Key affected women and girls include:

- Women and girls living with HIV
- Female spouses/intimate partners of men with high-risk behaviours
- Female sex workers
- Female drug users
- Transgender women
- Young women aged 15-24
- Female migrant workers who may be vulnerable to HIV due to the conditions by which they migrate

Thailand Country Brief

HIV and Key Affected Women and Girls

Percentage of total adults living with HIV who are women:

42%

Estimated number of women living with HIV (aged 15+):

200,000

About one-third of new HIV infections are attributable to intimate partner transmission.

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UN WOMEN
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About the Country Briefs

- These country briefs synthesize some of the current available data and evidence on key affected women and girls into one, easy-to-read report. For the first time, available data and research on national AIDS responses as it specifically relates to key affected women and girls were collated and carefully reviewed together, to improve understanding of women and girls most at risk of, and most affected by, HIV in the region. In doing so, the aim of the briefs is to increase understanding of the specific needs of key affected women and girls in ASEAN Member States and to support national efforts to ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls, in all their diversity. The briefs were developed in response to requests from partners at the regional and national level to assist them in prioritizing which women and girls to comprehensively target in national AIDS responses.

- A consistent approach has been applied in order to produce an off-the-shelf analysis of HIV and key affected women and girls which synthesizes information from disparate national sources. While multiple data sources have been used to compile each brief, country progress reporting on HIV and AIDS is widely cited. Each of the briefs includes an overview of the following as it specifically relates to key affected women and girls in the context of the national AIDS response:

  - Epidemiology
  - Modes of transmission
  - Social and economic vulnerabilities
  - Access to information
  - Access to services
  - Legal and policy environment
  - Current international and regional policy guidelines
  - Information gaps
  - Recommendations

From the cover page

Percentage of total adults living with HIV who are women: 42%[1]

1 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

Estimated number of women living with HIV (aged 15+): 200,000[2]

2 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

About one-third of new HIV infections are attributable to intimate partner transmission.[3]

3 National AIDS Committee Thailand. (2012). Thailand Global AIDS Response Progress Report, 2012. (http://www.aidsdatahub.org/dmdocuments/UNGASS_2012_Thailand_Narrative_Report.pdf)

EPIDEMIOLOGY

- Thailand has one of the highest female HIV infection rates in Asia.[4]
- Heterosexual transmission accounts for the majority of new HIV infections. A decade ago, around 80% of HIV infections occurred among female sex workers (FSWs) and their clients. Based on recent estimates, around one-third of new infections occur in women infected by husbands or intimate sexual partners.[5]
- Among the estimated number of new infections, 62% will be through transmission among FSW and their clients, people who inject drugs and men who have sex with men (MSM); 32% will be through intimate partners; and 6% through casual sex.[6]
- The trend of HIV prevalence during the past few years remained stable at around 2% for venue-based female sex workers (FSW). Recent evidence from prevalence surveys among non-venue-based FSW revealed higher HIV prevalence than venue-based FSW.[7]
- The trend of HIV prevalence among transgender populations was around 10% in 2010 but the trend did not decline over the past years.[8]
- After experiencing a decline from 1.0% in 2006 to 0.6% in 2007 to 0.5% in 2008, HIV prevalence among young people aged 15-24 remained at 0.4% from 2009 to 2011.[9]

MODES OF TRANSMISSION

Sexual transmission

- Despite the stable and slightly declining trend of HIV prevalence among pregnant women aged 15-24 years, the risk behaviour data in youth which reported an increase in sex-partner mixing without condom use could be contributing to the increased risk for sexually transmitted infections (STIs) and unwanted pregnancy. The age distribution of STI patients in which the highest number of cases was in the 15 – 24 year age group, and the number of teenage deliveries per 1000 girls aged 15 – 19 years had increased from 33.7 in 1989 to 50.1 in 2010.[10]
- Fully 95.7% of FSW reported using condoms with their last customer, yet only 45.4% of FSW reported using condoms with a lover or husband.[11]

Injecting drug use

- HIV prevalence among IDUs is showing no signs of decline. Prevalence of HIV among intravenous drug users (IDU) attending detoxification centres is still high, at levels of 30% to 40%.[12]
- Females who inject drugs used sterile needs and condoms less frequently compared with their male counterparts, and had a higher HIV prevalence, 30.8%, compared to 24.2% among male injectors.[13]

Vertical transmission

- Among antenatal care (ANC) clients who are HIV-positive, the proportion who receive antiretroviral (ARV) prophylaxis, and the proportion of HIV-exposed infants receiving ARV prophylaxis both continue to exceed 90%.[14]

SOCIAL AND ECONOMIC VULNERABILITIES

- Qualitative research conducted in Thailand by academic institutions and women's organizations, suggest that HIV infection among women within intimate partnerships is caused by their inability to negotiate safe sex with their regular sexual partners due to a range factors that include attitudes and behaviour regarding the use of condoms, unequal power relations, the reluctance to reveal their HIV-positive status to their partners, and intimate partner violence (IPV).[15]
- Recent studies have suggested that women living with HIV are more likely to experience IPV than women among the general population. For example, an assessment of HIV positive women's experiences of IPV was conducted in two provinces in 2008 and results found that 43% of positive women surveyed experienced IPV but felt nothing could be done. While respondents generally felt that they had adequate access to HIV services, they identified far fewer service options for women confronted with IPV. When asked where women might seek help to deal with domestic violence, the majority identified private and informal sources, with a small proportion mentioning government services or the police.[16]
- Increasingly, youth view sex before marriage as normal and women are more likely to have sexual partners before they wed. A 2008 survey among high school students in 24 provinces found that one in five female students had more than one sex partner in the previous year.[17]
- Two to three times higher HIV prevalence has been found in pregnant migrant women as compared to Thai pregnant women in selected provinces.[18]

ACCESS TO INFORMATION

- According to the 2010 Integrated Biological and Behavioural Surveillance (IBBS) survey, 50.4% of venue-based FSW received an HIV test in the previous 12 months and knew their results and 56.6% of venue-based FSW were reached with HIV prevention programmes.[19]
- Proportionally more of the non-venue-based FSW are outside of the formal HIV prevention programme than the venue-based FSW, and may not be receiving the same level of care and information about prevention of HIV and STIs.[20]
- Data for the past two years show that there have been declines in HIV knowledge and understanding (less than 30% in every subgroup youth on surveillance) and increased risk behaviour in the youth population (e.g., having more than one sex partner at a time, low condom use).[21]
- The proportion of transgenders having had an HIV test in the prior 12 months and who knew their results was 41.3%.[22]
- The 2010 IBBS found that comprehensive HIV knowledge was low among the migrant population. Only a quarter of migrant workers could answer all the HIV/AIDS knowledge questions correctly. Thai illiteracy also represents a barrier to migrant women accessing information and services for prevention of HIV and STIs.[23]
- Although there is widespread knowledge of STIs and HIV among women and men, adverse affects of the 1990s 100% condom use campaign are beginning to surface such as condoms becoming associated with sex work, with the result that it is perceived to be socially unacceptable to suggest condom use with a regular partner.[24]
- It is well recognized that to increase access to HIV prevention among [key affected] populations, health service providers have to understand sex/gender/sexuality issues in order to make their services friendly to these target populations.[25]

ACCESS TO SERVICES

- As of end 2011, the male to female ratio of patients receiving antiretroviral therapy (ART) was 1:1.[26]
- While more than 90% of people living with HIV have their ART financed by one of three government health security schemes, some patients are still unable to benefit from these schemes, including female migrant workers.[27]
- 94% of HIV-positive pregnant women receive ART to reduce the risk of mother-to-child transmission.[28]
- Despite impressive progress, providers of prevention of mother-to-child transmission of HIV (PMTCT) services, HIV voluntary, testing and counselling, and user-friendly services for youth, women and vulnerable populations, need improved awareness of the need to respect client rights including an understanding of the diversity of sex lifestyles, gender and sexuality.[29]
- Other challenges associated with PMTCT include scaling up provision of PMTCT services for migrant workers who are not registered.[30]
- Although services for pregnant women, their partner, and family members have been introduced, there is a need to increase the number of women coming to ANC clinics with their partners as part of wider efforts to increase the participation of male partners in HIV testing and counseling in ANC settings.[31]
- The PMTCT programme overly emphasises the health of the infant. It does not consider the woman's body, her decision options, and pregnancy planning, carrying the pregnancy, or choosing abortion. These decisions need to be based on comprehensive information for the pregnant woman and her partner. Voluntary counselling and testing services in mother and child health centres for pregnant women are not yet totally voluntary.[32]
- Increased attention needs to be given to reducing stigma and discrimination in clinics and communities which leads many HIV-positive pregnant women to refuse to return for ANC services in subsequent pregnancies.[33]
- Human rights violations against women living with HIV have been recorded. These include violations of their right to informed consent and confidentiality and instances of forced sterilization. Studies have also found that HIV-positive women don't always recognize what happens to them as being a form of violence, and thus do not seek help.[34]

- Less than the recommended global standard of 30 hours of sex education per academic year are being provided in most schools, not all schools in different geographic locations are providing sex education, and to date there has been no evaluation of the effectiveness of the programme of instruction in altering behaviours.[35]
- Most youth-friendly service delivery centres are still not meeting felt needs of young key populations and not all geographic locations are yet providing these services.[36]
- Youth under age 18 who desire HIV counselling and testing still require parental consent.[37]
- The referral system for FSW from outreach services provided by NGOs to voluntary, counselling and testing (VCT) and STI services in hospitals needs to be improved and local participation and involvement also remains weak.[38]
- FSW who are non-Thai lack access to free services and essential information which is reserved for Thai nationals. In this way, laws and regulations are still an obstacle to access to prevention and health care.[39]
- Police reportedly target the carrying or distribution of condoms as evidence of sex work, thus discouraging the availability and use of condoms.[40]
- Many IDUs, including female IDUs, are afraid to access harm reduction and other health services because injecting drug use is illegal and widely discriminated against.[41]
- Stigma and discrimination against transgender populations acts as a deterrent to demand for services and needs to be addressed.[42]

LEGAL AND POLICY ENVIRONMENT

- Thailand launched its National Strategy on HIV/AIDS 2012-2016, entitled 'AIDS Zero', in June 2012. The plan has two main strategic directions: 'Innovation and Change' and 'Optimization and Consolidation'. The 'Innovation and Change' section focuses on promoting strategies to better prevent new HIV infections particularly among key populations (including key affected women and girls); to better localize responses at the sub-national level; and to better address the social and cultural factors which hinder access to HIV prevention and care services, and fuel stigma and discrimination. Under the 'Optimization and Consolidation' section, strategies aim at continuing and strengthening effective programmemes already in place. Examples of strategies falling under this area are the elimination of new infections among children and HIV prevention among young people.[43]
- A national policy and associated strategy for reproductive health was developed during 2010-11 and includes expansion of youth-friendly services, delivery of sex education in the community, and strengthening of life skills through school-based education.[44]
- Under Article 30 of the Constitution, it is clearly specified that there be no discrimination against persons based on ethnicity, place of origin, gender, language, age, or religion. Nevertheless, enforcement of the laws is at times unevenly applied.[45]
- In the period 2010-2011, the subcommittee for the Support and Protection of AIDS Rights was established under the National AIDS Committee. The committee monitors HIV and human rights related situations and programmes at various levels and oversees the policy direction on HIV/AIDS and human rights in Thailand.[46]
- Spending on the enabling environment, which has been indicated as a key factor in achieving the zero stigma and discrimination goal in the National AIDS Strategy for 2012-2016, accounted for 1.4% of total HIV/AIDS spending in 2011.[47]
- There are laws which impeded implementation of AIDS policies and programmes on prevention, treatment and care especially discrimination against some groups of population, for instance the drug law 1979, which considers drug users as criminals.[48]
- The Prostitution Prevention and Suppression Act (1996) decriminalized the act of sex work, but created offences for soliciting, pimping, advertising, procuring sex workers and managing sex work establishments.[49]

- EMPOWER advocates for sex work to be recognized as legitimate employment under the Thai labor law, social security legislation, and occupational health and safety codes. EMPOWER has worked with government agencies to address HIV and improve working conditions.[50]
- In 2009 the Ministry of Health signed a memorandum of understanding for cooperation on harm reduction for IDU with the Office of the Permanent Secretary for Health, the Department of Medical Services, the Department of Disease Control, the National Health Security Office, and the Office of the Narcotics Control Board.[51]
- The abortion law in Thailand is governed by the provisions of Sections 301-305 of the Thai Penal Code of 13 November 1956. Under the Code, the performance of abortions is generally prohibited. A woman who causes her own abortion or allows any other person to procure her abortion is subject to up to three years' imprisonment and/or payment of a fine (there are no paternity consequences). The performance of an abortion is legal under the Code if carried out by a medical practitioner and (a) the abortion is necessary for the sake of the woman's health or (b) the woman is pregnant as a result of a criminal offence (e.g., rape). Grounds for permitting abortion are decided entirely by professional staff, with little opportunity for women to input into the decision. With the introduction of the national PMTCT programme, abortion for women living with HIV is no longer considered valid. As a result HIV-positive women with unwanted pregnancies seek illegal and unsafe abortions.[52]
- National efforts to address intimate partner violence, including its intersections with HIV, in the years 2010 – 2011 have their basis in the Protection of Domestic Violence Victims Act BE 2550 ("DV Act") which came into force in 2007. Article 276 of the Penal Code was amended in the same year to extend the penalty for rape to, among others, cases of marital rape, recognizing that sexual violence within intimate partnerships including marriage is a matter of concern.[53]
- There is an urgent need to assess current policies, legislation, and programme implementation by government organizations and NGOs related to HIV/AIDS prevention and spousal/partner transmission among sero-discordant couples and to identify gaps and examine the assumptions underlying these policies, laws, and programmes.[54]

CURRENT INTERNATIONAL AND REGIONAL POLICY GUIDELINES

- HIV and the Law: Risks, Rights & Health (Global Commission on HIV and the Law, July 2012)[55];
- Sex Work and the Law in Asia and the Pacific (UNDP, UNFPA, UNAIDS, 2012)[56];
- UNAIDS Guidance Note on HIV and Sex Work (UNAIDS, 2009)[57];
- Agenda for accelerated country action for women, girls, gender equality and HIV (UNAIDS, 2009)[58];
- Community Innovation: Achieving sexual and reproductive health and rights for women and girls through the HIV response (UNAIDS/The ATHENA Network, 2011)[59];
- Joint UN Statement: Compulsory drug detention and rehabilitation centres (March 2012)[60].

INFORMATION GAPS

- The complexity of data collection at national level on FSW, multiple sources of surveillance data, and differing techniques of data collection make it difficult to consolidate the data into a national picture of the situation. This, in turn, presents a challenge in increasing the effectiveness of HIV prevention programming for FSW.[61]
- There is no publicly available data on estimated HIV prevalence among female injecting drug users.[62]
- There appears to be little or no data or policies on the female partners of male drug users, nor on female injecting drug users and their intimate partners.[63]
- There is a lack of data and operational research on violence against women as a cause and consequence of HIV in Thailand.[64]
- Data collection on intimate partner violence (IPV) is being strengthened based on recent recommendations made in December 2011 by the Office of Women's Affairs and Family Development (OWAFD) within the Ministry of Social Development and Human Security (MSDHS). This includes efforts to move towards a standardised methodology for collection of data on IPV and to strengthen coordination among involved organizations.[65]

RECOMMENDATIONS

- Strengthen the legal and policy framework for protecting and promoting the health and human rights of people living with HIV and key populations, including key affected women and girls. This includes reviewing existing laws, regulations and policies that impact on women, girls and youth affected by HIV within a broader human rights framework in order to create an enabling environment for the national AIDS response.
- There is a critical need for age- and gender-sensitive and specific approaches to be applied in HIV programming with key populations, especially young key populations.
- Provide training and supportive supervision to health care providers in HIV and gender-based violence (GBV) programmes, and ensure that facilities (including the One-Stop Crisis Centres) are equipped with commodities, including HIV tests, post-exposure prophylaxis (PEP), emergency contraception and treatment for STIs.
- Integrate the family planning needs and rights of women and girls living with HIV, especially their reproductive rights, into the national policy and associated strategy for reproductive health.
- Improve access to and use of HIV-related information and services for migrant workers, including access to PMTCT services for unregistered migrant workers.
- More meaningful involvement of key affected women and girls in the development of policies and programmes that affect them.
- Greater investment in networks and self-help groups of women living with HIV, particularly in the leadership of HIV positive women, noting the 2012 WHO guidance on couples HIV testing and counselling that recognizes how women living with HIV “have played a unique role in supporting people through the HIV testing and counseling process and, if they test positive, especially in post-test care.”
- Improved research and data related to intimate partner transmission by prioritizing operations and behavioural research on HIV transmission from key populations at higher risk to their intimate partners.
- Improve post-test counselling support for disclosure of positive status to long-term partners.
- Integrate and increase follow-up for partner notification services for both client-initiated and provider-initiated testing.

- In light of the effectiveness of treatment-as-prevention, facilitate access to antiretroviral drugs for all serodiscordant couples, regardless of how the HIV positive partner became infected.
- Engage men in a substantial way to address sexual communication, sexual behaviour and male responsibility in relationships and sexual health.
- Ensure national and provincial level HIV prevalence data is disaggregated by sex and age and that official government reports standardize the use of this disaggregated data.
- Ensure that government staff involved in the HIV response at all levels better understand the gender dimensions of the epidemic, as well as how their HIV programming could be improved if gender is more strongly taken into account.
- Ensure that monitoring and evaluation frameworks include gender equality indicators and set a baseline in order for the HIV response to measure the effectiveness of HIV programmes from a gender perspective.

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WHO ARE "KEY AFFECTED WOMEN AND GIRLS" IN ASEAN?

Depending on the circumstance and country, the following groups have been identified as key affected women and girls in ASEAN:

- Women and girls living with HIV
- Female sex workers
- Women and girls who use drugs
- Transgender women and girls
- Mobile and migrant women
- Female prisoners
- Women with disabilities
- Women in serodiscordant relationships
- Female intimate partners of men who engage in behaviours that put them at a higher risk of HIV infection
- Women and girls in HIV-affected households

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The country brief is available to download at www.aidsdatahub.org and www.genderandaids.org.

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