they should be protected to make it possible for one to choose one's own gender and to be free from any violence and harm against the body and mind. Therefore, the rights should be upheld in a manner that fits the sexuality desired by individual sexual partners. Nobody, including family members, relatives or community members owns the rights to the body of another person. And such a body shall not be subject to exploitation, sale or servicing any debt. It shall be protected against discrimination, violence, arrest and detention. In addition, the government shall refrain from acting directly or indirectly to promote violence against sexual rights. Proposed amendments to the Act are made as follows:

● The law should be subject to revision including its purpose and enforcement procedures, from the level of initial complaints to the judiciary process, making it more sensitive to issues of gender, sexuality and the respect for sexual rights – with the primary aim to protect the victim from violence, rather than upholding the family institution at the expense of domestic violence. Reviewing sexual violence in families should

be based on a broader concept beyond male or female identities. It should be based on a concept of violence that may have been inflicted on people with diverse gender identities, violence committed by parents against their gay children, transvestites, transgenders, through verbal offence, contemptuous acts, labeling and physical abuse, or offences committed against a member of the family who chooses to have a different sexuality. Such violence has to be embraced by broader definitions and the law should be amended to encompass these meanings. Law enforcement officials and actors at the operational level should also be encouraged to embrace this concept of violence in order to ensure that all members in a family shall be protected against any violence. Also, people who have diverse gender and sexuality should be encouraged to have access to and be protected by the law.

- Safeguards must be put in place to prevent violence against any family member and closely related persons. In particular, they should lead to campaigning for change in the public sphere, encouraging the state to accept that violence committed against a family member and closely related person is no longer an individual matter, and the intervention

by community members to stop domestic violence from being committed. Concerned agencies should act to raise awareness and to mobilize cooperation within the community and civil society, including encouraging members to monitor any violence committed against any family member and closely related person in their own communities. Such a victim needs to be informed of her or his legal rights, the option to complain and access to solutions. Though the roles of community are not clearly specified in the Act, Sections 5 and 6 can be interpreted to support this attempt.

- An effective system should be put in place to review cooperation between various agencies to act in compliance with the Act. Such a monitoring system should be used to assess any violence committed against a family member or closely related person in order to gauge the level and pattern of the violence.

Anti-Trafcking in Persons Act B.E. 2551 (2008)

The Anti - Trafficking in Persons Act B.E. 2551 (2008) was first published in the Royal Thai Government Gazette on

6 February 2008 and came into force on 5 June 2008 and in effect led to the repealing of the Prevention and Suppression of Prostitution of Women and Children Act B.E. 2540 (1997). The former Act aims to enhance efforts to prevent and suppress human trafficking. It provides for the establishment of a fund for the prevention and suppression of human trafficking and the reform of assistance and rescue processes for victims of human trafficking, making them serve their best interest.

Based on civil society experience working to rescue human trafficking victims, several practical problems related to the enforcement of the Act have been reviewed, some of which may affect the transmission of HIV and impede access to care and treatment.

The Foundation for Women, for example, previously rescued a Laotian girl who used to work as a waitress in Nongkhai and was lured into sex work in Suphanburi. Though this girl's employer applied for her work permit, she was forced to provide sexual services and was indebted to him from the start of her work. After servicing all the debts she was resold to other brothels and found herself in another spiral of debts. This cycle occurred three times before the Foundation rescued her and discovered she was living with HIV/AIDS.

This is obviously the case of a victim of human trafficking, and the circumstances which she experienced made her vulnerable to HIV infection since she had no bargaining power. In addition, after becoming infected, her access to care and treatment was further impeded since she was deprived of liberties due to her illegal migrant status.

Another constraint of the Act with victims of human trafficking who have HIV/AIDS is that the law provides no measures to give them any protection or support. From the viewpoint of civil society, since the victims were infected with HIV while in Thailand, they effectively have no other choice; the Thai state should thus introduce processes to provide them with aid, care and treatment. And before the repatriation, efforts must be made to ensure that in the receiving country, social support and medical arrangements can be made to continue the treatment. The state needs to ensure that victims continue to receive ART through an effective referral system.

Meanwhile, the Act has caused concern among voluntary sex workers and they have had to endure many impacts since the Anti - Trafficking in Persons Act came into force. The law gives draconian power to enforcement officials. For example, any parlor can be raided without having to seek a court order².

This has led to instances of abuse of power by officials. They may threaten to charge sex workers with selling sex, or if they find migrant sex workers in the place, they will threaten to sue the employers on an anti - human trafficking offence, which carries severe penalties. Most female sex workers will then be arrested and repatriated as victims of human trafficking and/or illegal migrants. Such a treatment by officials simply forces sex workers to go underground. This makes it difficult for them to seek public health services.

Civil society has the following recommendations for the Act:

- Officials at the operational level should receive training emphasizing that the primary aim of the law is not to arrest, detain and punish survivors of human trafficking, particularly “those who have been forced into sex work”. They should focus

2. Section 27 For the purpose of prevention and suppression of trafficking in persons, the competent official shall have the following powers and duties: (1) to summon any person to give statements, or submit documents or evidence; (2) to search the body of any person, with his consent, where there is a reasonable ground to believe that such person is a trafficked person; in case such person is a woman, the searcher shall be another woman; (3) to search any conveyance with a reasonable ground to suspect that there is evidence or an individual who has been harmed in the context of human trafficking. therein; (4) to enter any dwelling place or a premise, to search, seize or attach, when there is a reasonable ground to believe that there is evidence of trafficking in persons, or to discover and rescue a trafficked person therein, and that by reason of delay in obtaining a search warrant, such evidence is likely to be removed, concealed or destroyed, or such person is likely to be assaulted, relocated or concealed.

their efforts on suppressing the commercial process and those reaping the most benefits from human trafficking.

- Law enforcement should not become an impediment for survivors of human trafficking – particularly “those who have been forced into sex work” – when accessing health services including HIV/AIDS care and treatment. In addition, “those who have been forced into sex work” should not be regarded as accomplices in order to help them gain access services for prevention, care and treatment.

- The law should provide for protection of survivors of human trafficking regardless of their gender and without considering only biological sex, i.e. just men and women.

- The laws mentioned above seem to provide for protection of rights. However, due to various reasons, some of them have failed to deliver, as far as the genuine protection of sexual rights is concerned. Nevertheless, it also seems the Thai state is endeavoring to change and revise the laws or issue new laws to make them suitable to the current situation and to make possible greater compliance with the Constitution and

other international obligations that Thailand has committed to and now has to practice in order to ensure that all rights are universally applied. As for sexual and reproductive health rights, two bills are being mulled including the Draft Reproductive Health Protection Act B.E.... and the Draft Promotion of Gender Equality and Opportunity Act B.E....

The Draft Reproductive Health Protection Act

Overall, the Bill looks fairly progressive with regard to the attempt to protect sexual and reproductive health rights . Broader definitions are given to sexual and reproductive health rights, and several terms are carefully used. It shows greater sensitivity than other laws including the use of the term “termination of pregnancy” to simply convey the essential meaning without attaching any judgmental labels. In another instance, the term “counselor” is defined as “a person knowledgeable and capable of giving counseling on reproductive health with the awareness of human rights”. Please note the annex “with the awareness of human rights”. Also, it could be the first time that the term “sexual rights” is clearly included in the text.

In addition, it emphasizes the importance of sexual health and embraces the existence of diverse ways to lead one's sex life while promoting diversified services to cater to the particular needs of each group as stipulated in various Sections, including Section 24, 25 and 26.

As for the promotion and support of sex education, the contents serve well the purpose of the aforementioned National Integrated Strategic Plan for Prevention and Resolution of HIV /AIDS. The sex education curriculum adopted by the Ministry of Education has been developed jointly with the Department of Health, MoPH, and features quite comprehensive content. It shall be used as the core curriculum. In addition, the Bill provides for many obligations of the state to ensure that people receive good services and help to address the current problems. Yet there are still many issues of concern which are missing, including

A lack of policy for women's termination of pregnancy, and the Bill still places an emphasis on control of one's body, and restricts women's sexual and reproductive health rights based primarily on a medical approach. For example, Section 38 states that "a termination of pregnancy can be performed only for reasons related to the physical or mental health of the

women or when the woman's pregnancy has been caused by a criminal act specified in Section 276, 277, 282, 283 or 284 and it has to be performed by a medical professional pursuant to rules and regulations and methods provided for by the Medical Council of Thailand Regulation Concerning the Practice of the Medical Termination of Pregnancy as per Section 305 of the Criminal Code B.E. 2548 (2005).

Though definitions given in the Bill encompass diverse forms of sexuality, when it comes to Sections concerning the provision of health services, an emphasis is still placed only on reproductive health for child delivery. It leaves out groups with diverse sexualities, hindering their access to reproductive health services, including individuals who have had sex changes or otherwise manipulated the sex organs. These people also deserve to have standard care and treatment like other groups, including hormone treatment, standard operations, etc. Yet the Draft Reproductive Health Protection Act still hinges on conventional views of sex which is underpinned by the notion that sex is meant for reproduction and that the protection of reproductive health is still primarily applicable for either women or men.

In addition, though the contents of the Bill deal with many other issues beyond health including sex life, culture and human rights, the MoPH alone is supposed to be the main enforcement unit; this makes it look less credible for the effective implementation. Indeed, the Bill should be developed as a collective platform of work among concerned agencies and aims to enhance cooperation to protect sexual and reproductive health rights.

Draft Promotion of Gender Equality and Opportunity Act B.E....

At present, the Bill has passed the third reading of the Council of State. A number of civil society organizations working on women's issues have many concerns to share. They would like to propose some revisions so that the Bill can help to effectively provide for gender equality and to make possible compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), to which Thailand is a state party.

In view of its intent, the Draft Promotion of Gender Equality and Opportunity Act could be cited as another sign

of progress in Thai law. It touches on issues concerning the equality of opportunity and gender equality, and specifies measures to promote equal opportunity while also criticizing gender-discriminatory approaches. It could set the standard for implementation to solve issues around gender inequality and to effectively promote sexual rights. Nevertheless, much of the explanation about sex still refers to biological sex including exclusively male and female aspects. As a result, perceptions of sexual violence and proposed resolutions were restricted to that limited framework. Instead, the perspective could have been broadened to cover more gender diversity.

As said, inequality and gender discrimination contribute to greater vulnerability to HIV transmission. Therefore, had the Bill embraced more gender diversity, rather than limit itself to the biological sex, it could have helped people with sexuality diverging from biological sex gain access to equal protection as well.

The two draft laws concerning sex are still found to be lacking as far as the gender equality of people with diverse sexuality (beyond male and female) is concerned. However, they signify some progress is being made by Thailand, and our more serious attention given to obligations concerning

women's rights. Still, these are lacking in terms of the inclusion of the rights of other genders; unlike the Yogyakarta Principles, which give importance to gender identity and sex life and consider them part of human rights.

The development of Thailand's laws concerning sexual rights, particularly the two aforementioned Bills, should be based on principles of human rights and sexual rights of/for all genders. Therefore, the drafts should be revised to become more comprehensive and reflect diverse sexual rights so they can be enforced, serve the best interest of all genders, and promote the sexual rights of everyone.

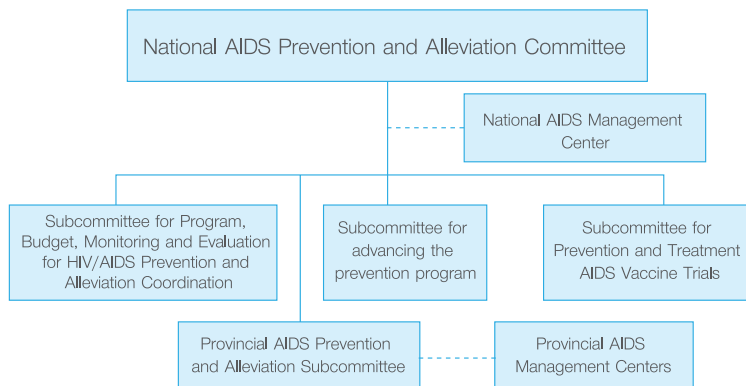


Part IV

Structures and mechanisms for developing policy and implementation

In its response and prevention of HIV/AIDS programs in Thailand, the National AIDS Prevention and Alleviation Committee or “National AIDS Committee” is a major mechanism to mobilize policy to address HIV/AIDS at the national level. Chaired by the Prime Minister, the First Vice Chairperson is Minister of Public Health and its board members are composed of Permanent Secretaries, Directors of concerned agencies and another 11 experts. The representation also covers NGOs and TNP+ as part of the expert members. The Director General of the Department of Disease Control acts as the committee member and secretary, Director of the Bureau of AIDS, TB and STIs and staff from the National AIDS Management Center (NAMC) are a committee member and vice-secretary, respectively.

The current structure of mechanisms for mobilizing response to HIV/AIDS at the national level can be illustrated in the following diagram;



The implementation and constraints of the National AIDS Committee

The 2007 Review of Implementation for Prevention and Resolution of HIV/AIDS Report published by the National AIDS Committee describes previous implementation and constraints in the overall response to HIV/AIDS in Thailand. Many factors are identified as obstacles to the mobilization around AIDS, including the decentralization of power to local administration organizations, the reform of the public health and bureaucratic systems as well as the introduction of the Government Fiscal Management Information System (GFMS) and other political factors.

The decentralization to local administration organizations as per the “Act on Planning and Steps toward the Decentralization of Power to Local Administration Organizations B.E. 2542

(1999)” which came into force on 17 November 1999 has led to the reallocation of the budget, a step which also affected the response to HIV/AIDS. The law requires the central government to earmark budget to support public services organized by local administration organizations. As the budget has to be funneled directly to local administration organizations, central agencies have seen their budgets cut and regional agencies now have to seek financial support from local administration organizations. The impact on the prevention and resolution of HIV/AIDS is previously the Provincial AIDS Prevention and Alleviation Subcommittee used to receive funding from the Department of Disease Control which was given 55 million baht a year. But after 2005, the MoPH gave the amount together as a big package to the Provincial Public Health Authorities without specifying that it shall be used for HIV/AIDS activities. The actual use is left to the discretion of each provincial authority. After that, the financial support was totally cut, and each provincial public health authority has to seek funding support from the local administration organizations instead (National AIDS Committee, 2007b). This change may prompt the provincial authorities to review whether they shall continue to give an emphasis on HIV/AIDS. As their budget has been slashed, the provincial authority may give less importance to HIV/AIDS work.

As for the reform of the public health system, the report goes on to state that this reform has affected the overall response to HIV/AIDS, including the introduction of universal health care coverage since fiscal year 2002. As a result of the reform, budget earmarked for prevention of HIV transmission and treatment of opportunistic infections (OIs), about 480 million baht/year by the Bureau of the Permanent Secretary of MoPH, has been cut and included in the Universal Health Care Coverage scheme, managed by NHSO (from fiscal year 2002 onward).

The per-head allocation of budget to hospitals country wide has been used without considering the different scales of problems in each locality. Most hospitals end up using the money for treatment rather than prevention, since there have been more patients, but each of them can be charged only for 30 baht. A decrease in the budget has affected HIV/AIDS prevention programs as well.

The bureaucratic reform in pursuit of the “Reorganization of the Ministries, Sub-Ministries and Department Act B.E. 2550 (2007)” has prompted government agencies to change their roles and duties, the structure of human resources, and budget allocation from the fiscal year 2003 onward. This has some effect on the prevention of HIV/AIDS and STIs as well.

Previously, each Provincial Public Health Authority hired about 8-12 persons for HIV/AIDS and STIs work, while under the new structure, HIV/AIDS is included as part of the disease control division and only one officer is assigned to be responsible for not just HIV/AIDS but other communicable diseases as well. Thus under the new structure, the importance of AIDS work has been diminished.

Another factor affecting prevention efforts is the introduction of the Government Fiscal Management Information System (GFMIS). Previously, the Department of Disease Control used to be in charge of setting aside budget for AIDS prevention, for different governmental agencies inside and outside the MoPH. But after the introduction of GFMIS by the Ministry of Finance, the Department of Disease Control is not allowed to propose budgets on AIDS prevention for other governmental agencies. Thus, beginning in the fiscal year of 2007, each agency has to propose its budget through its Ministry. And the overall figure has decreased. In the fiscal year of 2006, the Department of Disease Control proposed 55 million baht for AIDS prevention, but some agencies have failed to apply for the fund at the Budget Bureau. And in fact, it could also be possible that a request for funding was turned down and not submitted to the Budget Bureau (National AIDS Committee, 2007b).

Reading from the aforementioned review report, one may come to the conclusion that in theory the devolution of power and budget to local levels should contribute positively to the local HIV/AIDS response, since it can be adjusted to cater to the specific needs and problems in each place. In reality, the result is has had the opposite effect. It has simply made AIDS-related work decrease in importance. From the review report in 2007 and from the actual conditions that occur as a result of introducing the national health security system, the decentralization of power, the readjustment of roles of central administration with an increase of their academic work, support, monitoring and evaluation as well as prevention and social campaign has affected HIV/AIDS response in Thailand in the following ways:

- The varying levels of importance assigned to HIV/AIDS in each area depend on how familiar each area is with the implementation of HIV/AIDS-related projects. Without stimulation and support from the central administration, the provincial and regional mechanisms may give less importance to the issue.
- The bureaucratic and health system reforms have led to the adjustment of the human resource structure. As a result,

some public health technical officers with experience working on HIV/AIDS at the regional and provincial levels have been transferred to somewhere else. Some have decided to accept early retirement causing the area to lose experienced officers who are well-versed in HIV/AIDS work and used to function as the main motivators for implementation at the local level.

- The adjustment of the central technical structure has failed to provide effective support and stimulation to agencies at the provincial level. Previously, the support from the central technical structure has led to significant enhancement of the response to HIV/AIDS at the local level. But the central structure has been weakened during the transition to realizing reform and decentralization.

- Furthermore, in the past two years (2007-2008), not a single meeting of the National AIDS Prevention and Alleviation Committee was called. The first meeting took place only in mid-2009 with Mr. Abhisit Vejjajiva, the Prime Minister, chairing the meeting. He promised to call more frequent meetings of the National AIDS Committee to strengthen the implementation of the AIDS response.

● All said situations have affected the implementation of HIV /AIDS-related work. According to the experience of civil society representatives, who understand the issues, are familiar with relevant mechanisms and also Committee members themselves, the mobilization of the HIV/AIDS response has been retarded due to a lack of training for personnel to prepare them for their new roles. For example, the Bureau of AIDS as Secretary to the National AIDS Committee used to be in charge of allocating budgets to local provincial subcommittees. Now the budgets are directly funneled through local administration organizations. Thus central and local officers have to adjust their roles, from following up on budgets to providing technical support. But these officers have received training and preparation in order to adjust to the new roles. Meanwhile, with the arrival of the Global Fund in Thailand, skilled and hard-working personnel from the central administration have been transferred to serve the need to work with the Global Fund. This has led to the weakening of human resources in the state sector to work on HIV prevention.

Efforts to enhance the implementation of mechanisms

● The bureaucratic reform and decentralization of power has made the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation simply become guidelines for various agencies and sectors. This differs from past processes, when the plan and budget are developed and allocated by the central administration under the MoPH. In order to accelerate efforts to monitor and evaluate the HIV/AIDS response, pressure has been placed on the government to declare AIDS-related work as part of the comprehensive inspection program. With its agreement, the government set up an inspection team to review prevention and resolution initiatives at the regional level as specified by the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation and to serve the implementation of government policy. In the first year, 2007, the MoPH's Inspectors General were appointed Chief and Deputy Chief of the Public Health Review Taskforce with representatives from the Prime Minister's Office, Ministry of Education, Ministry of Interior, concerned agencies and representatives from the Bureau of AIDS, TB and STIs as secretaries. The inspection team has gone to work in 13 regions /provinces (National AIDS Committee, 2007a:2007b).

Agencies slated for inspection include the representatives from the provincial authority and civil society in the Provincial AIDS Prevention and Alleviation Subcommittee. The inclusion of the Prevention and Resolution of HIV/AIDS Project in the integrated inspection program has stimulated provincial agencies to give more importance to work on HIV/AIDS.

In addition, to develop and enhance management and coordination processes, the National AIDS Prevention and Alleviation Committee issued an order (no. 1/2007, dated 4 April 2007) to appoint the Subcommittee for advancing the prevention program effort composed of 24 members and headed by Mr. Meechai Viravidaya as Chairperson and the Deputy Director General of the Department of Disease Control as Vice-Chairperson, with representatives from the state sector, NGOs, TNP+ and other concerned parties. Mr. Veerasit Sitthitrai holds the post of secretary and Dr. Suriyadev Tripathi and a representative from the Bureau of AIDS, TB and STIs function as assistant secretaries.

The Subcommittee is mandated to hold responsibility for ensuring compliance with the guidelines set by the National AIDS Prevention and Alleviation Committee. Management mechanisms and AIDS prevention initiatives are developed to enhance prevention program. Emphasis is given to a

transparent working process that avoids conflicts of interest and is equipped with monitoring and evaluation mechanisms to develop policy proposals.

Another important element of the Subcommittee is the Office of the Secretariat, which is tasked to oversee and manage part of the budget. It is supposed to draw on participation from civil society. Some progress has been made after the Subcommittee had been set up for well over a year, including the development of four strategies to enhance the prevention response and the budget allocated to such strategies. This should to encourage actors and agencies to become more involved in preventive work.

Though it is a new mechanism, the Subcommittee can play an important role in mobilizing preventive work at the national level. Apart from developing the strategies and action plans as described above, it can propose a process to review, monitor and evaluate the implementation of projects based on internal and external participation in order to encourage monitoring and solicit input regarding the implementation of this Subcommittee's work.

Another important mechanism is the Subcommittee for Program, Budget, Monitoring and Evaluation for HIV/AIDS Prevention and Alleviation Coordination. Civil society agrees

with the attempt to develop monitoring mechanisms at the local, regional and provincial levels. This has been a practice in the past and continues today. The input from the monitoring process is used to compile the country report as required by Thailand's obligations on HIV/AIDS conventions. However, civil society also thinks this mechanism should prioritize monitoring, follow up and evaluation of project implementation and health service delivery, along with efforts to promote education and awareness to uphold rights. Such duties should be included as part of the role of the Subcommittee and its various mechanisms.

Meanwhile, the National AIDS Committee appointed the Provincial AIDS Prevention and Alleviation Subcommittee as the mobilizing agency chaired by the Provincial Governors and with the Chief of the Provincial Public Health Authority as secretary to serve the policy of the National AIDS Prevention and Alleviation Committee.

Nevertheless, it was found the Provincial Subcommittee has failed to perform its duty effectively since most of the structure falls under the bureaucratic system and high ranking officers. If the Governor does not pay attention to or fails to stimulate work on HIV/AIDS, the Subcommittee in the province will simply exist for ceremonial purposes. Therefore,

a new mechanism at the provincial level has been proposed, including the Provincial Coordinating Mechanism (PCM), which will probably replace the Provincial Subcommittee or attempt to motivate it to work more effectively.

Civil society representatives who work closely with the core members of the National AIDS Committee have commented that apart from a lack of support for personnel to change their roles, the National AIDS Management Center (NAMC) in its capacity as secretariat has failed to implement any activities since its previous executive officers did not give any consider HIV/AIDS work important and failed provide clear guidelines to staff members.

The establishment of the Subcommittee for Mobilization is an obvious attempt to enhance the implementation of HIV/AIDS-related work. However, civil society notes that although the Subcommittee was created in order to solve the current deadlock, it has so far failed to deliver any significant impact, especially given that the monitoring and evaluating mechanisms have been not clearly developed. Therefore, the Subcommittee may also be ambivalent as to how large a mandate it actually has. The ongoing political crisis has also contributed to a lack of confidence in the sustainability of any new initiative, including the Subcommittee.

The problem has not been ignored, however. When Dr. Mongkhol Na Songkhla was Minister of Public Health, he proposed the establishment of a new agency under the direct supervision of the Prime Minister's Office. It was expected to draw on collaboration from personnel in all concerned agencies to enhance the implementation of HIV/AIDS-related initiatives, using funding support from the NHSO. This idea was shelved since the Prime Minister's Office regulations prohibited the creation of any new agency or an increase of personnel in any circumstances. Thus, the deadlock has been drawn out further. Though the problems are obvious, no solutions have been identified.

Civil society does not believe this is a dead end. A new Director of the National AIDS Management Center (NAMC) has been appointed. NAMC still needs more funding and human resources in order to be able to implement activities effectively. In addition, the Subcommittee for Mobilization has been criticized for spending too much time on monitoring projects, though it is supposed to focus more on structural reform.

Other impacts from mechanisms on HIV/AIDS

Since 2003, with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, or the Global Fund), Thailand has established a Country Coordinating Mechanism (CCM) to oversee projects supported by the Global Fund domestically and to ensure efficiency and compliance with Global Fund policy. The CCM shall also function as a coordinating agency between various organizations in Thailand and the Global Fund. The CCM is thus another major entity that functions to mobilize work on HIV/AIDS in Thailand.

Under the CCM, a Technical Committee (TC) has been set up to analyze and develop proposals and guidelines for developing project proposals to seek further funding from the Global Fund and other funding sources. The TC is expected to strengthen coordination between sectors under the CCM. The CCM secretariat has been established to coordinate the efforts and initiatives related to the Global Fund within and outside the country. This includes information dissemination and providing support to the TC.

At present, Thailand has been granted funds by the Global Fund in the Eighth Round and the Rolling Continuing Channel (RCC) which was the continued support after the First Round has been completed.

Under the Eighth Round of meetings of the Global Fund, funding has been allocated to work with four target groups including Female Sex Workers (FSW), Men who have Sex with Men (MSM), Intravenous Drug Users (IDU) and Migrant Workers (MW). The five year project covering 41 provinces was divided into two phases, with the first two years under Phase One and the three following years under Phase Two.

During the First Round of the Global Fund, from 2003 - 2008, Thailand was allocated funds for prevention work among youth and for care and treatment of PLHIVs and AIDS patients. The prevention work targets youth at the reproductive ages of 12 – 24 years, since they are highly vulnerable during these years and risk contracting HIV. An emphasis is placed on working with youth in the community, schools and at the workplace.

The evaluation after the end of the project yielded positive results, and thus during the Rolling Continuing Channel (RCC), the project was permitted to continue for another six years, divided into two phases (three years/phase). The project's name was changed while the target group remained the same. Efforts have also been made to integrate care and prevention work and to allow Youth PLHIVs and AIDS patients Friendly Services (YPFS) to operate in 43 provinces.

The project shall be implemented through the Provincial Coordinating Mechanism (PCM) which shall coordinate and advocates for the project's tactics, integrating them into the regular implementation of local programs. This includes the provincial development plan and fundraising as well as monitoring and evaluating provincial-level strategies.

The PCM's structure is different from the Provincial Subcommittee since it cannot be composed of more than 15 members. This allows it to mobilize with great flexibility. In some provinces, the existing Provincial AIDS Centers were allowed to continue to operate since the PCM is currently at the inception stage and has not yet delivered any concrete results. Under the RCC, PCMs shall work in 43 provinces drawing on funding from the Eighth Round of the Global Fund. It is hoped that the PCM under the GFATM shall help to meet the demands of the situation with powers being decentralized. Thus, the PCM could become a major implementing mechanism and work together with health advocacy groups. It may help to address problems stemming from the budget allocation and human resource development.

Meanwhile, civil society believes that mobilization at the provincial level should be treated as a major strategy since national-level mechanisms are found to be chronically paralyzed.

This issue was raised in 2007 during the development of the AIDS Agenda by the people's sector. At the time, concrete recommendations were proposed to place greater emphasis on local mechanisms. And in order for the implementation of HIV/AIDS-related work to continue, it was suggested that the "government has to support and provide encouragement to local administration organizations and local civil society including Sub-district (Tambon) level or Village AIDS Committees. They should be supported in developing the master plan for the prevention and resolution of HIV/AIDS based on collaboration with TNP+, NGOs and state agencies at the operational level. It was even recommended that 10% of local administration organizations' budget shall be set aside to implement prevention work and the overall HIV/AIDS response in the community."

Civil society mechanisms: a weakened movement

- It is known that implementation of HIV/AIDS-related work by civil society has been mobilized through TNCA since 1993. TNCA is a major coordinating mechanism, including the regional TNCA and member organizations. All along, TNCA has

played an active role in promoting collaboration between actors in order to enhance the response to HIV/AIDS in Thailand.

At this point the mechanism seems to have gotten weaker, and it has since 2004 been less active. The following remarks have been made regarding the situation:

- The devolution of powers to the local level and various structural reforms have led to a decrease in funding from the national sector to support NGO work. From a high of 90 million baht annually, funding has declined to 40-50 million baht. The National TNCA itself has failed to help member organizations access more funding.

- The implementation of large-scale projects with support from the Global Fund has enabled some of the larger member organizations to access more sustainable big funders. These organizations have thus shifted their attention to fundraising via these channels. As a result, they have relied less and less on the National TNCA to raise funds for local initiatives and policy advocacy.

- The growth of networks and organizations including TNP+ has become more visible. Beginning in 2004, 15-18

networks under the National TNCA have developed proposals to gain access to the funds provided by the GFATM. Though it may look like a positive development that coalition members have started to apply for resources by themselves, it has also resulted in their paying less attention to the role and relevance of the National TNCA.

- Implementing mechanisms for both the Regional and National TNCA have become less active. The board members who are representatives from various organizations have felt compelled to manage their own projects, particularly those being supported by GFATM. A lot of bureaucracy is required for the funders. As a result, TNCA mechanisms at the national and regional level have started to become paralyzed, proven by the fact that a National TNCA meeting has not been called for years.

- Apart from working on fundraising, the National TNCA's roles in policy advocacy and the provision of technical support to member organizations have been weakened. The National TNCA no longer functions as a space for exchange among

members. Meanwhile, highly experienced personnel at the National TNCA and those who represent the interests of a wide range of civil society organizations that have participated in many joint initiatives with the state sector have failed to take on a meaningful role. A lack of support has seen their involvement shift from being active members to merely participants that attend meetings. Though some members may have relevant points to make, the lack of supporting mechanisms have prevented them from being able to share those points. Despite their representation at the top and as part of policy mechanisms, a lack of information exchange and support from members below have weakened the TNCA's overall movement . Attempts were made by civil society to revive the roles of TNCA again at the end of the Ninth Plan (The National Economic and Social Development Plan) and at the drafting of the Tenth Plan through the mobilization of the four regions of TNCA. This led to the "Nonsi Declaration", adopted during the TNCA Assembly meeting in 2007; the declaration later became the People's Sector AIDS Agenda. Still the endeavor has failed to reactivate TNCA and the implementation of the People's Sector AIDS Agenda has not been followed up on.

● It is difficult to be certain if the reasons stated above have directly contributed to the overall deterioration of the civil society movement, since at times some factions within civil society are still able to mobilize action around their own cause. However, it is clear that the overall movement has changed. In 2009, TNCA made another attempt to resolve the crisis and to revive its involvement as a central forum for policy advocacy rooted in civil society. It remains to be seen if the current process will help to strengthen the overall engagement of civil society to allow it to once again become a social movement that can introduce constructive change to the country.

It is also obvious of funds from the Global Fund has contributed significantly to the resurrection of HIV/AIDS-related work and prevention measures at the community level. A number of organizations suffering from funding shortages have been given the chance to once again mobilize their work more effectively. Yet civil society cannot help but question the way in which many organizations have rushed to work directly with GFATM, an action that may lower the overall strength of the network. Criticisms abound that in complying with the GFATM's mechanisms each of the involved NGOs tends to work in a segregated fashion, impeding the exchange of knowledge

and experience between civil society organizations. A further reason for the lack of exchange has apparently been caused by the principal recipients' (PR) inefficient implementation and management processes.

Another concern regarding the response to HIV/AIDS in Thailand which should be considered by both the Thai state and civil society is that much of the prevention work in Thailand is dependent on funds made available by the GFATM. Efforts should be made early on to identify solutions for the time when the GFATM pulls out of Thailand. Both the state and private sectors should start preparing and provide for careful planning.

Civil society recommends the following adjustments to the existing structure and mechanisms for developing policy and action in Thailand:

- As part of the transitional phase during the reform of all sectors, national and provincial mechanisms including the National AIDS Prevention and Alleviation Committee and the Provincial AIDS Prevention and Alleviation Subcommittee, respectively, need to adapt their way of working to develop

joint and collective leadership. In other words, decision - making should not be subject to one single leader or individual such as the Chairperson of a committee or the Chairperson of a subcommittee, as was the case under the past and now outdated structure. This should be replaced by the establishment of a collective leadership mechanism including all members of each committee. A parallel can be drawn from the current operation of the CCM along with PCM at the national and provincial levels. It continues to be necessary to restructure mechanisms and review project implementation in order to strengthen operational work and remove obstacles to the country's overall HIV/AIDS response.

- As for the national and provincial supporting mechanisms including the The Subcommittee for Program, Budget, Monitoring and Evaluation for HIV/AIDS Prevention and Alleviation Coordination, the Subcommittee for advancing the prevention program effort, the Subcommittee for Prevention and Treatment AIDS Vaccine Trials and the Provincial AIDS Prevention and Alleviation Subcommittee, civil society considers them to be vitally important for decisions made concerning major action plans and policy. They should

operate along with other major mechanisms to ensure unified decision-making and to encourage participation from the local level and different sectors to serve the purpose of decentralization. This will eventually engender a genuinely participatory and efficient response to HIV/AIDS.

- Another important issue is technical support at the central and local levels. The National AIDS Management Center (NAMC), the Bureau of AIDS, TB and STIs, Disease Control Offices, the Provincial AIDS Management Centers and the Provincial Public Health Authority Offices should make an effort to impart technical knowledge in order to enhance the delivery of services and to promote access to services that are part of the response to HIV/AIDS in Thailand. Implementation should be subject to review in order to ensure further improvement.

- As for the Subcommittee on Mobilization civil society believes that prevention work should encompass a human rights perspective, including sexual rights. Initiatives to enhance prevention should be developed based on the relevance of human rights, human dignity and sensitivity to sexual diversity.

This will prevent the measures and services available for prevention from being disenfranchised, since efforts should focus not only on educating people about HIV/AIDS, distributing condoms or lubricants, but also on promoting a respect for human rights, eradicating labeling and discrimination, promoting choices and the opportunity to remove gender-based social inequalities. It should enable everyone to make the most suitable choices for herself/himself to enhance her/his sexual health and safety.

- In the course of TNCA's policy and social mobilization efforts, sexual rights are a major challenge. Social awareness has to be fostered in order to promote a peaceful co-existence based on the respect for human rights and dignity and the acceptance of sexual diversity. This will help broaden the HIV/AIDS response beyond a merely epidemiological discourse and towards promoting a healthy society. Meanwhile, civil society, particularly among TNCA members, needs to review numerous issues including:

- Reviewing the necessity to create a “common platform” to mobilize the of TNCA movement as part of the larger civil society movement. Is it still necessary to have such a common platform to enhance HIV/AIDS response in Thailand?
- If yes, what should it look like in order to make its impact most meaningful? Amidst the expansion and fragmentation of initiatives and areas of operation, what can TNCA do to weave all the factions together and enable them to mobilize as part of a single civil society movement to mobilize social and policy agendas?
- How can TNCA improve its mobilizing mechanisms in order to support the learning process and project implementation by organizations and individual members, networks and movements?

Appendix

The process to develop and synthesize information in the 2009 Policy Analysis Report on the HIV/AIDS Response in Thailand

Thai civil society forum to express views on the state's policy, law and response to address HIV/AIDS from 26-27 June 2010, Grand Tower Inn Hotel, Bangkok: 47 participants –

- Representatives from 15 networks, national NCA, and regional NCA coordinators were invited to brainstorm on common campaign agendas for the next two years including gender rights and reproductive rights.

Three policy watch team meetings

- First meeting: 15 July 2009: 10 participants
- Second meeting: 20 August 2009: 10 participants
- Third meeting: 8-9 October 2009: 10 participants

Two policy analysis forums

First forum: “After two decades of the development of VCT in Thailand”, 14 October 2009, Kant Manee Hotel, Bangkok: 37 participants

Second forum: “On policy in the response to HIV/AIDS: Most At Risk Populations/MARPs”, 16-17 September 2009, Ban Sabai, Bangkok: 37 participants

TNCA Policy watch group

- Ms. Sureerat Treemanka, NNCA
- Mr. Niwat Suwanphatthana, NNCA/Freelance
- Ms. Usa Lerdsrisuntad, Foundation for Women
- Ms. Supecha Baotip, Raks Thai Foundation
- Ms. Sulaiporn Chonwilai, Freelance/women's network
- Mr. Nimit Tienudom, TNCA board member and Director of ACCESS Foundation
- Ms. Supatra Nacapew, Chairperson of TNCA and Director of Foundation for AIDS Rights (FAR)
- Ms. Kanjana Thalaengkit, TNCA Coordinator
- Ms. Sutthida Malikaew

