



Responding to Feminization of AIDS: A Rapid Assessment on
Spousal/Partner Transmission of AIDS and Sero-Discordant Couples
in Indonesia, Laos PDR and Thailand

Country Assessment Report

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Executive Summary

The 'feminization of AIDS' refers to the concept of seeing the HIV pandemic through the eyes of women and understanding the HIV pandemic's impact on women of all ages. Rather than reinforcing stereotypes about men's and women's behavior, analyzing the feminization of AIDS forces us to look closer at the evolving pandemic in each country's unique context, and the often significant variance within national borders. In this context, from the perspective of women, we can also attempt to understand the vulnerability of both women and men to 'spousal transmission' or rather HIV transmission between partners in relationships (whether married or not, whether short or long term). Public health messages about the prevention of STIs and HIV have translated most effectively into action (namely condom use) among commercial and casual sex partners, albeit to varying degrees among the countries that are the focus of this research. The feminization of AIDS also reveals the impact of HIV and AIDS on women, including the increased layers of stigma faced, and the burden of care that accompanies AIDS-related illnesses and the expectations of women's roles.

Across Asia, 75% of men are estimated to have commercial sex, potentially exposing themselves to HIV infection and their 50 million wives.¹ In Thailand half of new infections are estimated to occur in women who have contracted HIV from their male partners. Approximately one third of new HIV infections in 2005 were among married women who probably acquired the virus from their spouses. In Indonesia, where injecting drug use initially drove the epidemic, 2008 figures are expected to reflect unsafe sexual behaviours as the dominant transmission mode. This is already the case in Papua where 96% of the new infections are through heterosexual transmission. In Laos PDR, of the known mode of transmission of HIV, 85% is transmitted through heterosexual sex.

It is within non-commercial sexual relationships where condom use is lowest and there is increasing concern that women and men in relationships are at risk of STI and HIV transmission because of concurrent or previous sexual relationships of either partner. In addition several factors increase the risk of HIV transmission between discordant couples across Indonesia, Laos PDR and Thailand: expectations about intimacy within relationships; the stigmatization of condoms (commonly associated with sex work); gender differences (resulting women's lack of negotiation power, and men's lack of empowerment to protect themselves and their partners); and low levels of integration between sexual and other health services. While these overall similarities exist between the epidemics in all three countries, each context has unique factors that need to be understood to respond effectively. Equally, it is important that we continually update our understanding to remain responsive to the epidemic as it interacts with the national and local contexts affecting the vulnerability factors for both women and men.

The rapid assessment in Indonesia revealed a recurring theme of gender power imbalance and the incidence of gender-based violence appears to be high. Women's low status means they have little negotiation ability on sexual matters within relationships. The status of female sex workers is even lower. This coupled with widespread beliefs equating masculinity to virtual immunity from STIs and misinformation among men about STI prevention; commercial sex workers have little room to negotiate condom use with their clients. A complex political climate includes political leaders who are self-declared champions of religion and who promote conservative views on issues they perceive to be relevant within Islam. The effect is to drive behavior patterns like sex work, injecting drug use and sex between males underground making identification of the most at risk women (and their partners) and men (and their partners) to STI and HIV transmission. Indeed, Indonesia's response to injecting drug use is progressive in comparison to other countries in the region. The shift in perception of injecting drug users are victims and survivors rather than criminals has paved the way for harm reduction programmes.

A major theme in Laos was the internal and external migration of women and men for work. 50% of the people who seasonally migrate to Thailand are women who do so illegally. It is not fully known how vulnerable they are to exploitation or abuse, or to what degree they take part in the sex industry. Gender power imbalances also appear to leave women with little negotiation power about sex and contraception in relationships. While gender-based violence within relationships was not raised among respondents, it was noted several times that over a quarter of women's first sex was coerced or forced. Condom use among

¹ *Redefining AIDS in Asia: Crafting an effective response, Report of the Commission on AIDS in Asia (2008)*

couples in relationships is very low. Abortions are relatively high, despite being illegal, suggesting high levels of unwanted pregnancies resulting from unprotected sex. Conservative views about sexuality make it difficult for young people to access sexual health information and services; potentially more problematic now that the age of marriage has been raised to 19. Sex work is on a different scale in Laos to its neighboring countries. Very few women sell sex as their main source of income. Instead women who work in the service or entertainment industry (i.e. in bars) sometimes sell sex (on average two clients per week). But again like Indonesia condom negotiation power is low among sex workers and their clients, and even lower among couples in relationships.

Indonesia's enormous population and vast area is home to diverse traditions and cultures that overlap each other. Overall women are disadvantaged by these as they result in higher levels of stigma for behaviors deemed socially unacceptable but men are also constrained by gender expectations. The decision making power within relationships, including related to sex, usually lies with men. Condom use is very low among married couples, and female sex workers do not have sufficient bargaining power to insist on condoms being used. Female drug users are most disadvantaged socially and are vulnerable to exploitation and violence which increases their vulnerability to HIV and STI infection. Interestingly, female drug users expressed the most control over their sexual relationships with partners. However, they remain criminalized and under-recognized and served by HIV, harm reduction and health programmes.

There is widespread knowledge of STIs and HIV among women and men in Thailand. But adverse effects of the 1990s 100% condom use campaign are beginning to surface such as condoms becoming firmly associated with sex work, and therefore it is socially unacceptable to suggest condom use with a regular partner. The decentralization of the health system has seen dedicated STI clinics relocated to hospitals reducing the access of some sex workers. Gender inequality prevails within relationships including in relation to sex. Sexual and reproductive health policy and practice reinforces women's lack of power in several ways. Women often receive little information about the nature of STIs they receive from their husbands and the widespread promotion of chemicals and sterilization for contraception and cures (e.g. hysterectomies for cervical cancer) rather than preventative approaches pose risks to women's current and future health. A reliance on interacting with women during pregnancy means that many women who have been sterilized do not access STI and HIV prevention or treatment services until they are symptomatic.

In all three countries gender power dynamics were found to impact on the legislature, service provision, women's decision making and men's involvement in sexual and reproductive health. The implications of these findings are widespread in terms of responding to the feminization of AIDS and spousal transmission of HIV. Each country's situation is unique and further research and responses will need to reflect this. At the same time the countries' regional context provides an opportunity for shared approaches especially on issues such as advocacy and migration – which inextricably links all three countries. Further research to provide a much deeper understanding of each context is required to ultimately develop a comprehensive strategy at national and regional levels to reduce both women's and men's vulnerability to HIV.

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante natal care
ART	Antiretroviral therapy
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
HIV	Human Immunodeficiency Virus
ICW	International Community of Women Living with HIV/AIDS
IDU	Injecting drug users
Laos PDR	Laos People's Democratic Republic
MSF	Médecins Sans Frontières
MSM	Males who have sex with males
NAC	National AIDS Commission
NGO	Non-governmental organization
STI	Sexually transmitted infection
TWATF	Thai Women's HIV and AIDS Task Force
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session [on HIV/AIDS]
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary counseling and testing
WAPN+	Women's working group of the Asia Pacific Network of People Living with HIV and AIDS
Waria	Transgender (Indonesia)
WHO	World Health Organization

I. Introduction

The 'feminization of AIDS' refers to the concept of seeing the HIV pandemic through the eyes of women and understanding the HIV pandemic's impact on women of all ages. Rather than reinforcing stereotypes about men's and women's behavior, analyzing the feminization of AIDS motivates us to look closer at the evolving pandemic in each country's unique context, and the often significant variance within national borders. In this context, from the perspective of women, we can also attempt to understand the vulnerability of both women and men to 'spousal transmission' or HIV transmission between partners in relationships (whether married or not, whether short or long term).

Public health messages about the prevention of STIs and HIV have translated most effectively into action (namely condom use) among commercial and to some extent casual sex partners, albeit to varying degrees among the countries that are the focus of this research. It is within non-commercial longer term sexual relationships where condom use is lowest and there is increasing concern that women and men in relationships are at risk of STI and HIV transmission because of the concurrent and/or previous sexual relationships of both partners.

In addition several factors increase the risk of HIV transmission between discordant couples across Indonesia, Laos PDR and Thailand: expectations about intimacy within relationships; the stigmatization of condoms (commonly associated with sex work); gender differences (resulting women's lack of negotiation power, and men's lack of empowerment to protect themselves and their partners); and low levels of integration between sexual and other health services. While these overall similarities exist between the epidemics in all three countries, each context has unique factors that need to be understood to respond effectively. Equally, it is important that we continually update our understanding to remain responsive to the epidemic as it interacts with the national and local contexts affecting the vulnerability factors for both women and men.

This report synthesizes research from a rapid assessment carried out in Indonesia, Laos PDR and Thailand in two phases. The first phase (A) consisted of a desk review and in-country rapid assessment among key UN agencies, government departments and civil society organizations by the UNIFEM consultant. The report of the first phase of the research is available from UNIFEM-ESEARO.² The second phase was conducted by in-country research teams commissioned by UNIFEM, adding depth by further analyzing the legislative context and service provision, particularly VCT, and by consulting focus groups and interviewing primarily women affected by spousal transmission of HIV. This report incorporates the findings for Phase A and B in Laos PDR, Thailand, and Indonesia. The overall rapid assessment took place within a limited time frame. As a result the issues reported are unlikely to be fully comprehensive and must be viewed in the context that this rapid assessment signals the beginning of UNIFEM's research on the feminization of AIDS and partner transmission of HIV.

i. Rationale for rapid assessment

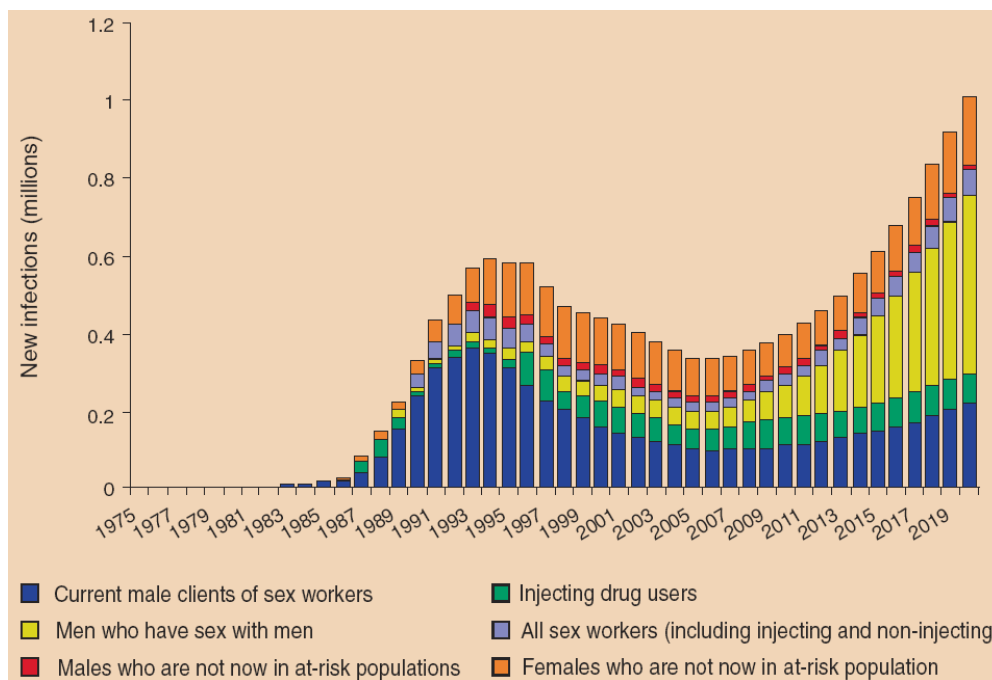
'*Feminization of AIDS*³ with spousal and partner transmission of HIV is a critical problem unfolding in many of the ASEAN member countries. Despite evidence that prevention programs are beginning to have an impact in some countries, (for instance Thailand and Cambodia both show a decline in HIV prevalence), the HIV epidemic continues to grow and new infections among women, especially young women, continue to outpace those among men - a stark reminder that gender inequity and violence against women fuel the epidemic. Epidemiological evidence from most of the countries in the region underpins the fact that the largest number of new infections are taking place within stable relationships, with married women

² *Responding to Feminization of AIDS: A Rapid Assessment on Spousal/Partner Transmission of AIDS and Sero-Discordant Couples in Indonesia, Lao PDR and Thailand, Phase 1 Country Assessment Report, UNIFEM-ESEARO, November 2008*

³ *This term includes both the increasing numbers of new infections among women and the increasing impact of the epidemic on women*

accounting for most of the new HIV infections in the region and notes the rise of the number of discordant couples.⁴

An estimated (minimum of) 75 million men buy sex regularly from about 10 million women, and as a result more than 50 million women are at risk of STI and HIV infection; another 20 million or so through relationships with men who have male-male sex and inject drugs.⁵ As a consequence more than 50 million women will have been exposed to HIV during sex with a husband or partner who was already infected. Although three out of four adults living with HIV are men, the proportion of women within the total figures has risen from 19% in 2000 to 24% in 2007.



Annual new HIV infections in adults by population group: a decline from early prevention successes, an increase from current failures

Source: Asian Epidemic Model estimates for the Asian region

Reproduced from: AIDS in Asia Commission report 2008

In **Thailand** an estimated half of new infections are occurring in women who have contracted HIV from their male partner. An added dimension, and as reported by Thai Ministry of Public Health, is that approximately one third of new HIV infections in 2005 were among married women who probably acquired the virus from their spouses. Thailand’s 2008 UNGASS progress report revealed that new infections in women infected by their husband or sexual partners and in males who have sex with males are higher than through other routes of transmission.

Projections made using the AEM⁶ show that between 2007-2011, the number of women who will acquire the virus from their husband or regular partner will increase significantly compared to other sub-populations. This finding is reinforced by the data compiled from the HIV infection surveillance system that shows an increasing trend of HIV prevalence in women at 2nd and 3rd pregnancies,⁷ which is an indication of the

⁴ *Discordant couple, where one partner is HIV positive and one who is HIV negative*

⁵ *AIDS Commission on Asia, 2008 op. cit.*

⁶ *ibid. the Asia Epidemic Model software, allows projections both backward in time as well as the future; the increase is also noted among MSM*

⁷ *Thailand-UNGASS Country Progress Report 2008*

deep inroads the virus has made into families in general and of men's behaviour, namely their engagement in unprotected sex and specifically during and shortly after their wives pregnancies; it is also a reflection of deeper malaise in the Thai gender dynamic. With more than 500,000⁸ people estimated to be living with HIV, the global inclination of 'Feminization of AIDS'⁹ is also apparent in Thailand.

In **Indonesia**, 'the epidemiological data shows that there has been a significant increase in HIV cases over the last 3 years. The number of AIDS cases increased from the 1,371 reported by 25 provinces at the end of 2003 to 6,871 cases reported by 32 provinces by end of September 2006'.¹⁰ Indonesia, except in the Papua province, has a "concentrated epidemic" – i.e. an epidemic concentrated among four particularly vulnerable populations: sex workers, injecting drug users (IDU), males who have sex with males (MSM) and *waria* (transgender population). Two categories of women who are particularly affected by HIV are female sex workers and the wives and partners of intravenous drug users and of clients of sex workers.

Transmission of HIV through sharing contaminated injecting equipment was identified as the cause of acceleration in the number of infections nationally in the last five years. However, it is predicted that in 2008 unsafe sexual behaviours will begin to dominate transmission. This prediction has been true in the Papua region, where HIV transmission through unsafe sex is the primary mode of transmission.

In the Papua provinces, the epidemic is a generalized one with a national HIV prevalence rate of 2.4%, reaching 3.2% in the remote highlands.¹¹ The majority of new infections are through heterosexual transmission: there is also a high incidence of gender-based domestic and sexual violence in Papua which could be fuelling the epidemic.¹² In addition to Papua, other provinces of high HIV prevalence rates are Jakarta, West Java, East Java, Riau and Bali.

Overall, **Laos PDR** remains a low prevalence country with an estimated 0.2% HIV prevalence in the adult population.¹³ At the end of 2007, the official cumulative number of people identified with HIV was 2,630; 57% of reported cases were male and 43% female.¹⁴ Of the known mode of transmission of HIV, 85% had been transmitted through heterosexual sex, 3.5% transmitted from mother-to child, 0.7% through men who have sex with men, 0.3% through blood products and 0.2% through unsterilized needles.¹⁵

ii. Terminology

The language of the terms of reference for the research uses the phrase 'spousal transmission' which implies a focus on STI and HIV transmission between spouses i.e. married women and men. It is important to note that while the rationale for the research includes the reported increased proportions of HIV infections among married women, the research seeks to examine transmission between both women and men in a broader context than marriage. UNIFEM recognizes the potentially exclusive nature of the terms 'spouse' and 'marriage'. Several alternative suggestions have been put forward, particularly from ICW Thailand, to capture all women who are in relationships, for example, 'women in intimate partnerships'. Future phases of the research will seek to define the most appropriate language in consultation with the research partners. In this report the terms that the study was initiated under will be used: the impact of "spousal transmission of HIV" on women refers to transmission from long term male partners who: inject drugs; have sex with other men; are clients of sex workers; or have additional concurrent casual or long term relationships. The term further brings into focus sero-discordant relationships.

⁸ *Country Situation Analysis: Thailand*

⁹ *Refers to the increasing impact of the epidemic on women*

¹⁰ *National AIDS Commission: 2007-2010 HIV and AIDS Response Strategies*

¹¹ *2007 Asia AIDS Epidemic Update, Regional Summary, UNAIDS & WHO, P.14*

¹² *ibid*

¹³ *2008 Report on the Global AIDS Epidemic, UNAIDS & WHO*

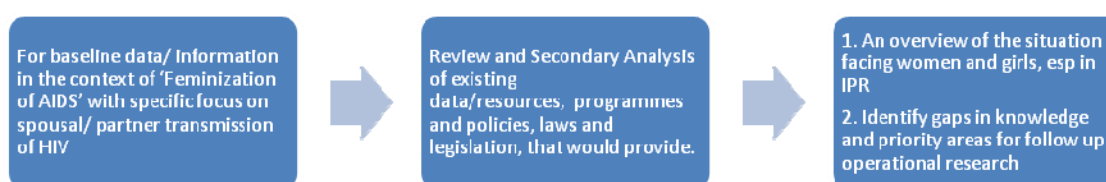
¹⁴ *The Center for HIV/AIDS/STI (CHAS), HIV at a Glance: Lao PDR, First Edition 2008*

¹⁵ *ibid*

iii. Objectives of the rapid assessment

The purpose of this phase was to gather secondary data from policies, report and key informant interviews with UN agencies, National AIDS Commissions, government health providers and ministries and selected NGOs. The consultant used other opportunities that presented themselves during the field work such as meeting with young adults affected by injecting drug use including a female partner of an injecting drug user, and male and female former injecting drug users. These inputs are incorporated into the analysis.

Overall objectives of the rapid assessment:

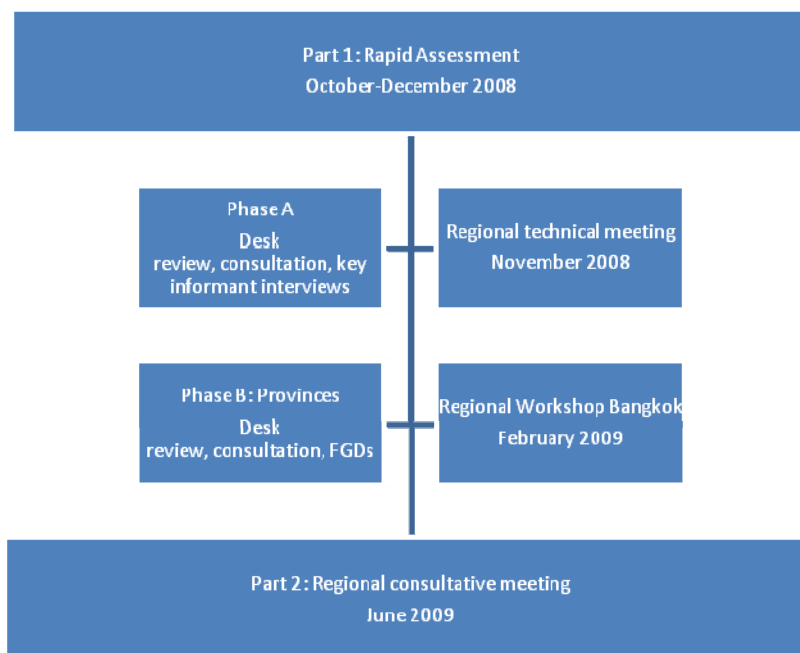


Combined objectives of Phase A (external consultant) and Phase B (provincial research):

1. Assess current available data on spousal/partner transmission of HIV and provide with necessary baseline data/information for a follow up study on 'Feminization of AIDS'
2. Provide an understanding of sexual and behaviour patterns, practices and risks which exposes married women/or those in long term relationship and sero-discordant couples to the risk of contracting HIV through spousal transmission
3. Assess implications and make recommendation to (i) reduce spousal/partner transmission of HIV and (ii) methodologies and approaches for a follow up study on 'Feminization of AIDS'

iv. Methodology

This report combines the findings from a rapid assessment of the feminization of AIDS and vulnerability factors of HIV transmission among women in relationships conducted in (phase A and B of) Part 1 of this longer term UNIFEM research project. It is part of a wider research objective that UNAIDS is conducting in a total of 11 countries in Asia, including the three countries which are the focus of this UNIFEM-led work: Indonesia, Laos PDR and Thailand. This rapid assessment is the precursor to an in-depth research agenda which UNIFEM intends to take forward in Part 2 of the project.



Interviews with key informants

Interviews for Phase A took place between 1st October and 22nd October 2008. With the exception of telephone interviews with UNICEF, UNFPA and WHO in Thailand all the consultations took place in-country.

The interviews followed a prepared format to discuss a number of issues related to the feminization of AIDS (i.e. the impact of HIV and AIDS on women) and factors contributing to HIV transmission between partners. Each respondent had a unique perspective and was not compelled to respond to all the questions equally but was encouraged to share their most pressing concerns and priorities.

After each interview respondents were asked to validate the transcripts by confirming or amending the text. Respondents were also invited to make additions to the information already provided and share any relevant documents. The findings of the research from reviewing the policies and reports and conducting the interviews were then consolidated into this report to assess the implications of and make for interventions in spousal transmission of HIV.

Interview discussion topics

1. The national policy environment and the national response to HIV and its impact on women in relationships
2. The role and strengths of the agency being interviewed in responding to women in relationships and their vulnerability to HIV infection
3. The various factors that increase the vulnerability of women in relationships to HIV transmission
4. The agency's expectations of and recommendations for Phase B of the research and future in-depth field research which UNIFEM intends to implement

Provincial data collection by in-country research teams

Phase B of the research was implemented by in-country research teams to validate the findings from the secondary data analysis by collecting primary qualitative data from interviews with focus groups in geographically diverse areas. Concurrently any outstanding secondary data collection (key informant interviews with organisations and services) was also conducted.

Indonesia's National AIDS Commission commissioned NGO Ikatan Korban Napza (IKON) Bali¹⁶ to undertake the field research. The study took place in four cities: DKI Jakarta, Pekanbaru, Denpasar, dan Timika. All four cities were selected based on experience in responding to the AIDS epidemic and each is dominated by different modes of transmission. DKI Jakarta and Bali have higher cases of HIV and AIDS from injecting drug users while Pekanbaru and Timika's epidemic are fueled by transmission from sex. The research involved networks of vulnerable groups (networks of drug users and sex workers) in each city. These networks supported the research by recruiting participants and preparing all the interviews. Data gathering from focus groups discussions and in-depth interviews took place between February and May 2009.

The research in each city consisted of three groups of women who were a combination of: (1) Injecting drug users (2) Female sex workers, (3) Housewives. Each group discussion had 8-10 participants based on the criteria described in the table below.

Participants criteria for focus group discussions

Criteria	Female Drug Users	Female Sex Workers	Housewife
Number of participants	10 people each city	10 people each city	10 people each city
Sex	Female		
HIV status of partners	Had or has sexual partner [married or not]	Had or has sexual partner [married or not]	Is or was married
Occupation, daily activities	Used drugs in the past year	Sex worker for at least one year	
HIV Status	Has been tested for HIV and knows their status [herself and of her partner]. Partners are either discordant and concordant.		
Age	Between 18 – 40 years		

In-depth interviews verified information gathered in the group discussions, and elicited further information to better capture the social, political, economical contexts and the HIV responses in each city.

Recruited participants took part voluntarily in this study with all of their identities and recorded data kept confidential. Prior to gathering data, instruments were field tested with a trial group of female injecting drug users in Jakarta. Subsequently, the instruments were appropriately updated to ensure that they capture the reality of the participants. Each research team had their interviews and discussions transcribed, categorized and reported. In addition to interviews, a small survey was distributed to each participant with data including demography, health, income, HIV status and attitudes upon knowing their status. Eighty two questionnaires were gathered and analyzed for this study.

¹⁶ Balinese Association of People Affected by Drugs

The **Laos PDR** in-country research team was Laos Women's Union (LWU) which consulted with the National AIDS Commission and key partners (including international and national organizations, civil society partners, etc.) working on gender issues. LWU conducted a rapid situation analysis by holding in-depth interviews with key informants to collect qualitative data with the aim of analyzing sexual and behaviour patterns, practices and risks which expose women in long term relationships to the risk of contracting HIV through spousal transmission.

Finally LWU reviewed ongoing programmes and projects of the government, existing laws and impact of such laws on prevention strategies and current programmes on spousal transmission and sero-discordant couples implemented by major NGOs, CSOs, and international donors/organizations.

The **Thailand** research team was the Center for Health and Policy Studies (CHPS), Mahidol University. CHPS examined nine additional areas of legislation on issues such as divorce, gender based violence, abortion and harm reduction, and 12 further studies related to gender, sexuality and HIV.

The research employed gender-sensitive research methodology and was based on gender and sexuality concepts to serve as guidelines for analysis. As a result, the researchers emphasize narratives and experiences of different groups of women reflecting their multiple social identities, points of view, and social meanings.

The data were compiled from two sources: 1) research reports, theses, articles, and electronic publications about gender, violence against women, and HIV/AIDS and 2) in-depth interviews with three women living with HIV aged 30-39 years old – the first was an injecting drug user, who knew about her HIV status four months ago; the second was a former an injecting drug user and sex worker; and the third was a leader of the network of women living with HIV. All of them had a spouse/partner living with HIV. Two of them had a child with their ex-husband but their child was not infected with HIV; two of them were infected with HIV from injecting drug use; and one of them was infected with HIV from having sex with their spouse.

The research employed the data from in-depth interviews and focused-group discussions among female youths about factors concerning youth's safe sex practices (especially condom use) in Trat and Patthalung Provinces; the project 'Study of Social and Individual Factors Affecting Condom Use in Youth in Trat and Patthalung Provinces' of the Raks Thai Foundation in 2006; and a research project 'When Women Narrate Their Stories about Violence and HIV/AIDS' of the Thai Women and HIV/AIDS Task Force (TWATF) in 2007. The duration of the research was approximately two months, from October-December 2008.

II. Synthesis of the three country analyses

This chapter synthesizes the rapid assessments carried out by the external consultant in Phase A and the findings from the field research implemented by the in-country research teams in Phase B. It begins by looking at the existing data and policies on spousal transmission. In all three countries, while there were not necessarily specific mentions of spousal transmission, many documents made references related to the issue which helped contribute to an emerging picture of the situation.

Following this analysis there is a section on existing responses to HIV which have relevance for spousal transmission, which includes any information gathered on the legislative framework, programme coverage and VCT services, as these are key entry points which determine access to HIV services. Finally, an analysis is provided of the key factors that contribute to women's HIV vulnerability. Each sub-section introduces the key similarities and differences from a regional perspective and then looks at each country's unique context in more detail.

An analysis is provided in the annex of data, programmes, policies and research studies in Indonesia, Laos PDR and Thailand.

i. Existing data and responses related to spousal transmission

A range of policies data and programme reports were included in the rapid assessment. The rapid assessment looked for epidemiological information, statistics, social and gender perspectives. For all three countries the national HIV and AIDS strategy and plan, and the respective progress report for UNGASS 2008 were reviewed. National policies, selected sexual behavior surveys and several national surveys were the main focus of Phase A of the research. In Phase B the in-country research teams focused on legislation impacting on HIV; gender and HIV policies; and socio-economic impacts on HIV vulnerability.

In **Indonesia** 12 policies and reports (including newspaper articles) were analyzed, with several referring to spousal/partner transmission based on epidemiological modeling. The six research documents included: a comprehensive review of secondary data on migration and HIV; national estimates of most affected population; and a desk review of vulnerable groups. UNDP and the Census Bureau are planning a socio-economic study of 2000 households which may help identify issues that increase women and men's vulnerability to HIV infection. Further statistics are needed to understand the scale of spousal/partner transmission as are deeper gender analyses of the impact of HIV and of women's and men's vulnerability to HIV infection.

There were eight policies and reports surveyed in **Laos PDR**, of which the national policy documents acknowledge the vulnerability of women to partner transmission of HIV. Six studies provide epidemiological, statistical and behavioral data on specific groups (young women; female sex workers, male electricity workers; and men who have sex with men). Phase B of the research began the process of indentifying existing gender analyses of HIV transmission and of socio-economic factors which increase women's and men's vulnerability to HIV infection. The impacts of HIV were also examined, although this largely focused on the stigma surrounding the virus. The second part of the research, beyond the scope of this project, should further analyze the impact of providing care and treatment for people living with HIV and AIDS, which conventionally fall to women.

A total of 14 policies, strategies and reviews were included for **Thailand**, plus 18 examples of research including evidence from programmes, selected focus groups and two national surveys on sexual behaviors and on sex workers sexual health. Other relevant research included: attitudes towards sexuality; attitudes towards condom use within marriage; sex education in schools; and the impact of HIV on migrants. While a number of the documents acknowledge the increasing proportions of women testing HIV positive are in relationships, there does not yet appear to any policies or research studies specifically addressing the feminization of AIDS and spousal/partner transmission. Further research into available data identified some

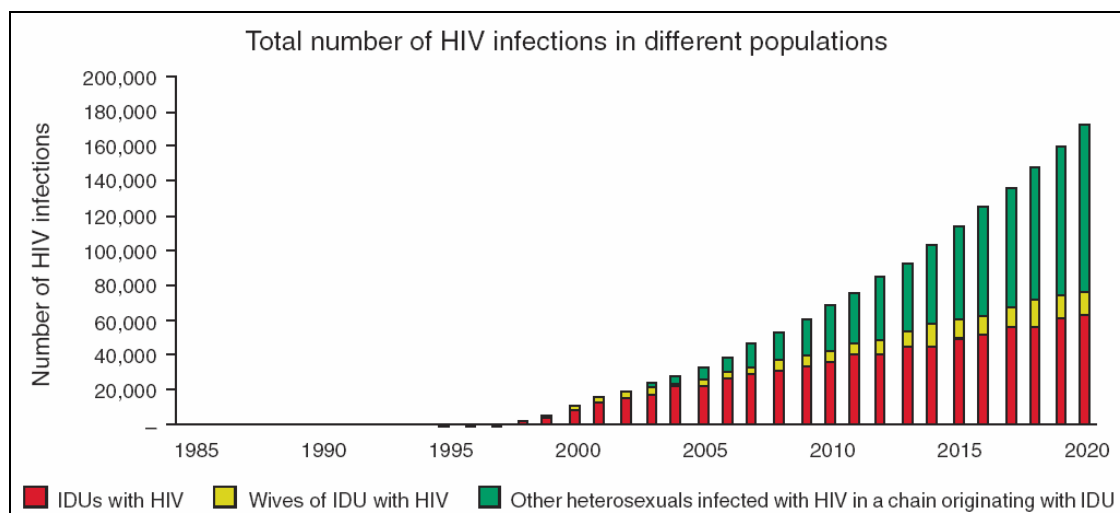
of the social and gender perspectives of HIV and sexual behavior, and these issues should be further investigated in Part 2 of the research project.

Further to the country specific policies and report, there were nine documents with an Asia regional focus and a further 24 which focused on prevention and gender. Redefining AIDS in Asia – the report of the Commission on AIDS in Asia 2008 – presents projections on the future scenarios of HIV in Asia based on epidemiological modeling. The other Asia regional documents are largely gender analyses rather than epidemiologically and statistically based. Of the 24 broader focused documents on prevention and gender some refer to partner transmission. Much of the gender analysis acknowledges the ‘feminization of AIDS’ from the perspective of the impact of HIV on women in relation to increasing numbers of women becoming infected, but there is notably little discussion on *prevention* priorities for women, including those in relationships.

Indonesia

Indonesia is the world's largest archipelago, with more than 17,500 islands, and a population of over 230 million. HIV prevalence is estimated to be 0.2% among people aged 15-49.¹⁷ Initially the epidemic was driven by injecting drug use. The response focused on harm reduction, its integration in public health system, and the development of active drug user movements. A “second wave” of HIV transmission through sex has revealed women’s vulnerability to infection: female sex workers are getting younger; some women have multiple partners; and in Papua more women than men are HIV positive which highlights a culture of domestic violence. Men’s vulnerability is also being revealed, particularly those with high mobility and multiple partners.

The current information on spousal and partner transmission is based on epidemiological modeling projections and subsequent references in national policies and reporting. The epidemiological modeling projections indicate that the proportion of new infections among women who are partners of sex worker clients (currently 3%) is likely to increase significantly.¹⁸



Projected total number of HIV infections in various population groups, 2000-2020

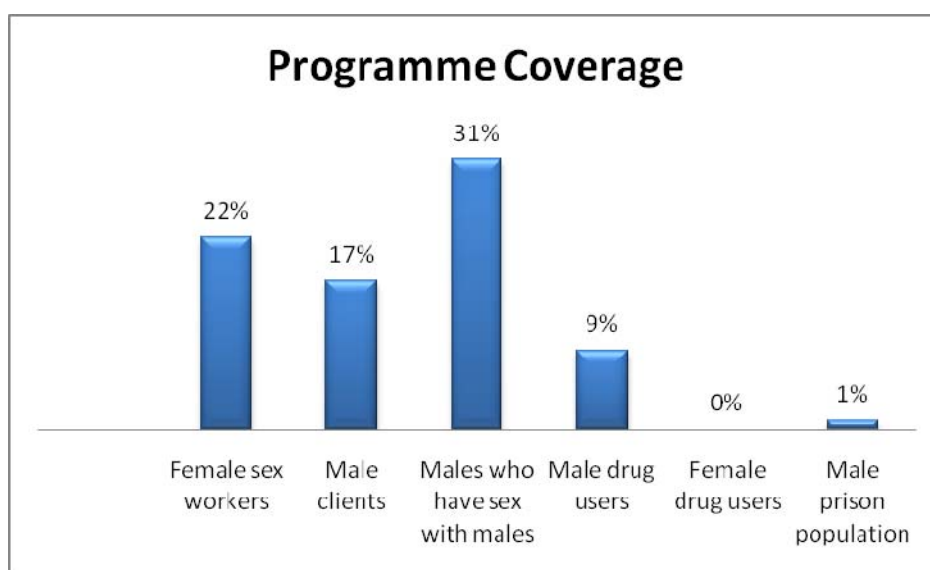
Source: Asian Epidemic Model projections using Jakarta data
 Reproduced from: AIDS in Asia Commission Report 2008

¹⁷ UNAIDS/WHO Epidemiological Fact Sheet on HIV and AIDS, September 2008

¹⁸ National report on estimates of adults vulnerable to HIV infection in Indonesia, 2006, Komisi Penanggulangan AIDS

Currently, 190,000-400,000 people are living with HIV.¹⁹ The overall prevalence among women is projected to be less than 0.5 per cent, but there will nonetheless be 200,000 non-sex worker women who are HIV-positive.²⁰ In Papua, the projected prevalence in women will be nearly ten times higher, with 40,610 women HIV-positive (4.3% prevalence), and 21,000 deaths by 2025. By 2004 there were 100 VCT centres and 25 hospitals providing ART.²¹ However, USAID and AusAID estimate that comprehensive programme coverage reaches 834 or 1% of people living with HIV.²²

Surveys and epidemiological data are available for populations most at risk (sex workers and clients; men who have sex with men, injecting drug users; prison populations). However a major gap is the lack of sex disaggregated data and gender analysis of injecting drug users. This translates into a lack of gender sensitive policies and programmes ultimately excluding female injecting drug users and the female (and male) partners of injecting drug users. Policies recognize the increasing impact of HIV on women in partnerships, based on the epidemiological data and projections, but as yet there are no specific studies (quantitative or qualitative) on the feminization of AIDS or of spousal and partner transmission.



Source: AusAID, 2006

The policies that this rapid assessment reviewed reflected a focus on the most at risk populations (sex workers and clients, injecting drug users, men who have sex with men; prison populations). There were few strategies which specifically address partner transmission, with the exception of National HIV/AIDS Action Framework: 2005-2007²³ which cited reducing risk of HIV transmission among injecting drug users and sexual transmission to their partners as a priority area. However, as partners of injecting drug users are not as yet included in the indicators of major external donors (where the majority of programme derives) there was no evidence of policies and programmes targeting the partners of injecting drug users. Women in relationships are targeted by NGO Kusuma Buana's five clinics with several initiatives to reduce partner transmission: empowering women with information; counseling for couples; and encouraging men's involvement in antenatal care and reproductive health. A proposal is being developed by ASEAN Foundation

¹⁹ UNAIDS/WHO, September 2008 *op. cit.*

²⁰ *Impacts of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor: Synopsis Report of the HIV Epidemiological Modelling and Impact Study, February 2006, AusAID*

²¹ *National data in NAC Desk Study 2005*

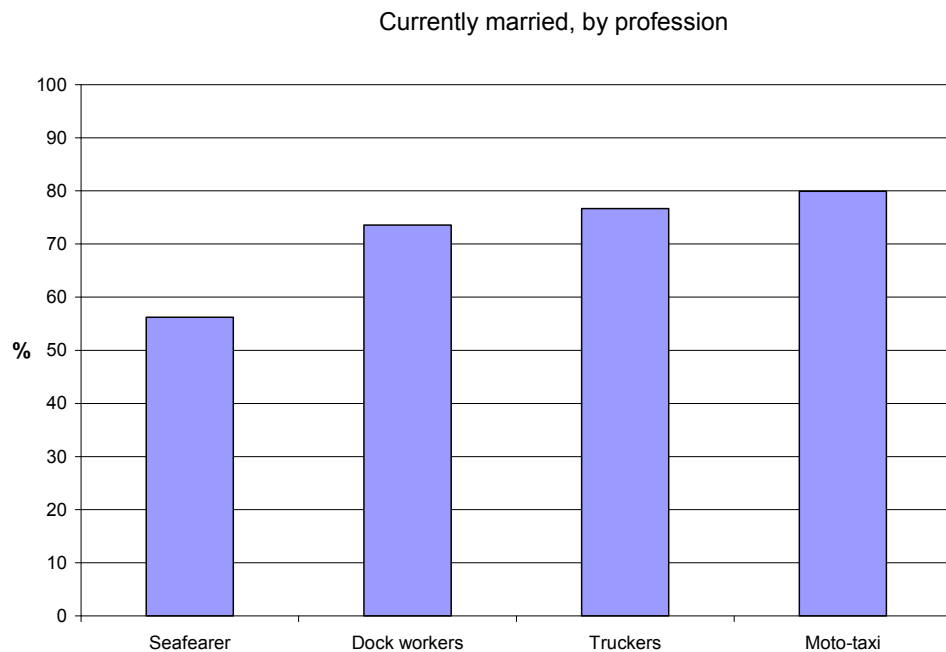
²² *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

²³ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS (NAC) : in support of The National Action Framework 2005-2007 for the National HIV/AIDS Strategy 2003-2007 to build sustainable partnerships for HIV/AIDS*

specifically aimed at preventing partner transmission. Further investigation is needed to understand whether there are programmes specifically addressing gender inequality, female injecting drug users, and the female partners of both male injecting drug users and male clients of sex workers.

There are a range of estimates about the number of injecting drug users. The national estimates (2006) estimate that there are 190-250,000 (male) injecting drug users with 81-105,000 (female) partners.²⁴ However, none of the estimates for injecting drug users and their partners are disaggregated by sex; women are estimated to account for 15% of injecting drug users. Programme coverage is estimated to reach 11,000 or 9% of drug users and zero female partners of drug users.²⁵

There is more data concerning female sex workers: the 2006 national estimates suggest there are 164,000-278,160 female sex workers.²⁶ Their (male) clients number between 2.3-3.9 million (less than half of 2002 figures). The number of female partners of male clients is estimated between 1.3 and 2.3 million.²⁷ AusAID and USAID estimate that programme coverage reaches 22% of female sex workers and 17% of male clients.²⁸ No programmes were identified as targeting the female partners of male clients.



Percentage of male clients of sex workers who are married

²⁴ National report on estimates of adults vulnerable to HIV infection in Indonesia, 2006, Komisi Penanggulangan AIDS Nasional

²⁵ 2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005

²⁶ Komisi Penanggulangan AIDS, 2006 op. cit.

²⁷ *ibid*

²⁸ 2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005

Male sex workers are estimated between 3,000-6,000.²⁹ Estimates of the number of clients of male sex workers in Indonesia are not available and neither have they been systematically studied.³⁰ The majority are assumed to be male. There is no data on the female or male partners (as opposed to clients) of male sex workers or the female partners of male clients. The transgender population is estimated at 20-35,000 (in 2006) who have an estimated 61-104,000 male partners.³¹ Overall the number of males who have sex with males is estimated at 384,000-1.1 million.³² There doesn't seem to be much analysis of their sexual patterns and sexual partners including the number of male and female partners, including whether they are married or not. USAID and AusAID estimate that programme coverage reaches 31% of the aggregate group (men who have sex with men, male sex workers, waria).³³

The male prison population is estimated at 75-116,000 (2006).³⁴ HIV prevalence has increased among prisoners, seemingly corresponding to the increase in the number of drug users in prisons. Numbers have grown from 7000 in 2002 to almost 12,000 in 2003 and 17,000 in 2004. Although some prisoners were infected outside prison there is evidence that that new infections occur in prisons and are due to unprotected sex and sharing of needles and syringes inside prisons. No data was found on the female or male partners of male prisoners. Programme coverage for male prisoners reaches 960 or 1% of the population.³⁵

Laos

According to estimates available, overall HIV prevalence in Laos PDR is 0.1% and 50% of those infected are between 20 and 39 years old.³⁶ 42% of reported HIV cases were female³⁷ and women account for a substantial proportion of HIV infections among young people between the ages of 15 to 24 years.³⁸

The overarching goal of the Laos PDR HIV response is to scale-up towards universal access for prevention, treatment, care and support. The National Strategy and Action Plan 2006-2010 sets clear priorities and targets, and serves as the overall framework for interventions on HIV/AIDS/STI. The targets were already revised once, and the costed action plan forms the basis for resource mobilization in the Laos PDR. The National Strategy and Action Plan targets were included in the 6th National Socio-Economic Development Plan in 2006. However, neither of these plans not make any reference to spousal transmission or sero discordant couples.

Laos PDR receives support in its response to HIV/AIDS from various international donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). GFATM approved a sixth-round grant from Laos PDR to scale up HIV/AIDS prevention, care, and treatment in 2006.

The actual national expenditures on AIDS activities between 2006 and 2007 by different organizations in the Laos PDR were assessed. The total amount of AIDS expenditure from 2006 to 2007 was 10.5 million USD, which slightly increased year by year. There were two sources of National AIDS Spending such as from the Laos PDR government and from external sources, but almost all of the funds (99.52%) came from external sources. The majority of the expenditures by functions were HIV prevention services: 39% in 2006 and 56% in 2007; followed by AIDS programme costs 43% in 2006 and 35% in 2007; and treatment and care

²⁹ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

³⁰ *NAC Desk Study 2005*

³¹ *Komisi Penanggulangan AIDS, 2006 op. cit.*

³² *ibid*

³³ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

³⁴ *Komisi Penanggulangan AIDS, 2006 op. cit.*

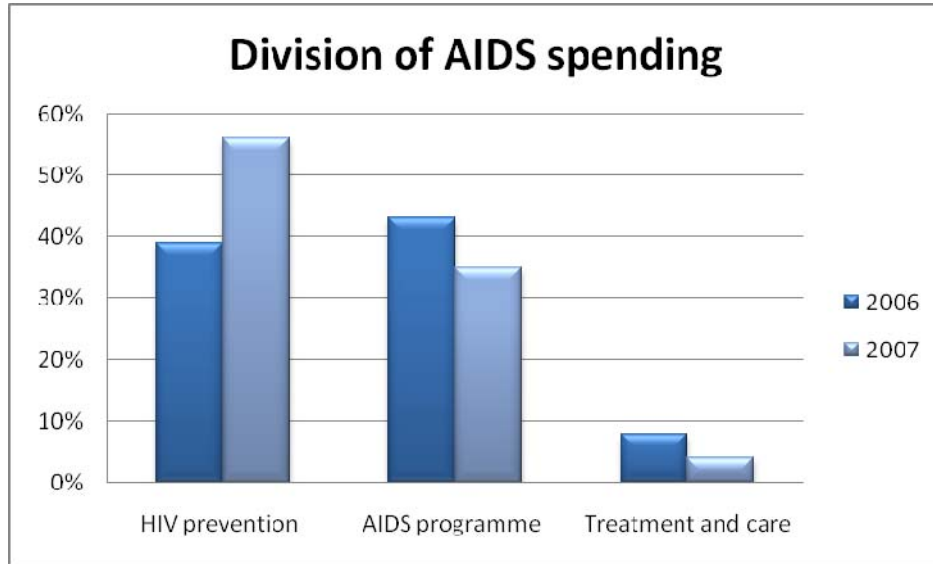
³⁵ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

³⁶ *Lao PDR UNGASS Report 2008*

³⁷ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011: Key Contents by The National Committee for HIV and AIDS Prevention and Alleviation, November 2007*

³⁸ *Young Women's Sexual Behaviour Study Vientiane Capital, Lao PDR*

services of 8% in 2006 and 4% in 2007. Through funding from GFATM (Round 6) the expenditures for treatment care and support will increase significantly from 2008 onwards.³⁹



The National Commitment and Action Policy Index showed considerable improvement over its reporting period. In particular, the increased participation and inclusion of civil society, targets, and expansion of services progress was noted.

In 2007 a Task Force on HIV and Drug Use was established to address the emerging issue of (injecting) drug use and HIV transmission. The task force is co-chaired by the Laos National Commission of Drug Control and Supervision, and the Ministry of Health. Compared to the previous reporting period, more line ministries became active in addressing HIV (i.e. Ministry of Public Security, Ministry of Labour and Social Welfare, Ministry of Defense, Ministry of Education, Ministry of Transport) and have developed sectoral plans, or implemented activities.

Laos PDR does not have specific laws and regulations that cite the protection of people living with HIV against discrimination, but has a national policy on non-discrimination which specifies protection for vulnerable groups (e.g. women, young people, drug users, males who have sex with males, sex workers, mobile populations/migrant workers). Strategies to ensure the implementation of this policy include increasing community awareness, strengthening of civil society, involvement of faith based organizations, and the establishment of the National Commission for Advancement of Women to monitor the implementation of CEDAW⁴⁰ objectives and regulations related to the advancement of women.

Programmatically, the national programme puts a clear focus on sex workers, partners of sex workers, clients, partners of clients, mobile populations and males who have sex with males in relation to HIV prevention, and the expansion of antiretroviral and opportunistic infection treatment and care and support. Expansion of voluntary counseling and testing services, strengthening monitoring and evaluation and surveillance are other priorities. In regard to blood safety data showed that 100% of donated blood units were screened for HIV in 2007.

With financial support from the GFATM, coverage of prevention services for sex workers and males who have with males increased by nearly 25%, treatment services were expanded to another site in Vientiane

³⁹ Reporting Period: January 2006 – December 2007.

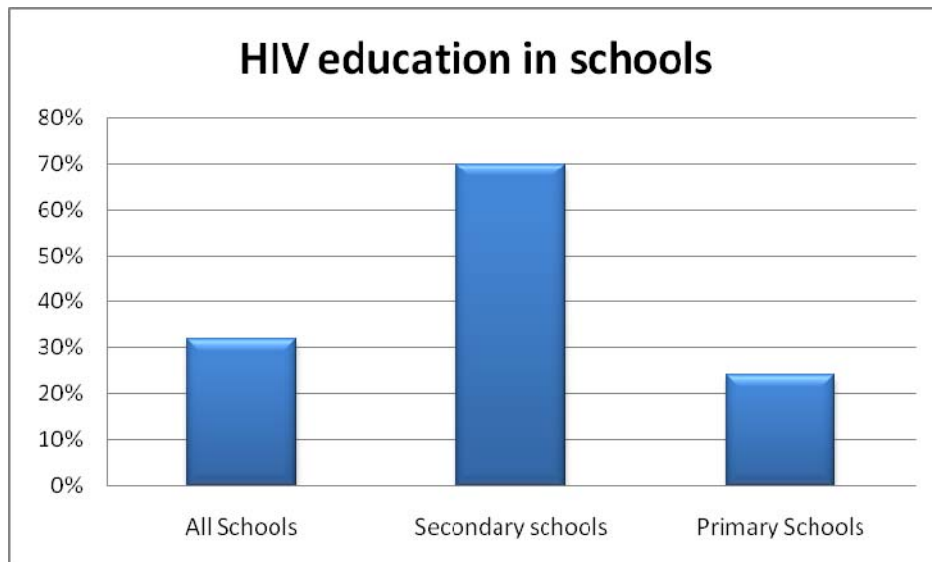
⁴⁰ Committee on the Elimination of all forms of Discrimination Against Women

Capital, and by the end of 2007 more than 700 people in need received ARV (60% of people in need), compared with 300 end 2005. In nine provinces self-help groups of people living with HIV were established and are functioning. While no new prevalence data are available for sex workers and clients (the 3rd round of surveillance is presently being implemented), new data on males who have sex with males (already quoted) show the urgent need to expand prevention services to more vulnerable groups.

100% Condom use programmes were expanded and cover 14 provinces, voluntary counseling and testing is available in 17 provinces and 16 districts. Drop-in centers for sex workers and males who have sex with males have been established in five provinces. HIV prevention programmes have been mainstreamed into many infrastructure development projects (i.e. road and dam constructions). Percentage of schools that provided life skills-based HIV education within the last academic year was 70% for secondary schools, 24% for primary schools and 32% for all levels of schools in the Laos PDR.

STI treatment services were expanded with a focus on sex workers and clients, and behaviour change interventions targeting mobile groups were implemented in many provinces.

Training activities for people living with HIV were conducted to enable them to work as resource persons in training and advocacy workshops. People living with HIV are members of all coordinating bodies, both at national and provincial level.



The Ministry of Education is promoting HIV/AIDS and sex education by training school principals and teachers in these areas, so they can transfer their knowledge to students. The objective is to reduce higher risk sexual behavior to reduce the number of new HIV infections.

Data is limited to national HIV estimates and studies of populations most at risk which have implications for spousal transmission. Surveillance of 'service women' (women working in bars who also sell sex) and selected groups of men (e.g. electricity workers) has been conducted which includes blood and STI tests as well as analysis of behavior patterns.⁴¹ A survey of males who have sex with males found that 30 out of 540 men (5.6%) tested positive for HIV, and of whom 43% also had a female sex partner in the last 3 months.⁴² The National Strategy and Action Plan on HIV/AIDS/STI 2006-2010 identifies a number of most at risk populations relevant to Laos's context (e.g. migrant and mobile populations) and pregnant women;

⁴¹ *STIs among service women & electricity workers: Lao PDR, 2008, Second Generation Surveillance (3rd Round), CHAS, 2008*

⁴² *Lao PDR UNGASS Report 2008*

but does not specify strategies for discordant couples and women in relationships. Other data analyzed included reproductive health surveys,⁴³ sexual behavior surveys⁴⁴ and gender analyses.⁴⁵

Policies and programmes reflected the data that was available on sex workers. A significant gap in responses is the information and services directed at clients of sex workers. The vulnerability of female migrant workers and their male partners, potentially one of the key HIV transmission priorities for Laos, needs more data (epidemiological, statistical and behavioral) before policies and programmes can be designed and implemented. The data pertaining to the sexual health of young people was matched by programmes aimed at them, particularly in Vientiane. Efforts to increase men's involvement in sexual and maternal health can be seen in voluntary testing and counseling for couples at Mahosoth Hospital and UNICEF's approach to supporting couples through antenatal care. Further investigation is needed into whether policies and programmes address the HIV vulnerability of migrant workers and address gender inequality.

The two key policies are the National Strategy and Action Plan 2006-2010 and the National Strategy and Action Plan on HIV/AIDS/STI (also 2006-2010). Both refer to female and male sex workers and males who have sex with males, while the latter also includes: male injecting drug user and their female partners, migrant and mobile populations, young people, uniformed services and ethnic groups. Unacknowledged are the female partners of male clients of sex workers, and female injecting drug users.

Laos Women's Union identified eleven HIV related research studies which focused on a range of key vulnerability and impact issues. Some of the key findings are highlighted here. Orphans and vulnerable children were the subject of more than one study: UNICEF found that adolescents (male and female) were being affected more than older adults, as is usually the case in other country's pandemics.

The high rates of migration are likely to contribute to young adults' increased vulnerability. HIV surveillance was carried out among the general population and found to have increased to 2% among women and remained low at 0.8% among men. Behavior studies to identify vulnerability among migrant workers in eight border provinces found condom use among regular partners was very low (only 0.7% of interviewees used condom at all times and 89% never used condoms). Condom use was higher among those who had had sex with non-regular partners: 20% used condoms all the time and 57% never used a condom with irregular partners.

Sexual behavior studies included: young men, young women, female sex workers, males who have sex with males, and transgender males and their partners. Population Services International (PSI) found that transgender males often have multiple partners, and the men that visit them for transactional sex are also likely to have girlfriends. PSI's research among sex workers found that condom use varied depending on the category of partner: the lowest levels of condoms use was among regular partners (65%) and higher condom use among casual partners and commercial partners (92.6%, and 96.7%, respectively).

Thailand

In Thailand, where HIV prevalence is estimated to be 1.4%,⁴⁶ an estimated 38.7% (6,399) of new infections are women infected through their husbands while 9.6% (1,578) of new infections are men who were infected via their wives.⁴⁷ The National HIV Plan 2007-2010 identifies women at risk of infection from their husband/regular partner and promotes them as target for HIV prevention programme development. Programme coverage includes the national prevention of mother to child transmission response and sex education in schools. UNFPA has launched a "Stay Negative" programme in six mother and child hospitals:

⁴³ *LAO REPRODUCTIVE HEALTH SURVEY 2005, UNFPA Project LAO/02/P07:*

⁴⁴ *Young Women's Sexual Behaviour Study Vientiane Capital, Lao PDR - The Department of Health of Vientiane Capital (PCCA) in collaboration with the Burnet Institute and UNFPA, April 2008*

⁴⁵ *"Lao PDR," Fighting a Rising Tide: The Response to AIDS in East Asia; (eds. Tadashi Yamamoto and Satoko Itoh). Tokyo: Japan Center for International Exchange, 2006, pp. 172-194.*

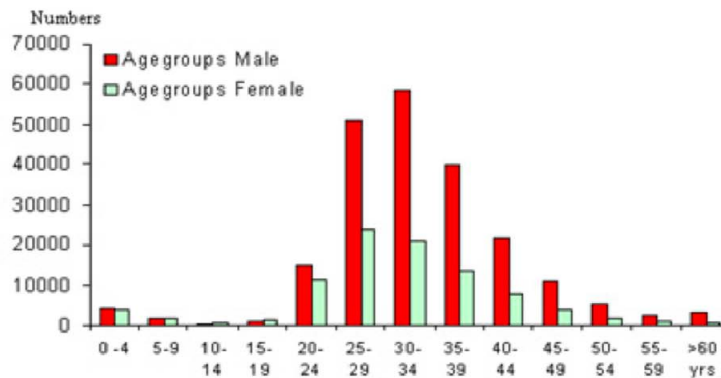
⁴⁶ *2008 Report on the Global AIDS Epidemic, UNAIDS*

⁴⁷ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

the response nationwide to HIV negative women was identified as a serious gap by Mahidol University's research for UNIFEM.

No estimates on the numbers of transgender males (nor HIV prevalence among this group) were found during this research, and therefore no data on their partners (female or male). More broadly, males who have sex with males are estimated to account for 5-10% of the male population and among males who have sex with males the HIV prevalence is 28.3% (2005 MoH).⁴⁸ While there is no national response to males who have sex with males, there are a number of small projects that outreach and facilitate access to VCT and treatment.

Figure 2 Distribution of reported AIDS cases by age group of diagnosis in Thailand, September 1984-December 31, 2006



http://www.aidsthai.org/aidseenglish/main.php?filename=situation_01

UNDOC estimates that there were 2-3 million of drug users in Thailand in 2001, including 275,000 heroin users, 70-80% of them injectors.⁴⁹ However there appears to be no data or policies on the female partners of male drug users, nor on female injecting drug users and their partners. The 2007 survey of sexual and reproductive health of female sex workers in Thailand found that 35.1% of sex workers have a male partner, two thirds of whom live with their partners, and two-thirds of whom do not use a condom with their partner.⁵⁰ Male sex workers were underrepresented in data collection, policies and programme coverage, although the Ministry of Health estimates that the number of male sex workers increased from 4,132 in 2000 to 4,460 in 2004.⁵¹

⁴⁸ Annex 4 – Prevention services. Review of the health sector response to HIV/AIDS in Thailand (External Review of the Health Sector Response to HIV/AIDS in Thailand), Ministry of Public Health, Thailand and the World Health Organization, Regional Office for South-East Asia, 2005

⁴⁹ *ibid*

⁵⁰ 2007 Survey of sexual and reproductive health of sex workers in Thailand, Mahidol University and UNFPA

⁵¹ Thailand and the World Health Organisation Regional Office for South-East Asia, 2005 *op. cit.*

Some limited data on the military and prison populations was found. As of 2003, the infection rate among married military recruits was almost twice that of single recruits (1% versus 0.47%).⁵² The male prison population is referred to in both the National HIV Plan 2007-2011⁵³ and UNPAF 2007-2011⁵⁴ but little data provided on HIV prevalence or analysis on risk and vulnerability of male prisoners and their female partners.

Registered and non-registered migrants are estimated to be up to 2 million people working in over 20 provinces⁵⁵ (no breakdown of male:female ratio). In 2004/5, HIV prevalence among migrants visiting antenatal care services in Region 3 was 5% compared to 1.1% among Thai women.⁵⁶ A number of NGOs target female migrant workers, but little programme coverage was identified as aimed at male migrant workers specifically. Ethnic minorities are identified as a target in UNPAF 2007-2011⁵⁷ and the NGO Thai Raks provides the most programme coverage for them.

Analysis

Of the three countries, Thailand seems to have the clearest estimates on women infected with HIV by their husbands and vice versa. In Indonesia and Laos PDR there does not seem to be any specific studies on the feminization of AIDS or partner/spousal transmission among the general population although both do make reference to preventing HIV infections among female partners of male injecting drug users.

All three countries focus understandably on the key populations, those most at risk of HIV transmission, and need to expand their remit to reach the partners of these key populations. In most cases, male clients of sex workers are not considered a key population, and therefore their female partners and spouses are even further removed from the mainstream HIV response.

A challenge for Indonesia and Laos PDR in addressing partner and spousal transmission, is their reliance on external donor funding: if the indicators for programmes funded externally do not include indicators on female partners (e.g. of male clients of sex workers etc) then there is very little chance these women will be targeted by programmes. However all three countries are beneficiaries of major donors and funds so the same context applies to Thailand as well.

Within Thailand, the Stay Negative campaign is a good example of a programme that targets women in relationships. To date the programme has not yet expanded to national coverage but has the potential to impact on a significant number of women. While this initiative targets women who interact with mother and child hospitals, a comprehensive programme aimed at women in relationships will need to reach women before they become pregnant and present themselves at pre and antenatal care clinics where service-provider initiated testing takes place.

⁵² *Thailand – UNGASS Country Progress Report 2008*

⁵³ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

⁵⁴ *UNPAF 2007-2011, United Nations Partnership Framework, Thailand: Well-being, Sufficiency and Equity*

⁵⁵ *Thailand and the World Health Organization, Regional Office for South-East Asia, 2005 op. cit.*

⁵⁶ *ibid*

⁵⁷ *UNPAF 2007-2011 op. cit.*

ii. Legislative frameworks

The legislative frameworks of all three countries are necessarily diverse, reflecting the uniqueness of each country's legislative machinery and national context. Gender equality is defined in all three countries as the equal rights of women and men. In Indonesia the Constitution (1945) promotes equality of "all citizens" particularly in freedom of religion. In Laos PDR the Constitution (2003) promotes equal rights and non-discrimination, and the enhancement of women's status. There is a specific law for the Development and Protection of Women, and both the Family and Healthcare laws emphasize women. In 2006 Thailand amended a range of laws that were previously gender biased. New laws have been introduced which protect women related to domestic violence and trafficking.

Indonesia

Indonesia ratified CEDAW in 1984, with one reservation: to an article on the settlement of disputes between State parties by the International Court of Justice (ICJ), which it maintained was a constraint on its national sovereignty. The Indonesia legal system encompasses the positivistic laws deriving from the Dutch Colonial system, the customary laws or adat and the Islamic laws or shariah in some provinces where the local government has formalized shariah as the legal framework in the region, such as is in Aceh. Some customary laws are strongly influenced by religious values including Bali [Hindu] and Pekanbaru [Islam] while Timika's customs are affected by Christian values. There are many facets to the legal framework that binds the Indonesian population in general and even more women.

The nation's constitution of 1945 guarantees "freedom for every citizen to embrace their own religion." Implicitly, this freedom applies to women. However, in practice restrictions may occur as a result of Act No. 7 (1989), which gives Religious Courts jurisdiction over Muslims in the areas of: marriage; inheritance and bequests; wakaf or the setting aside of possessions for religious or community interests; and hadaqah or alms. No women serve on the religious courts and Islamic law tends to be interpreted by male clerics inevitably from a male perspective. Women's religious freedom is at times curtailed.⁵⁸ Indonesian laws clearly state that the rights and position of the wife are equal to the rights and position of the husband. However, in practice, and in some regulations, treatment is unequal. The wife is assigned the nurturing and reproductive role in the private sphere, while the husband is assigned the productive role in the public sphere.

The major legal issues are problems caused by dualism in laws confronting married women who are increasingly engaged in business: there are no separate tax numbers for women, there are constraints in access to credit, seemingly few rights and protection of women workers in the non-formal sector; and there are difficulties associated with unregistered marriages.⁵⁹ For many years, women remained vulnerable to domestic violence without legal reprimand to their male partner. Women and legal groups became actively involved in organizing and carrying actions for legal reforms. On 14 September 2004, Indonesia enacted a law against domestic: under the new law, perpetrators of domestic violence could face "stiff fines and long jail terms".

The 22 and five year 1997 laws⁶⁰ on narcotics and psycho-tropics have reputations for being severe and punitive towards drug users in the country. The criminalization of drug users contributes to the isolation of users from the public sphere, and female users seem even more removed. The lack of protection from the state and from society increases women's vulnerability from: drug dealers, corrupt police officers, and

⁵⁸ *Sociolegal status of women in Indonesia, Malaysia, Philippines and Thailand, Asia Development Bank, January 2002*

⁵⁹ *ibid*

⁶⁰ *Legislators have just enacted a new drug law in September 2009, that is being scrutinized by activists for its lack of acknowledgment towards drug users and the equality of their rights. The law is seen as further criminalizing users and impeding efforts to provide health care and other social services including harm reduction services.*

abusive partners/husbands. A study concerning female drug users in eight cities confirmed these vulnerabilities.⁶¹ Some women reported using injecting drugs and subsequently becoming addicted as a means to maintaining their relationship with their partner. The study also indicated the lack of services accessible to female drug users, whether public services or private.

Women enter the sex industry through several routes: bonded entry (where a payment is made to parents, spouse, guardian or broker), involuntarily (by coercion, deception or abduction) and voluntarily albeit influenced by limited economic options, economic need and poor circumstances, such as a failed marriage or abuse in the family.⁶² While no law prohibits sex work in Indonesia, neither does one permit it. The criminal law does prohibit facilitation of illegal sexual activity (Article 296), the trade in women or underage males (Article 297) and earning profit from the prostitution of women (Article 506).

Laos PDR

Laos PDR has a legal framework to support gender equality. The revised Constitution in 2003 guarantees all people their fundamental rights and freedoms of the individual irrespective of race, place of origin, political opinions, colour, and sex. The Constitution is based on a number of articles that include gender perspective as follows:

- Article 21 provides for equal treatment in all spheres of life under the law regardless of sex.
- Article 31(1) entitles women and men to equal rights during and after marriage.
- Article 32(1) mandates the state to take affirmative action in favour of groups marginalized on the basis of gender or any other reason created by history, tradition or custom.
- Article 33(4) further avers that the state shall provide facilities and opportunities necessary to enhance the welfare of women to enable them realize their full potential and advancement.
- 33(5) accords affirmative action to women for purposes of redressing the imbalances created by history, tradition or custom.
- 33(6) prohibits "laws, cultures and traditions, which are against the dignity, welfare or interest of women and undermine their status."

The Law on the Development and Protection of Women was passed by the National Assembly in October 2004. The law elaborates on the constitutional guarantee of male and female equality in political, economic, cultural, social, and family affairs. The law also accords certain special rights and priorities to women related to work during pregnancy, maternity leave and benefits, divorce, criminal matters and health care.

The Family Law has four key related articles. Article 2: Equality between men and women in family relationships: family relationships arise independently from the origins, socio-economic status, nationality, ethnicity, educational level, occupation, beliefs, place of residence and others. Article 3: freedom to marry: men and women who have attained the age of marriage have the right to marry on the basis of mutual consent, freedom and love. It is forbidden to force or hinder another individual's marriage. Article 8: sexual relations before marriage: if sexual relations occur before marriage and the man does not marry the woman, he shall have to make offerings to restore the spirit⁶³ of the woman or of her family according to custom and tradition. If such sexual relations have resulted in pregnancy, in addition to spiritual offerings, the man shall also have to be responsible for the expenses of childbirth, recovery and others. The man also has the duty to look after the child born from such pregnancy until the child's maturity. Article 9: conditions for marriage: men and women have the right to marry at eighteen years of age. In special and necessary

⁶¹ *FDU. Perempuan – Perempuan Di Lingkar Napza Laporan Kajian Kebutuhan IDU Perempuan Dan Perempuan Pasangan IDU Di 8 Kota, 2007, supported by IHPCP-AusAID*

⁶² <http://intersections.anu.edu.au/issue10/surtees.html>

⁶³ *The phrase "restore the spirit" has both a secular sense of "repair the reputation" as well as a metaphysical sense of "undo any spiritual damage"*

cases, this limit may be lowered to less than eighteen years of age but not less than fifteen years of age. Marriage must be based on mutual consent from both sides without coercion from any side or individual.

The law on Health Care states in article 5 that the state pays attention to improve the quality of health care to ensure that the whole population, and in particular women and children, poor citizens and those who live in remote or isolated areas have a good state of health; the state implements the policy of paid and free health care in accordance with regulations; the state encourages and promotes all sectors, nationally and internationally, to invest in health-care services by using modern medical equipment and materials; the state promotes health-care services by combining modern and traditional medicine.

A number of national policies support gender equality. These include the following strategies and programmes:

Development Plan of the Laos Women's Union (2006-2010) includes five programs and 16 projects to promote Laos women's legal awareness, education, vocational skills, health and nutrition, and income-generating opportunities.

The *Sixth National Socio Economic Development Plan (2006-2010)*: the government recognizes that it will not be able to realize the goals of reducing poverty and improving national education, health and population indicators without the active participation of all women, and particularly poor and ethnic minority women. Therefore, the government is taking concrete steps in all key economic sectors and through national programmes to: (i) support poor women's economic activities; (ii) improve their access to basic services such as education and health and productive resources, such as extension services; (iii) involve them in local decision-making; and (iv) generally increase their involvement and take their needs into account when developing policies and plans. Under the guidance of the Laos National Commission for Advancement of Women (Laos NCAW) which has strengthened its own capacity, it is expected that all ministries will develop strategies and action plans to promote gender equality at national, provincial, district and village levels.⁶⁴

LaosNCAW prepared a *national policy plan on the advancement of women for the period 2006-2010*, which is in line with the Beijing Platform of Action, the relevant international treaties and Millennium Development Goals. This national policy plan aims at removing the obstacles to the advancement of women. It was approved by the Prime Minister on 30 January 2006. This national policy plan consists of five programs as follows:

1. Improve the participation of women in the implementation of the National Growth and Poverty Eradication Strategy;
2. Promote opportunities for women and girls to be equal with men in education and other fields;
3. Improve healthcare services for women;
4. Increase the number of women in the leading positions of all levels; and
5. Strengthen the capacity building of national organizations concerned that deal with the protection of women and the promotion of the advancement of women.

The government has given responsibility to line ministries, organizations and provinces to draw up the strategies and plans of action in order to mainstream gender equality into all sectors at the provincial, district and village levels under the leadership of Laos NCAW. To date, a number of ministries have done so, while some are in the process of setting up a team responsible for gender mainstreaming, advocating and building related capacity for the government officials, collecting relevant information and documents and assessing gender mainstreaming in their own agencies. Sex-disaggregated data on poverty alleviation has started to be collected. Some units have conducted studies to identify problems that hinder women's role with a view to formulating strategic and action plans to address such problems. Some ministries have enhanced personnel development while taking into account gender equality. At the same time, policies, programs and projects that focus on gender equality have been improved. Recommendations on how to design a gender related poverty eradication have been given to local women in order to ensure their

⁶⁴ *Sixth National Socio Economic Development Plan (2006-2010)*

participation in the project activities, including the expansion, management and services of such projects as well as in all trainings.

LaosNCAW was created by the Prime Minister's Decree N. 37/PM of 1 April 2003. The said decree defines the following functions and activities of the LaosNCAW: assists the Government in studying and defining a national policy, comprehensive strategic plan for the promotion of the advancement of women in all respects; serve as coordinating point for all relevant agencies and bodies within the country and abroad in the implementation of policy on gender equality and elimination of all forms of discrimination against women". The Prime Minister Decree also defines that the main objectives and activities of LaosNCAW are "to encourage, promote and protect the legitimate rights and interests of women in all fields: political, economic, social, cultural and family as provided for in the policy of the Party and Government, the Constitution and laws, as well as in various international instruments adhered to by the Laos PDR; to ensure the realization of those policies across the country with a view to the elimination of all forms of discrimination against women".

The Secretariat of the Laos NCAW was established by the Decision of the Deputy Prime Minister, Chairperson of the LaosNCAW, No.05/NCAW of 1 March 2004. The decision defines the functions of the NCAW Secretariat namely, providing overall and direct supports to LaosNCAW, undertaking studies and researches on policies, strategic plans for the advancement of women; coordinating among all relevant national and international bodies and agencies in the implementation of the action plan of the LaosNCAW. In addition, the LaosNCAW has issued a Notification No. 51/NCAW of 18 October 2006 on the establishment of a subsidiary unit of the ministerial and provincial committees for the advancement of women. Such a unit has 3-5 members and functions under the direction of the respective ministerial and provincial committee for the advancement of women.

At its inception in 1955, the Laos People's Revolutionary Party established the Laos Women's Union (LWU). LWU is an organization equivalent to a ministry. It has an organizational structure that expands from the central to the grass-root levels. It is mandated to protect the interests of women and children by upholding its role in forging solidarity among the Laos multi-ethnic women, to educate women about their rights and national duties and to actively contribute to the implementation of national socio-economic development as well as to actively promote the implementation of policy on gender equality and the advancement of women with an aim to improving the living standard of all Laos people, particularly the Laos multi-ethnic women. In 2006, the Laos Women Union's 5th Congress reaffirmed the so-called "Slogan of Three Good" namely: "To be good citizen, to have good development and to build a happy Family". The number of the LWU members across nationwide reached 1,011,595 making almost half of all Laos women in 2006. The LWU has expanded its organizational network across 399 villages, which did not have their own women unions before. Today, the LWU has made a great effort to mainstream gender perspective into all areas of work with a view to promoting the participation of women in decision making process at all levels as well as to carrying out the socio-economic development at the grass-root level through implementing the five-year plan on women development 2006-2010.

LWU has carried out five programmes, 16 development projects in Vientiane Capital, in 16 provinces and in one special zone (formerly called Special Zone), or as a whole all in 55 districts and 1,826 villages. The main activities of the projects were to organize trainings on improving knowledge and capacity of women in the fields such as development of women and children, promotion of gender equality, anti-trafficking in women, domestic violence against women, basic health services, preservation and promotion of national and women's culture. They also focused on improving vocational-technical skills, provision of jobs and appropriate knowledge on technology, promotion of commercial production, reduction of hardship of women, provision of loans and revolving funds, promotion of handicrafts and agricultural work with a view to income generation for their families, thus gradually reducing poverty.

Thailand

The following analysis is summarized from the 2009 report of the in-country research team.⁶⁵ Several Thai laws have previously reflected gender discrimination and the lack of women's decision making power over their bodies, sexuality and reproductive rights. In many cases these laws have recently been revised in 2006 to promote equity between women and men. However, knowledge of the changes has yet to be widely known and realized by the majority of women.

Overall, laws relating to women are created from the paradigm of maternity and view women from the perspective of marriage, the institution of the family and the idea of "good" women as a wife and a mother. This approach has affected several groups of women including those with unwanted pregnancies and who decide to have an abortion, female sex workers, and women living with HIV. These women face multiple problems as the consequences of the laws on Abortion, Prostitution Prevention and Suppression, and Domestic Violence. Arguably they have encouraged women to use marriage as a solution to achieve conflict resolution which facilitates an advantage for perpetrators of crimes against them. The laws are not yet mechanisms to empower women and girls to make their own decisions, negotiate for safer sex practices and escape from intimate partner violence. The laws relating to: engagement; sexual violence; abortion; prostitution; child sexual exploitation; intimate partner violence; and reproductive health are analyzed below.

The Engagement Law permits men to request financial compensation from another man who engaged in sexual relations with or raped his fiancé. Until 2006 the law did not allow the woman involved to also seek compensation. Similarly the Divorce Law permitted a man to take legal action on the grounds of his wife's adultery, but a woman had to prove that her husband had publicly acknowledged another woman as his wife. This law was also changed in 2006 to provide equal rights to women and men to sue for financial compensation but in reality many women have little knowledge about the changes and negative societal values placed on women who divorce make it difficult for women to choose this option.

Under the Criminal Code rape is illegal, however, until 2006 a husband was not prosecuted for marital rape, when the criminal code changed to redefine the term rape to include marital rape and same sex rape. Under the same law, men are not liable for prosecution if their wife is under 15 years of age. If the male perpetrator of rape is under 18 years old, he is exempt from prosecution if he marries the woman, paving the way for forced marriages of young women to avoid criminal charges against the male, and negate disrepute to the woman, and both their families.

The abortion law prohibits abortion, except on the grounds of physical or mental health,⁶⁶ and holds a woman responsible for terminating an unwanted pregnancy (there are no paternity consequences). A woman who causes her own abortion or allows any other person to perform an abortion is subject to up to three years imprisonment and/or payment of a fine not exceeding 6,000 baht. The grounds for permitting abortion are decided by professional staff, with little opportunity for women to input into the decision. With the introduction of the Prevention of Mother to Child HIV Transmission policy and program, 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.

Trafficking in women and children continues to be a serious problem, especially in border areas, where women and girls are more vulnerable to being forced into sex work, many are physically restrained and a large number are in debt bondage. The 1996 Prostitution Prevention and Suppression Act criminalizes people who have sex with child sex workers, and parents who allow their child to work in the sex industry, although prosecutions remain low.⁶⁷ In practice, existing legislation does not promote the rights of sex workers. Instead female sex workers who do not comply with strict controls are liable for judicial punishment.

⁶⁵ *Feminization of AIDS: Spousal/partner transmission and sero-discordant relationships in Thailand*, Pimpawun Boonmongkon, Sulaiporn Chonwilai & Ronnapoom Samakkeekarom, Center for Health Policy Studies, Mahidol University, 2009

⁶⁶ www.tmc.or.th/service_law02_16.php

⁶⁷ www.onlinewomeninpolitics.org/womensit/thai

The legislative framework allows for prosecutions for intimate partner violence. The 2006 Protection of Domestic Abused Victim Law was accompanied by the establishment of “one-stop” crisis centers in state-run hospitals to care for abused women and children. These centers continue to operate but face budget difficulties. Complementary services and awareness raising efforts have also been initiated. However, rules of evidence can make prosecuting such cases difficult and police often do not enforce the law vigorously. Intimate partner violence often goes unreported because many victims and authorities continue to regard intimate partner violence as a private rather than legal matter.⁶⁸

A Reproductive Health policy has been in development since 1996 and will eventually replace the existing Population and Family Planning Policy and the Maternal and Child Health Policy. The aim of the new policy is to promote the reproductive rights of women and men in term of exercising their choices and decision making and to provide access to sexual and reproductive health care and services. The reproductive health law is now drafted and emphasizes the right to sexuality education, family planning, pregnancy and pregnancy termination. However, as the law is not yet enacted, most of women’s health policies are still shaped by paradigm of maternity and population control.

Analysis

While laws exist which protect women and promote their rights, there is often a lag time between the introduction of legislation and changes in the judicial system and the wider public consciousness. However, extremely important advances have been made which enshrine women’s rights in all three countries and therefore provide the legislative mandate for increasing prosecutions for violations of law. Ambiguities remain in some laws which have the potential to dilute the strength of those which have more clarity. In Indonesia, for example, freedom of religion is promoted for all citizens; at the same time Religious Courts are given jurisdiction over Muslims and are arguably biased because no women participate in the courts’ decision making. In Laos PDR Family Law declares equality between men and women, and simultaneously demands that women and their families are compensated in cases where men have sex with a woman outside of marriage. Whilst this may serve as a deterrent for men to commit sexual violence against women, it reflects the continuing bias in society’s expectations of women and men, namely that it is more dishonorable for a woman to have sex outside marriage than a man.

Indonesia’s laws and practical regulations seem to lag behind the changing realities of women, particularly those in business. The domestic violence laws do allow for criminal action to be taken against perpetrators but it is not clear how awareness of the new legislation has filtered into public awareness and whether there are many prosecutions. The punitive drug laws continue to criminalize drug users and there seems to be little protection of female injecting drug users who are already marginalized by society and overlooked in many harm reduction programmes.

The Laos PDR government faces the same challenges as all other governments – how to best ensure the protection of an underclass without reinforcing their lower status in society. This applies also to the affirmative references to women in the healthcare and family laws, which promote women’s inclusion without necessarily their empowerment, unlike the law on the Development and Protection of Women which focuses on strengthening women’s economic positions.

Thailand has many laws and therefore has the advantage of potentially promoting the rights of women in a wide range of areas. A disadvantage to this more broad and complex legislative framework is that previously gender flawed legislation was pervasive in legal language and wider societal attitudes. 2006 saw many of these gender biased laws amended and, as with all changes in legislation, it will take time to see the new approaches become part of societal norms. From the perspective of the in-country researchers the policy and practice of the health service in particular continue to promote a morally polarized view of women. This demonstrates the need for capacity building among service providers to not only to help them understand the legislative framework, but also to give health workers the skills to provide an equitable service without prejudice to all members of society.

In all cases, policy and law makers need to ask themselves several key questions:

⁶⁸ www.onlinewomeninpolitics.org/womensit/thai

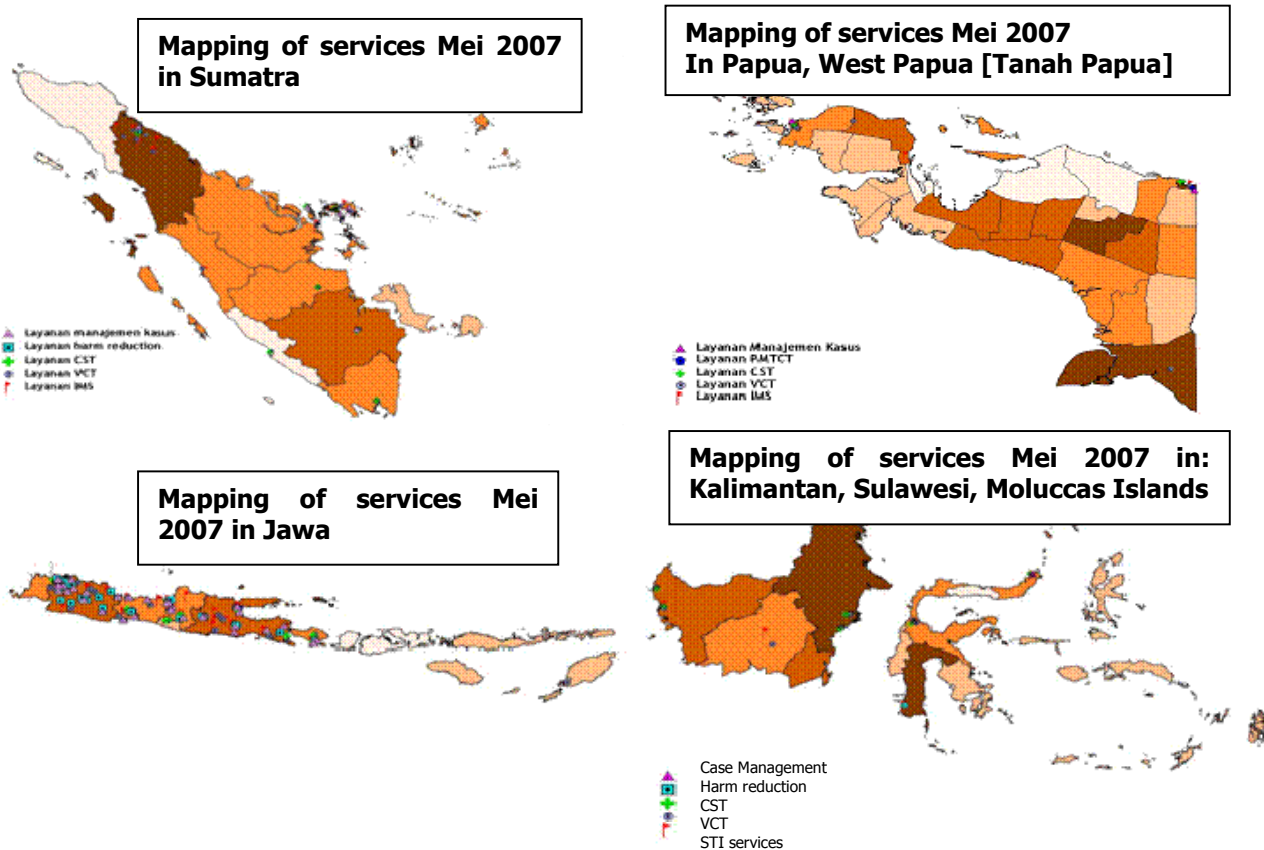
- In practice, how do attitudes that promote gender inequality in society prohibit the full implementation of the laws?
- How aware are members in society of the equality laws, and how aware are the judicial services including the police? Are women able to access the justice system?
- How aware are health service providers of the state's obligations to provide services to all citizens without discrimination (including against men, women, marginalized groups and people living with HIV)?
- Do laws relating to anti-discrimination apply to people living with HIV? And in practice, can/do people living with HIV invoke these laws when they are violated?
- What needs to happen for existing laws to be fully implemented? And what further changes or new laws are needed to ensure gender equality?

iii. VCT services

All three countries have seen significant increases in services and coverage related to HIV prevention and treatment. Indonesia has seen an increase in VCT services which are now available in over 150 hospitals. As a result the proportion of key populations who access the services has increased. Linked to the VCT response, Indonesia has dramatically scaled up needle syringe programmes which by 2008 were provided in 182 clinics – over 10 times the number just three years earlier. There has been a proliferation of Voluntary Counseling and Testing (VCT) services in Thailand particularly, which responded in the 1990s to the increasing HIV prevalence among sex workers. Dedicated STI clinics were introduced which have subsequently been subsumed by hospitals in the process of healthcare decentralization. VCT is now available in all hospitals in Thailand. Laos PDR faces the challenges of how to provide VCT in the face of a currently low level epidemic and with the majority of its population living outside of the major cities. It has plans to ensure a further 56 sites at provincial and district levels.

Indonesia

Health care for HIV treatment and prevention has increased rapidly in the last five years as more funds (from both international donors and the government) have been allocated to these programmes. The areas where VCT is most accessible are those that have had consistent funding from donors or the local government since 2004.



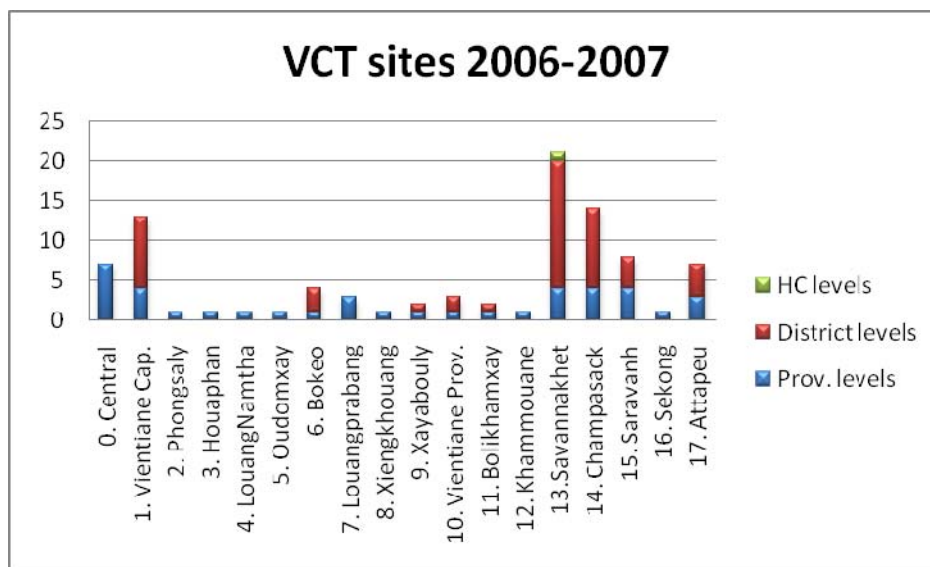
Between 2004 and 2007 VCT coverage has increased among key populations: the proportion of female sex workers accessing services increase from 27% to 41%; clients of sex workers increased from 6% to 10%; waria from 47% to 64%; males who have sex with males from 19% to 37%; and injecting drug users from 18% to 41%.⁶⁹ (STHP 2007)

Needle Syringe Programs increased from 17 service units in 2005 to 182 service units in 2008, comprising of 113 in Primary Health Clinic or Puskesmas and 69 in NGOs. Meanwhile, VCT is provided in 154 hospitals in 2009; an increase from 25 hospitals in 2004.

The Ministry of Health estimated there were 27,770 people in need of ART in 2008 (10% of the estimated total number of people living with HIV). By June 2009 there were 12,493 positive people in ART (or 45% of those in need). In terms distribution of access, it is clear that access is not equitable and is limited to particular areas. In most areas of where this study took place, VCT including ART is available at the local hospitals. Prevention programs, however, whether related to sexual transmission or injecting drug use, are not provided in all areas.

Laos PDR

The first specific project on HIV prevention and AIDS-related care in Laos PDR was initiated in Savannakhet Hospital. With support from Médecins Sans Frontières (MSF) health workers at the hospital were trained and the quality of the services provided increased to include counselling and testing, consultation, and hospitalisation of people living with HIV with debilitating symptoms.



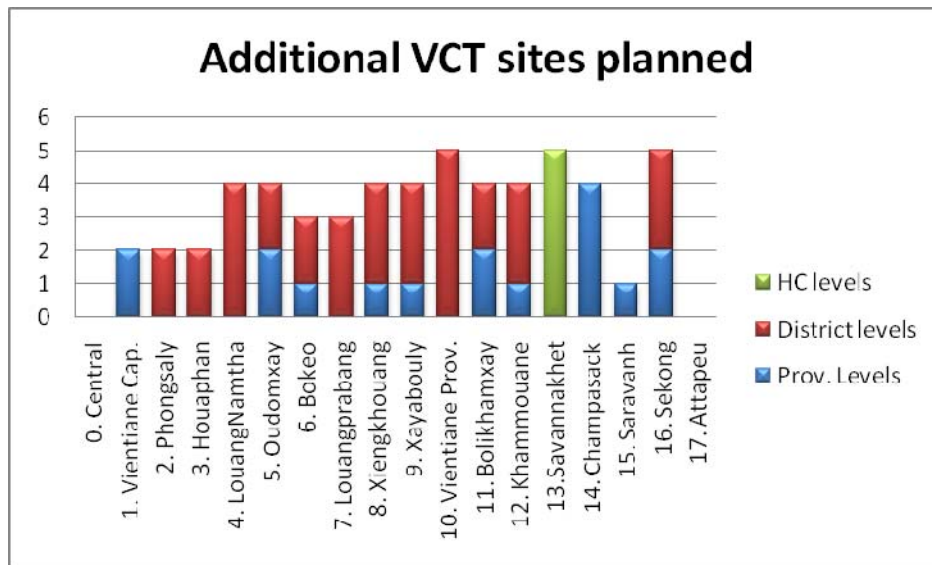
Treatment for opportunistic infections has been provided since 2001 and ART since September 2003, with lab equipment allowing blood HIV diagnosis and determination of CD4 counts. Savannakhet is the only institution offering such services in the country and there is a close relationship between patients and health

⁶⁹ IBBS 2007

staff at the hospital. Since the beginning of treatment provision at the hospital, there has been an association of people living with HIV fighting against the epidemic through a support group.

Savannakhet has had considerable experience of working in partnership with people living with HIV and other provinces are in the process of learning how to work efficiently with their associations. This situation is being paralleled in Mahosoth and Sethathirath Hospitals in Vientiane and at Pakse Provincial Hospital, where people living with HIV regularly meet. From these locations they travel to Savannakhet Hospital for check-ups, blood tests and ARV treatment.

Mother and infant mortality rates are high and ante-natal care coverage is low. In urban Savannakhet, only 31 % of women make three ante-natal clinic visits. In rural areas, 13.2% of pregnant women deliver in hospitals and 21.2% are attended to by traditional birthing attendants, while 55% deliver at home without professional assistance. Presently there is no strong community-based antenatal care system in place: such low coverage makes it impossible to provide VCT services to all pregnant women though antenatal care services.



Each hospital has an organised group of people living with HIV, meeting once a month with each other under the auspice of this group. The number of members of Savannakhet, Pakse, Sethathirath and Mahosoth hospitals are 175, 22, 85 and 23 respectively. UNICEF provided financial support to participants thus encouraging their attendance.

All but two of the people interviewed are or have been members of positive associations. Of the two that are not members of a group, one is a shop owner, who collects his ARV drugs in Nong Khai (Thailand); he does not want to meet people and be identified as living with HIV. In addition, going to Savannakhet takes time and is not compatible with his work. The second is newly infected and is still too shy to attend the support group. Another woman attended a couple of support group meetings but has stopped because of her professional activities.

The support group brings a lot of satisfaction for people living with HIV, especially increased psychological strength by reducing isolation. People living with HIV meet others with the same concerns and they share information and questions about their life with the virus. The support group pools knowledge about HIV and AIDS and compliance with ARV treatment.

Family members can also attend the support group monthly meetings. Members of the support group received training on ART literacy, counseling, Information Education Communication mobilization, and group

management. Some members have participated in a regional conference in Thailand with other people living with HIV and are in the process of setting up a national network.

The support group is also a mediator between people living with HIV and medical personnel. In Savannakhet, some of the people living with HIV have become involved in counseling and advocacy for the entire group of positive people in Laos. At the end of each monthly meeting, the participants receive a transport fee to facilitate their attendance. Providing the transport allowance dramatically increases the role of positive people in the management of their own infection. Group members also receive transportation fees if they need to attend a consultation in between monthly meetings.

Those attending the Sethathirath group's monthly meetings get financial support from UNICEF to the value of 40,000 - 70,000 Kip for transport and a 20,000 Kip per diem. Every month the hospital saves 5,000 Kip from each allowance which goes into an emergency fund, and last month the hospital retained 15,000 Kip per patient, in agreement with the group members, in order to equip the new HIV ward at the hospital.

The Mahosoth group gets support from the Laos Red Cross (LRC), a private individual donor and the Khop Chai Deu restaurant. The Pakse group gets an average of 100,000 Kip/person for transport and a per diem from UNICEF.

In Savannakhet, people living with HIV can go for a medical check-up and ART twice a month if necessary. They get free treatment and help for transport. If in an emergency people are required to stay in the hospital; they will get one meal per day.

"When I was sick I went to Savannakhet in emergency: the hospital provided an evening meal and for other meals I had to take care of myself. I got 160,000 Kip for my transport fee. If I go only for normal consultation I stay with the head of the HIV support group or in a guesthouse. The hospital pays for it. After March 2005 it seems the budget was limited and people living with HIV now receive only 110,000 Kip for transportation from Vientiane to Savannakhet and other expenses are on the patients themselves."

Female member of the support group for people living with HIV

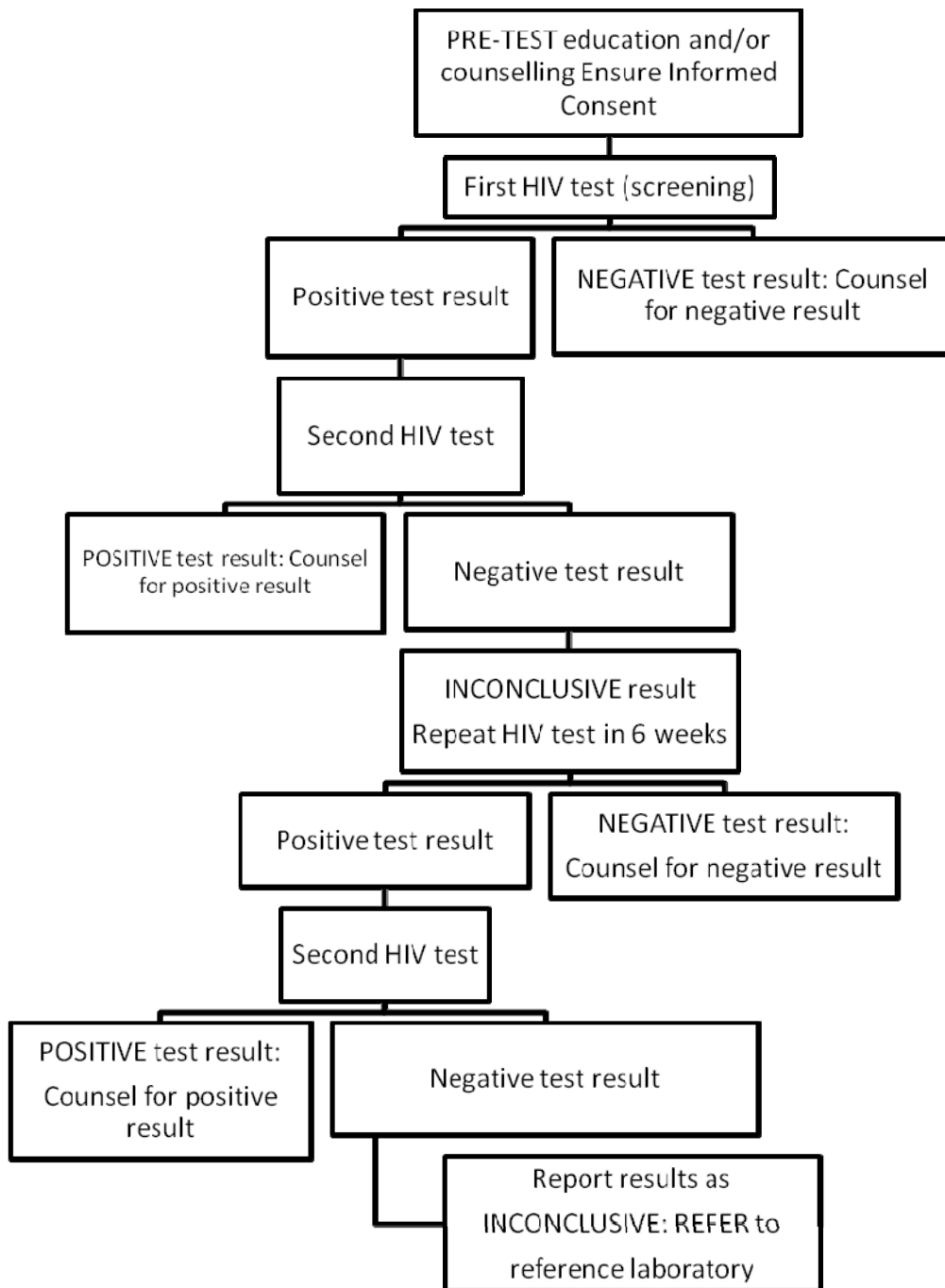
"When a person living with HIV was sick and had to go to Savannakhet hospital in an emergency, the hospital fed him twice a day but he had to take of the lunch by himself. For myself when I go to Savannakhet I stay at Kinoy's home and the hospital gives Kinoy 20,000 Kip per day. I got 100,000 Kip for transport. Since April 2005 the budget has been limited and now they give me only 90,000 Kip for transport and I have to pay for accommodation myself. I have seen people living with HIV without money sleeping on benches around the hospital."

Female group member from Pakse

The Guideline for Prevention of Mother to Child Transmission in Laos PDR (2007)⁷⁰ emphasizes that all women, regardless of their HIV status, should receive post-test counseling according to the post-test counseling format provided during counselor training.

If a woman tests HIV-negative, she receives post-test counseling focused on how to maintain her HIV-negative status with a focus on her health, safer sexual practices, and the high risk of transmission to her baby should she become infected during pregnancy or through breast-feeding. The window period should be explained once more and she should receive routine antenatal care.

⁷⁰ *Guideline for PMTCT in Lao PDR. Department of Hygiene and Prevention, Ministry of Health and UNICEF Lao Vientiane, June 2007.*



HIV testing process in Laos PDR

If a woman tests HIV-positive, she will be counseled about her HIV status, provided with immediate support, informed about the prevention of mother to child program and offered the opportunity to participate. She should be asked and encouraged to bring her partner for testing and asked who she wants to tell of her HIV status (according to Laos culture, the partner and family members would like to know and would like to help her. Post test counseling for family members may be needed also). Follow up visits are arranged and over the next visits, the newly-diagnosed HIV positive woman is also provided with:

- Ongoing counselling including emotional support, assessment of how she is coping, information about existing support groups, appropriate referrals for support and information on positive living (home visits may sometimes be considered if the hospital has the resources).
- Information about HIV, potential health problems and the importance of clinical care for the disease
- Information about the prevention of mother to child transmission programme and where these services are available, including the possible need for referral to another hospital where the prevention of mother to child transmission services, CD4 testing or ART are available.
- Advice on prevention of mother to child transmission services, including medicines that are offered (and their potential side-effects).
- Counselling about delivery options.
- Counselling about feeding options, including the health benefits and risks of formula feeding and breast-feeding.
- Counselling about partner and family notification and disclosure, stigma and discrimination.
- Information about safer sex during pregnancy and in the long term.

The guidelines also refer to information about testing partners and other older children if applicable. As this amount of information is extensive, several counselling sessions might be needed for the HIV-positive woman to receive all of it. Having several counseling sessions, for both the woman and her family is considered very important, at the hospital or at home, unless this will compromise confidentiality.

Thailand

VCT services are primarily available in hospitals. The UNGASS progress report (reporting period 2006-2007) highlights several areas that Thailand has identified as needing priority such as: the greater involvement of men in VCT and antenatal care; targeting couples (or partners) of reproductive age for HIV prevention; counselling for disclosure of blood test results; raising awareness and positive attitude to reduce sexual problems through campaigns specific to each target population; promoting preventive behaviours including condom use.

Specific initiatives are recorded to increase men's involvement in antenatal care, which create opportunities for ongoing HIV prevention interventions, but statistics are not as yet available on the coverage or impact of the implementation. HIV prevention initiatives for young people were launched in close cooperation with non-governmental organisations and delivered in schools, but these do not appear to be linked to VCT provision.

The strategy for HIV prevention among female sex workers remains focussed on the promotion of 100% condom use in commercial sex establishments. No mention is made of VCT services targeted at female or male sex workers, male clients of sex workers, the spouses or partners of male clients or the spouses or partners of sex workers. The challenges of providing services to sex workers are in fact increasing, given the health service reform (including the transfer of sexual health clinics to unprepared health staff already working at full capacity) and the rise in street-based sex work taking place outside of brothels.

Outreach (client-friendly drop-in centres and peer education) is targeted at males who have sex with males because attitudes within the mainstream health sector (compounded by unsympathetic laws on prostitution)

present serious obstacles to providing VCT and other services in a clinical setting. Similarly outreach approaches are also targeted at injecting drug users although this has seen much less coverage, largely due to the ambiguous position on harm reduction taken by the government.

Migrants, identified in the National Strategic Plan for HIV/AIDS Prevention and Alleviation as a target population, should eventually benefit from multi-sectoral approaches and border surveillance and health care initiatives. Already migrants are participating in HIV prevention and care initiatives as community health volunteers, providing the much needed roles of interpreters, educators and counsellors. There are currently at least 500 'foreign assistants' in the health system as migrant community health volunteers and migrant health workers, covering 30 provinces populated by foreign workers. The situation remains precarious, however, because although these migrant workers have been accepted into the health system for reasons of efficiency and need, their status in Thailand remains illegal.

A concerted effort (from 2000) has been made to offer all pregnant women VCT. In 2006, the hospitals' coverage of VCT for pregnant women was reportedly at 99.6% while the HIV infection rate was 0.85%.⁷¹ This comprehensive VCT coverage resulted in high proportions of pregnant women living with HIV receiving antiretroviral therapy for the prevention of mother to child transmission (90.1% and 95.9% in 2006 and 2007 respectively - adjusted for underreported percentage in number of born babies of the hospitals and of the Bureau of Health Policy and Strategy, Ministry of Public Health).

Whilst there is undoubtedly significant progress in linking reproductive health and prevention of mother to child transmission, there seems to be little review or evidence of sexual health services for men, for young people, and for unmarried women and those without children, or those who have been sterilized after having their desired number of children.

The evaluation of GFATM grants (rounds 1 and 2)⁷² highlight the efforts to expand access to VCT (available at hospitals) through its promotion in HIV related settings such the TB clinic, Drug Abuse Clinic, Maternity and Pediatric Clinic, STI Clinic, and In-Patient Department. Further, VCT was promoted in the community via mobile VCT clinics for sex workers and for prisoners. The GFATM evaluation report identified gaps in the strategy: importantly VCT should be more widely promoted to "any person who has a history of risk behaviors and do not know their HIV status".⁷³

The lack of VCT promotion among migrants was also highlighted, who consequently only present at hospitals after experiencing serious symptoms. The VCT services themselves were judged to have improved according to a survey among people living with HIV who received antiretroviral therapy, but a tendency remains for many people to prefer to obtain their HIV test results from private clinics. The evaluation suggests that this may be because private clinics can provide a more rapid service and greater anonymity.

Summary of recommendations on access to VCT services at an early stage from GFTAM evaluation⁷⁴

- The promotion of VCT services should be improved in terms of friendly and flexible service, so that the people having risk behaviors are encouraged to access the VCT service.
- The collaboration with private hospitals and clinics should be made and strengthened, since most of the clients who are potentially at risk of HIV, usually go to private hospitals and clinics instead of the government hospitals. They preferred to go to the latter when having severe symptoms.
- The pattern and decision process for accessing to VCT service should be studied so as to develop the appropriate service pattern, strategy and guidance for VCT service promotion in response to the actual situation and real needs of clients.

⁷¹ UNGASS Country Progress Report, Thailand, Reporting Period January 2006-December 2007, National AIDS Prevention and Alleviation Committee, September 2008

⁷² Evaluation Report of the Five Year Program on Strengthening National Prevention and Care Programs on HIV/AIDS in Thailand, supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Institute for Population and Social Research, Mahidol University, January 2009

⁷³ Mahidol University, January 2009 op. cit.

⁷⁴ Mahidol University, January 2009 op. cit.

- The strategies on self-care and self-risk assessment for comprehensive implementation should be developed to raise the awareness for access to the VCT service. Such strategies should be included in care and treatment as well as reduction of stigma and discrimination against PLHIV and confidentiality. These would increase the uptake of VCT services.

Overall, given the human resources constraints and the increased demands created by health sector reform, VCT is largely promoted as an entry point for identifying clients who need treatment rather than also as a tool and opportunity for HIV prevention interventions.

Analysis

Indonesia's coverage of VCT and has increased significantly. However, apart from waria, the percentage of key populations accessing the services has not surpassed 50%. Access by clients of female sex workers remains very low at 10% and this an important group to reach in order to reduce spousal transmission which affects women. Almost half of people who need ART are receiving it, but the researchers note that prevention programmes are not consistently evident in all regions including the areas that were the focus of this research.

Although Laos PDR currently has limited comprehensive services coverage, several hospitals provide good examples of constructive interaction and supportive approaches to people living with HIV. These should be considered important lessons during the scale up of VCT coverage. In particular, the increase in HIV related services must not be at the expense of the provision of direct financial support to people living with HIV to access them. Hopefully the increase in service availability will reduce people's travel costs and the need to stay overnight for appointments.

Laos PDR faces further challenges in that over half of women deliver their babies at home and do not attend antenatal care services which has conventionally been a mechanism for reaching pregnant women in Thailand and Indonesia. The role of traditional birth attendants offers opportunities for reaching 20% of women, but the need to reach the remaining 55% is a challenge not easily overcome.

Thailand has an impressive coverage for prevention of mother to child transmission. Despite this, support to women to stay HIV negative, outside of the Stay Negative programme coverage, seems inadequate. Equally, there seems little program response designed to reach women with information before they become pregnant. Further challenges lie ahead in monitoring whether the changes in the health sector (especially the transfer of dedicated STI clinics to hospitals) produce any detrimental impacts of people most at risk of infection coming forward for testing and treatment. There appears to be an increase in the reluctance of sex workers, drug users and males who have sex with males in accessing these more mainstream services. These services also need to support people to come for testing with their partners, and help people living with HIV to disclose their status to their partners.

iv. Vulnerability to HIV infection among women in relationships

Some common themes emerged from the study, although within them there are different emphases. For example, for all three countries there are analyses on gender and HIV; STIs and condom use; sex work; and males who have sex with males. To take one issue, it is clear that sex work, for example, is perceived very differently despite its widespread prevalence: in Indonesia there seems to be considerable denial about the existence of both brothels and street based sex work; in Laos PDR sex work takes place mostly informally through women working in bars, although a few brothels also exist; while in Thailand sex work is largely accepted as part of life. The acceptance/denial of sex work and the forms in which it takes place have implications for how effective the HIV response is.

Both Laos PDR and Thailand have traditional practices which affect HIV transmission, namely women's abstinence from sex during pregnancy which effectively legitimizes men's extra marital sex during this time particularly. Drug use in Indonesia has a particular gender dimension because of the lack of recognition of female drug users. Unique to Indonesia is the social caste system which compounds gender inequality but adds another layer of complexity between strata of society which acts as a deterrent to disclosure of HIV status. Thailand is facing fairly dramatic changes in attitudes among young adults: increasingly women are more likely to have sexual partners before marriage.

In Indonesia there is pronounced gender inequality which fuels the epidemic – women seem to have little decision making power and are unaware of the potential and reality of their husbands' extramarital sex; in Laos PDR there are opposing expectations of relationships between men and women, with more men looking for short term relationships while women would like long term relationships; in Thailand gender inequality is less overt but there are expectations that men will have multiple partners and visit sex workers, especially before marriage, while women's sexual behavior is expected to be confined to marriage.

The analyses of the three countries does not take place in a vacuum, rather the implications for their regional positions (geographically and economically) are also taken into consideration, particularly around issues such as international migration. Migration affects countries as their citizens leave their borders to work in industries with higher risk of HIV transmission (e.g. sex work) or work for extended periods away from their families and with more opportunities for exposure to HIV and STI infection. At the same time, within countries, migrant workers are often deterred from accessing health services for numerous reasons, such as language barriers, the cost of access for non-citizens, and because of the illegality of their status in many cases.

The impact of migration can be seen in Laos PDR where significant proportions of both women and men migrate internally to the cities' industrial areas and over borders. Often men are working in the construction industry in countries like Thailand, but the vast majority of women migrate illegally and there is little way for the Laos PDR health sector to identify these women as having increased vulnerability due to their migration.

Indonesia

The rapid assessment in Indonesia revealed a recurring theme of gender power imbalance and gender-based violence was mentioned by a number of interviewees. Women's lower status means they have little negotiation ability on sexual matters within relationships. The status of female sex workers is even lower. Their low status coupled with widespread beliefs equating masculinity to virtual immunity from STIs and misinformation among men about STI prevention results in commercial sex workers having little room to negotiate condom use with their clients. A complex political climate includes political leaders who are self-declared champions of religion and who promote conservative views on issues they perceive to be relevant within Islam. The effect is to drive behavior patterns like sex work, injecting drug use and sex between males underground making identification of the most at risk women (and their partners) and men (and their partners) to STI and HIV transmission. Indeed Indonesia's response to injecting drug use is progressive in

comparison to other countries in the region. The shift in perception of injecting drug users as victims and survivors rather than criminals has paved the way for the introduction of harm reduction programmes.

Gender and HIV

Gender inequality is a major driver of the epidemic in Indonesia. In a country with a recent history of dictatorial rule and colonization, perhaps it is unsurprising that men, who have been relatively subjugated by authority, continue to subjugate women. Within marriage many men do not tolerate their wives asserting themselves, and efforts to do so can end in violence against the women. Women take responsibility for birth control and use those methods they can control themselves such as oral contraception. There is little involvement by men in maternal care. Those men who do attempt to support their partners find that health centers lack information targeted at them and often even the physical space for them to wait during their partner's appointments. Overall little information exists to support both women and men to prioritize their sexual health.

Women who sell sex are stigmatized and have little protection whether they work in brothels, bars or are street-based. Men can rent their bodies for a short time, and therefore view them as a commodity over which they have temporary ownership. Sex workers who work in brothels possess greater bargaining power with their clients and some have the ability to refuse clients who are violent or do not want to use condoms. Most female sex workers cannot negotiate condom use before money has been exchanged or the client will simply seek a sex worker who does not insist on condoms. She cannot negotiate after the money has changed hands, as the client will not tolerate changing the parameters of the transaction after payment. However, a minority of men do cooperate in condom use when requested.

It tends to be more difficult for female drug users to express themselves and show their existence in public and access health services than sex workers. Female drug users are inhibited by current drug laws that criminalize them, and are punitive towards drug users. The result is that drug users are increasingly isolated from society. Female drug users are also vulnerable to physical, sexual and psychological violence, from husbands, boyfriends, drug dealers and police officers. Their social isolation makes it difficult for this group of women to protect themselves from violence or exploitation. Female drug users find it particularly challenging to seek appropriate health care. Services are lacking to accommodate their needs and, with the exception of Jakarta, the three other cities included in the research have very little health care or services that they can access.

Although less stigmatized than female drug users, female sex workers are still regarded as a socially undesirable group and largely excluded from society. They too have little protection provided by current laws. In some places, government is acknowledging the existence of the sex industry including some brothels. Female sex workers apprehended by the authorities while working are often referred to the social affairs agency for vocational training and released at the end of the training. However, the fact that these trainings exist does not seem to have a significant impact on their choice of or options for work. In contrast to the drug users, female sex workers find that there are health services (government, private and NGOs) accessible, especially those located near brothels. These are often the services of choice among sex workers because the health workers are aware of their profession and much more likely to respond to them without prejudice.

The status of housewife is without controversy so married women have more flexibility carrying out their daily social activities. Unlike female drug users and sex workers, housewives have better access to healthcare and have more liberty in choosing how and when they access services. Despite this, stigma still remains around HIV and faced with seeking HIV information and services, housewives are still uncomfortable and experience anxiety about seeking health care. Arguably the socially acceptable status of housewife is a social norm based on patriarchal values that view the position of women as weak whether it is inside the family or in the public sphere. The tendency of women to compromise their interests for men, pushes them further towards sexual psychological and physical violence and increase their vulnerability in relation to being infected with HIV by men.

According to the data from this research, housewives are the most inhibited when it comes to making decisions related to sexual relations with their partners. These decisions include style, time and frequency of having sex. Religious doctrines and the perception that wives are obliged to serve their husbands, forces housewives to comply with their partners' requests.

"... I do it because it is my obligation as a wife. Even if I am sick and I am not in the mood for it, or just physically am not feeling well, maybe it's the religious doctrine that not to serve your husband is a sin. At the end sexual intercourse becomes an obligated service to our husbands under any circumstance." (A, Denpasar, IRT)⁷⁵

Female sex workers feel that it is more important to provide better services to their clients than with their partners or husbands. If their husbands or partners are unaware of their profession, they pretend to be inexperienced during intercourse so that the partners do not suspect they are sex workers.

"... later my husband would become suspicious, how come I am able to provide such good service, he would get an idea of my profession. It's better to be quiet about it. Whatever my husband wants, he will get it." (A, DKI Jakarta, PSK)

In sexual relations that are based on economic motives, women tend to put themselves at a lower bargaining position to their clients, in order to ensure their satisfaction, fearing that otherwise they will not be in demand, or not get clients in the future. Some sex worker participants admitted being physically abused by their clients, yet still they would not refuse a violent client when asked to serve him again.

"I actually don't like it, but they [clients] pay, and because they are the ones paying, we just go along with whatever style they want." (Z, Denpasar, PSK)

Female drug users seem to be most at ease in deciding how to have sex with their partners, compared to both sex workers and housewives. Usually, sexual activities are decided together with their partners.

"...if my boyfriend doesn't want to do it my way, I can just leave him, find another man. Especially since we're not married yet..." (C, Denpasar, Penasun)

"...with my boyfriend I am more at ease to say what I want in sex, I can communicate or have discussion about it..." (Z, Denpasar, PSK)

STIs and condom use

Gender expectations also plays a large part in the misinformation that many people have about HIV. While basic knowledge of the modes of transmission is widespread, especially in urban areas, it does not necessarily translate into protective behavior where myths perpetuate: you can tell by looking at someone if they are HIV positive; a strong man is invulnerable to STIs therefore asking a man to use a condom with a sex worker is an affront to his masculinity and an insinuation that he is unclean; remedies (from herbal mixes to large quantities of alcohol) taken before sex prevent transmission of STIs. Another factor in men's reluctance to use condoms is that a high proportion of men report that they are too embarrassed to buy

⁷⁵ All quotations are from the focus group discussions conducted by the in-country research team

condoms, and to carry them. Consequently condom use between sex workers and their clients is low, and between married or long term partners extremely low.

Women who are aware of their HIV positive status tend to be more able to negotiate the use of condoms. Positive women also tend to take more responsibility because they do not want to add further burden upon their partners by infecting them. They also remind each other to use condoms when having sex. Female sex workers, while clients might not know of their status, still try to negotiate with their clients for them to use condoms.

"...my poor partner if I don't use a condom, he will get infected. Although he doesn't know my status, I feel bad if he doesn't wear a condom. But I'm always confused when he's asking why I'm always using a condom with him." (T, Penasun, Denpasar)

"...if there is no condoms, we try to buy one first, especially with boyfriends" (B, SW, Pekanbaru)

There are many ways a sex worker would negotiate with her client to use a condom,

"...if the client refuses to use a condom, I would use all sorts of excuses, I've got my period, I don't want to join family planning, or I am afraid to get pregnant." (R, SW, Timika)

On the other hand, women with a negative status but their partners are positive tend not to use condoms.

"...when he's really not in the mood for a condom, it's a bit difficult to force him. Yes, once in a while, it's OK, or he can just eject outside." (G, housewife, Denpasar")

Housewives that are not aware of their partners' status, find it more difficult to negotiate the use of condoms. Partners feel awkward suggesting using condoms when other forms of contraception can be utilized. As condoms are linked with extra-marital sex, suggesting them is perceived as inappropriate. When housewives know of their husband's status and have children, they reason with their partner that condoms are needed to protect themselves so that they can ensure the future care of their children.

Sex work

Much of the issues around sex work have been discussed in the sections above. However, it is worth noting that sex work in Indonesia is tolerated much less by wider society than in countries such as Thailand. There is resulting pressure on authorities (from more conservative elements) to close down direct commercial sex venues (e.g. brothels). The sex work, of course, continues incognito in massage parlors and bars where owners deny its existence. There is no incentive for sex workers and brothel owners to be open about their practices because they risk either closure or exposing themselves to paying bribes to the police to stay open. This makes promoting condom use among sex workers very problematic in terms of actually finding them and their clients. But the conservative population, many of whom are in national and local government positions and want to be seen as champions of religion, also view any kind of education work with sex workers as a form of encouraging commercial sex. Overall, the conservative religious element in society is generally considered to be in the minority, but this is not reflected in their significant influence in political matters.

On the surface, sex work is considered highly anti-social, and clients of sex workers are demonized as immoral people. However there is ample evidence of large proportions of men, especially young married

men, paying for sex. Overall, there is a culture of secrecy about sex work – by the sex workers because of its illegality and by their clients because of societal disapproval despite its widespread occurrence. Among married women there is either denial that their husbands visits to sex workers, or possibly they are insufficiently empowered to know about their husband’s sexual activity outside the home.

Men who have sex with men

Gender expectations also impact on males who have sex with males. With the pressure to marry and have a family, many men do so to avoid social and familial ostracism. They continue to have sex with other men whether in long term relationships and/or through commercial sex with male sex workers. Homosexuality is illegal leaving little incentive for men to be open about their sexuality. At the same time many men do not have a public gay identity and have sex with both women and men. Many waria (transgender population) are sex workers, but not all. Male clients often view waria as an expression of femininity and therefore do not consider having sex with waria the same as having sex with men. These clients are likely to have sex with both waria and women.

Injecting drug users

Harm reduction for injecting drug users is more tolerated than preventative work with sex workers. Progressive initiatives exist in terms of methadone replacement therapy and needle exchange, particularly with the justice authorities working with prison populations. However, injecting drug users remain a highly HIV affected group and outreach is often difficult. Outreach workers lack confidence and capacity to discuss sexual health issues alongside harm reduction. But the fact that resource packs for injecting drug users do include condoms means that injecting drug users report the highest use of condoms among all most at risk populations.

While there are initiatives which support injecting drug users to bring their families and their spouses to work in a holistic manner, outreach workers find it difficult to encourage many injecting drug users to bring their partners. While the female partners of injecting drug users lack support from formal health services, especially hospitals, it is also important to note that up to 15% of injecting drug users are women and are rarely targeted with outreach. Neither female injecting drug users nor female spouses of male injecting drug users are included as indicators in most external donor requirements and priorities, and therefore are simply not targeted by programmes.

Social and caste status: impact on the disclosure of HIV status

Women with partners with similar social backgrounds tend to be more open about their HIV status. Among sex workers whose partners are aware of their profession, it becomes easier to reveal their HIV status, especially if the partners was/is also a client. But generally revealing one’s HIV status is almost impossible with clients, due to financial motives. Those sex workers whose partners are not aware of their profession, tend to keep their status to themselves fearing being abandoned or divorced.

“I don’t feel ready to be open about my status with my partner, I am afraid he will not accept me, and will want to break up.” (R, WPS, Denpasar)

“...my husband works at night, so we both know the risks.” (M, WPS, Denpasar)

“I haven’t told him about my status, he’s a white collar worker and is not exposed to these issues.” (V, Penasun, Denpasar)

Female drug users whom partners are drug users too or with partners that are aware of their drug use tend to be more open about their HIV status, also to their peers. There can be a feeling of solidarity among drug users, where they inform each other of their status and encourage each other to go for testing.

On the other hand, most housewives were tested for HIV after their spouses and children were indicated to be positive and had already become seriously ill. They believe that there were infected by their spouses as

they did not have other avenues of exposure to the virus. Most of these housewives, as they became aware of their status and that of their husbands and children, tend to keep it secret, making it a matter between themselves and their husband. A couple will often keep it from their family or in laws. The reasons for a couple keeping their status to themselves become clear when the complex extended family relationships are examined in more detail. In each city the relationships with the extended family have different characteristics, informed by values and attitudes affected by local traditions, customs, beliefs and religion.

In the city of Timika, Papua Province, for example, the social order of a household is influenced by a mercantilist tradition, where a woman is perceived to be bought by her husband. The transfer of material wealth (money, cattle etc) to the women's family is an absolute condition preceding the wedding. This system has an impact on the spousal relationship. A husband who has not yet fully paid all of his marital offerings is considered in debt to the woman's family and is obliged to complete with these payments even if by installments. As long as the payment is not complete, the woman is still under the protection of her family. On the other hand, once payment is completed, the husband has full rights over his wife as she is released from the care and responsibility of her family. If the husband were to be violent, the woman's family cannot respond as they have no bargaining position anymore. However, this does not mean the man is beyond retribution for certain actions, including bringing HIV into the marriage. This tradition has a strong impact on whether the husband is open or not about his HIV status to his wife or/and his wife's family.

"...If ever I were to open up to my wife, and she were to reveal my condition to her family, then the wife's family might just kill the husband..." (M, Timika, IRT)

Whether or not the family would go so far as to commit serious violence resulting in death, the fear of such an extreme reaction is enough to dissuade men from revealing their status to their wives in some cases. Husbands that are open about their HIV status, are usually prepared to take their wives to be tested at the clinic, and sometimes get tested together, even if they are not totally open about the reasons they are bringing their wife with them to the clinic as the following quote shows.

"...it's better to pretend to take the wives to the doctor, get tested together, than having to admit being HIV positive, we could have a fight or a family feud." (S, Timika, IRT)

Overall the participants' obedience to their customs (or sometimes their fear of them) encourages men and women to be reclusive and keep their status from their families. While a couple may be able to provide each other with support and strength, their reticence to be open with their families reflects the continuing levels of stigma around HIV.

In Bali, there is a strong traditional kinship system regulating every aspect of each Banjar's (kin) population. These traditional customs have a strong influence upon the daily lives of Balinese people. The traditional leader is identified as the head of the Banjar and is very influential in deciding which individuals are accepted as part of the Banjar community (i.e. accepted into the neighborhood). Because the Banjar system and their leaders have not been involved in HIV related issues greatly to date, they are reported to frequently make uninformed decisions about HIV positive members which are detrimental to their health or are unsympathetic to people living with HIV and their families.

"...indigenous Balinese are divided into castes, so the head of the Banjar is the person with the highest caste and the person everyone listens to. It doesn't matter if he's rich or poor or highly educated or not, but traditionally he is very influential." (R, Denpasar, IRT)

"...his family didn't want take his body, he is not accepted in this village, they said the hospital can do whatever it wanted, throw it into the water if they wanted." (F, Denpasar, IRT)

Lack of understanding among local leaders and fear of rejection and eviction were the reasons that most of the Balinese participants kept their status from their family and the Banjar. The caste system creates more reasons for people to keep their status a secret. Within a couple who are of differing castes, the partner of the lower caste has more difficulty revealing their status in case the family of the higher caste rejects them. This is more or less considered true for both men and women, although men of a lower caste seem to have slightly more confidence in being open about their status than women in a mixed caste marriage.

"...if the woman's caste is higher, the burden on the woman is not as bad as when her caste is lower than her husband's, although his family could as well request a divorce." (V, IRT, Denpasar)

In Pekanbaru, Riau Province, participants reported similar difficulties in revealing their HIV status, although the main reason seems to be the strong patrilineal culture of the Malay (Melayu) population. The differing status between men and women acts as a disincentive to be open about one's HIV status. Those who find themselves HIV positive are likely to retreat from their neighbors and social environment, and avoid being seen with positive support groups or networks. This reticence also influences health seeking decisions, as people try to avoid anyone discovering their HIV status.

The situation is very different in Jakarta, however, with a complex, varied social and cultural tapestry among its population it no longer has one dominant culture. The result is that society is much more tolerant and accepting of diversity. The sex industry and drug trafficking in Jakarta is widespread and there is no district in wider Jakarta that is not affected by both. Therefore projects and services are made available in most parts of the city including information and HIV related services related to drug use and sexual transmission. The drug industry in Jakarta is more concentrated in specific areas, the same with the sex industry, although both are mostly formally unacknowledged by the government. Yet, these industries involve a much broader sector of society including drink sellers, washers, ojek (moto-taxi), security officers etc. This situation prepares people in Jakarta to accept the impacts of HIV more readily regardless of the mode of transmission. Ultimately, despite stigma and discrimination that continues to occur, relatively speaking Jakarta offers an enabling environment for HIV positive people to live in, to express themselves and to seek health care. During the group discussion, some female drug users indicated how their living environment actually protects them.

"...usually when a police raid is underway, they tell us first, ...so that the next day when the police come, we seek refuge somewhere else, so it's better for us to hide somewhere else until the raid is over." (Y, Penasun, DKI Jakarta)

"...housewives [ibu-ibu] they feel pity for us, so when the police is coming, they hide us away so that the police couldn't catch us." (S, Penasun, DKI Jakarta)

Summary of women's vulnerabilities to HIV infection in Indonesia

- Pronounced gender inequality resulting in women's low negotiation and decision making power within relationships
- The status of sex workers is low many find their negotiation power in the use of condoms is low to none
- Commercial sex, injecting drug use, and sex between males are socially and religiously unacceptable behaviors making responses focused on these issues controversial and often accompanied by considerable opposition
- Female injecting drug users are particularly vulnerable to exploitation and violence. Harm reduction programmes do not outreach sufficiently to female injecting drug users or the female partners of drug users
- Donor indicators do not require programmes to target partners of injecting drug users or female injecting drug users
- Men's perception of their immunity to STIs and widespread misinformation about remedies to prevent infection override correct knowledge about sexual transmission of infections including HIV
- Condom use among couples where both know their status is much more likely than among couples where one or both do not know their status. Condoms are associated with people who are 'unclean'; a women (whether sex worker or non-commercial sex partner) who requests their male partner uses a condom risks insulting him, potentially leading to violence
- Stigma continues to prevent people seeking information and services. The stigma surrounding the behavior males who have sex with males deters many men from seeking health care services. While the complexities of the caste system and local social hierarchies can discourage people from disclosing their HIV status to their partners and families. It further deters people from seeking information and treatment lest their status is revealed or suspected through association with STI and HIV services.

Laos PDR

A major theme in Laos was the internal and external migration of women and men for work. 50% of the people who seasonally migrate to Thailand are women who do so illegally.⁷⁶ It is not fully known how vulnerable they are to exploitation or abuse, or to what degree they take part in the sex industry. Gender power imbalances also appear to leave women with little negotiation power about sex and contraception in relationships. While gender-based violence within relationships was not raised among respondents, it was noted several times that over a quarter of women's first sex was coerced or forced. Condom use among couples in relationships is very low. Abortions are relatively high, despite being illegal, suggesting high levels of unwanted pregnancies resulting from unprotected sex.

Conservative views about sexuality make it difficult for young people to access sexual health information and services; potentially more problematic now that the age of marriage has been raised to 19.⁷⁷ Sex work is on a different scale in Laos PDR to its neighboring countries, however informal or indirect (as opposed to brothel-based) sex work is on the increase. Very few women sell sex as their main source of income.

⁷⁶ Source: key informant interview with UNAIDS

⁷⁷ Source: key informant interview with UNFPA

Instead women who work in the service or entertainment industry (i.e. in bars) sometimes sell sex (on average two clients per week; although a minority of women may have many more). But again like Indonesia condom negotiation power is low among sex workers and their clients, and even lower among couples in relationships.

Gender and HIV

Men in Laos PDR interviewed for this study, due to their mobility and sexual practice (higher numbers of partners and/or paying for sex), can be considered to be more at risk than women of encountering the virus and infecting their long term partners. Many of the male interviewees mentioned drug use and needle sharing, abuse of *yabaa* (methamphetamine), and alcohol intoxication. Many were looking for short-term and opportunistic relationships with women. In addition, their understanding of HIV and its dangers were vague. A male construction worker said that he had no clue what a condom was when he started having sex in Thailand in the late 1980s. Among those who knew about condoms, many said "*I wanted to use them but I was too drunk to do it*".

The women who participated in the study were more stable, with less travelling, fewer job changes, and fewer partners. They claimed to be looking for a steady and supportive partner for a long-term relationship, but were somewhat ignorant about the risk of infection and the fact that their own attitude increased their vulnerability to infection. Women conscious of the behavior of their partners have little ability to make influence their partners' actions. Reflecting the sentiments of many of the female respondents, one woman said "*I have had only one sexual partner; my husband, and now I am infected*". One said that she thought that people at risk of infection were those "*going at night, drinking and looking for pleasure*". She did not include herself, as a monogamous wife and loving mother, among them.

Another female participant trusted her husband, who had been monogamous all through their marital life. However, when he started to show symptoms that she recognized from information seen on the television as potentially AIDS-related, she asked him to get tested. He refused until three days before he died, when he told her about his work as fisherman and the group sex he had had with three colleagues and one Thai woman. All the friends had died already. Her husband refused to get tested because he feared he had the same disease as his dead friends.

It is fairly acceptable among men that they will have sex outside marriage. In a 2006 survey study of married men (Toole, Cghlan, Xeuatvongsa, Homes, Pheualavong & Chanlivong, 2006), extramarital sex was practiced when their partners were pregnant and during post partum. It was also reported in this study that most sex for money was negotiated outside of brothel settings. Sex with other partners is not usually seen as infidelity but a normal part of Laos male culture. Men often do not use condoms when they have sex outside marriage (Burnet Institute, 2006). Decisions on condom use is still subjective (Toole et al., 2006).

A Second Generation Surveillance (2004) conducted by the Laos PDR Ministry of Health reported that Laotian men were not only buying sex, they also had casual sex partners. High proportions of male police officers, military personnel, and truck drivers especially those in the Central and Northern provinces reported sex with someone who was not their spouse and whom they did not pay. According to study of the military and the police, married men only used condoms with people other than their wives. If they use condoms with wives, they are used as a contraceptive (PSI, 2000).

It is common for many men (married and unmarried) to have concurrent sexual partners. Having multiple partners at the same time increases their risk of STI and HIV transmission, and the risk to their temporary and long term partners (i.e. their spouses) greatly in the short run. Women's sexual behavior patterns are moving away from traditional expectations. Whereas in the past women were likely to have one relationship in their lifetime (i.e. when they got married) women are increasingly like to have more than one sexual partner. Although women are unlikely to have concurrent sexual relationships like men, they are increasingly likely to have a series of monogamous relationships. This increases their vulnerability to HIV transmission as well but more likely in the long run and depending on the sexual patterns of their male partners.

STIs and condom use

Compounding Laos PDR's vulnerability to an expanding HIV epidemic is a low level of knowledge about the disease among the general population. According to one study reported in the World Bank-sponsored Laos PDR Gender Profile, 23 percent of respondents did not know that HIV was transmissible by blood, and more than half did not know that it could be transmitted from mother to child during pregnancy and breastfeeding. Implementing programs to increase knowledge and awareness is difficult in Laos PDR because the country is home to 47 different ethnic groups with multiple native languages and a variety of cultures.⁷⁸

There are public health messages on TV and the radio and through posters in urban areas but overall sexual health issues are not openly discussed. The result is that women and men do not prioritize their sexual health. Even when women want sexual health information or services, they do not know where to access these. One woman said *"I don't know and I have never seen these programs and places where you can get information about this disease"*. Women are more likely to come into contact with formal health services than men through their access to mother and child health care, but an estimated 75% of pregnant women do not interact with such services (especially in rural areas⁷⁹). An issue related to sexual patterns during pregnancy arose in Laos and similarly in Thailand: men are more likely to pay for sex during their wife's pregnancy. The practice of abstaining from sex during pregnancy seems to be promoted by men, rather than women as is the case in Thailand, and could be said to legitimize visits to sex workers at this time.

Men are very reluctant to seek formal and government health services and prefer to visit a pharmacy or private clinic especially with a sexual health related matter. Anecdotal evidence suggests that many men persuade their female partners to seek medication and treatment on their behalf for sexually transmitted infections, particularly if both partners have the same symptoms or infection. Conservative views among health workers about sexuality and sexual activity prevent many young and unmarried women and men from seeking information and services. Young women are more concerned about getting pregnant than contracting an STI. Despite changing attitudes of young adults about pre-marital sex (which is increasing), it seems that young women still have low negotiation power and skills, with over a quarter reporting their first sex as coerced or forced.

Despite higher reported rates of condom use, for example in service workers and their clients, there is inadequate knowledge about the prevention and treatment of STIs and HIV, particularly in issues relating to treatment seeking behavior, risk assessment with regular partners or clients, and the connection between STIs and HIV. Socio-cultural issues prevent many sex workers from using and/or negotiating a condom with their regular partner/boyfriend/husband.

Sex education and reproductive health are key elements in the national curriculum now and most students want sex education. However, such education efforts do not always reach school children as parents often object to its introduction, feeling that students are too young or that it would encourage them to engage in sexual behavior. Some teachers are entirely unequipped to discuss sex with students and are overwhelmed with feelings of embarrassment and shame.⁸⁰

Among some of the population, levels of STI knowledge are low with many people believing that transmission is through toilets, kissing and hugging (UNICEF 2003). Some people have misinformation or have heard messages that are now believed to be incorrect. For example the respondents in the interviews mention several correct ways of HIV transmission but also mention 'touching blood' and 'blood fed insects'. There is currently no evidence that either of these factors facilitate transmission of HIV.

The level of knowledge is naturally lower in more remote, rural areas, particular among ethnic minority groups where both information and services are less accessible. In the UNICEF study mentioned above, among figures for ethnic minority groups interviewed (Hmong and Khmu), awareness of HIV caused by sexual intercourse was only 62.1%. Of those who had seen a condom before, Laos Loum interviewees reported 56.9% whereas Hmong and Khmu reported 45.7%.

⁷⁸ LWU Rapid Assessment for UNIFEM, March 2009

⁷⁹ Source: Key informant interviews with UNAIDS and MSF

⁸⁰ Kay Keo, Akkhamountry. *The Increasing Susceptibility of Adolescents to HIV Infection in the Lao PDR*. March 2003. NCA (Lao PDR).

The social marketing of condoms in Laos PDR was initiated in 1999 by Population Services International (PSI), an international NGO, at the invitation of the government. Behavior change communications materials have been developed, including an intensive national mass media campaign and special 'edutainment' events using mobile vans and traditional arts such as theatre and puppetry. The program is making condoms more widely known to the general public and is also de-stigmatizing them so they can be discussed more openly. To a certain extent promotion has also been done in bars, nightclubs, hotels and other non-traditional outlets such as barbers. The *Number One* brand of condoms is available in 98% of urban pharmacies. *Number One* condoms were launched in 1999 and PSI now records 13.6 million units being sold up to now. PSI has also begun to distribute lubricant with its condoms, which is aimed at targeting males who have sex with males.

In the second round of sentinel surveys (2004), the majority of respondents had a degree of awareness of HIV and AIDS: over 90% knew a source of condoms and knew that condoms prevent both HIV and STI. Nevertheless, condom use was inconsistent with high levels of knowledge and only 57.2% of men reported always use condoms with partners who engage in higher risk behaviours. Among service women, condom use with all clients in the prior month was as low as 29% in Louang Namtha and only 41% in Vientiane Capital. The lack of condom use among service women is largely due to their low negotiation skills, low literacy, education and health as well as the financial incentives for getting paid at higher rates by clients who request sex without using condoms. From the clients' perspectives, condoms are viewed as a barrier to having satisfying or gratifying sexual intercourse.

Behavioral surveillance has shown that 72% of female sex workers claimed to have used condoms consistently with clients in the past month, although consistent use of condoms with their regular partners is still very low. Despite higher rates of condom use amongst sex workers, rates remain low among the general population. The common and primary understanding of condoms as protection against STIs including HIV was shared by most couples. They also knew that condoms can be used as contraception but couples in both groups were not using it for family planning. A middle-aged husband was advised by his doctor to use condom as a contraceptive but he never complied. According to the participants, if couples trusted each other, condoms were never part of the equation. There should be little or no opportunity to have sex outside marriage since the village is far from the city and there were no drinking bars or other entertainment places nearby.

Household surveys on sexual behaviour by PSI show that almost 30% of married men interviewed reported having multiple partners in the past year and 27% of those had never used a condom. In another study (NCCAB 2001) the majority of men who had sex with girlfriends and commercial partners used condoms. In relation to girlfriends, 43.0% of men used condoms every time and 18.0% of men used condoms sometimes. With commercial sex partners, 71% of men said they used condoms every time and 14% of males used condoms sometimes. Meanwhile, among girls who had ever had sex, 33.3% of them used condoms. None reported using them every time and all reported using condoms sometimes. According to the focus group discussion for this study, many participants shared their concerns and constraints to buying condoms:

"Some people are poor and have not enough money to buy condoms. Lack of money to purchase one at the time of need can lead you to getting infected."

Even when condom use and safe sex are understood, gender imbalances prevent women from being able to use a condom when having sex. This is particularly low amongst ethnic minority groups. Carrying condoms is generally associated with female sex workers and so it is still a cultural taboo for non-sex worker women to carry them. Many sex workers, particularly in rural areas, lack negotiating skills about safer sex as well as the ability to seek treatment.

For non-sex workers, as already mentioned, it is quite common for men to practice extramarital sex and their spouses are often aware of this but do not have any power or ability for traditional cultural reasons to be do anything other than accept it. Some women reported that they are totally dependent on men and have no decisions to make in matters of sex. In the female group discussion, some women reported that they cannot refuse their husbands sex:

"My husband is a play boy. He goes away and commits adultery with other women and prostitutes. When he comes back, I have sex with him. Even when I am annoyed, I cannot deny him sex."

Sex work

In Laos PDR, there are few direct⁸¹ sex workers; instead 'service women', working in entertainment places (such as beer bars), sell sex occasionally or often to customers. Condom use among service women and paying clients is very low as is condoms use between these women and their regular partners. Within non-commercial relationships service women seem to have the same low negotiation power in sexual relationships as their female counterparts who do not sell sex.

It is important to note that sex work is evolving in Laos PDR. LWU's analysis goes as far as stating that the rate of selling sex has risen sufficiently that it can now be considered commonplace. LWU explains the recent changes: although officially labeled 'service women', most of these women are in fact sex workers and are travelling both within and outside of the country in significant numbers. Not all migrants are sex workers, and not all sex workers migrate, but there seems to be significant overlap between the two behaviours. The rate of HIV among service women is one of the highest out of all the population groups. Unlike Thailand in the early 1990s, sex workers operate in a far less organized environment; brothels are rare and most sex for money is negotiated in entertainment sites such as bars, drinking establishments and nightclubs. The nature of the work is also sporadic, transitory, and constantly shifting.

The most common clients are from certain groups such as transport workers and those who travel, such as businessmen, civil servants, the military and police and tourists. A behavioral surveillance study revealed that 32% of truck drivers and 24% of police interviewed reported three or more partners in the past year; approximately one third of truck drivers and one quarter of police reported paying for sex in the past year. In terms of the sellers, 61% of service women interviewed reported selling sex in the past year.

Recent changing dynamics in Laos PDR, which could potentially increase HIV transmission amongst this high-risk group, include a more visible population of street-based sex workers in some provinces and also more underground groups of women selling sex through mobile phone networks. In addition, sex tourism from Thailand and, potentially, other countries is on the increase as young women in Laos PDR are thought to be 'cleaner' and thus 'safe from infection'.⁸² One young woman reported earning USD \$500 for having sex with a foreign tourist who wanted to have sex with a virgin. In general male clients are reluctant to use condoms and often will not negotiate after payment. Existing surveys (for example of male electricity workers) show that up to 50% of men pay for sex on a regular basis.⁸³ There have also been recent signs of identifiable males who have sex with males and transvestite populations showing high-risk behavior, including more males selling sex, although this is conducted in a more covert fashion.

Sex workers and their clients are frequently stigmatised by health service providers and society in general deterring them from seeking care, encouraging them to practice self-treatment or to seek care from less skilled providers. Many Government employees and policy makers (particularly at higher levels) continue to link HIV with 'deviant behavior', which goes against strongly felt national cultural values. Therefore initiatives are still not reaching the groups at high-risk e.g. commercial sex workers. Many high level government staff do not discuss or face the challenges openly, which has detrimental effects on efforts attempting to combat the problem. Despite feelings among donors that views such as these are decreasing with more positive actions being taken, recent rumours have been circulating of the local authorities

⁸¹ *Direct sex workers is a term often used to describe individuals who sell sex as their primary or sole occupation, whereas indirect sex worker are those who sell sex on a more irregular or informal basis*

⁸² *FHI*

⁸³ *Source: Female Sex Worker and Male Electricity Workers Second Generation Surveillance (3^d Round), CHAS*

arresting service women who had met for a workshop organized by an international organisation in Louang Prabang. This indicates that negative views are still visible in some areas of the country.

Men who have sex with men

Many males who have sex with males are married to women or have both male and female sexual partners outside marriage. With a high HIV prevalence among males who have sex with males there is an increased risk of transmission to their male and female partners. A recent survey among males who have sex with males in Vientiane Capital showed that 30 out of 540 men (5.6%) tested positive for HIV, of whom 43% were men who had also a female sex partner in the last 3 months.⁸⁴ Many of the men who participated in this survey had sexual experiences with both men and women. Even though 85% of men knew that unprotected sex is a high risk behavior, only 24.2% of them always used condoms with non-regular partners in the last 3 months. It is important to note that the HIV prevalence figure is ascertained from Vientiane only and not nationally representative.⁸⁵

Traditional practices

Many ethnic groups have very open sexual practices and many people start having sex at a very early age. For example, young people commonly have sex before marriage and extramarital sex with sex workers is a common practice. It is also very common for young women to become pregnant and deliver a child before marriage, which can happen when women are as young as 12 or 13 years old. It is also acceptable in Katang culture for young men to have sex with many people.

This can have very serious implications for the spread of HIV, particularly in these areas of low education levels (or none at all), poor reproductive health awareness and poverty. So far, much of the responses attempting to address these issues have found both language and cultural barriers and so it remains a sensitive area. Each ethnic group requires individual consideration when addressing HIV/AIDS although it seems that they are being discriminated against for having such practices rather than being educated on making these practices safer.

Sex during pregnancy is considered taboo, and seems to be a widespread belief that both men and women adhere to. In part it may stem from protecting the fetus in the womb. Consequently during pregnancy there is an implicit understanding, and even expectation, that men will have find alternative sexual partners paid and/or casual. As part of UNICEF's work with pregnant women, the agency has published a booklet explaining how sex during pregnancy can be safe in order to support couples reduce the need for extra marital sex.

Migration for work

Laos PDR challenges the stereotype of 'mobile men with money' in several ways. A recurring theme with many respondents is the vulnerability of HIV transmission among women (and their partners) who seasonally migrate for work. Women make up 50% of the population who migrate externally (usually to Thailand) but unlike their male counterparts they work abroad illegally. These women usually cite 'domestic work' as their occupation in Thailand but it seems that little is really known about what they actually do. Whether they work in the domestic or entertainment sectors, there is potential for them to be highly sexually active, engaged in commercial sex and/or vulnerable to sexual exploitation. UNICEF has found that 80% of those infected with HIV in Champasak Province in Southern Laos are returned migrant workers who went to Thailand.⁸⁶ Without the legal right to be in Thailand their ability to negotiate a safe work environment, safer sex, the justice system (in the case of violations of their rights) and access health services are bound to be much lower than the ability of Thai women.

While people who attend VCT clinics are asked their occupation, identifying migrants on their return is not an easy process. There is no incentive for a women to declare she has recently been working illegally in Thailand, and even less to reveal to a formal health care workers that she was sexually active (whether commercially or non-commercially). Migration within Laos PDR also occurs as women and men move to

⁸⁴ Draft report on assessment of HIV infection and risk behavior among population of men who have sex with men in Vientiane capital, Lao PDR, 2007.

⁸⁵ Source: Participants at Lao Stakeholders Meeting and UNGASS 2008 Country report

⁸⁶ Cited in Lao Women's Union's rapid assessment report for UNIFEM, March 2009

urban centers often to work in factories and other large industries. Many migrate independently and many join recruitment drives initiated from the cities.

Stigma and discrimination

According to participants in LWU's research, one aspect of stigma is that people who are HIV positive are afraid that other people will find out about their status. In the workplace, people living with HIV experienced stigma from their co-workers and employers, such as social isolation and ridicule, or discriminatory practices, such as termination or refusal of employment. Fear of an employer's reaction can cause a person living with HIV anxiety. A police officer who is living with HIV said:

"I have to stop my work at the Ministry of Security because I am afraid that they will know my HIV situation and I have to avoid to face my working counterparts to keep this secret."

Alcohol and drug use

Alcohol and the use of amphetamines are increasing in Laos PDR, particularly amongst young people who are also starting to drink and take drugs at an earlier age. Both substances lead to higher risk behaviour such as sex without condoms which has been raised by young people in discussions about HIV and AIDS.

Injecting drug use is uncommon in Laos PDR although the use of oral illicit drugs, particularly amphetamines, is becoming more common, which is increasing higher risk behaviour. The NCCAB⁸⁷ reports that only one person has contracted HIV through injecting drug use to date although no specific studies have been conducted in this area.

Summary of women's vulnerabilities to HIV infection in Laos PDR

- Seasonal migration for work is a major vulnerability factor for both men and women. 50% of people who migrate externally (especially to Thailand) are women who work in the domestic services or entertainment industry with no legal status or protection. Significant internal migration also occurs from rural to urban areas.
- The risk of STI and HIV transmission is low in Laos and consequently perception of risks and therefore condom use are also very low.
- Most people don't know their HIV status exacerbating the risks of HIV transmission within discordant couples for both women and men. (At Mahosoth Hospital VCT clinic in Vientiane approximately a third of discordant couples the women is positive and the man is negative.⁸⁸)
- Sexual health issues are not openly discussed or prioritised by men and women.
- Few women engage in commercial sex as their sole source of income but many women in the service industry (i.e. working in bars) sell sex sometimes, and increasingly commercial sex is becoming accessible on the street and by telephone.
- In Vientiane there is a high HIV prevalence among men who have sex with men, making them and their partners (both male and female) vulnerable to HIV infection.

⁸⁷ National Narcotics Committee

⁸⁸ Source: Key informant interview with Mahosoth Hospital

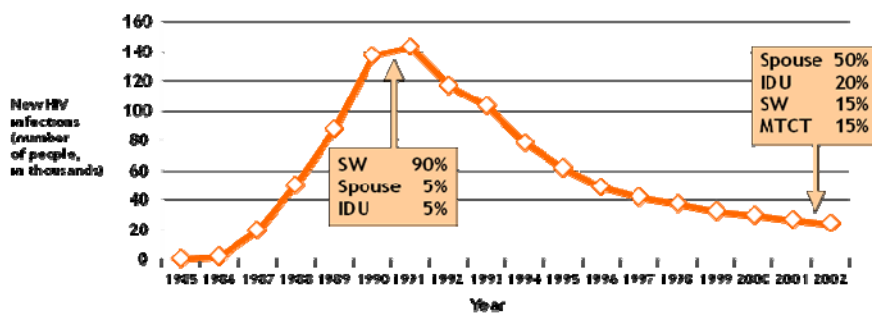
- Gender inequality reinforces women’s low negotiation power in sexual relationships (including condom use in commercial and non-commercial sex) and increases barriers to their access to information and treatment.
- Men’s reluctance to attend clinics or seek treatment means they don’t prioritise their or their partner’s sexual health.
- The highly dispersed population in rural areas have very low coverage of services.
- The sexual patterns of men often include having multiple concurrent partners and the sexual patterns of women include having serial monogamist relationships.

Thailand

There is widespread knowledge of STIs and HIV among women and men in Thailand. But adverse affects of the 1990s 100% condom use campaign are beginning to surface: condoms are firmly associated with sex work, and therefore it is socially unacceptable to suggest condom use with a regular partner; the initial success of the campaign is being eroded by the closure of dedicated sexual health clinics; the enormous public health message drive was not aimed at protecting the rights and health of the sex workers who now find it difficult to access sexual health services in the recently decentralized system; a similar campaign for today’s contemporary young adults (including sex workers) does not exist translating into their low self-perception of risk of STIs.

However, the 100% condom use campaign of the 1990s is not the major concern for the evolution of the epidemic in Thailand. Gender inequality prevails within relationships including in relation to sex. Sexual and reproductive health policy and practice reinforces women’s lack of power in several ways. Women often receive little information about the nature of STIs they receive from their husbands and the widespread promotion of chemicals and sterilization for contraception and cures (e.g. hysterectomies for cervical cancer) rather than prevention pose risks to women’s current and future health.

Estimated number of new HIV infections in Thailand by year and changing mode of transmission



Spouse: heterosexual transmission of HIV in stable partnerships; SW: HIV transmission through sex work; IDU: HIV transmitted through injecting drug use; MTCT: mother-to-child transmission of HIV

SOURCE: The National Commission on HIV/AIDS in Thailand, 2002
 UNAIDS/WHO Collaborative Programme on HIV/AIDS

Gender and HIV

Most women are brought up in accordance with a social expectation of being “good” daughters. Within marriage, women’s vulnerability to HIV infection is related to their conjugal relationships and a social expectation of being “good” mothers and wives.⁸⁹ Much research suggests that HIV infections among women within conjugal relations are caused by their inability to negotiate safe sex with their partners because of, for example, the attitudes to and behavior of condom use, revealing their blood test result to (or concealing it from) their partners in case of living with HIV, and spousal or partner power relations.⁹⁰ In many cases, women are faced with violence from their spouse/partner or other people.⁹¹ The vulnerability exposing women to the risk of HIV/AIDS from their spouse/partner includes the following:

Economic vulnerability – many women have lower educational experience, leaving school to manage household tasks or prioritize education for male siblings. This causes them to lack occupational knowledge and skills as well as chances to access sex and reproductive health education in the formal education system. Women move to access work, and marry to gain economic stability, often leaving work once they are married. Their economic vulnerability was also related to the fact that their spouse/partner worked outside the community, which increased the likelihood of him buying sex or having extramarital sex and exposing himself and his wife to STIs.⁹² Women living in poverty are more likely to sell sex, whether married or not, and the lower a woman’s educational status, the less likely she is able to negotiate safer sex with clients.

“My husband knew that I’d sell sex on this side (Thailand). He didn’t blame me for this. Other people in my family also knew this. If I hadn’t done this, I’d have had no money to buy food. After farming season, I had nothing to do.”

Wan, a 30-year-old Laos woman living with HIV, and former sex worker (In Prapasiri: 2005)

Economic vulnerability also affects whether women will disclose their HIV positive status. Many fear rejection from their partner, but also from the wider community whom they may rely on as customers for their business.

Socio-cultural vulnerability - Family background, parenting methods, and socio-cultural contexts also affected the agency of the women in negotiating safe sex. Being brought up in a broken family, a family that was strict with daughters, a family in which the father used violence, or a family that adhered to the value of masculinity obviously as a Chinese-Thai family affected the learning processes and cultivation of male and female roles and duties as well as lifestyles of women at a great extent.⁹³ The view that an important duty of women is to be a good wife and to live in another family forced them to be trained by their mother in household work and looking after other people in family.

Patriarchal vulnerability (gender, sexuality and power relations) – being brought up under the values of being “good” women, the women interviewed believed that conjugal relations and marriage should be based on love and that being a good woman was related to preserving her virginity for her first husband; having no premarital sex; and performing duties of a good wife – doing household work, having fidelity, believing and conforming to her husband, looking after him and other family members, responding to his sexual desire, and giving birth to children to succeed their family.

The double standards of patriarchal values and beliefs allowing men to have freedom outside home, to learn about sex ,have sexual freedom before and after marriage, and to have power to make a decision on

⁸⁹ Mahidol University 2009 *op. cit.*

⁹⁰ Prapasiri: 2005, Wongklom: 2006, *The Thai Women against HIV-AIDS Taskforce (TWATF): 2008; Upariphutthikhun: 2007*

⁹¹ Prapasiri: 2005, Wongklom: 2006, *TWATF: 2008*

⁹² Boonmongkon: 2000; *Interview with Women Living with HIV, 2008*

⁹³ Wongklom: 2006, *Upariphutthikhun: 2007*

condom are used to confine women to the convention female responsibilities. As a result a large number of housewives acquire HIV from their husband due to their inability to negotiate safer sex and the ability of their husband to have extramarital sex and his expectation to have sex with his wife on his terms.

"If I'd asked my husband to wear a condom, I'd not be like this. He didn't buy sex from sex workers, but had a relationship with a singer. When he went out to another province, they always met each other. It seemed he had his own belief as Thai men in general that women who aren't sex workers might not have the disease."

Tum, 30-year-old Thai woman living with HIV, who used to be a housewife and is currently a leader of Women Living with HIV(Interview, 2008)

The patriarchal power relations increased women's vulnerability of HIV not only due to non-negotiable sexual relationships but also due to sharing needles when they and/or their partner were injecting drug users. Within their relationships, women's male partners tended to have superior power to theirs. Due to the fact that the position of blood veins are either difficult for women to find or they lack confidence to inject themselves, women often need to ask their male partner to inject them. Accordingly, these women are beholden to their male partner. Even if they don't usually share injecting equipment, there may be times when a woman's vulnerability to HIV infection is greatly increased if she can't access clean needles, or she may choose or be forced to sell sex, or she may be vulnerable to sexual coercion or violence.

Individual vulnerability – Every woman has different characteristics, personalities, attitudes, viewpoints, and experiences of sexual relationships and reproductive health as well as awareness and ability to protect themselves and their partner from sexually transmitted infections (STIs). These are all important factors for protecting themselves from HIV infection or receiving more viral load from their partner or for protecting their partner from getting infected with HIV from them.

Most women defined conjugal relations as related to marriage, possession of husbands, nature, and a duty to give birth and respond to sexual desire of husbands.⁹⁴ Sexual partners may be classified into temporary or permanent sexual partners according to the type of sexual relationship.⁹⁵ Types of sexual partnership and their meanings are factors that affect the safer sex practices of women and their partner.

Some sex workers realized they could protect themselves from acquiring and transmitting HIV to other people through regular condom use with clients but failed to negotiate safe sex with their spouse/partner by using condom for several reasons. Some loved and pitied their partner living with HIV; and some feared that their husband would blame them that they did not trust him.⁹⁶

The first sexual relationship of some women was a consensual one but of some it was coercive. Many married more than once or had overlapped relationships because they did not know that their partner had already a wife or a partner. Many of them had sex with other men in revenge of their husband that had left them. Some had a female partner whilst still keeping a relationship with their husband and did not reveal their blood test result to either of them. These factors increased women's vulnerability to acquiring and transmitting HIV. The vulnerability did not depend so much on the number of partners but on a woman's inability to negotiate safer sex and their lack of awareness and perception of their susceptibility to STIs and HIV/AIDS.

Disclosing a HIV positive blood test result is more of a problem for women than men because it is related so closely to a woman's social value. For women, telling someone about HIV infection is admitting to the loss of their virginity loss or their "immorality" as a result of having sexual experience.⁹⁷ Many women concealing their blood test result from their husbands had married more than once and could not tell from

⁹⁴ Prapasiri: 2005, Wongklom: 2006

⁹⁵ Yoddumnern-Attig et al 2006, Wongklom: 2006

⁹⁶ TWATF: 2007, and Interview, 2008

⁹⁷ Thawesit and Punpung: 2008

whom they had been infected with HIV.⁹⁸ Choosing to conceal or disclose the blood testing result to the partner living with HIV is an important factor significantly affecting HIV infection because it is directly related to the awareness and responsibility for safer sex practice. If a woman conceals her HIV positive test result from her husband, she is very likely to fail to negotiate condom use or safer sex. Despite reasoning about contraception, if her partner refuses to use a condom or removes it while having sex, she can do nothing about it.⁹⁹ The research 'Voice and Choices of HIV-infected Women in Thailand' shows that among the group of women whose partner did not know their HIV infection status, there was no condom use. The women gave the following three reasons for using no condom: 1) Condom use is a symbol of HIV infection. 2) Condom use is a symbol of distrust. and 3) They did not want to have family conflict, especially in case their partner did not like condom use. As for women whose partner knew their status of HIV infection, they regularly used a condom or abstained from having sex.¹⁰⁰

Due to social values, which do not give women a chance to learn about sex before marriage and suggest that good women do not talk about sex or express sexual desire, most women learned about sexual practices from their husband.¹⁰¹ Even when experiencing sexual desire, they could not tell their husband through a direct request and opted for non-verbal communication, i.e. creating a good atmosphere around the house or some gestures. Their husband might or might not understand or might or might not respond to them. Almost all women said their husband usually initiated sex.¹⁰² Some said that a sexual act with their husband occurred because of their duty rather than their own sexual desire.

"...I used to experience non-consent sex despite being my partner or husband. But I didn't negotiate it. I didn't dare to tell them that I didn't like or want it or I wasn't ready to do it."

Yok, 36-year-old living with HIV (Wongklom: 2006)

Apart from performing a duty of good wives to respond to their husband's sexual desire and fulfilling their own sexual desire, they had sex because they wanted to have a child, which made them communicate with their husband about their sexual desire so that they did not use a condom for HIV prevention.¹⁰³

Their husband was the first person teaching them about sex and different patterns of sexual acts. Although they did not like some forms of sexual activities, e.g. oral and anal sex, their love and desire to please their partner or thinking that it is a duty of good wives made many of them do so and increased their vulnerability to STIs/HIV because they lacked negotiation power and knowledge of protecting themselves from HIV from different patterns of sexual acts.¹⁰⁴ In addition, women can confront physical and psychological violence if they refuse their husband's request for sex.

When having sexual desire, some women chose to have safe sex without depending on a partner through, for example, masturbation. Despite knowing how to masturbate, many women do not do so because they associate masturbation with women who have high sexual desire or are obsessed with sex. In addition, the fact that the women had never explored or touched their genitals completely discouraged them from masturbation experiences,¹⁰⁵ thus increasing their vulnerability to HIV because they had to depend on intercourse to respond to their sexual desire. As for female drug users, some kinds of drugs affected their health; for example, causing vaginal dryness, which increased their risk of HIV infection because there might be wounds or tearing in their vagina caused by sexual intercourse.

⁹⁸ Prapasiri: 2005

⁹⁹ Wongklom: 2006, Upariphutthikhun: 2007

¹⁰⁰ Yoddumnern-Attig et al 2006

¹⁰¹ Wongklom: 2006

¹⁰² Prapasiri: 2005

¹⁰³ Upariphutthikhun: 2007

¹⁰⁴ Prapasiri: 2005, Wongklom: 2006

¹⁰⁵ Wongklom: 2006

There is no doubt that the Thai government has invested resources to promote the prevention of HIV transmission. Mahidol University in Phase B of the research¹⁰⁶ offers an important analysis on the gender expectations placed on women through the government's approach: Arguably, the campaigns for HIV prevention are based on mainstream social values about gender and sexuality, and focused on heterosexuality within marriage, which coexist with the values of monogamy, fidelity, and having a warm family. The exclusive promotion of these ideas have the effect of dividing women into two groups, namely "good" women, who lead their life in accordance with sexual patterns under marriage as monogamous housewives; and "bad" women, who have sex before marriage, concurrent relationships, numerous relationships, or who exchange money for sex.

The government's policy and program implementation on HIV prevention and treatment for women was based on an epidemiological approach which covers only a certain amount of women who are identified as at risk. As a result, a large number of mainstream women are excluded who are from different socio-cultural backgrounds and identities. Many Thai women still face vulnerability to HIV infection because they cannot negotiate safer sex practices due to an inferior economic, social and educational status. Relevant government policies reflect a certain gender-bias of policy makers, who view sexual matters in a negative way and focus on controlling the sexuality of women without issuing the same policies to men. Furthermore, the implementation reveals a lack of awareness of women's rights and how to empower them to negotiate safer sex with their sexual partners.

"At that time, my doctor told me that my baby will be infected and could live for around 3-4 years. He told my husband that our baby was infected with HIV. He didn't tell him that the baby 'might' be infected with it from me. Before, there was only AZT, which cost around 10,000 baht per month. The doctor told him that if I wanted to have an abortion, I had to go back to see him and if I wanted to have an abortion, I had to be sterilized and my husband had to sign a consent form. I thought a lot about my children. The first was very young and the second in myself. I worried about what I should have done if I'd given birth to the second one. I didn't want my baby to be infected with HIV from me. If delivered, he or she would have had a short life. Then, I decided to have an abortion."

Tum, a 39-year-old Thai woman living with HIV, former housewife and current leader of
Women Living with HIV

(Mahidol University, Interview, 2008)

STIs and condom use

The 100% condom-use among sex workers has been very successful in terms of lowering national HIV prevalence. The tolerance of brothels meant their relative easy identification for targeting, while the technical illegality of sex work was used as leverage to persuade brothel owners and sex workers to use condoms or be shut down. Mahidol University's analysis notes that the programme aims to directly control the sexual behaviors of female sex workers. It clearly states that female sex workers have a higher risk of HIV infection than male clients because a client usually has sex with only a sexual partner per day or not many partners per month while a female sex worker provides sex services to many men per day.

According to the government, it can be said that the number of sexual partners is a significant indicator of the level of the risk of HIV infection. From this perspective, the 100% condom-use programme is seen as the best measure to protect female sex workers from HIV infection. It assumes that the power of safe sex negotiation lies with the female sex workers because female sex workers choose their clients (in general) and, therefore, it does not control or violate female sex workers' rights. However, in reality, not all female sex workers have the power to choose their clients and to negotiate safer sex with all of their clients.

¹⁰⁶ Mahidol University, 2009 op. cit.

The programme does not protect sex workers from acquiring HIV through other channels, e.g. through non-commercial sex with a HIV positive sexual partner without protection or sharing injecting drug with other HIV positive users. The programme cannot reach indirect female sex workers.

Despite high levels of condom use reported by sex workers (i.e. 90%) a lower percentage is reported by their clients (i.e. 60%). The laws which make condom-use compulsory also provide an incentive for sex workers to report higher than actual levels of condom use. Another factor could be that there are sex workers not captured in surveys that also do not access any sexual health services i.e. large numbers of non-Thai women, potentially the many Laos women who come to Thailand to work in 'domestic services'. If significant proportions of these women sell sex while they are in Thailand illegally they may have less negotiation power with their clients to insist on condom use. They may also miss out on public health messages and sexual health information because their first language is not Thai. Whatever the reason for the discrepancy between Thai sex workers' and Thai clients' reporting of condom use, it seems that many male clients are having unsafe sex with female sex workers as well as with their long term partners or wives.

Condom use between men and women in relationships (long term and married) remains very low. A consequence of the 100% condom-use programme is that it has firmly associated condoms with "sex with female sex workers" and the wider general public view the condom as sign of "distrust". As a result, it becomes an obstacle to the campaign for safer sex practices between regular sexual partners or those of the same or different HIV blood test results.¹⁰⁷ Men are unlikely to use condoms with their wives, girlfriends or casual partners because it suggests disrespect towards non-commercial partners, as if they are treating their wives as sex workers. Also, men report disliking using condoms because they reduce sensation. Therefore, while using them with sex workers is considered a necessary albeit undesirable practice, their desire to have sex without condoms can be met by their wife or other non-commercial partner.

The association of condoms with sex work also makes it difficult for married men and women to ask each other to use them: a woman suggesting condom use to her husband can be considered an accusation that he has been paying for sex or having sex with another non-commercial partner (the double standard of intolerance of women's extramarital sex means the possibility that a woman has had extramarital sex is rarely considered). Equally for a man to suggest using a condom with his spouse is tantamount to admitting to having extramarital sex. These are however generalizations. While there remains gender inequality between women and men in Thailand, some women report that they do insist on their husbands using a condom when they suspect or know him to have had commercial sex.

Condoms are not used for STI protection within relationships and marriage, and nor are they prioritized as a form of contraception. Contraception is considered a woman's responsibility so women use forms which they have control over. Condoms necessitate male cooperation unlike oral contraception, injections, intrauterine devices and sterilization, all of which have implications and higher risks for women's health than condoms. Female condoms have been introduced although availability is not widespread. The second generation female condom, with improvements based on feedback from earlier consultations, will soon be launched in Thailand.

During pregnancy is one of the main opportunities for Thailand's HIV response to interact with women. But this reliance on interacting with women during pregnancy and the overall family planning policy has the potential to put both women and men at risk. Family planning's ability to intervene in preventative approaches is very limited, especially for those women who have finished having children and therefore will not attend antenatal care. These women are most likely to seek medical help only after they or their husband is symptomatic which could be years after infection. For those male partners who are infected first and know their status, they may be able to hide their status and treatment from their wives or partners. When women are attending antenatal care, provider initiated HIV testing does not include the male partner in the VCT creating a situation where women are blamed within the relationship for testing positive which can lead to rejection and violence.

The widespread use of sterilization after the desired number of children limits women's negotiation to use condoms in relationships. The emphasis on sterilization and treatment is neither preventative nor educational. Women infected with human Papillomavirus are often advised to have their cervix removed without any explanation of the root causes of disease. In the case of newly married women who contract

¹⁰⁷ Mahidol University, 2009 *op. cit.*

STIs they are frequently informed by doctors or other health professionals that this is normal and due to being newly married, rather than being informed of the causes or supported to bring their husband for treatment. The health care system needs to review how it intervenes with both women and men in relation to all diseases especially STIs, and how it impacts on gender inequality. The health system must approach its objectives, not only from a public health perspective but also from the perspective of men's and women's empowerment.

The government has introduced policies for the prevention of vertical (mother or parent to child) transmission of HIV. Mahidol University's research identified a number of shortcomings in their implementation. Many hospitals ceased to provide HIV-infected pregnant women with abortions, propelling those that want a termination towards illegal and unsafe abortion procedures. Pregnant women confront various problems: being coercively persuaded by health providers to have their blood tested when using antenatal services; being coerced into abortions or carrying the pregnancy to term; being coerced into sterilization; and coerced into receiving antiviral drugs and confront the many effects of antiretroviral drugs. A further criticism of the programme is that it prioritizes prevention of HIV transmission to children rather than among women. Women who test HIV negative are not provided with support to remain negative, while women and men who test positive also lack information, for example on preventing re or cross infection.

"I didn't know about exchanging the infection. I've just heard it. Now, I don't take antiretroviral drugs because my coworker at the center who's taken them has skin problems. Her scalp skin is peeling. My boyfriend and I don't want to take them. My CD4¹⁰⁸ isn't low. I don't need to take them."

Jan, a 33-year-old Thai woman living with HIV, whose partner had the same blood testing result (Interview, 2008)

Sex work

Heterosexual transmission of STIs including HIV is concentrated in sex workers and their clients. The sex industry is a relatively accepted part of Thai life, despite being technically illegal. Men and women expect unmarried men to have commercial sex. While married women usually dislike their husbands visiting sex workers, they often tolerate it and do not view the practice as a serious breach of trust. Women would much prefer their husbands to visit a sex worker occasionally than to have a long term relationship.

The most detested form of extramarital sex by women is when their husbands have a girlfriend or 'minor wife' which threatens their own family's security because of the drain on their husband's financial as well as emotional resources. In this scenario women would much prefer their husbands to visit sex workers. When sex is paid for, women view it as a form of entertainment for men and their security is not threatened as long as their husbands do not drain the family's resources by spending too much money on commercial sex.

Traditional practices

There is strong societal expectation of men to get married and have children. The fact that women in Thailand do not have sex during pregnancy and the view (of both men and women) that men's sexual desire is pronounced and in need of fulfillment, mean that women are most likely to tolerate their husbands visiting sex workers during pregnancy. This could explain why so many new infections in female spouses are being identified during their second and third pregnancies.

The widespread practice of no sex during pregnancy has not been studied in detail as far as can be determined by this assessment. Anecdotally it is thought that it is women's preference not to have sex during pregnancy, rather than men's as is the case in Laos.

¹⁰⁸ CD are white blood cells, which are main agents for eliminating and controlling germs and have a role in increasing body immunity to fight against germs. Examining CD4 is related to counting the number of white blood cells of CD type in blood of 1 microliter (around 1 drop). Normally, the value of CD4 in a healthy person is more than 700. The value of less than 200 shows immunity deficiency (Information from the AIDS Access Foundation).

Young people's increasing levels of sexual activity

Mahidol University's research examined the sexual behavior and attitudes of young people. Thai young people tend to be more sexually active than in the past especially in the form of cohabitation. The number of new HIV cases among the youth has also increased continually, especially among young women. Many young men and women who live with HIV are unaware of their status or unlikely to disclose their status to their partners due to fear of their partner abandoning them or refusing sex. These factors lead to an increase in HIV transmission and re-infection in the context of refusing condom use, which results from fears that condom use would make others suspicious that one has HIV, or increase the perception of one as engaging in inappropriate behaviors.

A key differences in attitudes towards sex between young men and women is that women view sex as a result of love and affection, while men view having sex as the satisfaction of a sexual need or resulting in love. The reasons young women have consensual sex include: sexual desire; fear of rejection if they do not have sex with their partner; competing with their female peers; as part of indirect sex work to pay for their studies or keep up with the latest consumer fashions. Among many young women who exchange sex for gifts and money, there is little awareness of STIs transmission, and little condom use because they do not wish their partners to know that they have other sexual partners.¹⁰⁹ Most young women believe that using condoms is the man's duty, and view using condoms as a sign of having sex with female sex workers or with women who have had sex with several men already. After marriage it is not necessary to use them.

The use of condoms among young people is more likely to be for birth control than for protection against HIV or other STIs.¹¹⁰ Islamic young women tend to believe that condoms are not necessary if one follows religious principles strictly.¹¹¹ Young women who are already having sex are unable to negotiate condom use with their male partners because they dare not raise the subject with their partners, afraid of being perceived as sexually experienced.¹¹² The reasons that women young women have non-consensual sex include: coercion by their partner or his friends (sometimes by invitation from her partner); rape committed by their partner, family members or acquaintances. In these kinds of situations, young women do not have any opportunity to negotiate for consensual and safer sex.

For those young people who have left the family home to continue their studies in town or city schools, they have the liberty to choose their lifestyles. Plentiful free time, loneliness, the need for love, warmth and various kinds of assistance from a partner all influence the decision to have sexual partners. Young people may also consider having a partner as a measure of one's own value, 'coolness' and modernity, and being sexually active is a choice representing freedom and maturity.

Young people generally receive sex education in junior high school but the content is limited. It may include the anatomical differences between male and female sex organs and the changes that occur in teenagers' bodies during puberty, but little attention is given safer sex, birth control equipment, STIs, or sexual harassment. Gender related beliefs affect the learning processes involved in youth sex education, with many women saying they would prefer to study the subject with a female teacher, and to have gender-segregated learning groups because they feel embarrassed to study the subject together with their male classmates. Young people view HIV prevention and birth control through gender roles, believing that men should have more knowledge about the use of condoms than women, as men are the group actually wearing them, and that women should know more about contraceptive drugs or female condoms, as women are the group using these types of equipment.

A problem encountered in sexuality education is that teachers may be reluctant to speak about sexual matters, explain the benefits or demonstrate the use of birth control and STI prevention devices as directly and comprehensively as they should. This creates confusion among the students. The personal experiences of the person providing the sex education classes also constitute a factor affecting the credibility of the teaching, as young people generally view that the person teaching sexuality education classes should personally have had sexual experience.

¹⁰⁹ *Raks Thai Foundation, Youth Team, no date*

¹¹⁰ *Raks Thai Foundation: 2006*

¹¹¹ *Thai Women and HIV/AIDS Task Force: 2007*

¹¹² *Youth team, no date*

The societal perception that young people are not at an age appropriate for knowing about or having anything to do with sexual matters causes both young men and women not to seek sexual and reproductive health information or safer sex commodities. In many cases, existing reproductive health services are aimed at married women. The result is either intentional deterrence of young people accessing sexual health services, or unintentional exclusion through service provision that is unfriendly towards youth or materials that do not capture the attention of or issues that affect young people. Young people who are living with HIV, may be extremely reluctant to disclose their status to health providers in this environment, and may stay away from support groups because the average age of other members is much higher and they perceive their interests and needs will differ significantly.

The vulnerability of young women and working age women over the age of 25 to HIV transmission may not differ much in terms of being under the influence of patriarchal gender and sexuality related values that reduce the ability of women in both groups to negotiate safe sex with their partners. The difference lies in the fact that younger women have to hide their sexualities even more, due to the societal perception that they are too young to be having sex, while they themselves value having a partner as a part of their lifestyle, and see having sex as acceptable for a couple without necessarily expecting to marry their current partner.¹¹³

Summary of women's vulnerability to HIV infection in Thailand

- Men's unsafe sex with commercial partners and very low condom use within marriage/long term relationships
- The association of condoms with sex work create a barrier to both men and women requesting condom use with their partners
- The dual benefits of condoms to prevent both pregnancy and STIs are not widely recognized
- The practice of no sex during pregnancy legitimizes men's visits to sex workers or sexual relationships outside marriage
- Between leaving school and a women's first pregnancy there are few opportunities to reach her and her partner/husband with targeted sexual and reproductive health information
- Men are likely to seek preventative and sexual health information and access services only after they are symptomatic and need treatment
- The 100% condom use campaign has not adapted to the changing epidemic, and clients report much lower condom use than sex workers (60% and 95% respectively)
- The decentralization of the health system has resulted in STI clinics relocating to hospitals. Sex workers attend these relocated clinics less because of the perceived bureaucracy, waiting times, less sympathetic (i.e. trained) and specialist staff,
- Neither men nor women are empowered to prioritize their own or their partners sexual health needs
- Migrants and other non-Thai speakers are excluded from access to STI information, broader health services and legal protection

¹¹³ *Yamarat: 2008a, 2008b*

Analysis

Gender inequality is a pervasive theme throughout the analyses of all three countries. In Indonesia women seem to have much less decision making power than men and are at liberty to be accepted members of society as long as they conform to societal expectations about their behavior and roles. In Thailand gender expectations of women and men are perhaps less pronounced on the surface but there is an underlying moral polarization of women. In Laos PDR men are expected to have multiple partners while women are not. Gender inequality affects women's decision-making power and then negotiation ability in sexual relationships. Overall there was an expectation of married women that they are less sexually experienced than men and that they tolerate their husbands sexual relationships especially if it is paid sex. However in Indonesia women seem less likely to know if such relationships take place.

The taboo nature of sex between males means that many men get married to conform to societal expectations but continue clandestinely sexual relationships with other men.

The expectation (or acceptance) that men will have many partners creates a paradox if women are expected not to have sex, and therefore creates a demand for sex workers in all three countries. However in Indonesia sex workers still criminalized and despite the existence of brothels there is little protection of the rights of sex workers. Subsequently female sex workers have little ability to protect themselves from violence and to negotiate condom use.

Laos PDR has responded to sex work with a 100% condom use campaign, following Thailand's lead. Given the more informal nature of sex work it can be hard to reach all women who sell sex, although arguably women working in bars perhaps have more control over who they sell sex to, as they are not obligated in the same way a woman in a brothel is. At the same time sex tourists are reportedly coming to Laos PDR because of the perceived lower risk of STIs and therefore seek sex without condoms. More informal street-based sex work is beginning to increase including contacting women by telephone.

The HIV prevention response needs to be continually updated to take account of changing behavior patterns and new understandings of societal factors which have the potential to increase HIV transmission. Even in Thailand where there is confidence in the existing strategies, unforeseen consequences to changes in the health system structure are already being identified, namely the reluctance of most at risk populations to present to large hospitals for testing and treatment of STIs. Additionally the discrepancies between reported condom use of female sex workers and male clients need to be further understood. The differences may easily be explained: a sex worker who has sex without a condom with just one client may record her consistency at 99%, while man who has had sex without a condom with a sex worker once out of three encounters that his consistency at 66%. At the same time the generally punitive rather than protective approach to sex workers in Thailand may discourage their accurate self reporting of actual levels of condom use.

Low levels of condom use among couples are common throughout Indonesia, Laos PDR and Thailand. In all three countries the emphasis on condoms for sex workers has firmly associated them with infidelity and mistrust making a virtue impossible for men and women to suggest that their partners or spouse is using them. One strategy could be to promote condom as an alternative to hormonal contraception and permanent sterilization. The challenge that continues to exist with condom is that, as pointed out by the positive networks, sex is more pleasurable without a condom.

All of the above discussion on condoms has focused on male condoms. The first generation of female condoms was distributed to female sex workers in Thailand but the general feedback was negative: they were considered noisy and a ring of their entrance uncomfortable to wear. As a result they have not been made widely available in any country and are more expensive to purchase and male condoms. New phases of the female condom are now available as it may be possible to introduce fees to married couples rather than sex workers to avoid the stigmatization that male condoms now suffer from.

Stigma and discrimination continue around HIV and STIs, as does misinformation. In all this translates as a relatively low level of knowledge, while in Indonesia Miss seem pervasive and are closely linked to men's image of their masculinity and therefore their invulnerability to infections. A lack of information and the existence of misinformation put both men and women at higher risk of HIV and STI transmission.

III. Priorities for developing an evidence-based effective Prevention Strategy

This section makes recommendations on the priorities for action to develop an evidence-based prevention strategy for each country. The first recommendation in all three cases highlights the existing unmet information needs which need to be addressed in order to gain a fuller understanding of the vulnerability of women to HIV infection through partner and spousal transmission, and further understand gender inequality issues.

Indonesia

1. Address unmet information needs on HIV vulnerability through further research

Overall an appropriate regional focus is needed: to understand the behavior, decisions and needs of the different communities, qualitative data is needed from the highest prevalence regions and the local areas that many women have migrated internally from. Sex-disaggregated quantitative data is also required to ascertain the patterns of women who migrate (internally and externally) and to understand the complexity, similarities and differences in the behavior patterns of all women in the many provinces. There are provinces however that are most affected by HIV and these should be prioritized, for example, the most eastern provinces like Tanah Papua and cities like Bali. But much more detail is needed to understand the situation in these areas. Research must include men and their partners, women, and couples. Any research that is carried out should be designed to inform and develop policy and new programmes, rather than be research for its own sake.

Gender inequality needs to be addressed to change the norm of men's subjugation of women. A truly creative approach is required that will change attitudes and empower women. To achieve long lasting change, more societal discussion and work on attitudes are needed to encourage men to take responsibility for protecting their families. On the whole, many people have heard of HIV and know some of the ways it is transmitted, but misinformation is pervasive and negates the efforts made in distributing the correct information. Men's definition of masculinity is reducing their STI and HIV preventative behavior and contributes to subjugation of women.

The conceptualization of risk needs to be developed and deepened: people at risk and not at risk are not discrete groups. STIs and HIV are integrated somewhat but issues such as sexual networking are not understood, reproductive health even less so.

The sexual and reproductive health needs of women and men need better understanding. Approaches to overcome the barriers to women's access to sexual health information are needed; as are approaches to overcome the barriers to men's access to sexual health information and their lack of participation in ANC. Further there is very little focus on the sexual and reproductive health needs of young people. Conservative views prevail that incidence of pre-marital sex is low resulting in few places for young adults to access sexual health information and services.

Female sex workers are vulnerable because of their illegal and low social status which means that it is difficult to identify them and provide them with protection, information and services. Their vulnerability to violence, exploitation and STI and HIV infection needs to be understood and reduced by programmatic and advocacy interventions.

The needs of female partners of male injecting drug users are currently overlooked. Several estimates have been put forward for the number of partners of injecting drug users; but currently no policies or programmes target them, nor have they been the subject of surveys or research. Further there is not yet enough responses to injecting drug users as a 'bridging population' (and similarly the clients of sex workers,

and males who have sex with males) whose behavior results in transmitting HIV to their lower risk partners/spouses.

An analysis of the impact of the legislative framework on HIV and AIDS is required. An assessment of Indonesia's legislative and policy framework in relation to HIV would identify the enabling and hindering factors to develop a progressive and comprehensive HIV response.

From the literature surveyed migration is an example of research and recommendations still valid and in need of implementation. Indonesia collects HIV related data regularly through behavioral research and censuses and much of it is currently available through KPAN's website. KPAN are increasing the amount of data available through its website. This rapid assessment included mainly quantitative and secondary data and research. An example is ILO's 2001 study *Population Mobility and HIV/AIDS in Indonesia* which was commissioned to ascertain the pattern of movement, both internally and internationally, and the implications for the HIV epidemic from both national and regional perspectives.¹¹⁴ A comprehensive gender analysis should include the findings of this study to increase understanding of the impact of HIV on women who migrate and the female partners of men who migrate, as part of a broader assessment of the feminization of AIDS.

2. Complement concurrent research and opportunities to fund responses

UNDP is involved in two upcoming areas of research and funding relevant to UNIFEM's plans for future research on partner transmission. UNDP and the National Census Bureau are funding a socio-economic impact study in four provinces including Papua to look at the impact of HIV and gender on women's workload and rights. UNIFEM and UNDP should collaborate to review their respective plans for qualitative and quantitative research to ensure they are complementary. Additionally UNDP and KAPN are launching a call for proposals to provide grants to organizations, networks and civil society. This year the focus is on strengthening networks and community mobilization in Papua, with emphasis on strengthening networks of vulnerable groups. The National AIDS Commission's emphasis on strengthening networks could potentially be aligned with UN agencies and organizations working on themes that could complement the ongoing studies on spousal/partner transmission.

3. Extend harm reduction attitudes to sex work

There have been changes in attitudes towards injecting drug users. Where once the police saw them only as criminals, the national health approach had facilitated an understanding of injecting drug users as patients and victims, and has introduced harm reduction strategies. An assumption of the response so far is that injecting drug users are male which has resulted in the exclusion of women from programmes and policy. However, the positive approach being fostered towards injecting drug users indicates that there is potential to extend 'harm reduction' to sex workers. While some conservative elements of society are adamant that supporting sex workers even with information is sanctioning sex work, it may be possible to encourage debate to broaden understanding of sex workers to see them as economic survivors and foster more sympathetic harm reduction approaches towards them. There is some analysis of the interaction between injecting drug use and sex work. The NAC desk study makes the link between injecting drug use and selling sex citing the AIDS in Asia report's estimates that up to 3% of sex workers in some provinces reported also injecting drugs.¹¹⁵

4. Engage local community leaders

At local level local leaders (including religious) can play a significant role in supporting the communities. UNICEF has held meetings with local leaders in selected provinces which generated positive feedback from the participants. This and other approaches that have been implemented should be assessed to develop effective strategies to work with local religious and traditional leaders. The social order of society such as banjar, ethnic groups, tradition-based social system can all become the social capital for the development of HIV and AIDS programmes across the country.

¹¹⁴ *Population Mobility and HIV/AIDS in Indonesia*, Graeme Hugo, 2001, ILO

¹¹⁵ *Report of the Commission on AIDS in Asia (2008) op. cit.*

5. Provision of services to women affected by injecting drug use

There are few, if any, initiatives that target female injecting drug users or the female partners of male injecting drug users. The recognition of this gender bias towards men affected by injecting drug use needs to be considered by future HIV prevention strategies.

6. Move beyond approaches targeted at individuals

Program intervention that engages HIV risk groups, should go beyond these groups and involve common society as major actors in the HIV response, starting from planning, prevention and care in order to build a communal system based on local values [gotong royong] and to ensure sustainability.

7. Provide sexual and reproductive health services for men

The strengthening and empowerment of women often happens in the form of encouraging them to demand openness from their sexual partners about their health status. This must not be the only route to accessing men. The ability of men to be open about their status needs to be supported by programmes as well health services in order to protect both women and men. Very few men currently access SRH services in Indonesia. Existing and new services need to become more accessible for men to both accompany their female partners, and to seek services for themselves.

8. Integrate HIV services with the existing healthcare system for women

In order to make sure that women are able to access HIV services, they need to be mainstreamed into the health care that women already access, namely family planning, healthcare for mother and child [KIA], and immunization programmes. This is also a strategy for raising awareness more generally about HIV and AIDS, and mainstreaming it into the public sphere so it is not an exclusive issue, separate from the main health system.

9. Cooperate regionally to meet the needs of migrants

Indonesia's HIV prevention strategy needs to be coordinated with other national strategies in the region, especially the countries that are most popular destinations for Indonesian migrants, to target migrant workers with services and support before and after the work abroad.

Laos PDR

1. Address unmet information needs on HIV vulnerability through further research

Overall, the limited data for the Laos PDR do not allow disaggregated reporting for all indicators defined for UNGASS. While considerable progress both in quantity, quality and accessibility of services was made, the measurement of this progress is often made at the operational level (i.e. process indicators, qualitative surveys), and because of the low prevalence, impact studies and surveillance are only done in bigger time intervals.

Not enough is understood about the social (or other) structures through which women receive sensitive information (e.g. about sex). Nor are the gender dynamics within households and between couples fully understood. Conclusions about women's economic dependence on men and the potential impact on sexual relationships are largely based on anecdote rather than evidence. The diverse and sparsely populated nature of Laos, with 49 ethnic groups, means there are myriad languages and behavioral norms that are not understood.

In particular the practice of no sex during pregnancy which seems to be the preference of men is little understood. It is during pregnancy that many men are increasingly likely to pay for sex and therefore potentially increase their risk of HIV infection. Understanding the cultural taboo around sex during pregnancy may help identify strategies to reduce HIV vulnerability.

Many men prefer not to use condoms because they reduce pleasure. Research needs to investigate what factors will change men's behaviors to offset the reduced sensitivity experienced in condom use against maximizing long and short term sexual health protection for themselves and their partners.

The vulnerability of migrants was a recurring issue among service providers and NGOs as was the need for understanding how to reach migrants with services. The seasonal movement south to Thailand, and internally to urban areas, challenges stereotypes of women's vulnerability. And linked to the movement of people, there is also trafficking which needs to be understood and mitigated against.

Recent research on young urban women's sexual patterns by the Ministry of Health and the Burnet Institute reveals the circumstances around women's first sex and many of the attitudes towards sexual relationships.¹¹⁶ The study findings underscore the need for youth-friendly sexual and reproductive health services; and counselling on sexuality, pregnancy, abortion issues and family planning. They also argue for sex education programs which are:

- Age-appropriate, acceptable and recognize and address the unique misconceptions held by adolescents in different settings;
- Build life and negotiation skills that will enable safe and informed choices;
- Raise awareness of sexual coercion and equip young men and young women to counter it; and
- Confront existing double standards in what is acceptable for females and males.

The recommendations also note the importance of programs' engagement with parents to enable them to overcome inhibitions in communicating with and counselling their adolescent children. Finally, if services are to be truly youth-friendly, youth must be involved in their design and content.

2. Focus on discordant couples

While VCT is available, especially in Vientiane, many people are reluctant or refuse to bring their spouses with them. However, among discordant couples condom use seems to be high as among the 30 discordant couples at one of the VCT clinics as yet none has transmitted an STI or HIV to their negative partner.¹¹⁷

3. Provide basic STI and HIV prevention information for the general population

Overall there is a lack of basic prevention information among the population. Those services that do integrate STI and RH services tend to be directed at women who sell sex – for women, particularly young women, not engaged in commercial sex and for young women there are not many services they can access for information, counseling and testing.

4. Address gender inequality

Women have few skills or power to negotiate or resist sexual demands from men. Anecdotally men can demand sex from their wives and women see sex with their husbands as an obligation. Both women and men need empowerment in order to increase equality in sexual relationships, in taking responsibility for contraception and ANC.

5. Cooperate regionally to meet the needs of migrants

Laos's HIV prevention strategies need to be coordinated with other national strategies in the region, especially Thailand, to reach women who migrate seasonally for work.

¹¹⁶ *Young Women's Sexual Behaviour Study Vientiane Capital, Lao PDR, The Department of Health of Vientiane Capital (PCCA) in collaboration with the Burnet Institute and UNFPA, April 2008*

¹¹⁷ *Source: Key informant interview with Mahosoth Hospital*

Thailand

1. Address unmet information needs on vulnerability through further research

Qualitative research into the reality of life for positive people (their decisions and behavior patterns) is an area that needs deeper understanding to make appropriate recommendations for HIV prevention among discordant couples.

In particular the practice of no sex during pregnancy which seems to be fostered by women is little understood. It is during pregnancy that many men are increasingly likely to pay for sex and therefore potentially increase their risk of HIV infection. Understanding the cultural taboo around sex during pregnancy may help identify strategies to reduce HIV vulnerability.

The often cited reasons that men prefer not to use condoms because they are associated with sex work and because they reduce pleasure need addressing. Research needs to investigate what factors will reduce the stigmatization of condoms and change men's behaviors to offset the reduced sensitivity experienced in condom use against maximizing long and short term sexual health protection for themselves and their partners.

Positive prevention must also include building the capacity of health workers to respond appropriately to people living with HIV and support them to bring their partners for testing. VCT in general needs to be strengthened and expanded.

There are a number of groups of people where more needs to be done to address their marginalization: 1. Women and men who are non-Thai, e.g. migrants, or don't speak Thai, including ethnic minority groups within Thailand, who have limited access to services and experience negative attitudes towards them from the general population. 2. Women who inject drugs are also stigmatized and have difficulty accessing neutral or non-judgmental services.

There is a serious gap in reaching women between (or out of) school and their attendance at ANC clinics. Whilst regular health checks and education about sexual health needs to be fostered among women, they are even more urgently needed among men who are most likely to seek medical intervention once they have become sick. There seems to be few if any systematic entry points to reach men with STI and HIV information.

Men's involvement in ANC is highly desirable and pilot programmes report positive responses and high client satisfaction. There remain many barriers to men's participation (gender role expectations, inability to take time off work, or working away from home for long periods of time) but men-friendly services and couple-friendly environments can and should be created.

Understanding of the gender-power dynamics and sexuality is needed among: sero-discordant/ concordant couples, young women living with HIV, female injecting drug users, and their impacts on HIV infection and re infection. Linked to this is the need to understand health providers' perspectives on gender and sexuality of women living with HIV and impacts on quality of care and services.

From 2001 Horizon's key baseline data from three countries including Thailand on reducing HIV infection among young people researched knowledge, attitudes and behavior.¹¹⁸ While the data collection on experiences and attitudes was sex disaggregated, different strategies for young women and men were not identified. The research proposed a number of recommendations to strengthen programmes in schools for young adults:

- Teachers need to be prepared for students with a range of sexual experiences, including forced sex.
- Strategies for negotiating or refusing sex should take into account the intermittent nature of adolescent sex.

¹¹⁸ *Horizons, 2001, Reducing HIV Infection Among Youth: What Can Schools Do? Key Baseline Findings from Mexico, Thailand, and South Africa*

- Courses should examine peer pressure.
- Programs need to teach students to accurately assess their personal risk of HIV infection.
- Teachers and curricula planners need to know that students know some things about HIV but that they also misunderstand or are unaware of other aspects of HIV.
- Programs need to talk about PLHA.
- Programs need to address condom use.

Many of the above recommendations are being implemented through a number of pilots and curriculums being developed by the Ministry of Education, but according to WHO teachers need more support and experience in teaching sexual health education. The NGO PATH is also working closely with Ministry of Education to expand the curriculum in schools. There are four books for each level in teaching and learning. Given the constraints of the teaching staff, the curriculum may benefit from being streamlined. The major challenge for Thailand in terms of comprehensive sexual health education in schools, as with other HIV prevention approaches, is that the responses need scaling up to have national coverage.

Qualitative research from as early as 1996 by Knodel and Pramualratana identified the shortcomings of the 100% condoms use campaign among sex workers in terms of its limited impact on the broader population.¹¹⁹ The research looked at the barriers to condom use within marriage. It noted that "any general campaign to promote condoms among couples is likely to face formidable barriers... promoting them as a contraceptive is unlikely to be successful. The increased use of condoms for couples is theoretically possible. But change will be slow because of the widespread view that condoms reduce pleasure and are associated with commercial sex work.

Given that other methods of contraception are more effective, efforts to increase condom use with marriage will have to focus on their prophylactic value." In which case it is most likely that discordant couples will choose long term prophylactic condom use and therefore the most effective strategy will be to target these couples truly at risk by linking condom use to voluntary counseling and testing. The researchers advocate for a public health campaign that encourages married men with a history of behavior that may have exposed them to HIV infection to seek testing in order to "portray receipt of an HIV test as an act of family responsibility, stressing the testing for the well-being of both the spouse and the children." From the research and discussion the following recommendations are made:

- Promote voluntary testing of people who are at an increased risk of testing positive. Incorporate clear descriptions of risk behaviors, including premarital sex, which could lead to infection.
- Promote the theme of family responsibility which has the widest potential for arousing concern about the consequences of risk behavior among married men.
- Encourage and facilitate voluntary premarital HIV testing, although active promotion of voluntary testing and counseling for couples would be appear to be the most sensible route.
- Continue with the campaign for condom use by sex workers.
- More emphasis on the risks of unprotected casual sex with women who are not professional sex workers, as men may feel a false sense of safety with noncommercial casual partners.
- Promote condom use by married men in their extra marital sexual contacts.

Some of the above recommendations are being implemented but again not on a national scale.

More recent research in 2003 by VanLandingham and Knodel focuses on the sexual patterns of a specific cohort of older single men.¹²⁰ It notes that "several men report having lost friends or colleagues to AIDS, and such experience may provide a good foundation for interventions that would target unmarried older men who remain sexually active. Such campaigns would do well to emphasize the risks of having sex with sex workers, the ability of condoms to prevent the transmission of HIV, and the risks of alcohol numbing an older man to the potential dangers of his sexual activities, especially during special and festive occasions."

¹¹⁹ *Prospects for Increased Condom Use Within Marriage in Thailand, Knodel & Pramualratana, 1996, International Family Planning Perspective, Volume 22, Number 3, 1996*

¹²⁰ *Sex and the Single (Older) Guy: Sexual Lives of Older Unmarried Thai Men During the AIDS Era, Mark VanLandingham and John Knodel, PSC Research Report, 2003*

Le Coeur et al from the Institut National d'Études Démographiques studied the circumstances which increase the risk of HIV infection by exploring the notion of "vulnerability", defined less in terms of epidemiological or risk factors than in relation to socio-cultural, psychological and economic aspects.¹²¹ To identify vulnerable situations, the researchers adopted a life-event history perspective through which individual life histories are considered as a continuum of events of different kinds relating to family, housing, occupation, health, etc., and affecting the dependent variable, i.e. vulnerability to HIV. The subsequent published paper assessed the feasibility of a specific survey technique and sampling plan designed to serve these objectives, through a pilot survey conducted in Thailand in 2001. Overall, the life-event history approach appeared to be highly suitable for obtaining information about vulnerability and health issues.

2. Take a rights-based approach to sexual and reproductive health policy and practice

Prevention strategies should consider the implications of current sexual and reproductive health policy and practice and how they potentially increase women's susceptibility to HIV and STI transmission. HIV/AIDS policy formulation needs to take in consideration the sexual and reproductive rights of both women and men, gender equality, and use a positive approach to sexuality which includes an emphasis on sexuality education and information throughout women and men's life cycle, sexual communication between couples and mutual responsibility.

At the same time, gender needs to be mainstreamed into HIV and AIDS policy formulation to enhance gender equality and eliminate inequity found in the legal system, public and private policy, accessibility to public and private health care and services, economic and educational system. Policies and programs are required which change traditional gender norms and value which perpetuate gender inequality in Thai culture and society, i.e. training, teaching, communication about gender and gender inequality in school and non-school system, families, communities and society. HIV/AIDS related policy and program must shift away from epidemiological paradigm and take into account of uneven social, economic and political structural context of women and women living with HIV/AIDS in which cause women to be vulnerable to HIV/AIDS and re-infection

3. Build the capacity of health service providers to deliver a gender-sensitive response

Arrange activities that build knowledge and understanding on gender, sexuality and concealed sexual and religious standards that lead to violence against women and unsafe sex by women, targeting those providing services to women living with HIV and to the general public. Create mechanisms in private and state health services that have awareness of and sensitivity to differences between men and women, as well as the sexuality issues that constitute obstacles to women's access to information on protecting themselves against disease transmission, in various formats:

- Train and support service providers
- Arrange discussion groups to provide exchange of experiences, e.g. on obstacles in the service providers' work with HIV positive people.
- Create community level networks of HIV positive people and facilitate ways of providing mutual assistance and counseling by members for members of the network
- Create counselling formats that involve the partners of HIV positive clients
- Reform administrative and health service provision structures. For example, increase the number of health officials, maintain policy continuity, avoid moving health officials from one unit to another too often, arrange the physical setup of the health service provision units with regard to confidentiality, and do not separate HIV positive clients from other clients (to avoid creating feelings of being singled out).
- Provide more reproductive health services for women. Make sure women have access to them and feel safe in using them. Create service provision standards and train the officials to pay attention to

¹²¹ *Living with HIV in Thailand: Assessing Vulnerability through a Life-Event History Approach*, par Sophie LE COEUR, Wassana IM-EM, Suporn KOETSAWANG et Éva LELIÈVRE, Institut National d'Études Démographiques/ Population-E, 2005, 60(4), 473-488

the needs and problems of HIV positive women, using the principle of respect for sexual and reproductive rights of HIV positive people.

- Adjust service standards by reviewing problems created by existing policy and work practices, listening to the voice of HIV positive women clients on problems such as VCT that involves pressuring clients to take an HIV test, pressuring women to bring their partners to have a test, and bringing change to attitudes of officials who view that HIV positive women will not have new partners, sex or children. Women should be provided the option of safe abortion in case they themselves wish termination of pregnancy. Women who are not ready to disclose their HIV positive status should have options for accessing information and treatment, including continual follow-up of the service users.

4. Provide comprehensive services for people living with HIV

Fund activities for HIV positive people through existing positive peer support groups, clinic services and networks of people living with HIV to present correct and appropriate information on the exchange of viral strains and re-infection, create awareness of safer sex, provide an easy access to condoms, lubricant, and clean needles. Arrange social and medical welfare for women living with HIV, without compelling women to disclose their HIV positive status.

5. Promote male participation in sexual, reproductive and maternal health services

Policy related with HIV/AIDS Prevention and Care must be formulated on the basis of reproductive rights policy which emphasize the provision of sexual and reproductive health care and service and the PMCT program which emphasize male participation and involvement in prenatal care, childbirth, postnatal care, decision for blood testing and post-abortion care. Create entry points in the health system as well as user-friendly services and an enabling environment for men to access to VCT services and disclose their status to their partner.

6. Scale up national coverage

Future research needs to support the identification of those successful interventions which impact on preventing spousal transmission and can be scaled up at national level. For example: UNFPA's Stay Negative programme for HIV negative and discordant couples currently in 6 hospitals; the Ministry of Education's sex education approach in selected provinces (with PATH and WHO); WHO's pilot project to support men and women to attend ANC together. These and other programmes need assessment to understand their suitability for replication for scaling up.

7. Revise and retarget HIV prevention messages and campaigns

Create campaign materials for HIV prevention among women that attract the target group's interest and appear desirable to women in various contexts of life, such as young women, housewives, both HIV positive and negative women with partners, drug users, both in urban and rural locations, as well as to migrant ethnic minority women. Arrange activities that create knowledge, understanding and skills for using STI prevention equipment among all groups of women, including all age groups, urban, rural, migrant and ethnic minority women. Prevention equipment must be provided with easy access, low price and matching existing needs.

- Devise campaigns for changing the socio-economic context that empower women, create educational opportunities, take into account diversity among women, do not view that only some groups of women are risk groups, and pay attention to violence, sexual rights. Officials or NGOs should in their practices give more importance to and have more sensitivity toward perspectives involving gender, sexuality and women's social lifestyle.
- Arrange activities that build skills of sexual negotiation, negotiation of safe sex, and violence avoidance among women, based on an approach of exchanging experiences.
- Arrange activities that provide information on reproductive health: HIV/AIDS, infections of the reproductive organs, safe and protected sex, consensual sex, living with HIV positive people, caring

for HIV positive people. Create access to groups of women through diverse, appropriate and desirable types of media, considering the diversity of women's identities in all age groups.

- Arrange thought-provoking campaigns that provide information, build skills and knowledge, to deconstruct misconceptions related to condom use, among all people.
- Facilitate the inclusion of women, HIV positive people, and NGOs to state projects or activities involving women, giving them a role and power on all levels, from policy making to implementation.

8. Empower women through reproductive health care

The Thai Positive Women's Organisation made a presentation to the joint UNIFEM and UNAIDS regional research workshop on the feminization of AIDS and spousal transmission (Bangkok, February 2009) which highlighted societal gender expectations which act as barriers to women's and men's access to information, prevention and treatment services.¹²² Reproductive Health care services for women should empower them to make choices and offer all available services, and strategies are needed to build the capacity of women, men and services providers.

For women, pre-post test counseling should be strictly voluntary and be effective in helping women to assess their risk (including from their husband) properly. They should be able to make *informed choices* of drugs in prevention of mother to child transmission. They should have choices for contraception and getting pregnant. The service should help women to understand the cultural factors of their attitudes and that they have the right to express their opinions and needs which is a key strategy for rejecting unsafe sex.

For men, more programmes are needed to encourage them to understand their attitudes that prevent them from: performing participatory parenthood; expressing their feelings and needs; and communicating in sexual relationships. Direct programmes are needed to promote male involvement in: birth control; preventing unwanted pregnancies; and pregnancy preparation and testing.

For health care workers, they should be prepared for discussions on sexuality and gender. They need to be able to practice effective counseling especially: deep listening; understanding their own and their clients' attitude towards sexuality and gender; respecting women's choices and rights rather than controlling and deciding for "the best choices" for women. Finally health care workers need to be able to provide choices of contraceptives and other tools including female condoms and lubrication.

9. Facilitate the meaningful participation of women living with HIV

It is crucial if services are going to be of relevance to women, that the participation of positive women is promoted as part of the counseling system and in the planning process of the program for prevention and care for women (Thai Positive Women's Association)

10. Ensure comprehensive VCT coverage

VCT and prevention programmes need to be scaled up to include those who currently fall through the gaps such as migrants and injecting drug users/drug using woman. Female injecting drug users also need prevention programme which include Needles and Syringe exchange and the implementation of harm reduction Methadone, especially for pregnant women (Thai Positive Women's Association)

11. Reach diverse and marginalized Thai indigenous populations

Thai society is diverse and there are a number of ethnic and religious minorities that are marginalized from the mainstream response. Additionally geographical areas that historically had low HIV prevalence (i.e. the South) received fewer resources for HIV prevention work and consequently the current levels of knowledge among the general population (and potentially health staff) are lower than national averages.¹²³ The groups that are most marginalized are the non-Thai speaking indigenous populations (especially in the North and

¹²² *Regional Technical Meeting on Responding to the Feminization of AIDS: Gender Power Dynamics in Marriage and Sero-Discordant Relationships – Implications for Practice, Workshop Report, Jo Kaybryn for UNIFEM, February 2009*

¹²³ *Source: Key informant interview WHO*

the borders of other countries) and the Muslim population (in the South). These diverse groups need to be targeted with culturally appropriate and language specific responses.

12. Promote comprehensive sexuality education and sexual health services for young people

Policies and programs related with sexual and reproductive health care and services for young people and young people affected with HIV/AIDS must be formulated and implemented. These services must be youth-friendly, build upon their needs and problems and cultural sensitive to their sub-culture. Create or adjust youth sex education syllabi for all youth, both within and outside the school system, so that the contents are comprehensive and diverse, covering gender, sexuality, and reproductive health problems, such as STI's, cervical cancer, sexual violence, difficulty getting pregnant, unwanted pregnancies and abortion. Make sure learning activities and processes are student-centered, respect the students' rights, and increase the abilities of the youth.

13. Cooperate regionally to meet the needs of migrants

Thailand's HIV prevention strategy needs to be coordinated with other national strategies in the region, for example, Laos PDR, to target migrant populations with services and support particularly those that do have legal status in Thailand and those that are non-Thai speaking.

IV. Perspectives of regional positive networks

This section focuses on the outcomes from the joint UNIFEM and UNAIDS regional technical meeting on responding to the feminization of AIDS. This meeting provided an opportunity for representatives of networks of people living with HIV, UNAIDS and UNIFEM gender focal points and regional researchers to discuss the country research reports and the Asia Pacific regional perspectives. Discussions between three regional positive networks (ICW, WAPN+ and Seven Sisters) and UNIFEM and UNAIDS highlighted the following issues.

Enabling environment

UN agencies and positive networks need to look at how they collectively create an “enabling environment” within the larger context of each country’s legal framework – criminalization, discriminatory policies, freedoms and liberties (e.g. right to speech).

Representation

The expectations on the networks of people living with HIV are very high. The priorities that they are asked to deal with are increasing and the expectations from the UN, governments and donors are growing along with these priorities. The pace at which external stakeholders would like them to respond does not match the pace they receive resources and support, including capacity building. The networks recognize that there goodwill among their partners to involve them but caution against assuming the networks have all the tools and capacity in place. They do not have everything they need yet, but they also have the potential to deliver if they are invested in sufficiently enough that they can participate effectively and meaningfully. Another important issue to consider is the actual meaning of “involvement”. Providing the networks with opportunities to share their perspectives is often not followed up with their involvement in the planning of initiatives. Networks are further challenged by the pace of the requests that come to them. Deadlines loom and new initiatives introduced often and quickly, and it takes a tremendous amount of resources to respond and consult with their partners on the ground, especially given the size of the Asia Pacific region.

The diplomacy that networks are required to perform is often overlooked. Each time a networks speaks out it takes a risk. It must balance making its members voices heard and not causing embarrassment to its government or non-governmental organization partners.

Regional networks are also conscious that they struggle to fully represent all people who are most at risk and there are many internal inclusion and mutation issues that they must address.

Positive prevention¹²⁴

The community stressed the fact that the promotion of positive prevention should be a joint responsibility between all stakeholders and not the sole responsibility of people living with HIV. Positive networks would like its stakeholders to admit that sex without a condom is nice. Yet using condoms is the main message in positive prevention. The networks need time and space to do their own paradigm shift. Deep inside, no positive person wants to spread the virus because they know the pain of stigma.

Women and spousal transmission

Networks recognize that more spouses are being infected but any kind of response is being undermined by the moral good/bad polarisation. Allocation of resources may later be a problem as government will prioritize the “good” over the “bad”. It is important not over-amplify the “good vs. bad” concept and create artificial fear such as allocation of resources. Stakeholders must recognize that women get infected through no fault of their own, and we need to deal with this issue with more prominence.

¹²⁴ *At an international technical consultation on ‘positive prevention’ convened by the Global Network of People Living with HIV/AIDS (GNP+) and UNAIDS on 27-28 April 2009 in Tunisia, experts outlined the ways in which people living with HIV should be central to HIV responses, in particular when and where those response have a direct impact on the lives of people living with HIV. Positive Health, Dignity and Prevention is the new term from the Tunisia consultation. A short version that seems acceptable is “positive health”*

The issue of spousal transmission is no longer academic; it is already happening. It is not good enough to wait or remain passive for X million women to be infected before action is taken. Is this a gap that can be addressed? Is it sufficient to start with sex workers and their clients? The response must empower women to act as their own agents of change. This is not about shifting responses from one to another. The Commission on AIDS in Asia is clear about focus on most at risk populations but also need to address the issue of spousal transmission.

The approach to women to date has been piecemeal. Some of these groups are not in water-tight compartments. The spouse has no face; the networks are able to give them a face. It is important to look at strategies and entry points – the most at risk populations will definitely be an entry point, then spouses of most at risk populations.

Priorities, strategies and questions

After a discussion with the positive networks, following priorities, strategies and questions were recorded:

Priorities	Strategies	Burning Question for Regional Networks
Enabling environment to reach women in marriage from prevention to impact mitigation	Empowering women to access prevention, treatment, care and support services	How can regional networks help communities on the ground in our communities?
Paradigm shift in the way we do business – moving the burden of interventions/ response away from the "victims" to what?	No business as usual with regards prevention programmes More gender friendly interventions	Can we do it?
Enabling environment which will lead people to disclose, seek testing, access services, reduce stigma	Involvement of men, government, CSO, PLHIV network, local service providers, media practitioners, political champions	Do you feel there is real space and involvement of communities in all levels of the response, including decision-making?
Advocate for safe sex in marriage	How to advocate/negotiate safe sex among married couples	How do you get different government agencies to involve positive networks in the response?
Changing power dynamics between genders in society to prevent new infections	Working with men and partners of MARPs	Within the rights framework, what duties do PLHIV networks have in promoting safer sex and changing power dynamic within in the community? Working at the inclusion concept, why do positive networks feel insecure about the diversion of resources and focus away from them to their partners with regards the discourse on spousal transmission?
Raise awareness of sincerity in relationships	Open discussion about sex and sexuality within relationships Start talking within the community about sincerity in relationships Stop dividing of "groups" (MARPS)	What is holding us back from expressing how we feel?
Documenting and disseminating information on good and promising practices	Gather information but work with positive networks in defining "good practice"	What are your criteria for good and promising practices in reducing spousal transmission?

V. Conclusions

This rapid assessment has looked both at spousal transmission of HIV and the particular implications for the vulnerability of women. On the surface we understand that gender inequalities contribute enormously to women's vulnerability to HIV infection. However, this rapid assessment has confirmed that gender inequalities are part of the problem, and revealed some of the many more layers of complex societal and personal expectations that vary greatly between countries, between communities and between couples. A huge task lies ahead: the focus on key populations for reducing HIV transmission has been undoubtedly an effective strategy, given the declining prevalence among sex workers in Thailand, for example. But over the long term, low HIV prevalence rates in key populations have not eliminated the gradual spread to their sexual partners (whether commercial or not).

Arguably, given the response to date, the majority of people who are *most at risk* are likely to have some idea of their vulnerability to HIV infection. The partners they have sex with may have some awareness, but as the chain of sexual partners gets further from those most-at-risk, the level of personal risk assessment decreases significantly. The problem is that a sexual network does not have to reach very far for people to not know they are even part of one. A female sex worker may be well aware of her personal risk, her male client may be partly aware of her and his own risk, but his wife may have not have any awareness of her husband's risk and therefore her own personal risk assessment is uninformed. On the other hand, she may be aware of her husband's risk but has no negotiating or decision making power to reduce her risk.

Emerging issues common to all countries:

- Sex work: it's illegality or ambiguous status which reduces sex workers' ability to negotiate condom use, and the challenges of reaching male clients of sex workers
- Stigmatization of condoms: this is a major barrier to couples in relationships using condoms
- Gender-based violence: there is a lack of data on its prevalence and its impact on STI transmission
- Gender expectations: which encourage men to have multiple sexual partners, reduce women's power in decision making, exclude men from participating in sexual and reproductive health services, and promote hormonal therapy and sterilization among women which in turn reduces their ability to negotiate condom use
- Traditional practices: such as women's abstinence from sex during pregnancy creates expectations and opportunities for men to have extramarital sexual relationships, whether casual or paid
- Migration affects all countries, whether it's immigration or emigration for work

In Indonesia, Laos PDR and Thailand, HIV exposes aspects of society that already exist: sex work and injecting drug use as key transmitters of the virus; gender expectations which inhibits women's ability to make decisions and men's ability to change their behaviors; exploitation and victimization of sex workers and female injecting drug users which increases their vulnerability to HIV and STI infections. These are issues that have been discussed at great length. What this rapid assessment has revealed is that the issues are much more complex and layered.

In Indonesia the Banjar and caste systems add extra dimensions to the patriarchal society which need to be negotiated by programmes. In Laos PDR sex work takes place at a more casual level than in brothels making targeting sex workers with information and services more challenges. In Thailand, the efficiency of the earlier response to sex workers is gradually unraveling as the health system is decentralized. In both Laos PDR and Thailand sex during pregnancy is taboo which legitimizes men's patronage of sex workers. In all three countries traditional values of how women and men should behave impact on women who have little say over when or how they have sex with their partners. For younger generations values related to sex before marriage are being adhered to less and less: sex education in schools needs to catch up with reality of these countries' young people.

Condom use among sex workers is highest in Thailand, but in all three countries condom use between couples in relationships is very low. Part of the reason for this is the availability and promotion of other types of contraception such as hormonal injections and sterilization, which increase women's vulnerability to HIV infection and reduce their ability to negotiate the use of condoms. However, common to all countries is the association of condoms with sex work; they have come to symbolize infidelity and mistrust and are

considered to have no place within marriage. This makes it extremely difficult for both men and women to suggest using them with their partners. An approach to overcoming this stigma could be to promote the female condom to couples as a contraceptive.

All of these issues affect the personal, intimate and private lives of citizens. Programmes need to understand these complexities and find ways to navigate through them and reach all of those at risk of HIV and STI infections.

HIV testing (for both women and men) and enabling disclosure between couples seem to be common issues. Linked to this is the need to promote voluntary, confidential counseling and testing as opposed to mandatory testing. Responses which promote 'positive prevention' (reducing infection rates among discordant couples and reducing re-infection among concordant couples) also need to increase significantly.

Gender inequality is exacerbating vulnerability to HIV infection across the region and future research needs to understand gender-based interpersonal dynamics, which vary greatly between countries, cities and communities. Within marriage women are economically and socially dependent on men. Gender-based violence (GBV) also occurs and was reported anecdotally but few studies were found which investigate GBV and its relation to HIV transmission. Outside marriage some women have more economic power (such as sex workers) but they are socially disadvantaged and have varying degrees of negotiating power with clients and their partners. Female injecting drug users seem to have the least power overall, and are most vulnerable to exploitation and violence from their partners, drug dealers and authorities. Programmes need to be able to reduce incidences of sexual coercion, and increase sexual negotiation power and condom use.

At the same time health service providers need to understand how to develop their approaches. A largely clinical approach means that the social aspects of HIV and gender are often absent from services. At the same time without a full appreciation of the social aspects, health service providers lack the experience and knowledge to respond appropriately to those people affected who are outside the mainstream society. At best sex workers, female drug users, and males who have sex with males receive inadequate service, and at worst they are denied access to services which they seek. A shift in perception of key populations needs to take place from viewing them with stigma to viewing them as both vulnerable populations that need extra support and as potential key actors in the prevention response.

Another issue common to all countries is the lack of participation of men in sexual and reproductive health services. Attempts have been made in Thailand by the government in conjunction with WHO, and in Laos by UNICEF, and at local level by NGO Kusuma Buana in Indonesia to include men in antenatal care. However, a concerted effort is needed to include men by providing services aimed at them, as well as aimed at couples. This is important to both to reach them with information and services as part of realizing their own rights and health needs, and encouraging them to prioritize the sexual health needs of themselves and their partners. Ultimately this approach is also needed to reduce the vulnerability of their female partners and spouses to STI infections.

The nexus between sex work and injecting drug use is beginning to be revealed, as is the relationship between commercial sex and HIV transmission within marriage. However, research on these dynamics is lacking, as are programmatic responses. The dynamics of these interacting issues are likely to be complex with many unique factors contributed by the individual personal dynamics between couples. Programme responses need to know what communication systems work when targeting what is essentially a private relationship.

Further studies need to look at secondary transmission of HIV i.e. the transmission that impacts people beyond the key populations. Spousal transmission is one of these areas that need greater understanding: programmes need to respond effectively to the partners of key populations and the partners of clients of sex workers.

Thailand already has a vast array of national surveys and data collection on HIV related issues, Indonesia has had research conducted on key population issues, such as the internal migration of sex workers, and Laos has HIV surveillance and studies including among men about their interaction with commercial sex. However, all three countries need their capacity developed to undertake in-depth research into these more complex and overlapping issues that ultimately affect both key populations and the broader population.

Even where research exists, and with the addition of new research, countries and their development partners need the capacity to make effective use of research findings by developing relevant programmes.

At anecdotal level the main barriers to disclosing one's status are known, but simply acknowledging the barriers is not enough to change the situation. This includes understanding the norms and practices that increase risk of spousal transmission and within sero-discordant couples. The intimate dynamics between couples and partners needs to be understood, and how programmes respond to these by tackling societal attitudes as well as supporting individuals and couples at a much more personal and tailored individual level.

There is a risk that approaches to reduce spousal transmission will rely too heavily on simply persuading people living with HIV to disclose. The danger of this approach is two-fold: it increases the burden of responsibility on people living with HIV and there are few safeguards to prevent coercion of the most vulnerable into disclosing their status. It is, of course, imperative that the wider societal as well as intimate relationships provide an environment where people are comfortable to both get tested and to disclose their results. But it is also important to prioritize alongside this those measures that will reduce the risk of transmission such as bio-medical determinants including treating and reducing other sexually transmitted infections and lowering viral load (through antiretroviral therapy as well as good nutrition etc).

It is vital that governments and health providers facilitate the participation of networks and organizations of women living with HIV. Without their input into the analysis of the situation and the design of responses, efforts take place without their expertise and risk falling short of meeting their needs. Part of this process includes strengthening positive networks and organizations so they have the capacity to contribute fully.

Whilst there are similarities and differences in the national contexts, one issue that closely interlinks Indonesia, Laos PDR and Thailand to each other and neighboring countries in the region is migration. Both Indonesia and Laos PDR have a significant amount of outward migration. These migrant workers are potentially more susceptible to STI infection while they are outside the country because of their vulnerability to exploitation and abuse. In the case of Laos PDR, most of the women who migrate to Thailand, do so illegally and it is not known to what extent they take part in Thailand's sex industry.

What is clear from this rapid assessment is that there is much more to learn if the HIV response is to comprehensively address HIV transmission between spouses, and reduce the vulnerability of women to infection. The findings in this report provide a platform to develop a strategy to understand both the complexities of the societal and personal arenas in order to develop effective responses to make an impact on reducing HIV.

Annex: Contributors

The following individuals extended their personal and professional cooperation, sharing their time and knowledge with the consultant:

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	Adji Vera R. Hakim	UNDP
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¹²⁵ National AIDS Commission

Annex: Data, programmes, policies, research

Indonesia

	Adult population	Women	Men
Estimates	<ul style="list-style-type: none"> 90,000-130,000 people living with HIV¹²⁶ 4,683,100-8,323,760¹²⁷ population at 'high risk' (2006 national estimates) By the end of 2015, HIV will have been transmitted to more than 38,500 children through their HIV- positive mothers. The majority of these mothers will have contracted HIV from their husbands.¹²⁸ 	<ul style="list-style-type: none"> 1,607,510-2,688,730¹²⁹ women at 'high risk' (2006 national estimates) 58,785,560-59,866,780¹³⁰ women at 'low risk' (2006 national estimates) 	
Projections:	<ul style="list-style-type: none"> By 2010, 400,000 people will be living with HIV, and 100,000 will have already died of AIDS.¹³¹ In 2015, there will be 1 million PLHIV and 350,000 HIV-related deaths in Indonesia. The risk of HIV transmission is not limited to people who engage in high risk behaviour; HIV can also be transmitted to partners or wives of those with high risk behavior.¹³² 	<ul style="list-style-type: none"> The prevalence overall among women is projected to be less than 0.5 per cent, there will nonetheless be 200,000 non sex worker women who are HIV-positive.¹³³ In Papua, the projected prevalence in women will be nearly ten times higher, with 40,610 women HIV-positive (4.3 per cent prevalence), and 21,000 deaths by 2025. 	
Policies & plans		<p>The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS</p> <ul style="list-style-type: none"> Indicator: % of women aged 15-24 testing positive for HIV during routine sentinel surveillance at Jayapura, Papua antenatal clinics. (ASA and IHPCP Projects)¹³⁴ 	
Programme coverage	<ul style="list-style-type: none"> 834 or 1% of people living with HIV (USAID and AusAID)¹³⁵ 100 VCT centres in 2004¹³⁶ 25 hospitals providing ART¹³⁷ 	<p><u>Kusuma Buana</u> Empowering women: KB works to educate women about STIs. KB provides information about HIV to help HIV negative women stay negative but it is</p>	<p><u>Kusuma Buana</u> Men's involvement in family planning: KB has 5 clinics (4 in Jakarta, 1 in Bandung). There are special</p>

¹²⁶ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹²⁷ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹²⁸ *UNGASS 2008 report*

¹²⁹ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹³⁰ *ibid*

¹³¹ *UNGASS 2008 report: Country report on the Follow up to the Declaration of Commitment On HIV/AIDS, (UNGASS) Reporting Period 2006-2007, National AIDS Commission, Republic of Indonesia*

¹³² *ibid*

¹³³ *AusAID 2006, op. cit.*

¹³⁴ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹³⁵ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

¹³⁶ *National data in NAC Desk Study 2005*

¹³⁷ *ibid*

		<p>difficult to tell how effective the messages are when so many women don't consider themselves at risk.</p> <p>Sex education in schools KB provides this for schools and works with conservative teachers to show them the data which demonstrates that it's better to provide sex education sooner to avoid problems later. Because sex education needs experienced communicators KB builds the capacity of teachers as well as providing the information directly to young people.</p>	<p>programmes for men in FP and MCH and they are encouraged to come to the delivery room. The aim is to include men and make them feel important. Male role models who undergone vasectomy raise awareness among men (vasectomy and castration is often confused) in order to reduce the more invasive sterilization procedure among women.</p> <p>Couples counseling The process begins with KB talking to men and encouraging them to get tested. They have produced high quality educational materials but would like to get involved in a study which looks at approaches to communicating with men and with husbands.</p>
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	Injecting drug users (male)	and their partners (female)
Estimates	<ul style="list-style-type: none"> • 190,000-247,800¹³⁸ (2006 national estimates) • 80,000-144,000 (ASA and IHPCP)¹³⁹ • 124,000-196,000 (UNAIDS/WHO)¹⁴⁰ • 508,000 (National Narcotic Board (BNN)) • Neither the estimates for injecting drug users nor their partners are disaggregated by sex; women are estimated to account for 15% of injecting drug users. 	<ul style="list-style-type: none"> • 81,100-105,590¹⁴¹ (2006 national estimates) • 94,000-148,000¹⁴² (2002 national estimates) • 24,598 (range 18,055-31,140) non-injecting partners of IDU who are at high risk of becoming infected from their partners in 2005.¹⁴³ • 18,000-31,000 (ASA and IHPCP)¹⁴⁴
Programme coverage:	<ul style="list-style-type: none"> • 11,000 or 9%¹⁴⁵(USAID and AusAID) • 3,796 in Jakarta through five NGOs¹⁴⁶ including drop-in centres, outreach, advocacy, detoxification and rehabilitation, support groups and VCT¹⁴⁷ • 2 Methadone replacement therapy providers¹⁴⁸ • 22 needle & syringe exchanges¹⁴⁹ 	<ul style="list-style-type: none"> • zero¹⁵⁰(USAID and AusAID)
Surveys &	Sexual Behaviour Among Injection Drug users in 3 Indonesian Cities Carries a High potential for HIV	

¹³⁸ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹³⁹ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁴⁰ *NAC Desk Study 2005*

¹⁴¹ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁴² *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁴³ *NAC Desk Study 2005*

¹⁴⁴ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁴⁵ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

¹⁴⁶ *Yayasan Pelita Limu; Pusat Penelitian Kesehatan; Universitas Indonesia (PPK-U); Kios Informasi Atmajaya; Kelompok Independen Stigma; Yayasan Kharisma*

¹⁴⁷ *AHRN/UNODC 2005 in NAC Desk Study 2005*

¹⁴⁸ *National data in NAC Desk Study 2005*

¹⁴⁹ *ibid*

¹⁵⁰ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

studies	spread to Non-injectors, 2003 Pisani et al ¹⁵¹ Key findings: - 650 respondents 648 heroin injectors. - Despite knowledge about transmission of HIV through injection 85% continued to share - Very few has had an AIDS test - 2/3 + were sexually active - 48% had multiple partners - 40% bought sex from female sex workers in previous 12 months - Consistent condoms reported by 10%	
Policies & action plans	National HIV/AIDS Action Framework: 2005-2007 ¹⁵² <ul style="list-style-type: none"> Priority area 2: Individual risk of HIV transmission among injecting drug users and sexual transmission to their partners reduced Indicator: % of IDUs reporting condom use during most recent sex act with any partner. 	National HIV/AIDS Action Framework: 2005-2007 ¹⁵³ <ul style="list-style-type: none"> Priority area 2: Individual risk of HIV transmission among injecting drug users and sexual transmission to their partners reduced

	Female sex workers	Male clients	And their female partners
Estimates	<ul style="list-style-type: none"> 164,000-278,160¹⁵⁴ (2006 national estimates) 158,000-241,000¹⁵⁵ 	<ul style="list-style-type: none"> 2,342,660-3,981,180¹⁵⁶ (2006 national estimates) 6,859,000-9,585,000 (2002 national estimates)¹⁵⁷ 2,500,000-3,473,000¹⁵⁸ Studies indicate that the average age of clients is between 20-40 and the majority are married¹⁵⁹ 	<ul style="list-style-type: none"> 1,362,330-2,304,980¹⁶⁰ (2006 national estimates) 4,935,000-7,293,000 (2002 national estimates)¹⁶¹ Partners of clients of sex workers estimated to be make up 3% of the total number of people who are HIV positive.¹⁶²
Programme coverage	Programme coverage <ul style="list-style-type: none"> 45,000 or 22%¹⁶³(USAID and AusAID) 60 outreach projects¹⁶⁴ 	Programme coverage: <ul style="list-style-type: none"> 534,000 or 17% (USAID and AusAID) 	
Surveys & studies	Behavioural surveillance survey (BSS 1996-2000) of FSW and adult male respondents ¹⁶⁵ <ul style="list-style-type: none"> Some increase in condom 	Behavioural surveillance survey (BSS 1996-2000) of FSW and adult male respondents ¹⁶⁷ <ul style="list-style-type: none"> % of men reporting sex 	

¹⁵¹ *Sexual Behaviour Among injection Drug users in 3 Indonesian Cities carries a High Potential for HIV Spread to Noninjectors (2003) Pisani E., Dadun, Suahya, Purwa K., Kamil Octavery, Jazan Saiful, JAIDS, 34,4*

¹⁵² *The Indonesian Partnership for HIV/AIDS - Komisi Penanggulangan, op. cit.*

¹⁵³ *ibid*

¹⁵⁴ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁵⁵ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁵⁶ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁵⁷ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁵⁸ *ibid*

¹⁵⁹ *IHPCP (2001) in NAC Desk Study 2005*

¹⁶⁰ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁶¹ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁶² *UNGASS 2008 report*

¹⁶³ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

¹⁶⁴ *National data in NAC Desk Study 2005*

¹⁶⁵ *2001, Editors: Budi Utomo & N. Dharmaputra, Centre for Health Research, University of Indonesia*

	<p>use but condom use remains extremely low and consistent condom use unchanged from year to year</p> <p>'Keep Surabaya safe from HIV/AIDS' (2004)¹⁶⁶</p> <ul style="list-style-type: none"> • HIV prevalence among sex workers is 3.8% • 7800 sex workers, 113 900 clients, 36450 wives of clients <p>Low condom use (12% of sex workers in red light district used with all clients last week.</p>	<p>with sex worker has risen. Study of Clients of female sex workers (2001)¹⁶⁸</p> <ul style="list-style-type: none"> • 92 clients interviewed • Male clients aged 20-40 • 90% married • Level of knowledge on HIV/STI high -Only 15% use condoms regularly • 50% use condoms sometimes • 55% have had an STI • 53% treat themselves and only ---39% go to doctors <p>There are few studies describing the behaviours of clients of sex workers, though the number of men reporting sex with sex workers seems to be rising¹⁶⁹</p>	
Policies & plans		<p>HIV Action FW indicators:</p> <ul style="list-style-type: none"> • % of Target Male Groups reporting commercial sex in the last 12 months. • % of Target Male Groups reporting condom use during most recent sex act with commercial partner. 	
Programme coverage			HIV prevention strategy for spousal transmission – ASEAN Foundation proposal

	Male sex workers	Male clients	And their female partners
Estimates:	<ul style="list-style-type: none"> • 4,807¹⁷⁰ • 3,000-6,000¹⁷¹ • The majority live in Java and Bali and 40% in Jakarta¹⁷² 	<p>Estimates of the number of clients of male sex workers in Indonesia are not available neither have they been systematically studied.¹⁷³ The majority are assumed to be male.</p>	
Programme coverage:	<ul style="list-style-type: none"> • 19,000 or 31% of the aggregate group: men who have sex with men, male sex workers, waria (USAID and AusAID)¹⁷⁴ 		

¹⁶⁷ Centre for Health Research, University of Indonesia, 2001 op. cit.

¹⁶⁶ 2004 Pisani E. Surabaya Data Analysis Group

¹⁶⁸ 2001, Indonesia HIV/AIDS prevention and Care Project- Phase II, IHPCP

¹⁶⁹ BSS 2001 in NAC Desk Study 2005

¹⁷⁰ NAC Desk Study 2005

¹⁷¹ The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS

¹⁷² IHPCP as above in NAC Desk Study 2005

¹⁷³ NAC Desk Study 2005

¹⁷⁴ 2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005

	Transgender 'Waria'	Their male partners	And their female partners
Estimates:	<ul style="list-style-type: none"> • 20,960-35,300¹⁷⁵ (2006 national estimates) • 21,415¹⁷⁶ • 17,000-26,000¹⁷⁷ 	<ul style="list-style-type: none"> • 61,610-104,640¹⁷⁸ (2006 national estimates) • 173,000 and 340,000¹⁷⁹ • 184,000-312,000¹⁸⁰ • 2-4,000 non-paying sexual partners¹⁸¹ 	
Programme coverage	<ul style="list-style-type: none"> • 19,000 or 31% of the aggregate group: men who have sex with men, male sex workers, waria (USAID and AusAID)¹⁸² 		

	Men who have sex with men	And their male and female partners
Estimates:	<ul style="list-style-type: none"> • 384,320-1,149,270¹⁸³ (2006 national estimates) • 1.2 million¹⁸⁴ • 21,000-47,000¹⁸⁵ • 2.5% prevalence of HIV¹⁸⁶ 	There doesn't seem to be much analysis of their sexual patterns and sexual partners including the number of male and female partners, including whether they are married or not.
Programme coverage:	<ul style="list-style-type: none"> • 19,000 or 31% of the aggregate group: men who have sex with men, male sex workers, waria (USAID and AusAID)¹⁸⁷ 	

	Male prison population	And their partners
Estimates:	<ul style="list-style-type: none"> • 75,580-116,840¹⁸⁸ (2006 national estimates) • 106,000-112,000¹⁸⁹ • 17.5% prevalence (2000 MoH data)¹⁹⁰ • 22% prevalence (2002 MoH data) • 24.5% prevalence in Jakarta prisoners • 10.2% prevalence in Bali prisoners <p>This increase seems to correspond to the increase in the number of drug users in prisons. Numbers have</p>	No data found on the female or male partners of male prisoners

¹⁷⁵ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁷⁶ *Source CDC & EH-MOH, 2004 in NAC Desk Study 2005*

¹⁷⁷ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁷⁸ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁷⁹ *NAC Desk Study 2005*

¹⁸⁰ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁸¹ *NAC Desk Study 2005*

¹⁸² *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

¹⁸³ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁸⁴ *NAC Desk Study 2005*

¹⁸⁵ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁸⁶ *Pisani, Girault et al 2004*

¹⁸⁷ *2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005*

¹⁸⁸ *Komisi Penanggulangan AIDS, 2006 op. cit.*

¹⁸⁹ *The Indonesian Partnership Fund for HIV/AIDS - Komisi Penanggulangan AIDS*

¹⁹⁰ *NAC Desk Study 2005*

	grown from 7211 in 2002 to 11,973 in 2003 and 17,000 in 2004. Although some prisoners were infected outside prison there is evidence that that new infections occur in prisons and are due to unprotected sex and sharing of needles and syringes inside prisons.	
Programme coverage:	<ul style="list-style-type: none"> • 960 or 1%¹⁹¹ (USAID and AusAID) 	
Surveys & studies	<p>Need Assessment of prisoners in Penfui and Atambua relate with HIV prevention (2001)¹⁹²</p> <ul style="list-style-type: none"> • Structured interview of 150 male prisoners: • 50% are married • 10 % in Penfui and 15% in Atambua are in prison because of rape/sexual violence, but only 1% are in prison because of narcotics • 47% had suffered an STD • There is sex inside prison, but only 20% had ever used a condom 	

¹⁹¹ 2004 data from Ministry of Health and ASA / IHPCP Monitoring data in NAC Desk Study 2005

¹⁹² 2001, Liliانا P. Amalo, Yayasan Tanpa Batas

Laos PDR

	General population	Women	Men
Estimates	<ul style="list-style-type: none"> • 0.1% prevalence¹⁹³ • 50% of those infected are between 20 and 39 years old¹⁹⁴ 	<ul style="list-style-type: none"> • 42% of reported HIV cases were female¹⁹⁵ • Women account for a substantial proportion of HIV infections among young people between the ages of 15 to 24 years¹⁹⁶ 	<ul style="list-style-type: none"> • 58% of reported HIV cases were male¹⁹⁷
Projections	<ul style="list-style-type: none"> • National Strategy and Action Plan on HIV/AIDS/STI 2006-2010 		
Policies & plans	VCT: National Strategy and Action Plan on HIV/AIDS/STI 2006-2010	<ul style="list-style-type: none"> • National policy on non-discrimination¹⁹⁸ • PMTCT: National Strategy and Action Plan on HIV/AIDS/STI 2006-2010 • Laos Women's Union Strategy and Action Plan on HIV/AIDS/STI 2007-2010 	
Programme Coverage	<ul style="list-style-type: none"> • VCT is available in 17 provinces and 16 districts¹⁹⁹ • Percentage of schools that provided life skills-based HIV education within the last academic year was 70.56% for secondary schools, 24.17% for primary schools and 32.30% for all levels of schools in the Laos PDR.²⁰⁰ 		
Surveys & studies	"Laos PDR," Fighting a Rising Tide: The Response to AIDS in East Asia; (eds. Tadashi Yamamoto and Satoko Itoh). Tokyo: Japan Center for International Exchange, 2006, pp. 172-194. LAOS REPRODUCTIVE HEALTH SURVEY 2005, UNFPA Project LAOS/02/P07:	Young Women's Sexual Behaviour Study Vientiane Capital, Laos PDR - The Department of Health of Vientiane Capital (PCCA) in collaboration with the Burnet Institute and UNFPA, April 2008	STIs among service women & electricity workers: Laos PDR, 2008 Second Generation Surveillance (3 rd Round), CHAS, 2008

¹⁹³ Lao PDR UNGASS Report 2008

¹⁹⁴ *ibid*

¹⁹⁵ *ibid*

¹⁹⁶ Young Women's Sexual Behaviour Study Vientiane Capital, Lao PDR

¹⁹⁷ Lao PDR UNGASS Report 2008

¹⁹⁸ *ibid*

¹⁹⁹ *ibid*

²⁰⁰ *ibid*

	Female sex workers	Male clients	And their female partners
Estimates	HIV sero-prevalence among sex workers had increased from 0.9% in 2001 to 2.02% in 2004 ²⁰¹		
Policies & plans	National Strategy and Action Plan 2006-2010 National policy on non-discrimination ²⁰² National Strategy and Action Plan on HIV/AIDS/STI 2006-2010	National Strategy and Action Plan 2006-2010 National Strategy and Action Plan on HIV/AIDS/STI 2006-2010	
Programme Coverage	100% Condom use programmes were expanded and cover 14 provinces ²⁰³ Drop in centers for sex workers in 5 provinces ²⁰⁴		
Surveys & studies	<ul style="list-style-type: none"> STIs among service women & electricity workers: Laos PDR, 2008 Second Generation Surveillance (3rd Round), CHAS, 2008 	STIs among service women & electricity workers: Laos PDR, 2008 Second Generation Surveillance (3 rd Round), CHAS, 2008	

	Male sex workers	Male clients	And their female partners
Policies & plans	National Strategy and Action Plan on HIV/AIDS/STI 2006-2010		

	Men who have sex with men	Their male partners	Their female partners
Estimates	<ul style="list-style-type: none"> 30 out of 540 men (5.6%) tested positive for HIV, of whom 43% were men who had also a female sex partner in the last 3 months²⁰⁵ 		<ul style="list-style-type: none"> 30 out of 540 men (5.6%) tested positive for HIV, of whom 43% were men who had also a female sex partner in the last 3 months²⁰⁶
Policies & plans	National Strategy and Action Plan 2006-2010 National Strategy and Action Plan on HIV/AIDS/STI 2006-2010		

²⁰¹ Lao PDR UNGASS Report 2008

²⁰² *ibid*

²⁰³ *ibid*

²⁰⁴ *ibid*

²⁰⁵ *ibid*

²⁰⁶ *ibid*

Programme Coverage	Drop in centers for MSM in 5 provinces ²⁰⁷		
Surveys & studies	<ul style="list-style-type: none"> • Survey of HIV infection and risk behaviour among men who have sex with men, Dr Chansy Phimpachanh, CHAS, 2007 • Study of MSM in the Laos PDR, June 2006 (not yet published) • 		

	Male injecting drug users	Female partners
Policies & plans	National policy on non-discrimination ²⁰⁸ National Strategy and Action Plan on HIV/AIDS/STI 2006-2010	National Strategy and Action Plan on HIV/AIDS/STI 2006-2010

	Migrant & mobile populations
Policies & plans	National policy on non-discrimination ²⁰⁹ National Strategy and Action Plan on HIV/AIDS/STI 2006-2010

	Young people
Policies & plans	National Strategy and Action Plan on HIV/AIDS/STI 2006-2010

	Ethnic groups
Policies & plans	National Strategy and Action Plan on HIV/AIDS/STI 2006-2010

	Uninformed services
Policies & plans	National Strategy and Action Plan on HIV/AIDS/STI 2006-2010

²⁰⁷ *ibid*

²⁰⁸ *Lao PDR UNGASS Report 2008*

²⁰⁹ *ibid*

RESEARCH				
Title	Author	Objective/Hypothesis	Methodology	Key Findings
Orphans, children affected by HIV/AIDS and other vulnerable children in Laos PDR Vientiane, 2004	UNICEF	<p>The objectives of this assessment are as follows:</p> <ul style="list-style-type: none"> ▪ To estimate the number of vulnerable children in the Laos PDR. ▪ To better understand the situation and needs of vulnerable children and their families. ▪ To investigate current mechanisms for formal and informal support. ▪ To review the legal and policy framework for protecting the rights of vulnerable children. ▪ To promote the development of integrated policies and strategies for support to community-based programs of care for vulnerable children. 	<p>This study incorporates both quantitative and qualitative information on the situation of vulnerable children and their families.</p> <p>Quantitative data provides information on the number of orphans, children affected by HIV/AIDS and other groups of vulnerable children.</p> <p>Qualitative information gives an insight into community perceptions of vulnerable children and appropriate options for care and support which might otherwise be overlooked in a quantitative study.</p>	<p>It appears that adolescents and young adults - male and female alike are being hit harder than older people, who in other societies are usually the first to become infected. The high migration rates of young people, combined with high levels of ignorance about HIV/AIDS and STIs, create a substantial risk of HIV infection in people under 30 years of age.</p> <p>A cumulative total of 25 infants under five years of age were tested HIV+ between 1990 and April 2003.</p> <p>57 children under the age of fifteen have lost their mother due to AIDS.</p> <p>It is estimated that 376 children have been born to HIV+ mothers but are not themselves infected. This estimate is based on the number of HIV+ females (344) multiplied by an age adjusted fertility rate; then the number of HIV+ children is subtracted.</p>
Sexual behaviour and HIV/AIDS risk among transgender men and their partners in the Laos PDR: A qualitative Analysis October 2004	PSI	<p>The aim of the study was to gain qualitative data to inform the design of HIV prevention programmes for MSM, with the specific objectives of:</p> <ul style="list-style-type: none"> • Collecting relevant information for future behaviour change communication (BCC) strategies; • Identifying locations for campaign events and/or interpersonal communication (IPC) activities, as well as for distribution of 	<p>This qualitative study was undertaken through key informants and in-depth interviews, and investigated the sub-groups of MSM formed by transgender men (referred to as Katoey) and their partners.</p>	<p>Youth are attracted to sexual relations with katoeys primarily because of the payment received.</p> <p>Multiple partners are common among katoeys, even to the point of having multiple partners in one day. Students may visit different katoeys and many have girlfriends.</p>

		<p>Number One Deluxe Plus;</p> <ul style="list-style-type: none"> Developing a network of MSM for future IPC activities and direct sales; 		
<p>Second Generation Surveillance 2nd Round on HIV, STI and Behavior</p> <p>December 2005</p>	<p>Ministry of Health</p> <p>Center for HIV/AIDS/STI</p>	<p>The two rounds of the national surveillance of HIV and sexually transmitted infections (STIs) in Laos PDR in 2001 and 2004 are the result of extensive collaboration between Laos government agencies, multiple donors, and a range of international NGOs. No single agency could have provided all the material and technical resources to achieve the quality results of this effort</p>	<p>The selection of respondents to include in the surveys used a variety of methods.</p> <p>In some cases, all persons in a category were selected if the sampling universe was small. In other cases, if the populations of eligible respondents was large, a sample was taken in proportion to the total number in the group (e.g., service women in some provinces). In cases of highly mobile groups (e.g. truck drivers) a sample was taken of persons who were available at a certain location during a fixed time period.</p>	<p>In this second round, HIV among service women had increased to 2.0% and was distributed widely around the country:</p> <p>HIV prevalence was scant among men in the 2nd round of surveillance: only 0.8% of a single sample sub-group (electricity workers) was infected. By contrast, STIs were detected in all groups of men, but these were mostly the non-ulcerative STIs (gonorrhoea and/or chlamydia). Syphilis prevalence was nearly zero for both men and women.</p>
<p>Study of young men's sexual behavior</p> <p>February 2005</p>	<p>Burnet Institute</p>	<p>Objectives of the Male Sexuality and HIV Prevention Project:</p> <ul style="list-style-type: none"> To increase understanding of the nature and extent of high-risk sexual behaviour among young urban men, including men who have multiple sexual partners, and men who have sex with men. To increase awareness of HIV/AIDS and STIs among young urban men who engage in sexual behaviour that places them at high risk of HIV infection and other STIs. To promote safer sex among young urban men who engage in high-risk sexual behaviour in order to prevent HIV infection. 	<p>The qualitative aspect consisted of focus group discussions and semi-structured key informant interviews.</p> <p>FGDs were conducted with general young men, factory workers, soldiers, labourers, men who openly identify as "gay", entertainment venue and hotel employees, transvestites and male sex workers.</p> <p>Semi-structured key informant interviews with 12 male sex workers were also carried out by trained Laos interviewers.</p>	<p>Sexual health education is a priority for young urban men. This should commence when boys are 13 to 14 years old, the age they start to have sexual desires.</p> <p>Sexual health education for men should stress the risk of infecting their wives and children if men engage in unsafe sex with other sex partners outside the marriage, especially during pregnancy and lactation.</p> <p>Sexual health education for men and women should include information that sex during all stages of pregnancy and in the post-partum period is safe and acceptable so long as the woman does not experience any pain (non-penetrative sex should be encouraged if the parents fear that sex might harm the unborn</p>

				child). Antenatal care programs should routinely include counselling of women and their husbands or partners about sexual health and the prevention of HIV and STIs during pregnancy and lactation.
Needs Assessment on Children and Adolescents Affected by HIV/AIDS	UNICEF	<ul style="list-style-type: none"> • Provide substantial information on the physical, psycho-social and economic needs of children affected by HIV/AIDS compared to other children in Laos PDR, to direct the consortium partners' country programmes and strategies. • Recommend care and protection arrangements, especially community-based approaches, which are in the best interests of children affected by HIV/AIDS and will build their resilience, health and welfare. • Recommend appropriate policies and national plans responding to the current situation of children and their families affected by HIV/AIDS. 	Quantitative assessment on the life situation and psychosocial factors of HIV/AIDS affected children and youth.	<p>A total number of 230 people were interviewed. 80 of them were HIV/AIDS affected children and youth and 80 were their parents or other guardians.</p> <p>HIV/AIDS shapes the lives and well-being of children and adolescents in Laos PDR primarily through economical difficulties and orphanhood. Support and help for HIV/AIDS affected children shall therefore have a special focus on economical/income support and tailored support for orphan children. Stigma and discrimination on HIV/AIDS affected children has remained relatively low in Laos PDR.</p>
Qualitative study to determine the impact of HIV & AIDS on adult and children in Laos PDR	<u>UNICEF</u>	To provide a better understanding of the situation of PWHIV in the Laos PDR, the study looks into the existence of the sample PWHIV, 'the participants', covering their lifetimes before the test, experience of the test, and period between the test and the present time. The test is considered the crucial point in the life of a PWHIV, the moment of passage from infection to knowledge of the infection and its consequences.	Qualitative study: Interviewed the families of PLWH and the caretakers of Children with HIV (CWHIV), and some PWHIV. Another assistant, a medical doctor, interviewed health workers who work with PLWH in the hospitals	<p>Family members describe their initial fear of having someone infected among them, and recall how they avoided any contact with the infected child or adult. After visits from volunteers or a health team the family members understand they cannot be infected through breathing or sharing daily utensils</p> <p>They explained that there was no risk of transmission and the chief did not enforce their departure. However, the villagers still discriminated against the family, refusing to have contact and avoiding any</p>

				relationship.
Tracking Results Continuously (TRaC) Survey: Female Sex Workers in the Laos PDR	<u>PSI</u>	<ul style="list-style-type: none"> To gain comprehensive data for informing PSI/Laos' interventions with FSW; To segment the FSW population according to consistent condom use with "fan" (regular partners) consistent condom use with "ka pa cham" (casual partners) and consistent condom use with "kek" (commercial partners) To identify Opportunity, Ability and Motivation (OAM) determinants of behavior; and To obtain baseline information for monitoring key indicators, behavior change, OAM determinants, and exposure to interventions. 	<p>The questionnaire covered demographic information, sexual behavior, condom and lubricant use, OAM determinants, and exposure to interventions.</p> <p>Multivariate analyses were performed to identify significant determinants of condom use. Simple frequencies were run on descriptive data to complete the monitoring table.</p>	<p>Condom use at last sex with fan, ka pa cham, and kek varied depending on partner type, with the lowest level of condom use reported with fan (64.7%), and higher levels of condom use with ka pa cham and kek (92.6%, and 96.7%, respectively).</p> <p>Likewise, consistent condom use varied depending on partner type, with the lowest level among fan and the highest among kek (46.5% with fan, 77.7% with ka pa cham, and 82.1% with kek).</p> <p>Number One Deluxe Plus (NODP) was perceived to be easily accessible at convenient times by 78.9% of respondents, and 97.2% felt that the product was affordable.</p>
<p>Mid-Term Learning Review:</p> <p>Preventing HIV in Young People Affected by Population Mobility in Laos PDR</p> <p>September 2006</p>	World Vision Laos PDR	<ul style="list-style-type: none"> To build the capacity of the local community structures to protect young people from HIV infection To increase the capacity of young people to protect themselves from HIV infection To develop management capacity for HIV prevention programming 	<p>Preparation of the interview questions</p> <p>Interviews among the project's target population and the members of the Village Committees for the Control of AIDS</p>	<p>The community members know more about HIV/AIDS/STIs and on family planning. They have also learned how to use condoms correctly. Most informants also told that people's behavior has changed: they [men] do not go out for recreation so much anymore. If they do, they are less eager to have sex, because they know about the risks. They also use condoms more regularly.</p> <p>Several informants understand, how expensive treatment for STIs is, and this also encourages them to avoid infections.</p> <p>The women's group in Phengpheng was an exception: some, particularly older women, reported that</p>

				<p>they have never seen a condom.</p> <p>Particularly the women's group in Donhi village explained that as a result of the project, their attitude towards PLWHA has changed, from fear to sympathy.</p>
<p>HIV Prevalence Study among migrant workers at 8 border provinces in Laos PDR</p> <p>May, 2006</p>	<p>Center HIV/AIDS/STI (CHAS), MOH</p>	<p>Primary objective:</p> <ul style="list-style-type: none"> To determine the prevalence of HIV infection among migrant worker population at 8 border provinces in Laos PDR To determine the nature and level of behaviors that carry a high risk for HIV infections among migrant workers most likely to engage in risk behaviors in Laos PDR <p>Secondary objectives:</p> <ul style="list-style-type: none"> To measure the frequency of and the associations between risk behaviors and exposures to HIV among the groups tested To provide trend data for analyzing changes in prevalence and behavioral risk and to evaluate the national response to the epidemic To provide evidence for determining national HIV prevention strategies 	<p>The survey had two components:</p> <ul style="list-style-type: none"> A specific quantitative study of the behaviors of target populations. <p>And the study of HIV testing to look at prevalence.</p>	<p>Around 84.9% of men mentioned that they already had sex in the past. The range of age during the first sex was from 10 to 39 years old. Those who had sex with regular partner during the last six months, only 0.7% of interviewees used condom at all times and 89.88% never used it. 15% of those who had sex in the past six months had sex with non-regular partner, of this 20.43% used condom all the times and the majority never used condom at all (56.93%).</p>
<p>Survey of HIV infection and risk behavior among men who have sex with men</p>	<p>Center HIV/AIDS/STI (CHAS), MOH and Burnet Institute</p>	<ul style="list-style-type: none"> To assess HIV and STI prevalence, risk behavior and associated factors among men who have sex with men in Laos PDR To set a baseline for monitoring epidemiologic trends in HIV/STI prevalence among men who have sex with men in Laos PDR To develop capacity and human resources of the Laos MOH, CHAS, and the PCCAs to conduct HIV and STI 	<p>Data collectors introduced themselves to potential participants, explained the study, and asked them to participate</p> <p>If they met the study criteria they were given a consent form to read and provided verbal consent</p> <p>Participants filled in the questionnaire on a hand-held computer</p> <p>Saliva samples were</p>	<p>30 out of 540 men (5.6%) tested positive for HIV; of whom 43% were men who had a female sex partner in the previous 3 months.</p> <p>Primary sexual attraction</p> <ul style="list-style-type: none"> Men – 39.6% Women – 44.6% More than one sex – 15.8% <p>Sex of first partner</p> <ul style="list-style-type: none"> Male – 46.5%

		surveillance among men who have sex with men	taken using Orasure kits Urine samples were taken for testing for gonorrhea and chlamydia	<ul style="list-style-type: none"> • Female – 50.4% • Transgender man – 3.2%
Young Women's Sexual Behaviour Study Vientiane Capital, Laos PDR April 2008	The Department of Health of Vientiane Capital (PCCA) in collaboration with the Burnet Institute and UNFPA	<p>This study aimed to:</p> <ul style="list-style-type: none"> • Increase understanding of behaviours related to sexual and reproductive health, particularly the nature and extent of sexual behaviour, among young urban women; • Determine the sexual and reproductive health services required by these young women; • Elicit young urban women's ideas on how to make HIV/AIDS and SRH services more youth friendly; • Provide relevant information on the current sexual behaviour of young urban women to agencies and programs involved in sexual and reproductive health programs for young women. 	<p>This study consisted of both qualitative and quantitative components.</p> <p>The qualitative component consisted of focus group discussions, in-depth interviews and observation, while the quantitative component consisted of a structured questionnaire.</p>	<p>The factors influenced their decision to have sex the large majority reported being in love (73.4%) as a factor, identified the desire to have sex (40.8%), fear of losing one's boyfriend (35.7%) and becoming married (34%) as reasons.</p> <p>25.2% had sex (and 6.7% of the entire sample) reported ever being coerced into sex with a man. Never married women who lived alone or in shared accommodation (31% [13 of 42 women]) and those who lived with family (26.2% [22 of 84 women]) reported ever being coerced into sex with a man.</p>

Thailand

	Adult population	Women	Men
Estimates	<ul style="list-style-type: none"> Condom use for casual sex 2005: 36%; 2008: 60%²¹⁰ 	<ul style="list-style-type: none"> 38.7% (6,399) of new infections are women infected through their husbands²¹¹ 505 or 0.87% HIV prevalence among pregnant women (2008)²¹² No data on the number of women who are HIV positive²¹³ (2008) The increasing trend of HIV prevalence in ANC women at 2nd and 3rd pregnancies indicates that the infection is spreading more deeply into families in general, and probably will remain at relatively high levels going forward. Younger pregnant women (age 15 to 24) show distinctly declining HIV prevalence, while pregnant women age 25-29 remained the group with highest HIV prevalence over the past six years.²¹⁴ only 38.7% of pregnant women were joined by their husband for VCT²¹⁵ 	<ul style="list-style-type: none"> 9.6% (1,578) of new infections are men who infected from their wives²¹⁶
Policies & plans	<p>National HIV Plan 2007-2011²¹⁷</p> <ul style="list-style-type: none"> Youth: target for HIV prevention programme development UNPAF 2007-2011²¹⁸ Older people People with disabilities 	<p>National HIV Plan 2007-2010²¹⁹</p> <ul style="list-style-type: none"> women at risk of infection from their regular partner: target for HIV prevention programme development <p>UNGASS 2008 report²²⁰</p> <ul style="list-style-type: none"> PMTCT promotion UNPAF 2007-2011²²¹ Women and young girls <p>Protection of Human Rights in the context of HIV and AIDS in</p>	<p>National HIV Plan 2007-2011²²²</p> <ul style="list-style-type: none"> men at risk of infection from their wives/regular partners who are already infected: target for HIV prevention programme development

²¹⁰ *Moving from a National Prevention Goal to Multi-sectoral HIV Action Plans in Thailand, 2008, Dr. Somsak Pantuwatana, Dr. Wiput Phoolcharoen*

²¹¹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²¹² *Report on Thailand gender-disaggregated statistics 2008, Office of Women's Affairs and Family Development, Ministry of Social Development and Human Security, UNDP*

²¹³ *ibid*

²¹⁴ *Thailand – UNGASS Country Progress Report 2008*

²¹⁵ *ibid*

²¹⁶ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²¹⁷ *ibid*

²¹⁸ *UNPAF 2007-2011 op. cit.*

²¹⁹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²²⁰ *Thailand – UNGASS Country Progress Report 2008*

²²¹ *UNPAF 2007-2011 op. cit.*

²²² *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

		Thailand(Women and Children), Report to Office of the High Commissioner for Human Rights (OHCHR), Bureau of AIDS, TB and STIs Department of Disease Control, Ministry of Public Health	
Programme coverage:	<p>National PMTCT programme Sex education in schools</p> <ul style="list-style-type: none"> • WHO is working with the MoE on a number of pilots and curriculums, but teachers need more support and experience in teaching sexual health education. • PATH is also working closely with Ministry of Education to expand the curriculum in schools. There are four books for each level in teaching and learning. 	<p>Raks Thai projects :Voices and Choices of Women Living with HIV/AIDS UNFPA Stay Negative programme</p> <ul style="list-style-type: none"> • For HIV-negative pregnant women and their male partners to promote safer behaviors, involving 6 mother and child health hospitals. 	<p>UNFPA Stay Negative programme</p> <ul style="list-style-type: none"> • For HIV-negative pregnant women and their male partners to promote safer behaviors, involving 6 mother and child health hospitals.
Surveys & studies	<ul style="list-style-type: none"> • Prospects for Increased Condom Use Within Marriage in Thailand, Knodel & Pramualratana, 1996, International Family Planning Perspective, Volume 22, Number 3, 1996 • Policy Profile: HIV/AIDS Policy Lessons: Learning from Thailand, FHI, HIV/AIDS Prevention: Perspectives from the Field, Volume III, No 3, November 1996 • External Review of the Health Sector Responses to HIV/AIDS in Thailand, 2005 - Ministry of Public Health, Thailand and the World Health Organization, Regional Office for South-East Asia • Living with HIV in Thailand: Assessing Vulnerability through a Life-Event History Approach, par Sophie LE COEUR, Wassana IM-EM, Suporn KOETSAWANG et Éva LELIÈVRE, Institut National d'Études Démographiques/Population-E 2005, 60(4), 473-488 • Thai views of sexuality and sexual behavior, John Knodel, Mark VanLandingham, Chanpen Saengtienchai and Anthony Pramualratana, Health Transition Review 6, 1996, 179-201 • THAILAND Multiple 	<p>Report on Thailand gender-disaggregated statistics 2008, Office of Women's Affairs and Family Development, Ministry of Social Development and Human Security, UNDP</p> <ul style="list-style-type: none"> • HIV prevalence among pregnant women <p>National sexual behaviour survey of Thailand 2006, Mahidol University & UNAIDS</p> <ul style="list-style-type: none"> • 82% of women disclose their STI to their partner compared to 45% of men • 79% of rural pop disclose their STI to their partner compared to 57% of urban pop • 70% of women would try to protect their partner from an STI compared to 51% of men • Protecting your partners from STI: Abstain from sex: 80.8%: Use condom: 5.4%: Take medicine: 65.9% • 94.3% of women would talk to their sexual partner if they suspected or knew that they had a sexually transmitted disease • Protecting yourself if you suspected/knew your sexual partner had an STI: Stop sex: 39.8% : Use condom: 42.9% : Suggest they see doctor: 29.9% : Take preventive medicine: 2.0% : Other: 5.9% • 3% of women report having casual sex partners • Condom use data • Sexual behavior with multiple partners • External influences on 	<p>Sex and the Single (Older) Guy: Sexual Lives of Older Unmarried Thai Men During the AIDS Era, Mark VanLandingham and John Knodel, PSC Research Report, 2003</p> <p>National sexual behaviour survey of Thailand 2006, Mahidol University & UNAIDS</p> <ul style="list-style-type: none"> • Protecting your partners from STI: Abstain from sex: 68.6%: Use condom: 28.6%: Take medicine: 57.1% • 94.3% of women would talk to their sexual partner if they suspected or knew that they had a sexually transmitted disease • Protecting yourself if you suspected/knew your sexual partner had an STI: Stop sex: 45.6% : Use condom: 45.0% : Suggest they see doctor: 35.0% : Take preventive medicine: 4.1% : Other: 2.2% • 52% of men report having casual sex partners • 44% of older men report ever having had commercial sex compared to 24% of younger men

	Indicator Cluster Survey December 2005 – February 2006, Thailand National Statistical Office, UNICEF, United Nations Children’s Fund, 2006	<ul style="list-style-type: none"> behavior Substance use 	
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	Male sex workers	Male clients	And their female partners
Estimates:	<ul style="list-style-type: none"> The number of male sex workers increased from 4,132 in 2000 to 4,460 in 2004 (MoPH)²²³ 		
Policies & plans	National HIV Plan 2007-2010 ²²⁴		

	Transgender	Their male partners	And their female partners
Estimates:			

	Injecting drug users (male)	and their partners (female)
Estimates	<ul style="list-style-type: none"> UNDOC estimated that there were 2-3 million of drug users in Thailand in 2001, including 274,200 heroin users, 70-80% of them injectors.²²⁵ Condom use 2005: 76%; 2008:76%²²⁶ Needle sharing 2005: 36%; 2008: 18%²²⁷ 	
Programme coverage:	<ul style="list-style-type: none"> outreach to drug users and methadone substitution treatment, community outreach and drop-in centers, methadone maintenance and detoxification, VCT, peer education and support, training and education²²⁸ In Bangkok, BMA in collaboration with TUC conducts peer-based outreach to drug users in several communities and provides methadone maintenance therapy to about 700 IDUs. NGOs such as Raks Thai work with provincial hospital staff to extend drug treatment services through outreach and drop-in centers.²²⁹ 	

²²³ Thailand and the World Health Organisation Regional Office for South-East Asia, 2005

²²⁴ The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.

²²⁵ Thailand and the World Health Organisation Regional Office for South-East Asia, 2005

²²⁶ Dr. Somsak Pantuwatana, Dr. Wiput Phoolcharoen, 2008 op. cit.

²²⁷ *ibid*

²²⁸ Thailand and the World Health Organisation Regional Office for South-East Asia, 2005

²²⁹ *ibid*

Policies & action plans	National HIV Plan 2007-2001 ²³⁰ UNPAF 2007-2011 ²³¹	
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	Female sex workers	Male clients	And their female partners
Estimates	<ul style="list-style-type: none"> Condom use 2005: 82%; 2008: 95%²³² 		<ul style="list-style-type: none"> Among women newly infected with HIV in 2005, it was estimated that 37% were infected through sexual contact with their male partner, 80% of whom were infected through paid sex.²³³
Surveys & studies	2007 Survey of sexual and reproductive health of sex workers in Thailand ²³⁴ <ul style="list-style-type: none"> 35.1% of sex workers have a male partner, two thirds of whom live with their partners, and two-thirds of whom don't use a condom with their partner 		
Policies & plans		National HIV Plan 2007-2001 ²³⁵ <ul style="list-style-type: none"> men at risk of infection from sex workers: target for HIV prevention programme development 	National HIV Plan 2007-2001 ²³⁶ <ul style="list-style-type: none"> women at risk of infection from their from husband/regular partner: target for HIV prevention programme development UNPAF 2007-2011²³⁷
Programme Coverage	NGOs complement DDC efforts by conducting outreach and prevention activities in indirect venues such as bars, karaokes and massage parlours, and referring female, male and transgender sex workers to STI clinics. ²³⁸		
Policies & plans	National HIV Plan 2007-2001 ²³⁹ UNPAF 2007-2011 ²⁴⁰ (non-brothel based)	National HIV Plan 2007-2001 ²⁴¹	

Discordant couples

²³⁰ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²³¹ *UNPAF 2007-2001 op. cit.*

²³² *Dr. Somsak Pantuwatana, Dr. Wiput Phoolcharoen, 2008 op. cit.*

²³³ *Thailand – UNGASS Country Progress Report 2008*

²³⁴ *2007 Survey of sexual and reproductive health of sex workers in Thailand, Mahidol University and UNFPA*

²³⁵ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²³⁶ *ibid*

²³⁷ *UNPAF 2007-2001 op. cit.*

²³⁸ *Thailand and the World Health Organisation Regional Office for South-East Asia, 2005*

²³⁹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁴⁰ *UNPAF 2007-2001 op. cit.*

²⁴¹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

Estimates	Condom use 2005: 2%; 2008: 30% ²⁴²
Policies & plans	National HIV Plan 2007-2001 ²⁴³

	Military personnel	Their female partners
Estimates	<ul style="list-style-type: none"> As of 2003, the infection rate among married recruits was almost twice that of single recruits (1% versus 0.47%)²⁴⁴ 	

	Men who have sex with men	And their male and female partners
Estimates:	<ul style="list-style-type: none"> 5-10% of the male population²⁴⁵ 28.3% HIV prevalence among MSM (2005 MoH)²⁴⁶ The MSM surveys in 2003 and 2005 show that 22.3% and 17% of survey participants respectively identified themselves as bisexual and reported having sex with both men and women during the past six months.²⁴⁷ Condom use 2005: 70%; 2008: 85%²⁴⁸ 	
Programme coverage:	<ul style="list-style-type: none"> Several NGOs (Rainbow Sky, SWING) provide interventions to MSM with peer outreach, counseling, non-formal education and links to clinical services that can serve as models for scale up. SWING with over 100 members, is providing services such as non-formal education, counseling, HIV and STI education, outreach to MSM community, condom promotion, fitness, internet access and health referral for STI and VCT. The Rainbow Sky Association and Bangkok Rainbow Group in Bangkok are working with their group members to provide education, community outreach activities and advocate for protection of rights. TUC is setting up a research-based MSM clinic in Patpong area. Also TUC under the Global AIDS Program is collaborating with Patong Hospital in Phuket to set up a MSM clinic with outreach activities. PATH run a project 'M Plus' in Chiang Mai. MOPH has conducted a series of workshops to develop a national strategic plan for HIV prevention among MSM to be implemented beginning 2005 and as a part of the National AIDS Plan beginning 2007. 	
Policies & plans	National HIV Plan 2007-2001 ²⁴⁹ <ul style="list-style-type: none"> men at risk of infection from MSM: target for HIV prevention programme development UNPAF 2007-2011 ²⁵⁰	

²⁴² Dr. Somsak Pantuwatana, Dr. Wiput Phoolcharoen, 2008 *op. cit.*

²⁴³ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁴⁴ Thailand – UNGASS Country Progress Report 2008

²⁴⁵ Thailand and the World Health Organisation Regional Office for South-East Asia, 2005

²⁴⁶ *ibid*

²⁴⁷ Thailand – UNGASS Country Progress Report 2008

²⁴⁸ Dr. Somsak Pantuwatana, Dr. Wiput Phoolcharoen, 2008 *op. cit.*

²⁴⁹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁵⁰ UNPAF 2007-2001 *op. cit.*

	Male prison population	And their partners
Policies & plans	National HIV Plan 2007-2011 ²⁵¹ UNPAF 2007-2011 ²⁵²	

	Ethnic minorities	
Policies & plans	UNPAF 2007-2011 ²⁵³	
Programme coverage	Raks Thai projects	

	Young women	Young men
Surveys & studies	Horizons research 2001 ²⁵⁴ <ul style="list-style-type: none"> • A majority of female students have not had penetrative sex. • More boys than girls are having first sex at or before 15 years of age. • Students have sex intermittently. • Students misjudge peers' level of sexual activity. • Sexually experienced students do not see themselves at higher risk than sexually inexperienced youth. • Misperceptions and uneven knowledge about HIV persist. • Many youth have ambivalent feelings about people living with HIV/AIDS (PLHA). • Many students are not confident they know how to use condoms correctly. 	Horizons research 2001 ²⁵⁵

	Female migrants	Male migrants
Estimates	<ul style="list-style-type: none"> • registered and non-registered migrants numbering up to 2 million people work in over 20 provinces²⁵⁶ • 2004/5, ANC HIV prevalence among migrants in Region 3 was 5% compared to 1.1% among Thai women²⁵⁷ 	registered and non-registered migrants numbering up to 2 million people work in over 20 provinces ²⁵⁸
Programme	<ul style="list-style-type: none"> • PHAMIT (Prevention of HIV/AIDS among Migrant Workers in Thailand), funded by the Global Fund in 	

²⁵¹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁵² *UNPAF 2007-2011 op. cit.*

²⁵³ *UNPAF 2007-2011 op. cit.*

²⁵⁴ *Horizons, 2001 op. cit.*

²⁵⁵ *ibid*

²⁵⁶ *Thailand and the World Health Organisation Regional Office for South-East Asia, 2005*

²⁵⁷ *ibid*

²⁵⁸ *ibid*

coverage	<p>collaboration with 8 NGOs in partnership with MOPH and provincial health offices. The project has intervened in over 20 provinces throughout Thailand to prevent HIV, improve the quality of life among migrant workers, their families and sex workers. There are also some smaller scale interventions by CBOs in some southern seaboard provinces.²⁵⁹</p> <ul style="list-style-type: none"> World Vision Foundation of Thailand: Establishes migrant community-based health volunteers and workers for effective communication (Myanmar has at least eight main languages spoken among various ethnic groups) and to create a sense of responsibility by members to their own communities. It has strong collaboration with Ministry of Public Health officials at different levels is vital to the project as WVFT aims to achieve sustainable development.²⁶⁰ Plan UK, HIV prevention project 	
Policies & plans	<p>National HIV Plan 2007-2011²⁶¹ UNPAF 2007-2011²⁶² Country Partnership Strategy, Thailand (2007–2011), Asian Development Bank, 2007</p>	<p>National HIV Plan 2007-2011²⁶³ UNPAF 2007-2011²⁶⁴ Country Partnership Strategy, Thailand (2007–2011), Asian Development Bank, 2007</p>
Surveys & studies	<p>HIV-1 in ethnic Shan migrant workers in northern Thailand, Srithanaviboonchai 2001</p>	<p>HIV-1 in ethnic Shan migrant workers in northern Thailand, 2001</p>

²⁵⁹ *ibid*

²⁶⁰ *Prevention of HIV and AIDS among Migrant Worker in Thailand, World Vision Foundation of Thailand*

²⁶¹ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁶² *UNPAF 2007-2001 op. cit.*

²⁶³ *The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011, op. cit.*

²⁶⁴ *UNPAF 2007-2001 op. cit.*