



National Sexual Behavior Survey of Thailand 2006



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Cataloging in Publication Data

Aphichat Chamrathirong.

National sexual behavior survey of Thailand 2006 /
Aphichat Chamrathirong...[et al.]. --1st ed. --
Nakhon Pathom : Institute for Population and Social
Research, Mahidol University, 2007.

(Publication / Institute for Population and Social Research,
Mahidol University ; no. 338)

ISBN : 978-974-11-0876-3

1. Sexual Behavior Survey -Thailand. I. Sirinan
Kittisuksathit. II. Chai Podhisidha. III. Pimonpan Isarabhakdi.
IV. Malee Sabaiying. V. Mahidol University. Institute for
Population and Social Research. VI. Title. III. Series.

HQ799.T5 A639e 2007

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National Sexual Behavior Survey of Thailand 2006

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Foreward

Thailand has been regarded as one of the success countries to reverse the trend of HIV infection for many years. The incidence of HIV declined from 143,000 in 1991 to 19,000 in 2003 (Global HIV Prevention Working Group, 2007). For care and support, Thailand also launched universal coverage for ART in 2005 for eligible people living with HIV. With this strong commitment by the Thai Government and civil society network, Thailand still remain one of the countries that was regarded as a forefront in fighting against AIDS.



Even though success stories can be praised, Thailand has been and is still among the highest HIV prevalence countries in Asia and many challenges still remain. New group of people are at risk of HIV infection, new risk factors contribute to HIV infection, and slow down in prevention effort are among the most challenges facing the country. Moreover, new interventions to address the new challenges are not fully developed partly due to lack of information and evidence to inform policy.

In order to address the needs of the evolving prevention and care situation, in 2006 the Institute for Population and Social Research, Mahidol University conducted a third national survey with over 6,000 participants on risk behavior and antiretroviral treatments (ART) knowledge was implemented in 2006. This survey is structured to gather key policy-relevant information that will help to guide the Thai national program to further reduce new infections and provide the most effective and sustainable access to ART.

Particular interest of the survey during the period where attention has shifted to ART, are to explore knowledge and attitudes about HIV and knowledge and attitudes about ART. Current levels of sexual behavior of various forms including commercial sex, casual sex, and same-gender sex and other risk factors such as drug use and STIs experiences are also explored. The survey also include factor that increase vulnerability of people living with HIV such as discrimination and stigmatization.

We would like to thank all the individuals who participated in the survey and organizations and communities that contributed greatly to this study. It is indeed our hope that the results from this national representative sample survey will be useful to provide evidence for policymakers to ensure that our challenges are tackle effectively and will have impact to further reduce the epidemic in the country.

A handwritten signature in purple ink that reads "C. Kanchanachitra".

Churnrurtai Kanchanachitra, Ph.D.
Director of Institute for Population and Social Research,
Mahidol University

Preface



It is a definite pleasure for me, on behalf of both UNAIDS as well as the UN Thailand Country Team sponsors of this survey, to congratulate Mahidol University's Institute for Population and Social Research on the production of this long-awaited addition to the evidence base of the national and local response to AIDS in Thailand. Coming as it does at an important transitional moment in the Thai response to AIDS, this third Thailand Sexual Behavior Survey has the potential of making a great contribution to both advocacy as well as practical action towards Thailand's commitment to universal access to HIV prevention, treatment, care and support services in Thailand.

Thailand has more than twenty years of experience in addressing the challenges posed by AIDS, and because of this long and rich experience Thailand continues to be called upon to provide leadership in the response to the global AIDS epidemic. Time and again, governmental and civil society partners in Thailand - with assistance when needed from external partners - have banded together to respond successfully to these challenges, and the most successful Thai responses have indeed been those built on partnership and collaboration between a broad range of stakeholders, most importantly including those directly affected by HIV infection risks and vulnerabilities.

Thailand's successes in responding to AIDS include both Thailand's historical success in HIV prevention programming, as well as the current successful work in the prevention of parent-to-child transmission, as well as the rapid and successful expansion of accessible and affordable high-quality antiretroviral therapy to more than 130,000 persons living with HIV infection in Thailand.

Despite these successes, though, this survey now released by Mahidol University clearly demonstrates that the dynamics of HIV infection in Thailand continue to evolve and change, just as the dynamics of Thai society and Thai sexual behaviors are evolving and changing. Recent reports from the Royal Thai Government's Ministry of Public Health and other partners echo some of the more significant aspects of the evolving AIDS situation in Thailand highlighted by this survey, including in particular:

- The increasing tendency of Thai youth to engage in unprotected casual sex (often with their peers), and the worrying lack of knowledge or awareness that they demonstrate about their own risk of and vulnerability to sexually transmitted infections (including HIV).
- The growing feminization of the epidemic in Thailand, with up to 40% of all new infections taking place in the home primarily between female spouses of men (and in some cases the male spouses of women) who engage in risk behavior outside the home.
- The continuing reality of stigma and discrimination against people living with HIV infection in Thailand, despite the advent and rapid expansion of HIV care and antiretroviral therapy in the country. This situation is in no small part due to the absence of continued public information and community outreach initiatives to provide information and knowledge about HIV infection, as well as support to those persons infected or affected by HIV.

With as many as half of all people living with HIV in Thailand being between the ages of 25 and 34 years of age according to recent Ministry of Public Health releases, there is clearly a need for more urgent action on the broad front of HIV prevention, treatment, care and support services if Thailand is to reach their goal - outlined before the UN General Assembly in June 2006 - of halving the number of new HIV infections in Thailand by 2010.

We are confident that the information and evidence contained in this third Thailand Sexual Behavior Survey now being launched will provide important indications of both what needs to be done for an effective response to AIDS in Thailand, as well as how it can be done. We congratulate once again Mahidol University, IPSR and all their partners for an excellent effort in producing this report, and we look forward to the fruits of these labors as the Thai response to AIDS moves forward.

Sincerely yours,



Peter Piot

Executive Director

Joint United Nations Programme on HIV/AIDS



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Acknowledgement

This report, and the research upon which it is based, would not have been possible without the support and valuable contribution of UNAIDS. We are especially grateful to Mr. Peter Piot, the Executive Director of the Joint United Nations Programme on HIV/AIDS, and Mr. Patrick J. Brenny, the UNAIDS Country Coordinator, Thailand, not only for the financial or technical support throughout the project, but also for their encouragement for continuing the fight against the AIDS pandemic in Thailand.

This project was importantly inspired, initiated and supported throughout by Dr. Churnrurtai Kanchanachitra, Dr. Werisit Sittitirai, and Dr. Tim Brown. The inspiration consequently was turned into reality through funding by UNAIDS, Geneva and UN Agencies in Thailand, including UNAIDS, UNFPA, UNICEF and UNIFEM.

We also wish to thank Dr. Tim Brown and Dr. Peter Xenos of the East-West Center, for important inputs in the design of questionnaire. And, special thanks to Dr. Phillip Guest for his invaluable advice, including input into the sampling design and weighting procedure. Dr. Varachai Thongthai's advice on the analysis and tabulations design of this report is greatly appreciated. Most importantly, we would like to acknowledge Dr. Sombat Thanprasertsuk who was the director of BATS, who provided important endorsement for this national level study. We also appreciate the collaboration with Prince of Songkhla University who allows Asst. Prof. Malee Sabaiying to work on this study.

We would like to express our sincere gratitude to our advisory committee for their contributions, insights, opinions and recommendations from the beginning to the accomplishment of this report. They are, Dr. Churnrurtai Kanchanachitra, Dr. Kritaya Archavanitkul, Dr. Pramote Prasartkul, Dr. Phillip Guest, Dr. Varachai Thongthai, Dr. Werisit Sittitirai, Dr. Peter Ghys, Dr. Patrick J. Brenny, Mr. Scott Bamber, Mr. Bastiaan Van't Hoff, Dr. G. Giridhar, Dr. Chaiyos Kunanusont, Dr. Tim Brown, Dr. Peter Xenos, Dr. Sombat Thanprasertsuk, Dr. Kumnuan Ungchusak, Mr. Sue Lo-Utai, Dr. Pinij Phaamnuay, Ms. Waranya Teokul, Dr. Taweessap Siraprasiri, Dr. Petchsri Sirinirun, Mr. Promboon Panitchpakdi, Ms. Rachitta Na Pattalung, Dr. Orratai Rhuecharoenpornpanich and Ms. Supicha Baothip.

The difficult task of data collection was achieved through the invaluable efforts of our partner, OPTA who were in charge of Bangkok field work, and the IPSR team and with great help from Dr. Liwa Pardthaisong-Chaipanich Faculty of Social Science, Chiang Mai University and Asst. Prof. Quantar Barntip Faculty of Nursing, Prince of Songkhla University. The tasks were also facilitated by government officials in all provincial fieldwork. Most significant persons who contributed to the success of the project included: Ms. Kanya Ahipornchaisakul, who was the key research assistant of this study, Mr. Panya Choolert, Ms. Waewdao Nambutr, Mr. Chatri Suwanapray and Ms. Toungporn Sae-ue who provided their efficient assistance in data collection and analysis. Acknowledgement also goes to Dr. Nicolas Ford for important editorial guidance.

The production of this report was coordinated by Ms. Dusita Phuengsamran, her efficient efforts are especially acknowledged. Also, we want to thank for the secretarial tasks efficiently managed throughout the project by Mrs. Patama Yampeka.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
ABC	Abstinence, Be Faithful, Condom Use
CBO	Community - Based Organization
GFATM	Global Fund for HIV/AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Uses
IPSR	Institute for Population and Social Register
MICS	Multiple Indicator Cluster Survey
MOPH	Ministry of Public Health
MSM	Men who have sex with men
MDG	Millenium Development Goal
NGO	Non-Govermental Organizations
PMTCT	Prevention of Mother-to Child Transmission
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary Counseling and Testing



About the Survey

Chapter 1:

Introduction and Objectives of the National Survey

Chapter 2:

Methodology

Chapter 1:

Introduction

Thailand has been widely recognized for its effective and timely implementation of AIDS policies and programs. During the early 1990s, the Thai government launched a multi-sectoral nationwide campaign to reduce HIV transmission. Key elements of the plan included a comprehensive sexually transmitted infection STIs (STD) control program, an extensive mass media information campaign and the 100 percent condom program, which promoted universal and consistent condom use in sex work. Simultaneously, the country undertook comprehensive data collection efforts, including national HIV and STIs surveillance and two national surveys on sexual risk behaviour (Sittitrai et. al., 1992 and Thongthai and Pitakmahaket, 1994). This data clearly documented that the demand for sex workers had declined, condom use in sex workers had increased, the number of STIs cases had declined, and the prevalence of HIV among all surveillance groups had decreased considerably.¹

However, the Thai AIDS epidemic has continued to evolve, and behaviors have correspondingly changed. Sexual risk behavior has shifted from sex workers to non-commercial sexual partners, such as friends or boy/girlfriends. Furthermore, the new generation of youth and adolescents who are becoming sexually active have had less exposure to the comprehensive HIV prevention

campaigns previously implemented, and there is evidence of expanded sexual activity and increased drug use among them. A recent study has found high HIV prevalence among men who have sex with men in Bangkok, (Van Griensvan et al. 2004) and the limited epidemiological evidence available indicates that this may be an issue nationwide. Moreover, despite the prevention successes of the past, HIV continues to infect one to three percent of sex workers annually and 5 to 10 percent of injecting drug users. National HIV prevention efforts need to adapt and respond to this changing situation, and this requires a deep understanding of the current forms and levels of risk behavior in Thailand.

In addition to these behavioral changes, Thailand is the first country in Asia that has committed to providing access to antiretroviral treatment (ART) for all those in need. This is a major national commitment, but one which raises a number of new issues in policy and program planning. This is a concern that when widespread access to ART occurs there may be rapid increases in levels of risk behavior, possibly because of treatment optimism. This makes it essential that planners establish a baseline for future evaluation of the ART program and understand the relationship of people's behaviors to their current awareness, knowledge, attitudes and beliefs about ART. It is

¹ This trend is later confirmed in the study of the evaluation of 100% condom use promotion in Thailand (Chamratrithirory et al. 1999)

also important to assess knowledge of the availability of voluntary counseling and testing, and people's willingness to access it. This information will assist planners in creating programs to educate people realistically about these drugs and their effectiveness, to encourage them to seek HIV testing and, when necessary, treatment, and to minimize increases in risk behavior as they do so.

To address the needs of the evolving prevention and care situation, a third national survey on risk behavior and ART knowledge was implemented in 2006. This survey is structured to gather key policy-relevant information that will help to guide the Thai national program to further reduce new infections and provide effective and sustainable access to ART.

Objectives

The overall objective of this study is to gather information for use in planning and evaluation of the national AIDS program and related policies. Specific program and policy areas relevant to the current Thai situation that are included in the study are:

- Knowledge and attitudes about AIDS
- Exposure to HIV/AIDS information: Exposure to existing prevention campaigns and the association of this exposure with risk behaviors
- Knowledge and attitudes about antiretroviral treatments: Assessment of antiretroviral knowledge, beliefs about the efficacy of ART, and the relationship to risk behaviors
- Experiences with HIV/AIDS: Information regarding the uptake of HIV testing, awareness of its availability, and willingness to test.
- Stigmatization and discrimination
- Sexuality and sexual behavior: Current levels of sexual behavior of various forms including commercial sex, casual sex, and same-gender sex
- Marital status and sexual partners
- Sexual history (last 5 partners)
- STI experiences
- Drug use: Substance abuse (alcohol; drugs, including methamphetamines; injecting drug use, etc.) and its relationship to sexual risk behaviors, especially among youth
- Youth specific questions
- Voluntary counseling and testing

In the process, a substantial number of the indicators needed by the national program and the international community, are collected and reported based on a nationally representative sample.

Chapter 2:

Methodology

2

Methodology

The project has three major components:

- Formative qualitative work to assist in developing a questionnaire relevant to current forms and patterns of risk among youth and adults.
- A national survey with over 6,000 participants conducted with a representative sample frame of randomly selected individuals.
- A series of analyses and dissemination activities intended to feed directly into the programming and policy process and provide effective feedback to the Thai population on levels of risk, the factors influencing it, and the impacts of current prevention and care efforts.

Stakeholder involvement and formative qualitative work

Upon initiation of the project a series of meetings were organized with those who will use the outcomes of the survey to solicit their input, make sure the survey instrument gathered information relevant to policymakers and program planners, and meets the need of civil society groups engaged in AIDS activities. These included policy makers and program planners from the Ministry of Public Health, the UN partners in Thailand through the UN Theme Group, and Thai NGOs and CBOs involved with affected communities, including groups of people living with HIV and AIDS. These meetings sought to

determine what types of information were most relevant to their particular needs, what types of analyses they would like to see done, what dissemination mechanisms they feel would be most effective with their constituencies, and what major prevention and care programs should be included in assessing exposure.

In parallel with these meetings, IPSR conducted focus groups with the target survey population that were intended to assist in the formulation of a timely and pertinent questionnaire. These were used data to ensure that the questionnaire accurately reflected the variety of risk situations and patterns of risk in the Thai population.

A series of 14 focus groups of 7 to 8 participants each were undertaken stratified by residence area (Bangkok, other urban areas, and rural areas), gender (male and female), and age (15-24 and 25-59). These focus groups gathered specific information relevant to formulating a questionnaire, including:

- How do Thai men and women conceptualize different types of sexual partners and how do they assess the risk of these different types of partners?
- Where do men and women meet partners today and how is this related to the partners' perceived risk?
- What forms does part-time sex work take, especially among youth? Is this very common?

- Are the patterns of, and attitudes toward, sexual and drug-using behaviors among youth different from those of adults?
- What do people think about anti retrovirals, their effectiveness, their side-effects and their implications for risk behavior?
- Do people feel that the AIDS campaign is as effective today as it was in the past? (adults only) Do people feel that they receive adequate information about HIV and AIDS prevention and care, and through what avenues do they receive that information? (both adults and youth)
- Are there times they think people don't use condoms with some sexual partners? With whom and why?

Systematic analysis of the results of these focus groups guided the formulation of questions that reflect the way Thais think about risk behaviors. A pre-test of the questionnaire was undertaken in Bangkok and in Ratchaburi province in May 2006 to finalize the content of the questionnaire.

The questionnaire : key issues

The questionnaire gathered information and indicators needed to address the policy issues outlined earlier, while at the same time ensuring comparability with previous surveys so that behavioral and knowledge trends can be ascertained.

Gender matched interviewers administered the questionnaire in face-to-face interviews. The questionnaire, which is reproduced in the attached CD, has the following key sections:

- *Household listing and interview record.*
- *Demographics.* This includes age, gender, educational status and attainment, occupation, employment status, religion, etc.
- *Knowledge of HIV/AIDS and antiretroviral therapy.* Included here are knowledge of HIV and AIDS, its prevention, risk perceptions, and knowledge and beliefs about the availability, effectiveness and side-effects of antiretroviral therapy.
- *Attitudes and values about sexual behavior, risk of different partner types, and HIV/AIDS.* This section explores attitudes toward sexual behaviors, including abstinence and celibacy, by adult men and women and by youth, perceived risk of different partner types, and attitudes toward those with HIV and AIDS, including whether they know someone with HIV and have seen discrimination in their communities. Questionnaire modules from MICS/UNCEF project were utilized in the design of this section
- *Prevention program exposure.* Questions related to the extent to which participants have been exposed to HIV related media, prevention and care programs, and other sources of HIV related information are included.
- *HIV testing, STI treatment seeking behavior, and medical injections.* Includes past history of HIV testing, knowledge of sources of voluntary counseling and testing, past experience with STIs, sources of treatment, and experience in seeking STI treatment. This section concluded with questions on experiences with medical injections and blood transfusions and donation.
- *Marital status, sexual orientation, and sexual behaviors.* Information gathered in this section included marital status; sexual orientation; and sexual behaviors, partner numbers, and condom use by type of partner (including spouse/regular partner, sex workers, casual, and other partners). For those men engaging in recent same-sex behavior (MSM), a sub-section explored these behaviours in more detail. In addition, the history of sexual violence within and outside of marriage was captured.

- *Sexual history (last 5 partners)*. An abbreviated sexual history collected information on the last 5 sexual partners including gender, time of contact, duration of relationship to the time of contact, type of partner, condom use with partner, etc.
- *Young people's sexual experience*. Questions about first sexual encounters, sexual activity with friends, boy/girlfriends, and others were asked. Furthermore, for international comparison and the preparation of the national MDGs report, UNICEF's MICS sexual behaviour module was used in this section. The study also explored youth's life skills training and experience in decision making, negotiation skills, communication with and influence of peers, parents and others; and exposure to youth-focused prevention programs.
- *Substance use*. This section explored use of substances, including alcohol and drugs, injecting drug use and practice, and their relationship with sexual behavior.

Analysis of the findings

The key "risk behaviour" indicators, both sexual and drug related, and the other variables mentioned above are analyzed in the context of various determinants or independent variables. These include: gender, socio-economic status, cultural beliefs, social norms, religious factors, familial background, marital status, sexual orientation, absolute and relative poverty status, living arrangements, household structure, kinship and family ties and relations, working status and occupational and working environment, exposure to mass media, health and reproductive health status, fertility and family planning practice, alcohol and drug consumption, and history of sexual violence.

Analysis of risk behaviour is undertaken in terms of exposure to HIV prevention programs, mass media, and knowledge of service availability and anti retroviral therapy. At the community level, the impact of the implementation of mass media programmes on HIV and condom availability programmes was also examined.

Sample design

The sample was designed to allow in-depth comparison of differences in behaviour between three residence categories: Bangkok, other urban areas, and rural areas. Other key characteristics of the sample design include examination of differences by gender and differences between youth (18-24) and adults (25-59). Information was collected from a total of 6,048 respondents using face-to-face interviews. The population was stratified as shown in the table 2.1:

Table 2.1 Number of interviewed respondents by resident and age group

Residence/Age	Male		Female		Row total
	18-24	25-59	18-24	25-59	
Bangkok	504	504	504	504	2,016
Other urban	504	504	504	504	2,016
Rural	504	504	504	504	2,016
TOTAL	1,512	1,512	1,512	1,512	6,048

When properly weighted, this sample provides nationally representative estimates of risk behaviours, AIDS and ART knowledge, and other relevant topics for national program and policy planning. Data was collected in Bangkok and in urban and rural areas of 14 provinces, selected from the 75 provinces of Thailand (excluding Bangkok) with probability of selection proportional to the population of the province. Within each strata the sample size of 504 was selected to provide point estimates of the characteristics, behaviors, and attitudes of respondents with a maximum of five percent absolute error with 95 percent confidence.¹

¹ With a sample design based on simple random sampling a sample size of approximately 400 is sufficient to obtain estimates with five percent on either side of the estimate with 95 percent confidence. Because the sample design is clustered we adjust sample size to take into account, an estimated sample design effect of 1.2.

Random selection of survey respondents was undertaken within each residence stratum. To ensure coverage of the heterogeneous populations of Bangkok, including areas with more mobile populations, sixty three election districts were randomly selected from the list of all the election districts in Bangkok available from the civil registration.

For each election district, we systematically sampled four households from the list. Each team of interviewers consisted of four interviewers. Each interviewer was allocated one of the four listed households. At the selected household they listed all household members separately by sex and by the two broad age groups (18-24 and 25-59). Each interviewer was responsible only for interviewing persons in one of the four age/sex categories. Each team had two female interviewers and two male interviewers. Females were responsible for interviewing females and males were responsible for interviewing males. After the first randomly selected household interviewers proceeded to the immediate housing unit on the left of the original household, undertook the household listing and, if there was an eligible respondent, interviewed the respondent or, if they were not home, made an appointment to return. This process was repeated, moving to the household to the immediate left of the previous household, until interviewing was completed. Each interviewer was required to complete eight interviews. Supervisors checked progress to ensure no overlapping of households. Although this procedure results in a probability sample, data is not available to calculate sampling fractions.

The other two strata comprised provincial urban and rural areas of Thailand. The sampling strategy for these two strata was multi-stage. In the first stage, 14 provinces from the 75 provinces outside of Bangkok were randomly sampled, with probability of selection proportional to population size (see Annex 2 for list of selected provinces in the CD attached). Within each province two districts were selected and rural and urban areas in each of the two districts were listed.

The sampling for provincial urban areas followed closely the method used for Bangkok. For the 14 provincial urban areas, four election districts were randomly selected. This resulted in the selection of 56 election districts. For each districts, the same methods of sampling households and individuals was used as in Bangkok, with the exception that within each of the four age/sex categories nine persons were sampled for interview.

For the rural areas of each province, two selected districts and then two sub-districts were randomly selected with the probability of selection proportional to the number of residents of the sub-districts. Within each of the two sub-districts, three villages were randomly selected with probability proportional to the size of the population. The total number of villages selected was 168. For each of the villages selected, a household listing was obtained from either the sub-district office or village head. These lists were updated. Households were systematically selected from the lists. Interviewers were allocated households in the order that were selected. They then visited households in the order they were selected and if there was an eligible respondent interviewed that respondent. They proceeded down the list of allocated households until their quota of interviews was completed. Each of the four interviewers was responsible for three interviews. The total sample for each village was 12 persons.

The total interviews in Bangkok, the provincial urban areas of the 14 provinces, and in the rural provincial areas was 2,016 each. A post-facto population weight has been calculated and attached to the data set. This weight adjusts for the age/sex/geographical distribution of the population as reported from 2000 census data.

In rural areas, community level data on past and present prevention and care activities, local AIDS resources, and proximity of AIDS services were collected. This information can be correlated in the analysis phase with behavioural data in an attempt to assess the impact of these programs.

Response rates

In table 2.2, we show response rates. Overall, response rate exceed 80%, with rates highest for those aged 18-24. There were few refusals, with the main reason for not completing an interview being that the respondent was not home and could not be contacted after repeated visits.

Table 2.2 Response rates

	Male aged 18-24	Female aged 18-24	Male aged 25-59	Female aged 25-59
Interview completed	1512	1512	1512	1512
Respondent refused/ Interview not completed	2	9	21	44
Refused by the household, not cooperated/ Refused by parents/guardian of respondent	1	2	3	6
Not at home/Can't be reached	172	183	599	442
Language problem	0	2	0	0
Health problem	2	2	7	5
Total	1689	1710	2142	2009
Response Rate	0.90	0.88	0.71	0.75



The Vulnerability

Chapter 3:
**Socio-economic and Demographic Characteristics
of the Studied Population.**

Chapter 4:
**The Vulnerability Reflected in Attitudes
and Discrimination of AIDS**

The proportions of male and female at each age group are purposely the same. This will facilitate the analysis when comparison between male and female is important. Later in the report, the vulnerability of each sex and age group will be analyzed.

The vulnerability of the male population relates to their own sexual behavior, especially extramarital and male-to-male sex, while the vulnerability of the female population mostly relates on their husbands' risk, and the fact that they are still subordinated to men in many situations.

Double standards in culture and norms related to sexual behaviours for men and women is a major root cause of this age group's vulnerability. Doors are opened for men to explore sexuality from puberty, while closed for women who are not married. Though this situation seems to be becoming more relaxed, women still tend to be devalued if they have multiple sexual partners. The double standard lead to sexual and reproductive health risks, including HIV, which are greater for women more than men.

Such vulnerability, caused by the culture and norms, not only occur at younger ages, especially for those unmarried, but also pertain to married couples, when extramarital sex is engaged in by men. The Thai Bureau of AIDS, TB and STI has identified five vulnerable groups of people comprising the latest wave of new HIV infection, which include wives in HIV-discordant couples.

3.2 Religion and Language

Although almost universally Thai people are Buddhist, the proportion of other religions is not negligible. The religions of the "minority" may also indicate, to a certain extent, their vulnerability or weak position. Reflecting its dominance within Thailand, Table T1: 1.6 reveals that 96% of the Thai population is Buddhist, with about 3.4% reporting

as Muslim, and one percent Christian. Comparing among the three rural and urban areas, it is revealed that Bangkok residents include a slightly lower percentage of Muslims (up to about 10%) than people in the other two areas (Table B1: 1.6, Table U1: 1.6 and Table R1: 1.6).

The possible social vulnerability of the public can be reflected not only by their religion, but also by their religiosity. Table T1: 1.7, Table B1: 1.7, Table U1: 1.7 and Table R1: 1.7 shows that in terms of self perception of religiosity, it is surprising to find that a higher percentage of Bangkok residents, i.e., 66%, compared to 55% of the provincial urbanites, and 58% of the rural people describe themselves as 'at least fairly religious'. Whether or not religiosity described here is linked positively or negatively to sexual or other risk behaviour is to be investigated.

Although most Thai people speak Thai, the dialects may differ by region. Foreign languages may not be commonly spoken as the main languages, but as second or third languages they may be used to some extent. This complexity may have implications for the production of health promotion materials. Respondents were therefore asked to describe the first, second and third languages usually spoken within their families. It is revealed in Table T1: 1.8 that although very few reported speaking a third language within the family, nearly a fifth of Thai adult population mention of the use of a second language.

It is notable that Central Thai was the first language of almost half of the general public i.e., about 43%. The other main first languages are Northeastern Thai, used by about a quarter (27%), Southern Thai (12%) and Northern Thai (also almost 12%). Of the fifth of respondents whose family use a second language, it is striking to observe that Central Thai is by far the most common (68%), followed by Northeastern Thai (13%), Cambodian (7%) and Southern Thai (4.5%).

In addition, these tables reveal that there are variations in the levels using Central Thai as the first language among the rural and urban populations, ranging from about 81% among residents in Bangkok, to 46% in the provincial urban, and only 35% in the rural places. These variations reflect population distribution by the country's rural and urban areas of administration. The findings reinforce the need in health promotion programmes for careful consideration be given to languages other than Central Thai in the design of information, education, and communication materials.

In conclusion, the diversity of Thai people, in terms of religion, religiosity and languages used should not be ignored. The possible susceptibility to the HIV epidemic, across all the different populations is noteworthy. These populations tend to have diverse cultures, dialects and needs. Rather than one size fits all, custom made communication programmes specifically designed for their distinctive requirements have to be taken into consideration.

3.3 Education and Literacy

The percentage of respondents who are still currently students is investigated, with a focus among those in the age group 18-24. As expected, Table B1: 1.3, Table U1: 1.3 and Table R1: 1.3 show that Bangkok and the provincial urban population have a much higher overall percentage of the young adults (aged 18-24) still in education (38% and 34% respectively) than their rural counterparts (24%). It is also notable that within Bangkok, many more females (46%) remain in education than males (30%). More specifically, of those still in education, proportions of this younger age population attending university rise from 39% in the rural areas, to 51% in provincial urban places and to almost 69% in Bangkok. The proportions of university students in all areas are surprisingly high.

Opportunities for intervention programme development suitable for them seem to be encouraging.

In terms of the more basic indicator of education, which is the highest level of education attained for the whole age range (18-59 years of age), it is revealed in Table T1: 1.4 that about one-fifth (20%) of the adult population in Thailand graduated from at least junior high school level. Again, this group of population is probably responsive to health promotion programmes, and can access these programmes with little difficulty.

However, there are still those who have attained only grade 4 or less. Among the adult people in Thailand this accounts for about 24%. Among these non-or poorly educated adults, literacy seems to be a problem. About 10% of them report that they are unable to read. The majority of this group (66%) can read only fairly well. This category of population is probably in a weak position and is a vulnerable group. Comparing the three areas of residence, the rural population contains a much higher number of those who only attained grade 1 to 4 or never attended school (29%). These low or un-educated groups characterize about 20% in the provincial urban areas and about 19% in Bangkok. The vulnerable population is therefore more to be found in rural settings. However, the size of this susceptible group in the urban places is also not negligible.

3.4 Employment, Occupation and Workplaces

Although HIV in Thailand is recognized to be a generalized epidemic, various pockets of population are still more at risk than others. Apart from the vulnerable youth and women, and the low economic strata population including the low-educated groups, people who are in weaker position and are in more risky environments in

terms of their employment and occupation are to be given special attention. In this section, the employment and occupation of the population including their workplaces in the three areas of the country are investigated.

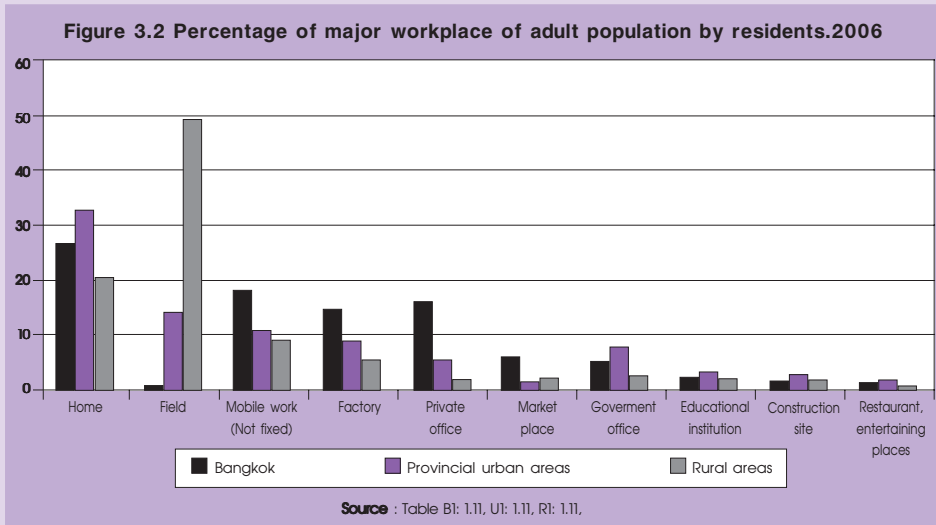
The pattern of employment in Thailand varies by age group, gender and urbanization. The younger age group (18-24) is characterized by a higher proportion 'currently not working' (ranging from 46% to 50% –Table B1:1.9, U1:1.9 and R1:1.9) reflecting the nearly one third (29%) in education (Table T1:1.3). Within this group is a higher percentage of males than females (36% as compared to 12% –Table T1: 1.10) looking for a job. Among the older adult population aged 25-59 years, a higher percentages of females (27.7%) than males (5.4%) are "currently not working" (Table T1: 1.9). For the vast majority (87%), this reflects their 'doing housework only' (Table T1: 1.10). This pattern of proportions working, by age group and gender is found to be consistent across all three areas.

The main forms of employment are sales and service (ranging from 12% to 29% –Table B1: 1.9, U1: 1.9, R1: 1.9), agriculture and fishing (18% –Table T1: 1.9) and mining, construction, production and construction (about 6% –Table T1: 1.9), and vary proportion across the three residential areas. As expected, 'sales and service' is dominant in both Bangkok (26%) and provincial urban places (28%), but "work in agriculture and fishing in subsistence economy" at about 23% is the largest single type of employment among rural people. Bangkok also has a much larger percentage (15%) in the broad 'construction' sector than the other areas.

Among the employed population discussed above, their workplaces are also investigated. Knowledge of the workplaces may assist programme designers to take advantage of workplace

management and propose workplace strategies for the prevention of the epidemic. It is revealed in Table T1: 1.11 that the majority, or about a quarter of the respondents, work at home. About 34% work in the field. About 10% have mobile workplaces or no fixed workplaces. Working in factories accounts for 7.3%. Other workplaces are each reported by less than 5% of the respondents. These include private offices (4%), market places (4%), government administrative offices (4%), education institutes (2%), construction sites (2%), and restaurants and entertainment places (1%). Other workplaces are mentioned by a small proportion.

Figure 3.2 presents the major workplaces among the working adult population in Bangkok, provincial urban areas and rural places. Major workplaces in the three areas are basically the same as discussed earlier. These include home, the field, mobile workplaces or no fixed workplaces, factories, private offices, market places, government administrative offices, education institutes, construction sites, and restaurants and entertainment places. The main variation is that working in the field predominates in the rural population. Working at home is also more frequent in provincial urban areas. Bangkok is also unique in having mobile workers, factory workers, those working in private office, to a much higher proportion than the provincial urban areas and the rural places. In addition, workers, probably in the informal sectors, who work at the market place, construction sites and restaurants and entertainment places, especially in the more urban areas, are also clearly observed. Special intervention programmes for all of these different groups probably have to be separately taken into consideration, with attention give to the context of their workplaces.



public include television and radio. Newspapers, magazines and the internet are also popular. Newspapers are more commonly by used males. Magazines and internet are widespread among the younger generation.

As presented in Table B1: 1.16, Table U1: 1.16 and Table R1: 1.16, there

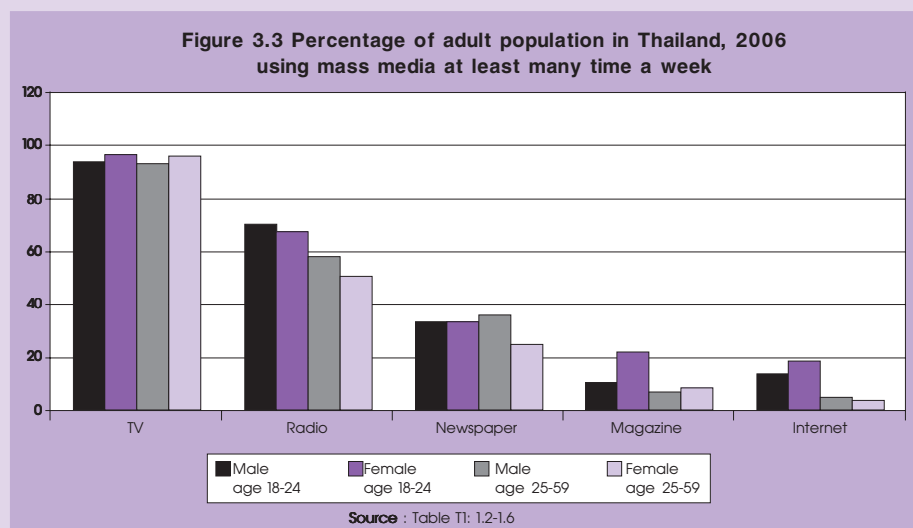
3.5 Exposure to The Mass Media

In order to assess the potential for obtaining access to HIV-related information, this study explores respondents' exposure to the mass media. This information will help in programme design so that knowledge on HIV can be effectively chaneled to each kind of media. This section will focus on the following features reflecting important aspects of the human capital of the adult population in Thailand. These include usage of newspapers, magazines, radio, TV and the Internet.

Access to mass media everyday almost everyday or many times a week, may be frequent enough to create some impact on individuals' knowledge and attitudes.

Figure 3.3 displays the percentages of the adult population in Thailand who access mass media at least many times a week. The figure shows the very positive picture of the media society in Thailand. The predominant media among the general

is a slight difference between Bangkok, provincial urban and rural population in terms of watching TV and listening to the radio. Approximately three-fifths (around 60%) of all groups listen to radio everyday or almost everyday, and almost all watch TV everyday. However, Bangkok and provincial urban residents report significantly greater reading of newspapers than their rural counterparts. Nearly half of the respondents in Bangkok (48%) report reading newspapers at least almost everyday, while this falls to 37% among the provincial urban residents and 25% among the rural residents. Similarly a somewhat higher proportion of Bangkok (17%) and provincial urban (15%) population than the rural residents (9%) report reading a magazine at least once a week.



The greatest differences in access to the media occur with respect to use of the Internet. As expected, Bangkok (16%) and provincial urban (13%) residents report higher weekly use of the Internet than their rural counterparts (7%). However, as shown in Table B1: 1.16, Table U1: 1.16 and Table R1: 1.16, across all three areas, the real difference in use of the Internet is between the two age groups. In terms of the total country, while only 10% of the 25-59 years of age report using the Internet at least once a week, 25% among the younger group of 18-24 years old do the same. Furthermore this is highest (38.4%) among Bangkok residents, although as noted above Bangkok also has the highest proportion still in education.

In terms of implications for the transmission of health information, these media-related findings clearly highlight the scope for TV and radio as a universal medium in all areas. More detailed information and advocacy may be addressed through newspapers to reach significant numbers.

Furthermore, as in many countries, the use of the Internet is rapidly increasing in Thailand. The greatest scope for flexible and detailed health information for the young is probably the Internet.

3.6 Conclusion

This primarily descriptive chapter provides an overview of the socio-economic, cultural, religious and media-accessing characteristics of the sample as a contextual basis for the subsequent more analytical chapters. Key aspects include homogeneity in terms of the Buddhist religion and familiarity with the Central Thai language, but with significant diverse minority populations. The chapter flagged the particular culturally related vulnerabilities of women and socio-economic vulnerabilities of the less-educated poor. This chapter also highlights the diverse patterns of vulnerability and provides some general guidelines for the development of appropriate programmes.

Chapter 4:

The Vulnerability Reflected in Attitudes and Discrimination of AIDS

This chapter explores attitudes toward abstinence and vulnerability by adult men and women and by youth, and attitudes toward those with HIV and AIDS, including whether they know if there is any HIV infected persons in their communities and they have seen discrimination against them.

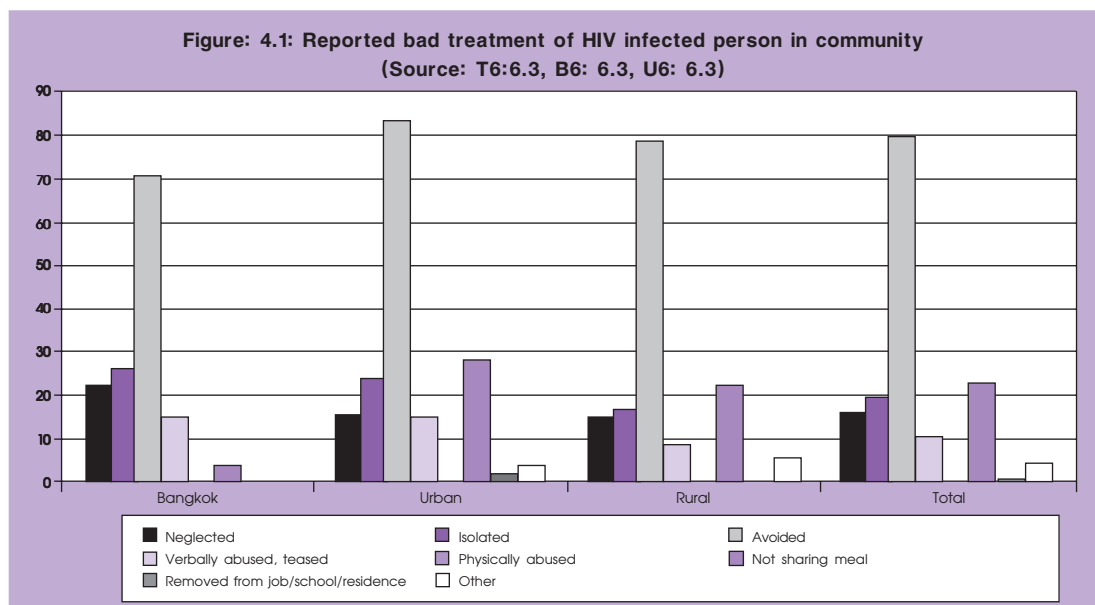
4.1 Stigma and Discrimination

Stigma and discrimination against people with HIV has often been identified as primary barriers to effective HIV prevention, as well as provision of treatment, care and support.

In this study, respondents were asked if there were any HIV infected persons living in their community. If there were any, then they were further asked

about their awareness of any discrimination against those infected persons. Table T6: 6.1 shows that approximately 20 percent of respondents reported that they were aware of HIV infected persons in their community in the past 12 months. However, the proportion of respondents reporting having HIV infected persons in their community is the lowest in Bangkok (13%) whilst the highest proportion is reported by the urban respondents (24%).

Regarding discrimination against HIV infected persons in communities, a little more than a quarter (27%) of these respondents had ever seen that HIV infected persons treated differently from others. Respondent reports of having personally seen or heard about discrimination against people with HIV is shown in Figure 4.1 below.



The most frequently mentioned bad treatment are avoiding contacting (79%), not sharing meal (23%), isolating (20%), neglecting (16%) and verbally abusing (11%) HIV infected persons. Actual physical abuse and removing from jobs were reported from less than one percent of respondents. The pattern of bad treatments reported is similar across groups of respondents, regardless of age group and their place of residence.

Attitudes of stigmatization of persons living with HIV is still prevalent among respondents. Table T6: 6.6 reveals that approximately two fifths of respondents reported that if members in their family become ill with AIDS, they would keep this confidential. However, the proportions vary among respondents in different age groups and places of residence. Tables B6: 6.6, U6: 6.6 and R6: 6.6 show that respondents in the younger age group were more likely than the older age group to say they would not reveal about a family member who was infected with HIV. The Bangkok and urban residents had higher proportions of respondents who would keep confidential the HIV status of family members, than the rural respondents.

However, the majority of respondents (90%) indicated that they would be willing to care for a family member who was ill with AIDS. Tables T6: 6.5-6.6 shows that there is no gender discrimination against a relative who was HIV-infected. Respondents' willingness to care for a relative who becomes ill with AIDS is reported equally whether the relative is male or female. The respondents also reported that they would feel no sense of discrimination towards a friend who is HIV infected. It is noted that respondents indicated some hesitancy about their feelings concerning an HIV infected teacher and factory worker. Approximately 70 percent of

respondents agreed with the statements that teachers and factory workers who were HIV infected should be allowed to continue working in their workplace. The strongest discrimination is demonstrated against infected shopkeepers or food sellers. Only a quarter of respondents would buy things or food from a shopkeeper or food seller that has HIV. When age, sex and place of residence are compared, the attitudes are not very different, except that the female respondents had a little more sympathy to HIV infected persons than did male respondents. (see Tables T6: 6.7-6.10)

Interestingly, results demonstrate that as HIV infection is found closer to home, i.e. family member, the participants are more accepting of the infected individual. Though some results are somewhat encouraging, stigma and discrimination remains an issue that merits additional and ongoing intervention.

In the Multiple Indicator Cluster Survey (MICS)¹, women aged 15-49 years old were interviewed about their attitudes toward people having HIV. Approximately one-third (37%) would want to keep the HIV status of a family member a secret, 29% thought that an HIV positive teacher should not be allowed to work and 65% would not buy food from a vendor with HIV.

4.2 The Fallacy of Abstinence as a Way to Prevent HIV

Respondents were asked to compare the effectiveness of two strategies used to campaign against AIDS. The first strategy is to persuade people to stop having sex with non-marital partners or non-cohabiting partners while the campaign for regular and consistent condom use is the second strategy. A higher proportion of respondents thought

¹ UNICEF has been instrumental in supporting countries to collect relevant data through household surveys. UNICEF developed the Multiple Indicator Cluster Survey (MICS) methodology in the mid-1990s, in response to the need for filling data gaps for indicators used to track progress toward the World Summit for Children goals. The MICS surveys are a major source of data for MDG monitoring, as well as the assessment of progress toward other international goals such as those included in A World Fit for Children, and the UNGASS on HIV/AIDS, etc. (www.unicef.org)

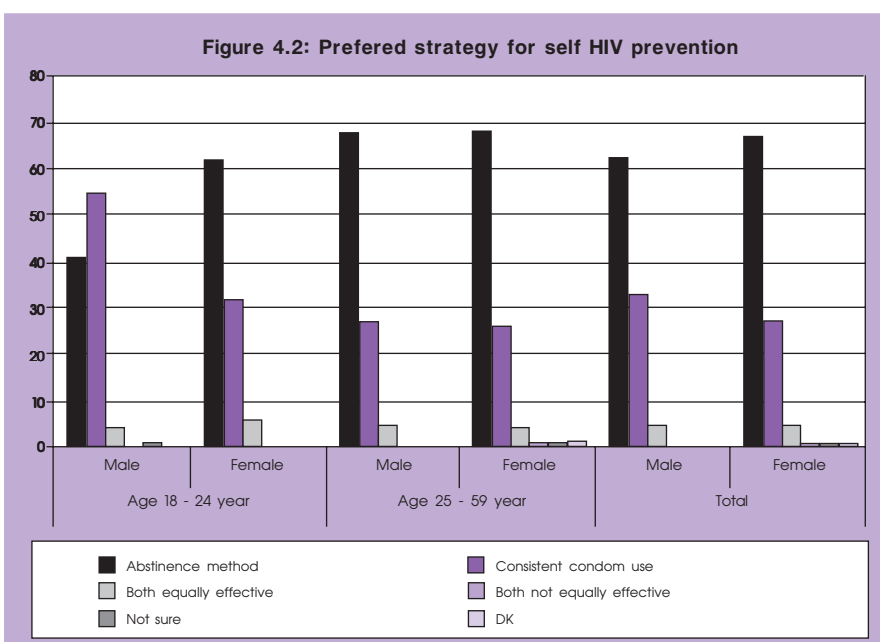
that consistent use of condoms would be more effective than relying upon stopping people having sex with non-marital partners or non-cohabiting partners in prevention of HIV infection. This answer is more prevalent among the younger than the older respondents. Moreover, the highest proportion of respondents who viewed using condoms consistently as the more effective strategy is found among young males residing in Bangkok and the other urban areas rather than in the rural areas (Table T2: 2.13, B2: 2.13, U2: 2.13, and R2: 2.13). This attitude may reflect the greater access to knowledge related to HIV prevention among the young Bangkok and urban respondents compared to young rural people.

Conversely, when asked about the strategy that they would use for HIV prevention, table T2: 2.14 shows that the higher proportion of respondents (65%) would choose to use abstinence with non-marital partners or cohabiting partners rather than regular and consistently condom use (30%). The older and the female rather than the younger and the male respondents, regardless of their place of residence, were more likely to choose abstinence than using condoms (Table B2: 2.14, U2: 2.14, and R2: 2.14).

Among those respondents who sought to avoid HIV infection by not having sex with a non-marital partner, approximately 83% believed they could do it forever. The respondents who said they could do it forever are more likely to be female and in the older age group. It should be noted that a high proportion of the young male respondents in all types of residential areas, but particularly those in Bangkok, reported they can practice abstinence but not forever. The abstinence component of the HIV prevention campaign could, therefore, gainfully also focus on young persons in Bangkok and urban areas.

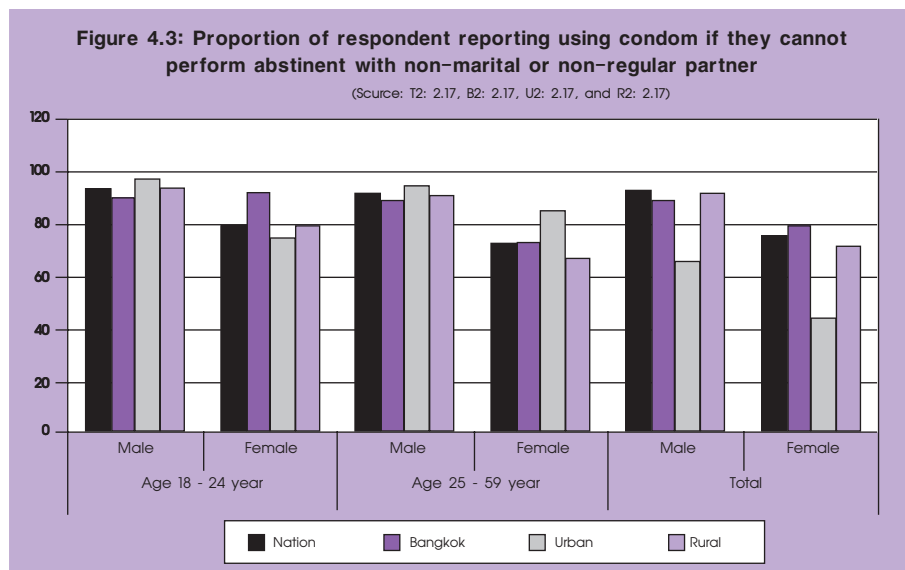
For those who said they can follow the path of not having sex outside marriage forever, the reason given by more than half of them is that they are faithful to their partner. However, it is not surprising that a higher proportion of females in all types of residence were more likely to give this reason than their male counterparts. The second most commonly reported reason is that they are afraid of HIV infection and do not wish to take any risk. The fore-noted two reasons were reported by more males than females. Reasons for respondents who said they could stop having sex with non-marital partner but only for some time are that nothing is certain, having

sex depends on situation; sex may happen unexpectedly since they still have to go out for pleasure and meet new people. For those who said they could not stop having sex with non-marital partners, the two most frequently reported reasons are they still like going out for pleasure and they do not trust themselves or may not be able to resist their partner. (see Table T2: 2.15, B2: 2.15, U2: 2.15, and R2: 2.15).



Among those who thought they could stop having sex with a non-marital partner but not necessarily forever, or cannot do it, or are not sure, on average they thought they could practice abstinence for approximately two years. The younger respondents on average could practice abstinence for nearly two years while the older respondents felt they could practice abstinence for nearly three years. On average, female respondents reported an almost three times longer period of being able to practice abstinence than male respondents (five years as compared to less than two years).

Respondents were asked in case that they could stop having sex with a non-marital partner but not all the time, or cannot do it at all, or are not sure, whether they will therefore use condom as a method for HIV prevention when having sex with a non-marital or non-regular (cohabiting) partner. Figure 4.3 shows that varying proportions of respondents reporting that they would use condom with non-marital partners.



The overwhelming majority (89%) of respondents who thought they could avoid having sex with a non-marital partner but not all the time (not forever), or cannot do it at all, or not sure, report that they would use condoms. However, it is found that the

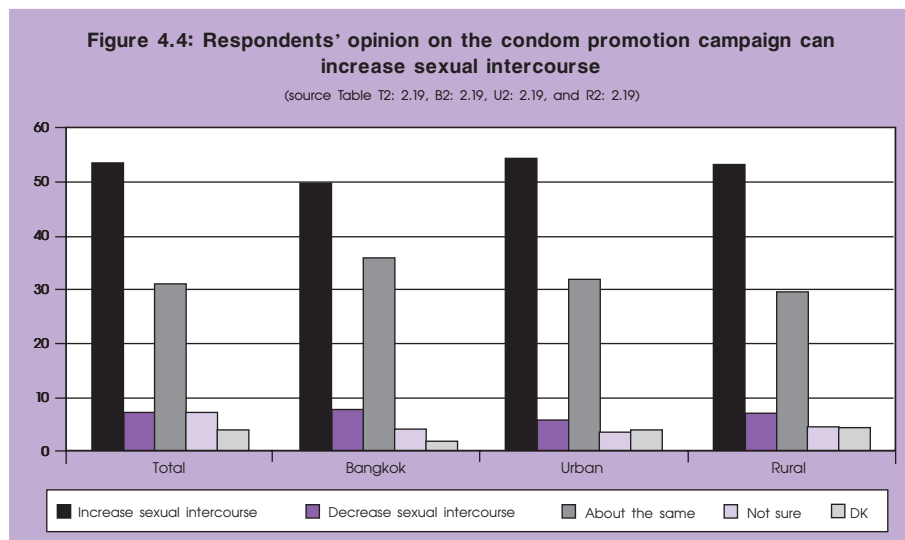
female respondents reported no (not using condom with non-marital or non-regular partners) in higher proportion than males. The highest proportion is found among the urban female respondents. Thus women have a lower sense of self-efficacy regarding being able to be sure of using condoms than do men.

Moreover, respondents were probed if they were to avoid sex with non-marital partners as a method for HIV prevention, would they need to also use other methods as a distraction or compensation. Such alternatives to non-marital sex were reported as finding some hobbies to do (65%), practicing religion (57%), playing sport (56%), not getting close to the one they like (55%), and masturbation (35%). Table B2: 2.18, U2: 2.18, and R2: 2.18 show that the pattern of responses are similar across gender, age group and residence. The only exception is for masturbation, in that a very low proportion of females reported they will use this method compared to male

respondents. Moreover, female respondents in Bangkok would use masturbation in a much higher proportion than female respondents in other areas (27%, 12%, and 11% in Bangkok, other urban, and rural areas respectively).

4.3 The Attitudinal Barriers to the Condom Use Campaign

Figure 4.4 shows the percentages of the respondents' attitudes toward the statement "Do you think the condom promotion campaign will increase sexual intercourse?" A little over half of respondents (53%) thought that the condom use campaign will increase sexual intercourse. Only 7% thought that such a campaign will decrease sexual intercourse while about one-third thought the condom campaign will make no difference in level of having sexual intercourse. The attitudes that condom use campaign will increase sexual intercourse are the same for the young and the older respondents in all types of residence (see Table T2: 2.19, B2: 2.19, U2: 2.19, and R2: 2.19). However, a higher proportion of female respondents than their male counterparts were likely to believe that condom promotion will raise the level of sexual intercourse.



4.4 Forced Sexual Intercourse: The Hidden Vulnerability

A person who experiences forced sexual intercourse is vulnerable to HIV infection because he or she may not be able to negotiate for safe sex, and because of possible trauma to the genitalia. In this

survey, the proportion of respondents who reported ever having been forced, physically or mentally, to have sex against their will is 4.4%. Tables T7: 7.14, B7: 7.14, U7: 7.14, and RT7: 7.14 show that a much higher proportion of female than male respondents who have ever had sex, particularly those in the young age group, reported having experience of forced sexual intercourse. A higher proportion of female respondents in Bangkok than their urban and rural counterparts reported having such experience. Approximately 15% of young Bangkok female respondents, and 9% and 8% of young urban and rural female respondents respectively ever had forced sexual intercourse. The pattern is the same for the older female and young male respondents.

4.5 Conclusion

Despite the scale of the HIV pandemic in Thailand only about one fifth of respondents report being aware of HIV infected individuals in their community within the past twelve months. This testifies to the largely hidden nature of the epidemic which in turn relates to the stigmatization of, and discrimination against, the HIV infected. There was a far lower awareness of HIV infected people being around them among Bangkok respondents than in the other urban areas, maybe this relates to the greater anonymity of life in the metropolis.

About one quarter of those respondents who were aware of HIV infected persons in their communities reported an awareness of discrimination against such individuals. The form such discrimination and

stigmatization appears to take in Thailand certainly falls far short of the horrors reported in many other countries, but basically involves the shunning, exclusion and marginalization of such individuals. Basically if someone is known to be HIV positive some people will avoid contact with them.

Respondents' own behaviour towards the HIV infected seems to come down to their emotional closeness to the individual. Most say they would not shun a close friend or member of their own family, but they would not buy food or other services from individuals they know to be HIV infected. The nature of spiritually-based compassion and social exclusion are rather complex in Thailand, and warrant further more detailed research. Given the awareness of

'political correctness' relating to stigmatization of AIDS sufferers, it is possible that actual stigmatization may well be higher than these findings would indicate. Thus there is clearly a continuing need for interventions that may be able to reduce such negativity.

With respect to general attitudes to HIV prevention strategies, although the promotion of condom use was widely regarded as the most effective, there was also appreciable support for (non-marital) abstinence. Whilst such abstinence was more strongly supported by the older age groups and females, significant proportions of young males also considered it a serious option.

4



The Knowledge, Prevention and Response

Chapter 5:

Knowledge of AIDS and Antiretroviral Therapy

Chapter 6:

Prevention Program Exposure.

Chapter 7:

**Responses to HIV and STIs: Testing, Treatment and
Behavioral Change**

Chapter 5:

Knowledge of AIDS and Antiretroviral Therapy

Current information on the level of knowledge of AIDS among the general population, and especially among young people, is the fundamental building block for the development of any rigorous programme to fight against the pandemic. In this chapter, in-depth knowledge of the primary infection and the development of AIDS symptoms among the general public are closely investigated. In this regard, it is important that knowledge of routes of transmission and basic prevention procedures, particularly among the new generation, is also assessed. The analysis also includes perception of individual risk of HIV infection since it reflects the vulnerability as well as the extent of awareness and individual responsiveness to prevention from infection.

As Thailand is among the very first groups of countries where Antiretroviral Therapy (ART) is available, the focus is also on Thai people's knowledge and beliefs on ART. In this era of ART in Thailand, where universal access to the treatment is targeted, the controversial issue concerns the misconceptions of ART, ART adherence and sexual activities among the infected cases, as well as the risk compensation among the general population. Along these lines, in order that the country's ART promotion and programme is carefully designed and strengthened, knowledge and beliefs about the effectiveness and side-effects of ART, and potential risk compensation among the general population will be investigated.

In addition, potential stigmatization towards ART recipients and the public reservations concerning the government's payment for HIV-infected persons and pregnant women will also be analyzed.

5.1 Knowledge of HIV, Routes of Transmission and Prevention

In general, Thai people have been well aware of the AIDS pandemic for a long time. Table T2: 2.1 shows that in 2006, such knowledge is virtually universal in Thailand. Almost 100 percent of Thai people, young and old, males and females, and in all areas of the country have heard about AIDS (Tables B2: 2.1, U2: 2.1 and R2: 2.1). However, simply knowing about HIV may not reflect the true knowledge of the virus and the transmission. Investigation of HIV knowledge or thorough comprehension is needed.

The closer experience with AIDS is first assessed by the question of whether Thai people actually knew of someone who was infected with HIV or died from AIDS. It is revealed that less than half of the respondents (44%) had that experience (Table T2: 2.2). The older population 25-59 years old had much more experience than the younger, that is, 47% compared to 30%. This age difference is, more or less, consistent in all areas of the countries and for both males and females (Tables B2: 2.2, U2: 2.2 and R2: 2.2). The higher knowledge among the

older people may be due to their longer exposure to the pandemic, as well as the broader social network of the older groups. The lack of individual experience among many of the young people in this matter may explain why young people need more attention than others when a prevention programme is designed.

Although knowledge of AIDS is universal, infected and primary acquaintance AIDS are evident, some misconceptions of HIV-infected person may still exist. The UN standard question to measure the extent of misconception of the infection was asked to the respondents. Table T2: 2.3 presents the percentage of people who understand correctly that "it is possible that a healthy looking person may have the HIV virus." The correct response was provided by only for about 80%. The rest either have misconception or do not know or are not sure about the answer. The population in Bangkok has a slightly better conception than the rural people, i.e., 84% and 79% respectively (Tables B2: 2.3 and R2: 2.3). The misconception in the rural areas is especially crucial among the older women. The correct knowledge among them is only 76%. Programme design to address the older women in the rural areas needs to take this into account.

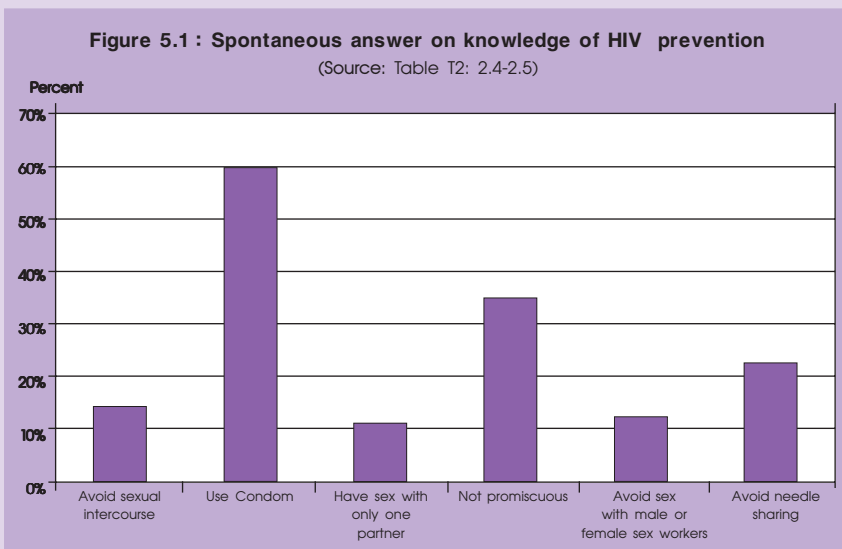
Tables T2:2.7-2.9 reveal the perception on the prevention or the chance of reducing HIV contraction. Respondents were asked about conditions where the chance of being infected with HIV will be reduced. Most of the respondents (about 90% and above) know that infection can be reduced if there is no sexual intercourse, or if one has sex with only one partner who does not have any other partner, or if condom is used during all sexual intercourse. This almost universal knowledge is prevalent for all age groups, males and females, and in Bangkok, provincial urban areas and in rural areas. It is truly encouraging that there is a good awareness of all components of ABC (abstinence, be faithful and

condom or safe sex) among the general population in Thailand. However, there are some reservations concerning these methods of prevention among nearly 10 percent of Thai people. This issue needs to be followed up in more detail in order to enhance programme development to fight against AIDS in Thailand.

Regarding transmission from mother to child, general knowledge on this subject is high among Thai people. Table T2:2.10 shows that the great majority of Thai people (92%) understand that HIV can be transmitted from mother to child during pregnancy. To a lesser extent, 73 to 79 percent understand that the transmission can also occur at delivery and during breastfeeding respectively. These levels of knowledge are fairly similar across age groups, sex and rural urban residence. There are about 10 % or more of respondents who still lack knowledge about these routes of transmission. These findings point to the need for programme design to educate all HIV mothers to be aware of the importance of medical treatment for safe delivery and to promote alternatives to breastfeeding.

Almost all of the respondents know how to avoid or prevent contracting HIV. Without probing, many of the Thai people know more than of the one methods of HIV prevention. The method with which they are most familiar is to use condoms. Table T2:2.4-2.5 reveals that up to 60% of the Thai people know that using condom can prevent HIV infection. About one-third of them (35%) also know that not being promiscuous is a way to avoid HIV. Other means mentioned by the respondents are avoiding needle sharing (accounted for 23%), avoiding sexual intercourse altogether (14%), avoiding sex with sex workers (12%), having sex with only one partner (11%), and avoiding touching blood while having a cut (9%) respectively. Other means are also mentioned, but by less than 5% of the respondents.

In all three areas of the country, (Bangkok, provincial urban and rural places) without probing, the dominance of condom being the most favorable way to prevent HIV is revealed to be very consistent. “Be faithful” and “abstinence” account only for the second and third most popular methods respectively. Moreover, as shown earlier, the extent of these preferences is much lower than the use of condom (Figure 5.1). For the programme design to focus on ABC, the C or the condom promotion seems to be the most suitable and responsive to the prevailing knowledge of the public.



In order to verify elements of comprehension of HIV infection among Thai people in more detail, eleven more questions were asked specifically on routes of transmission. Most of the respondents could answer correctly concerning the nature of HIV transmission. Table T2:2.6 reveals that the majority of the respondents (varying from 54% to 99%) have correct perceptions about transmission. They know that one cannot contract the HIV virus by merely touching an HIV-infected person (90%), by eating from the same plate or drinking from the same glass with HIV-infected persons (75%), by using a public toilet (77%), by mosquito or insect bites (54%), by touching blood of a person with

HIV while having no cut themselves (80%), and by blood donation using a new needle (92%). At the same time they are aware that the virus can be transmitted by having vaginal or anal intercourse or oral sex without a condom with an HIV-infected partner (99%, 89% and 77% respectively), by sharing needle with an HIV-infected person (98%), and if a man has sex with an HIV-infected man without using condom (87%).

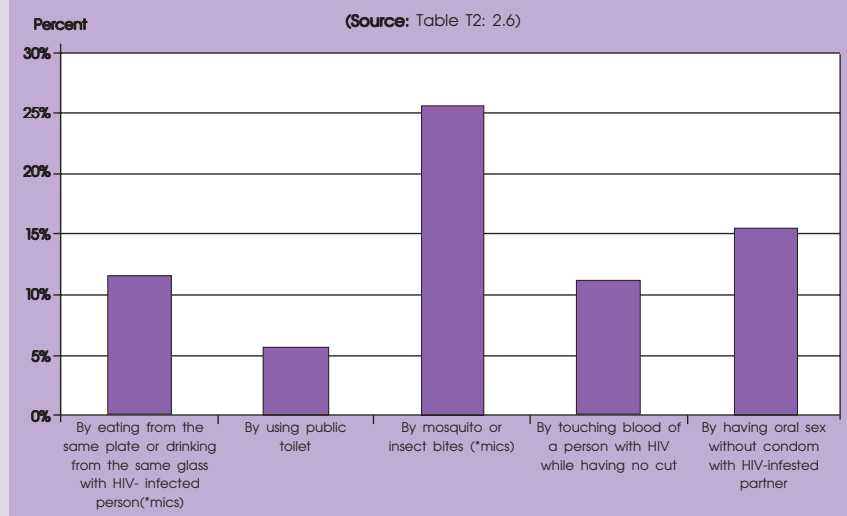
These findings are also by and large consistent across the three urban and rural areas of the country, and the pattern is generally the same for

both sexes and for both the younger and older population. However, it is important to note that although the majority of Thai people are knowledgeable about the nature of HIV transmission, misconceptions (Figure 5.2) among a minority still exists to some degree and needs to be addressed.

5.2 Perceptions of Own Risk of HIV Infection

The measure of self perception or self assessment of own risk of HIV infection may be potentially limited because the respondents' subjectivity contributes to the assessment of their own behaviour. However the measure can be very useful and practical, as is emphasized in both the health belief and AIDS risk reduction Models of prevention. This measure could reflect at least two scenarios of the AIDS pandemic among the public. Firstly, it would echo the extent to which the public have self awareness that HIV is real

Figure 5.2 : Major misconceptions of HIV transmission



Among those who appraise themselves as being at risk, the majority report that they have unprotected sex (15%), have sex with sex workers (16%), and visit sex worker or are not faithful to one partner (18%). Others provide different reasons including having many partners, having "accidents" (presumably condom slippage or breakage), mixing with infected people,

and not at all something out there or quite remote from them. Secondly, with information on their reasons given for their own risk, the information may help to quantify the intensity of the actual risk prevailing among the general population.

In this study, a question was asked concerning respondents perceived risk of being infected with the HIV virus in the next 12 months. Tables T2:2.11-2.12 reveal that 81 % of the answers are "no risk". It is interesting to note that almost 10 percent of the respondents said that they had some risk in the next 12 months. In addition, 1.8 percent and 0.7 percent said they have moderate risk and high risk respectively. That is to say, the self-perceived risk in the public is assessed to be about 13 percent in a one year period. It is encouraging to learn that the general population are not totally unaware of their own risk. At the same time the level of potential risk, is not negligible and needs attention. This is especially true among younger males. Their self assessment of risk, (including some risk, moderate risk and high risk, taken together) reaches 15 %.

their partner being infected, not knowing who has had AIDS or not being confident with partners or husbands. For those who reported that they have no risk, the majority said it was because they have only one partner (44%), not having sex with sex workers (26%) and having no sexual intercourse (14%). It is interesting to note that "using condom regularly" accounts for only 5% of the respondents. Apart from this, other reasons are given only by small numbers.

As shown above, the reasons for risk or no risk are very much related to the three programme components, A, B and C mentioned earlier, abstinence, being faithful and condom use. The three components are emphasized by the respondents quite unevenly. However, it should be noted that the majority of Thai people (80%) think that they probably have no risk, and consequently mention "be faithful" and "abstinence" as their main reasons. Further investigation into developing a suitable programme for Thailand that can give greater emphasis to including "be faithful" and "abstinence" into the condom promotion campaign should not be neglected.

5.3 Knowledge and Beliefs about the Availability of Antiretroviral Therapy (ART)

As mentioned at the beginning of this chapter, knowledge and beliefs about the availability of antiretroviral therapy (ART) are investigated. It would not be sufficient if ART knowledge was assessed only when it is specifically related to HIV infected persons or only with a high risk population. Correct knowledge among the general public is equally important for the design of the prevention programme. Misconception's about ART in the general population may be linked to risk compensation, i.e., people may decide to take risks thinking that the infection can somehow be cured or HIV will become just a common infection that is no longer fatal. The correction of such a view is especially crucial because the pandemic in Thailand is already generalized, and thus a rigorous prevention campaign has to be also designed countrywide.

Respondents were asked whether they know about drugs to fight against AIDS or drugs that would prevent HIV-infected persons develop AIDS. If the answer was positive, the interviewer would verify again whether the respondents really understand about that drug, although they might not call it ART. In Table T4: 4.1-4.2, it is remarkable to note that in 2006, as high as 48 per cent of the population in Thailand have already ever heard about ART. This is true for all age groups and for both men and women. However, there is a noticeable difference regarding the level of ART knowledge among the three respective urban and rural strata. More people in Bangkok (62%) know about this drug than those in the provincial urban areas (52%), and in the rural places (43%). The gaps are probably due to the higher education level of the urban people as well as the better access to the mass media and services in the more metropolitan and urban places.

(Table T4: 4.2) Sources of knowledge about ART are also shown in this Table. The most common source of information about drugs that can combat AIDS is television. Among those who know about these drugs, 71% of them cited television as their source. Other sources account for much less of the awareness. Only 12 percent of the respondents, who know about these drugs, received the information from radio. Other sources account for less than 10%. These include learning from physicians (7%), nurses and health workers (4%), neighbors (7%) and friends (5%), and family and relatives (3%). Newspapers, magazine, bill board and poster, flyers, training and seminar programmes, internet, school, partners, sex workers, workplace, HIV infected persons, colleagues, people the respondents know, community cable program, etc. are also cited as sources of knowledge about the drug against AIDS, but the percentages for each of these sources are small.

However, it is important to note that when the three areas are compared, television as source of information about drugs against AIDS is most significant in Bangkok. In this metropolitan area, 80% of the people cited television as their source, in comparison to only 70 % in the provincial urban and rural areas of Thailand.

5.4 Knowledge and Beliefs about the Effectiveness of ART

As discussed in the last section, knowledge about ART or drugs to combat AIDS among the general public is found among slightly more than half of the adult people, which can be considered to be a relatively high level. However, in order to understand the level and extent of their knowledge in more detail, the awareness and beliefs about the effectiveness of ART among the general public needs to be further investigated.

In this study, those who know about ART were asked further whether they think that ART can completely cure AIDS. Most of the respondents (almost universal) correctly answered negatively that it cannot completely cure AIDS (Table T4: 4.3-4.5). Only two percent believe that AIDS can be completely cured by the drugs, that is, leaving no virus and no illness. Most of the respondents, who answered correctly that the drugs cannot cure, are also able to provide accurate reasons about how the drugs work. Almost 88% of them said that there will be no symptoms but the virus will remain. It is therefore, very encouraging to note that the misconceptions of the effectiveness of ART among the general public is almost negligible. The data also confirm that this is consistently true across age, sex and the rural and urban residence in Thailand.

5.5 Knowledge and Beliefs about the Adherence and Side-effects of ART

The application of ART is a very complicated process and requires a series of standard procedures and strict rules both on the part of the team of the providers and counselors as well as the recipients and the community. Because of this complexity, knowledge and beliefs about the adherence and side-effects of ART in the general public would provide important baseline information for the development of any public programme such as universal coverage of ART for the entire infected population. Investigation of knowledge, misconceptions or beliefs about the side effects of ART across all areas in Thailand, is especially critical here.

Diverse aspects of knowledge on the application of ART to HIV-infected persons were assessed among the general public (see Table T4: 4.6-4.25). First, the respondents were asked whether they know that HIV-infected people have to take ART for the

rest of their lives. It is encouraging to learn that in Table T4: 4.13, the large majority of the adult population in Thailand, i.e., slightly more than 88%, who know about ART are also found to be well aware that ART needs to be taken for life. In addition, almost 89% (Table T4: 4.18) of the respondents know that ART recipients should not stop taking it when they begin to feel better. Lastly, a large majority (almost 72%) (Table T4: 4.19) of the respondents who know about ART, are well informed that ART recipients cannot live as long as the general population of non-HIV infected people. In general, therefore the general public in Thailand, once they know about ART, also have good knowledge on the application of ART.

Regarding the transmission from HIV-infected persons to others, those respondents who were aware of ART, were further asked whether they think that while under treatment with ART, ART recipients can transmit HIV to others. Again, the large majority (almost 90%) of the adult population in Thailand, who already know about ART, have accurate knowledge about this (Table T4: 4.11). In the same respect, almost all of those who know about ART also know that, while under treatment with antiretroviral drugs, HIV-infected people still have the HIV in their bodies (Table T4: 4.12).

However, regarding the fact that ART is not effective for all users, Table T4: 4.14 reveals that only about two-third (66%) of the public, who know about ART, are aware of this reality. Moreover, the same Table illustrates that most of the respondents wrongly understand the timing of treatment of the drug. About 90% held the mistaken belief that ART should be provided as soon as HIV is detected. The proportion that know (correctly) that the treatment should be given only when the CD4 count becomes low is negligible (less than one percent).

Knowledge of the side effects of ART is investigated in Table T4: 4.15-4.16. Only about half (48.7%) of the general public who know about ART also know that ART has side effects or can cause sickness in some people. Among those who reported that they know about the side effects of ART, the side effects they mentioned can be listed respectively as follow: becoming thin and weak (30%), having a rash (17%), losing hair (9%), death (5%) and liver disease (4%). It is evident that additional programme content to promote relevant knowledge about ART especially regarding the side effects of the drug is still definitely called for.

5.6 Attitudes on Risk Compensation and on Behavioural Change

It is a concern to policy makers that if ART is known to the public and if the public has misconceptions about it, the threat of AIDS may not be taken sufficiently seriously. Respondents who know about ART were asked about how serious they think AIDS is, after they have heard that Thailand has ART. Table T4: 4.6 reveals that the majority (about 72%) still think that AIDS is very serious, some (slightly less than 20%) think it is moderately serious. Fortunately the percentage who think that AIDS is not serious is negligible. A similar question directly asked the respondents whether they are more or less concerned about catching HIV themselves after they had become aware of ART. Table T4: 4.22 shows that respondents' concern remains about the same. Slightly over 67% of the adult population who know about ART state that their concern with catching HIV had not changed. However, almost 19% of them have less or much less concern. At the same time about 13% become more, or much more concerned, about becoming infected with HIV. Whether their concern changes because they have confidence in the treatment or because they may change

their risk behaviour or compensating their risk will be examined in the next section.

Attitudes of respondents on possible risk compensation among the public and among themselves are investigated. The respondents who know about ART were asked whether they think the majority of people have increasing or decreasing risk behaviour after they heard that ART is available in the country. Table T4: 4.7 reveals that the majority of the respondents (close to two-thirds (63.8%) of the respondents) estimate that there will be an increase in risk behaviour in the general public. Only about 10% think that there may be a decrease in the risk behaviour. At the same time about 23% of the respondents feel that risk taking behaviour will remain the same. In the same respect, Table T4: 4.9 and Table T4: 4.10 support the earlier findings of risk compensation anticipated by the majority of the respondents. In Table T4: 4.9, most of the respondents (about 68%) foresee that the majority of the people will be less cautious when they have sex. Similarly but to a lesser extent, in Table T4: 4.10, slightly more than half of the respondents (53.3%) forecast that most of injecting drug users will be less cautious.

The findings on risk compensation above are very important although they reflect only speculation on the part of adults in Thailand. They point to the fact that the public perceive that information on ART which may reflect only "half or partial knowledge" of the treatment, may cause increasing risk compensation in the public.

In order to investigate this issue in more detail, respondents were asked about their own sense of risk. It is revealed that, for the respondents' own risk, the problem is probably less crucial. A question on respondents' own risk, whether it increases or decreases their risk behaviour, was asked in Table T4: 4.8. Among those who know about ART, almost half of them (47.8%) feel that

they have no risk. But for those who feel that they are at risk, the majority of them (33%) think that their risk would remain the same. However, there are only about 9% who think that they would increase their risk. At the same time it should be noted that about 10% of those who consider themselves at risk, anticipate that their risk would decrease. It is interesting to record that while there may be some risk compensation among some of the adult population, others, to a lesser extent, may also learn to be more careful because of the information they have received about ART.

5.7 Potential Stigmatization of ART Recipients and Reservation on the Government Payment for ART

A major concern about the process of provision of ART to the population who have HIV infection, is to prevent or reduce the stigma that may be cast to the ART recipients. In order to assess the level of stigma prevailing in the public, a question was asked on the respondents' reaction to ART recipients. Table T4: 4.23 shows the percentage of respondents who would condemn or feel negatively towards a person who receives ART. It is encouraging to note that the percentage is very low, i.e. only about 5%. Most (74.7%) mentioned that they are afraid of infection. At the same time, almost all respondents state that they would not stigmatize against HIV-infected persons who receive ART. The reasons they give are that people cannot contract HIV easily and that they can live with people who are infected with HIV. Stigmatization following a universal programme on ART does not seem to be a problem among the Thai adult population. However, the assessment here should be interpreted with care since respondents may try not to show their own prejudice or stigmatization to the interviewers.

Besides the issues of discrimination, the agreement or disagreement of the payment of ART by the government is appraised among the general public. Respondents were asked who should be responsible for the costs of medicine for HIV-infected people. Table T4: 4.20 reveals that the majority of the people (about 39%) agreed that the government should take responsibility but make a reservation that the responsibility should be for only part of the cost. Only 25% feel that the government should take full responsibility for all patients. The others, approximately 34%, expect that the infected people or their family should pay the cost themselves, or the government should pay only for the poor.

Related to this issue, a question was also asked whether the respondents think that the government should provide ART under the 30 baht health scheme. About 81% of the respondents think that the government should provide this medicine under the 30 baht health scheme. The rest mostly disagree or are not sure. That is, about 20% of the respondents have reservations on universal coverage for ART. It may be speculated that the figure here may reflect only a conservative estimate since some of the respondents may not want to show their discriminatory view to the interviewers.

The reservation on the part of the general public revealed from the study and discussed in detail above, seems to be quite significant or at least, a problem that cannot be taken for granted. The programme for universal access to ART also needs to take into account the important opinions and reservations of many of the people. In order to achieve the greatest benefit, design for such a universal coverage should be carried out concurrently with the campaign to promote accurate knowledge of HIV and ART as well as continuing the battle to reduce discrimination against HIV-infected people.

Lastly, knowledge and opinion on the drugs that can prevent HIV transmission from HIV-infected mother to her child is also investigated. Table T4: 4.24 shows that only about 33% are aware of these drugs. As high as about 60% either think definitely that there is no such drug available, or do not know whether there are any drugs that can prevent such transmission. The lack of knowledge about these drugs in the general public seem to be extraordinary and needs to be urgently addressed in the national PMTCT programme.

Regarding the financing of the PMTCT programme, a question is asked whether the government should provide free antiretroviral drugs to all HIV infected pregnant women. Table T4: 4.25 found that almost all respondents (about 95%) agree that the government should provide free drugs. The expression of reservations is very rare but again, may be under-reported due to the interview effect whereby some of the respondents may not want to show their own discriminatory view especially on mothers and child. The PMTCT programme design still needs to be developed with participatory activities with the community or closely linked to public awareness events and perhaps the wider civil society in order to have smooth programme and be most effective.

5.8 Conclusion

Given that Thailand is among the first group of countries where ART is being made available and seeking to attain universal access, particular reference was made to knowledge of ART, adherence to usage procedures and sexual activities on the part of the HIV-infected.

Not surprisingly given the history of the epidemic in Thailand, practically 100% of the population has heard of AIDS. The study further confirmed that nearly half of the population have direct experience of personally knowing someone who

has become HIV infected or died from AIDS. However this figure drops to less than a third of the younger age group and may possibly relate to the signs of increasing sexual risk taking within this group. There were still some misconceptions about HIV for instance 20% still did not believe that a healthy-looking person could be infected with HIV. This misunderstanding rises to a quarter among older women living in the rural areas. There was generally very good understanding of sexual transmission of HIV and the means of prevention, although almost 10% had some reservations about the ABC components. Condom use was seen to be the most widely recognized means of preventing infection, followed by 'be faithful' and thirdly 'abstinence'. There may well be scope for the development of research to explore ways of giving more emphasis in the Thai HIV prevention programme to 'being faithful'. There was also good knowledge of mother-to-child transmission, although again nearly 10% of respondents had some misunderstanding. All of these findings were by and large consistent across all three residential areas and by sex and age group.

A key dimension in theories and models of behaviour change is that of self-perceived susceptibility to HIV infection. Four fifths of the sample believed they faced no risk of infection within the next 12 months. What is interesting is that among those who perceive themselves to be at some risk, the majority report that they have unprotected sex, engage in intercourse with sex workers, or are not faithful to one partner.

A whole section of the interview was addressed to knowledge of ART, by asking respondents whether and what they understood about drugs that could prevent HIV-infected persons from developing AIDS. Such information is especially important in terms of ensuring that misconceptions about ART do not encourage risk-taking behaviours. It was found that nearly half of the population have heard about

these treatments. Television was by far the most common source of this information. Whilst similar proportions of men and women and younger and older age groups have this knowledge, there is highest awareness in Bangkok (62%) and lowest awareness (43%) in the rural areas, with clear implications for programme targeting.

It is perhaps encouraging that of those who had heard of ART virtually all realize that it is not a complete cure for HIV infection or AIDS. Furthermore awareness of the benefits of ART have not led to a lessening of concern about becoming infected with HIV. Among those who have heard of ART this correct understanding about the limitations of ART is found across all three types of residential area, as well as by age group and sex. There was also found to be fairly good understanding of the procedures involved in taking and adhering to ART, and continuing infectivity once a person has begun a programme of treatment. There was, however, considerable confusion on the part of many respondents regarding precisely when it is appropriate for an HIV-infected person to begin receiving ART. As many as 90% of those who had heard of ART believed that it should be taken as soon as HIV is detected, rather than when their CD4 count becomes low. Many were also unaware of the possible side-effects of ART.

While respondents did not believe that their own awareness of ART had resulted in a more relaxed attitude to the threat of HIV, they did generally think that it would lead to greater sexual and

drug-injecting risk-taking behaviour on the part of the general public. However the findings on people's own feelings is probably the more salient.

With regard to the important matter of possible stigmatization of ART-receiving patients, almost all respondents denied that they personally would behave in such a way. However caution in interpretation is needed here as people may well be unlikely to express stigmatizing views in a survey interview. There were a fairly balanced mix of views as to whether the government should pay for the whole cost of ART for patients, although most (81%) felt that it should be provided under the 30 Baht scheme.

In contrast to the awareness of ART to delay the onset of AIDS, only a minority (33%) were aware that drugs were available to prevent mother-to-child transmission of HIV, but almost all agreed that if such drugs exist they should be provided freely by the government.

In overall terms it is perhaps encouraging that there is already fairly reasonable knowledge of ART in Thailand. However this clearly needs to be more widely disseminated to the many who are still unaware of ART's potential. Much more needs to be done to generate knowledge and awareness of the PMTCT programme. Finally although the survey revealed limited evidence of stigmatization of the HIV-infected, maybe different types of methodology could provide a richer understanding.

Chapter 6:

Prevention Programme Exposure

In response to the epidemic, apart from spending a large amount of money on care programmes, the country's important mission is also to launch the prevention agenda to educate the general public about the AIDS pandemic and to carry out the condom promotion campaign, such as the successful 100% condom promotion programmes of the country which started in the early 1990s. As the route of transmission of HIV seems to have changed in recent years, assessment of the Thai new generation and the adult population concerning current awareness of, and accessibility to, the on-going prevention efforts need to be carried out.

In this Chapter, the general public's exposure to the HIV prevention programme is investigated. The two main areas of inquiry are, the exposure to AIDS information, and the accessibility to condom promotion. The section on exposure to AIDS information includes analysis of mass media or sources of AIDS information, personal exposure to HIV intervention activities, and the issues on the general public's knowledge of AIDS that still need to be improved. The investigation of the accessibility of the condom promotion programme, is examined with reference to knowledge, attitude and practices of obtaining free condoms or buying them from vending machines, which comprise the core aspects of the current campaign being implemented by the Ministry of Public Health.

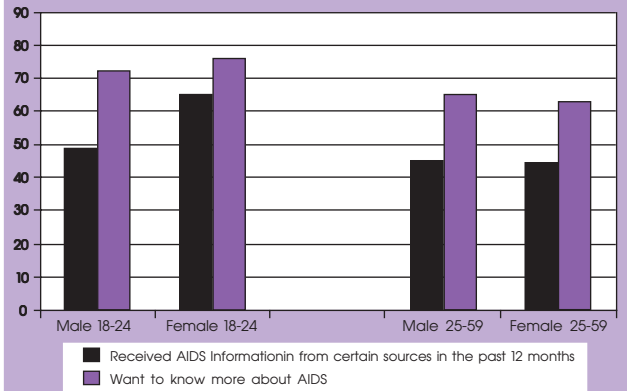
In the analysis, most questions refer to experience that had occurred during the last 12 months prior

to interview. There are some questions that concerned recent experience (in the last 4 weeks), i.e., receiving AIDS information from radio and television, and talking about AIDS with family members, friends, colleagues, acquaintances, training participants, instructors, employees, and AIDS workers. Therefore, if not stated all analysis reported here refers to experience during the 12 months prior to the interview.

6.1 Exposure to and Sources of AIDS Information

As discussed in Chapter 3, Thai society is characterized by a pervasive mass media culture. Whether or not the general public is sufficiently exposed to AIDS information is to be investigated here. Sources of AIDS information in the past 12 months was asked to the respondents. It is surprising to find out that less than half of the adult population reports any kind of AIDS information source at all in the past 12 months (Figure 6.1). At the same time, their need to know more about AIDS is as high as 66% (Figure 6.1). This gap obviously needs to be further addressed by more rigorous and appropriate programmes.

Figure 6.1: Percentage of adult population in Thailand 2006, who received AIDS information from certain sources in the past 12 months and who want to know more about AIDS



AIDS information can come from many sources, such as persons, events, and mass media. Table T3: 3.1 reveals that friends are the most important source (12%). Amongst persons, the range is from 12 percent for friends to less than one percent for employers. Ranked second is public health officers (10%), followed by physicians (8%), school teachers (6%), family members/relatives (5%), nurses (3%), AIDS volunteers (2%), NGO personnel (1%), and employers (0.3%).

For events as sources of AIDS information, the most cited event is teaching/training/lecture (19%), followed by campaign (8%), group discussion (7%), personal counseling (4%), and drama (0.3%) (See Table T3: 3.2). Mass media is the most popular sources of AIDS information, especially television. Of those who reported receiving AIDS information, nearly nine out of ten respondents (88%) cited television as their source. The second most popular mass media source is radio, but its popularity is only half that of television (42%). The third ranked is newspaper (25%), followed by flyers/journal (13%), magazine (7%), poster/sticker (6%), internet (6%), billboard (5%), VDO/CD (2%), and local public speaker (2%) (See Table T3: 3.3).

Generally, these sources of AIDS information are equally accessed by both males and females, as well as for both young adults and adults. However,

female young adults have a greater tendency to obtain AIDS information from teaching/training/lecture and magazine than their counterparts. Physicians are a more common source of such information for females, teachers for young adults, and friends for males.

Bangkok residents are less likely to receive AIDS information from most types of the mass media, compared to other urban provinces and rural areas. The differences are slight with regard to television, but more so for radio (37% of Bangkok, compared to 44% and 40% for rural and other urban areas, respectively). While the rural population tends to listen to radio more, a lower percentage of the population from rural areas (1.8%) cited the Internet as their source for AIDS information, comparing to Bangkok and other urban area (4.3% and 4.9%). Also, printed media such as flyers and journals, and newspaper, are more widely cited by respondents in Bangkok and other urban areas. (See table B3:3.3, U3:3.3 and R3:3.3)

6.2 Roles of Radio and Television in Providing AIDS Information

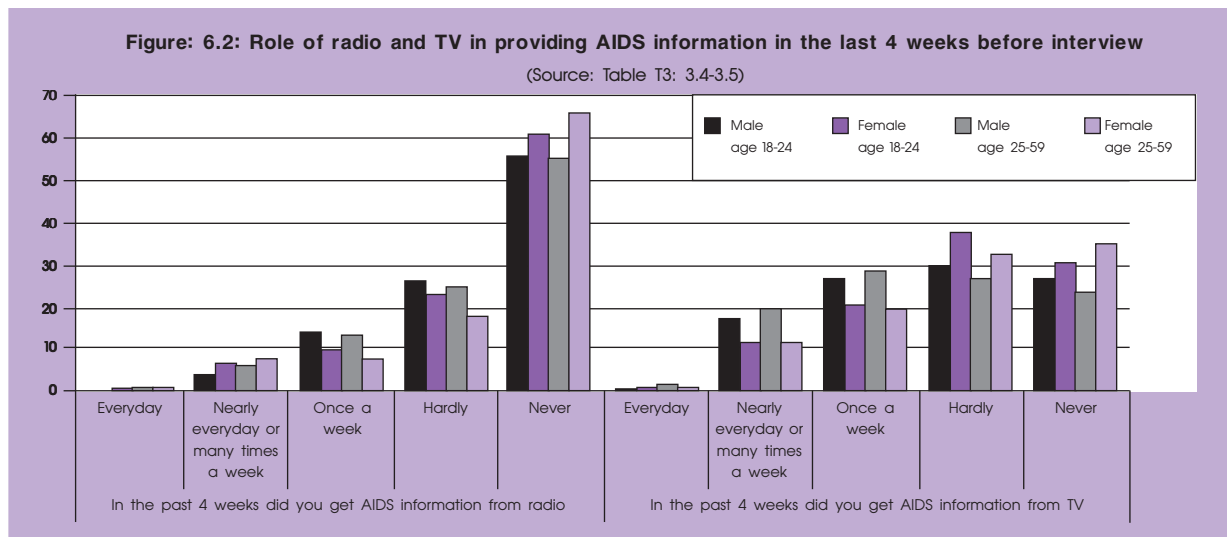
As discussed in Chapter Three, there were only three types of mass media that reach the majority of the population, namely radio, television, and newspaper. However, only one-fourth (22.2%) of respondents reported that they received AIDS information from newspapers in the last 12 months as compared to 41 percent for radio and 88 percent for television. (Table T3:3.3) Therefore, it is worth investigating the role of radio and television in providing AIDS information in the 4 weeks before the interview.

Although most people listen to radio or watch television everyday, they seldom receive AIDS information on an everyday basis. On the contrary, the majority of them had received AIDS information less than once a week from both radio and television.

However, they tended to obtain such information more frequently from television as compared to radio (see Figure 6.2, Source: Tables T3:3.4-3.5). Therefore, AIDS information from television was more accessible to the audiences than radio.

The patterns of frequency of receiving AIDS information were similar for male and female respondents. These similarities were also true in the case of different age groups. Therefore, it can be said that the AIDS information from radio and television was equally accessible to males and females and to youths and to adults.

Only the Bangkok population shows different level of demand for more AIDS information compared to the whole country. Females show more desire for such information than males in all age groups (Table B3:3.7) Moreover, the percentage of desire for more information about AIDS of those in living Bangkok is substantially lower than the percentages for those living in other urban province areas and rural areas. The desire for more AIDS-related information also varies by topic. Respondents, who answered that they wanted to know more about AIDS, were asked about what kinds of topic they would like to know more. AIDS transmission was the most cited topic



6.3 Desires for AIDS Information

More than one half of respondents (66%) reported that they wanted to know more about AIDS. For the younger age group, a slightly higher percentage of females desire to know more about AIDS than males (76% comparing to 72%), while slightly more males in the older age group desire to know more (65% comparing to 63%). However overall young adults show more desire for AIDS-related information than adults (74% comparing to 64%) (Table T3: 3.7).

(34%), followed by right method for protection (24%) and all about AIDS (other aspect of AIDS) (13%). These three topics were reported by two-thirds (71%) of those who want to learn more. Both sexes and age groups show similar interest in these topics (see Table 3.7).

Respondents who did not want to know more about AIDS information were asked for reason of not wanting to know more. "Have AIDS knowledge/ know how to prevent AIDS" is the most cited answer (67.7%).

The other two answers are “not at risk/trust own self” (9.6%) and “not necessary/ no involvement in risk behaviour” (19%) (see Table 3.7). Females are less likely to give the reason of “not at risk/trust own self” than males. The minority of young adults who do not want more AIDS-related information are more likely to cite “Have AIDS knowledge/ know how to prevent AIDS” than adults, but less likely to give “not necessary/ no involvement in risk behaviour” as a reason.

6.4 Supply of Condoms: Access and Reaction

The supply of condoms is an important factor in determining condom usage. Supply of condoms consists of availability and accessibility to condoms. In this study, condom supply is measured by availability of free or low price condoms and availability of condom vending machine in the community or workplace.

About one-third of respondents (30%) report the availability of free or low price condom in their community or workplace. Males tend to know more than females (34% versus 26%). Moreover, young adult males know more about this facility than do older adult males (36% versus 33%). Older adult females know slightly more about condom availability than do young adult females (27% versus 25%) (see Table T3: 3.8).

Less than ten percent of respondents know of a condom vending machine in their community or workplace (Table T3: 3.9). Almost twice as many males as females (11% versus 6%) know about condom vending machines. Likewise, it is (given the demography of HIV incidence) encouraging to note that younger adults know much more than older adults, for both males and females (see Table T3: 3.9). Source: Table T3: 3.8, T3: 3.9, T3: 3.10, T3: 3.11

Reaction to condom vending machines is a central issue of interest here. The responses to condom vending machines is very positive. Three quarters (75%) of respondents agree that condom vending machines make it convenient for obtaining condoms. There is little difference between males and females. However, young adults tend to hold more positive attitudes to condom vending machines than older adults (see Table T3: 3.11).

Only 5% of respondents report ever buying condoms from a vending machine. Most of the buyers are males (9%) with only a few being females (1%). Perhaps not surprisingly, young adults are more likely to buy condoms from vending machines than older adults (23% versus 5%) (Table T3: 3.10). Young males are most likely to use the vending machine (23%). The vending machine project of the Ministry of Public Health seems to be highly relevant and logical and can be considered a successful endeavor for the protection of the young generation in particular against HIV infection.

6.5 Conclusion

The general public’s response to AIDS pandemic seems to be generally encouraging. However despite the high profile of AIDS in Thailand less than half of the respondents reported receiving information about AIDS from any source in the last twelve months. Furthermore there is a lower demand for more AIDS-related information among the population in Bangkok than in the rest of the country. But overall about two thirds would like to find out more, especially among the younger members of the population. The prospects for greater use of the mass media to disseminate further information on HIV prevention can be thought to be quite optimistic. Mass media is the most popular source of AIDS information, especially television. The majority of respondents are enthusiastic to know more about AIDS. The

most cited topic of interest is AIDS transmission. "Already have AIDS knowledge or know how to prevent AIDS" is by far the most (by two thirds) cited reason among those who do not want to know more about AIDS. Only about a third of those who did not want more AIDS-related information gave reasons pertaining to not feeling themselves to be potentially at risk. The informational needs of the public therefore are not only still considerable but also becoming more sophisticated.

Secondly, this chapter reveals that the government's programme to promote the availability of condoms seem to be useful and appropriate for young people in Thailand. Perhaps given the pattern of sexual scripting in Thailand, males have a substantially higher awareness of access to both low cost condoms and condom vending machines than do females. The findings reveal that a substantial proportion of the population (30%) is already aware of access to low-cost condoms in their community or workplace. But that level also indicates the scope for an increase in provision of this vital service.

The survey also reveals highly positive attitudes to the provision of condom vending machines. However less than 10% report knowledge of such a machine in their community or workplace, and only 5% report having actually purchased from one. The current level of the popular support for condom vending machines is high. The potential use of these machines, especially by young males, in Thailand is significant and can probably be increased. Condom vending machines are clearly socially acceptable and could make a greater contribution to HIV prevention in Thailand. Perhaps some useful further research could examine the economics underlying the potential wider provision of condom vending machines.

Overall, the survey findings indicate a positive social climate for the further expansion of the national AIDS awareness and condom promotion programmes. Whilst much has already been achieved in raising awareness of HIV prevention there is still considerable scope for continuing focused expansion of the programmes.

Chapter 7:

Responses to HIV and STIs: Testing, Treatment and Behavioral Change

As is revealed in this study, many members of the adult population in Thailand are found to be particularly vulnerable to contracting HIV. It is well recognized that gaps in knowledge of transmission and misconceptions surrounding the drugs that can help resist the advance of AIDS persist, but what is required is a more precise understanding of such misunderstandings. The likely failures of mass media programmes to bring people better access to vital information, as well as the dilemma concerning confidentiality and stigmatization of HIV-infected persons prevailing among the general public, all point to the demand for rigorous and timely policy and programme responses. The reactions and adjustment can be both on the part of health care providers and relevant organizations, as well as individuals. People may start seeking HIV testing on their own initiative or be required to take the test by health care providers or from other organizations such as the military or their workplaces. Testing and treatment of STIs is, in addition, a natural and valid response to the pandemic. Other rational reactions would include the change of behaviour toward more and better partner communication, temporary abstinence or safe sex. In this Chapter, the range of responses to HIV and STI mentioned above, with their emphasis on HIV testing, AIDS treatment and behaviour change regarding HIV and STI prevention among the general public in Thailand is investigated.

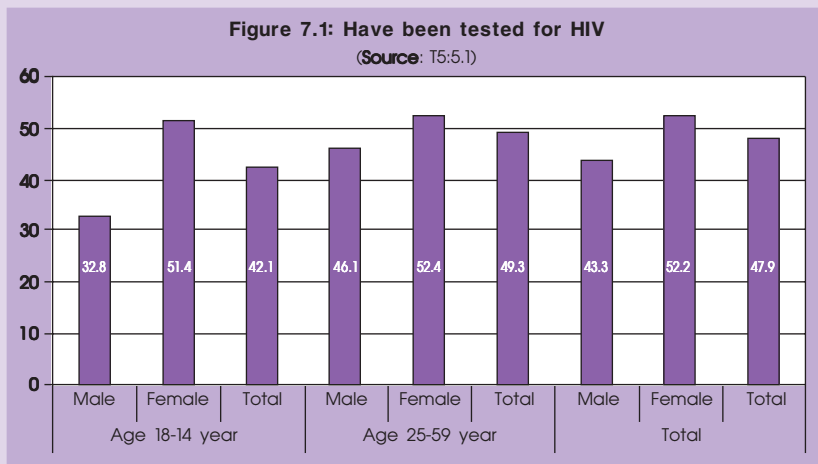
Firstly the past history of HIV testing including reasons for testing and reported barriers to testing is explored. The study examines places of HIV testing services for the general public. The intention to use, and knowledge of, services for HIV testing among those who do not have a history of HIV testing is studied, in order to measure the potential magnitude of the demand for VCT (voluntary testing and counseling) programme in Thailand. Secondly, the chapter investigates knowledge of STI among the general adult population. In addition, past experience of STIs infection and sources of treatment is explored. Lastly, the familial and partner communication and sexual behaviour and adjustment relating to the prevention of subsequent HIV transmission is presented.

7.1 Past History of HIV Testing

Thailand has now experienced the spread of HIV and AIDS for a substantial period of time and the nature of the outbreak is now considered to be a “generalized” pandemic. It is thus speculated that the general public would have some direct experience, one way or another, with AIDS, or at least with HIV testing. This is because in Thailand, HIV is not a “distant” disease but something, very close and in the environs of everyone. The public responses to the pandemic come naturally. In this section, the past history of HIV testing among

the general population of Thailand is explored. The investigation will also include reasons of HIV testing and places where the adult population under study, received such services, in Bangkok, provincial urban and rural areas of the country.

Table T5: 5.1 supports the above speculation. The data shows that as much as 48% of the adult population in Thailand has a history of HIV testing. This is true especially for women. It is remarkable that about half of women aged 18-59, have already experienced HIV testing.



Having a longer time exposure, not surprisingly, the older generation reports a higher level of HIV testing than younger people. For example, about 52% of women age 25-59 have ever had a HIV test. Furthermore, more urban residents are characterized by higher levels of such experience than their rural counterparts. (Table T 5: 5.1, Table B5: 5.1, Table U5: 5.1, Table R5: 5.1).

As for the context and reasons for undergoing HIV testing, the age and sex differences have to be emphasized. Table T5: 5.2 reveals the reasons for last HIV test as reported by respondents. The large majority of women (60%) undertake their test because of their pregnancy. These women have HIV testing probably as part of the routine ANC care and/or at the time of delivery. This is slightly more the case

for younger women than older ones, i.e., 68% and 58% respectively. The second main reason (17%) among women is as part of their annual health check up. The older women reported this reason to a slightly greater extent than younger women, i.e., 18% and 11% respectively. Other reasons among women are only minor, i.e., when they have an operation or when they are sick (8%), when they apply for a job (3%) and when they make blood donation (4%). HIV testing 'just for curiosity' among women is found for only about 4%.

For men, the main reasons of HIV testing are the annual health check up (19%), again more among older men (24%) than younger men (15%). Other reasons for HIV testing among men are blood donation (17%), having an operation or being sick (13%), job application (9%) and wife being pregnant (8%). It is also interesting to note that many men reported that they have HIV tests because of their own

curiosity or they just want to know whether they have HIV (14%), which is more than three times higher than that for women.

The reasons for HIV testing show the same pattern among the three areas of the country (Table B5: 5.2, Table U5: 5.2, and Table R5: 5.2). It is interesting to note that as many as 17% of young men aged 18-24 in the rural areas reported that they underwent HIV testing on their own initiative in order to know their HIV status just out of curiosity. This somewhat greater magnitude may reflect a higher perceived risk of HIV infection among these young men. This figure is higher than those of young men in Bangkok (12%) and in provincial urban areas (16%).

As for those who have never undergone HIV testing, a question was asked concerning their reasons for not undergoing such testing. The majority, (85% Table T5: 5.6), stated that they have no risk. This is slightly more the case for women (87%) than men (83%). Other minor reasons given by the respondents include, their risk is small (4%), afraid of needle/syringe injection (3%), not knowing where to obtain the test (1%), afraid of knowing the result (3%), afraid of being known (less than one percent). Although these reasons are minor, the respondents who reported these reasons may well be among those who may have high risk. Their reasons still possibly reflect important barriers to HIV testing, which have to be taken in account by the programme and policy makers. The advocacy behind, and promotion of, the VCT programme, taking into consideration the important issues of confidentiality and stigmatization, is still very relevant and clearly deserves further strengthening.

The places where HIV testing is performed are presented in Table T5: 5.3. About two-thirds (71%) of the respondents reported "public or government hospital" as their source of HIV testing. Public hospitals are widely utilized for this service by both males and females and by the younger as well as the older groups of population. Table U5: 5.3 and Table R5: 5.3 reveals that HIV testing at government hospitals is more prevalent in the provincial urban and in rural areas (74% and 73% respectively), rather than in in Bangkok, where public hospitals are a less common setting for this service (53%) (Table B5: 5.3).

Other places of HIV testing are much less frequently cited when compared to public or government hospitals. These sources include private hospitals and private clinics, accounting for only 10% and 6% of the respondents respectively. As expected, in Bangkok and provincial urban areas, private hospitals and private clinics are more common sites of testing than in rural areas (see Table B5: 5.3, Table U5: 5.3 and Table R5: 5.3). About 5% also reported that their HIV test was performed at the event of the health provider visit where the testing was carried out for them in their home. This is especially true for Bangkok (10%). In Bangkok as many as 27% of young men aged 18-24 reported that they are provided with HIV testing at a health provider visit (Table B5: 5.3).

Table T5: 5.4 presents the duration between the last HIV test and time of survey. Overall, 10% of respondents reported having a HIV test in the past year, while almost 32% of them reported having the test in less than one year before the survey, with 3% from this group having the test within 30 days before the survey.

On average, the population aged 25-29 years old, both male and female have had the last test in the past three years and more, while the younger population (18-24) had the test during the last one year and a half.

Population	Last HIV test
Male aged 18-24 years old	18 months
Female aged 18-24 years old	18 months
Total population aged 18-24 years old	18 months
Male aged 25-29 years old	39 months
Female aged 25-29 years old	39 months
Total population aged 25-29 years old	39 months
Male population all ages	37 months
Female population all ages	36 months
Total population all ages	36 months

Table T5: 5.5 reveals the extent to which the result of HIV testing is given to the respondents who reported that they underwent HIV testing. It is found that as many as 93% of the respondents obtained their result. A total of 98% of women received their test result. Of concern is that only 87% of men reported having received the result of the test. There is no difference as far as the age group of the respondents is concerned. This pattern of obtaining the result of the test is also uniform across the three areas of the country.

The significant role of government hospitals in providing HIV testing, and the almost universal practice of providing the test result, seem to be extraordinary but reflects the way HIV is now significantly related to Thai people's everyday life. However, HIV testing reported here is not all voluntary, in fact, most of the tests are probably compulsory, demanded either for health care procedures (such as in the case of pregnancy, blood donation, sickness and hospitalization and annual health check up), or required by job applications, military recruitment, or marriage. At the same time, up to 17% among young men aged 18-24 in rural areas, have HIV testing simply because of their curiosity related to their own perceived risk.

These findings indicate that the demand for VCT services, among the Thai population is probably high. HIV testing is found to be in demand by both the organizations, such as the hospital, military or workplaces, as well as initiated by individuals themselves out of their own curiosity and worry. Programmes to provide adequate VCT services for all areas of the country and for all ages and sexes, and at various life cycle periods, are therefore justified and have to be strengthened and expanded. These could include voluntary programmes, such as premarital testing which have to be discussed in more detail in order to inform the manner in which they may be properly adopted in Thai society.

7.2 Demand for Voluntary Counseling and Testing (VCT)

The purpose of this section is to assess the intentions towards HIV testing among the general public who have never undertaken HIV testing. The magnitude of the desire for HIV testing can serve to indicate the corresponding demand for expansion of VCT programmes for the adult population in Thailand.

As has been discussed in the earlier section, slightly more than half of the adult population (52%) in Thailand do not have a history of HIV testing (Table T5: 5.1). Their main reason of never having had an HIV test is that they thought they have no risk. Some of them, although a minority, mentioned barriers as discussed in the previous section. Among this group of people, when they were asked whether they want to have a test, it is important to note that the current demand to have HIV testing is as high as 33% (Table T5: 5.7). This is especially noteworthy for members of the younger generation, aged 18-24, and for both males and females, where the demand to undergo HIV testing for the first time is almost 48%. The intention to have HIV testing among the older group 25-59, is also significant, at 29%, slightly higher for men (32%) than for women (27%). This age and sex pattern of demand for HIV testing is consistent for all three areas of the country.

Figure 7.1 presents the percent distribution of respondents who have never tested for HIV by those who did not have such experience but wanted to have HIV testing at the time of the interview, those who did not have a history of HIV testing and did not intend to test for HIV, and those who were not sure whether they wanted to test for HIV.

The total demand for VCT can be calculated by adding those who had ever tested for HIV (since they may need to undergo the test again), and those who intend to test in the future. HIV testing therefore involves about 65% to 70% of the population.

The history of HIV testing is more significant among the older group of the population, aged 25-59, who had been exposed to a longer life course and risk. At the same time, the prospective demand or the intention to have HIV testing at the time of the interview is substantial among the younger people aged 18-24. VCT services are definitely important elements of the HIV prevention mission in its being able to respond to the needs of appropriate groups within the general population of Thailand.

In conclusion, it is important to note that the eventual demand for HIV testing among a large proportion of the adult population, and especially younger men aged 18-24, is quite significant, not only in terms of magnitude but also in terms of dynamism. HIV testing is related to risk behaviour and thus linked to the life cycle. The new generation, entering into the period wherein a need for HIV testing is increasing and indeed becoming essential to their living, is entitled to receive easily accessible and comprehensive VCT services.

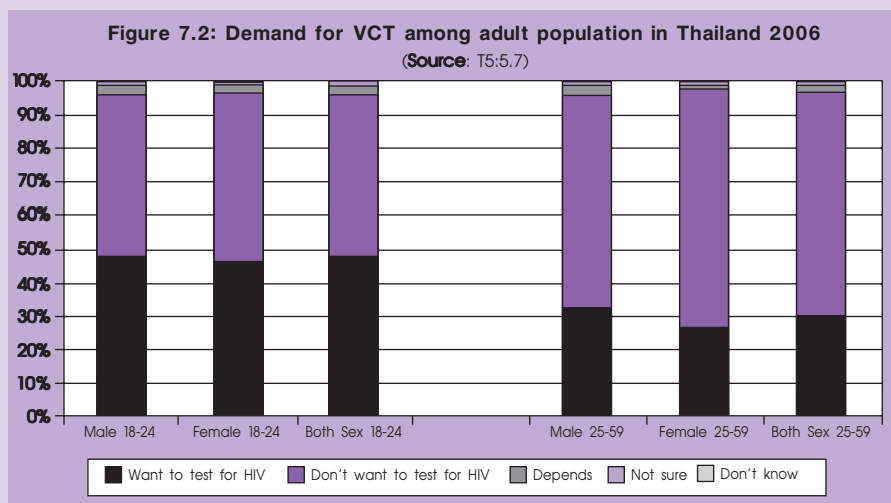
7.3 Knowledge of Sources of VCT

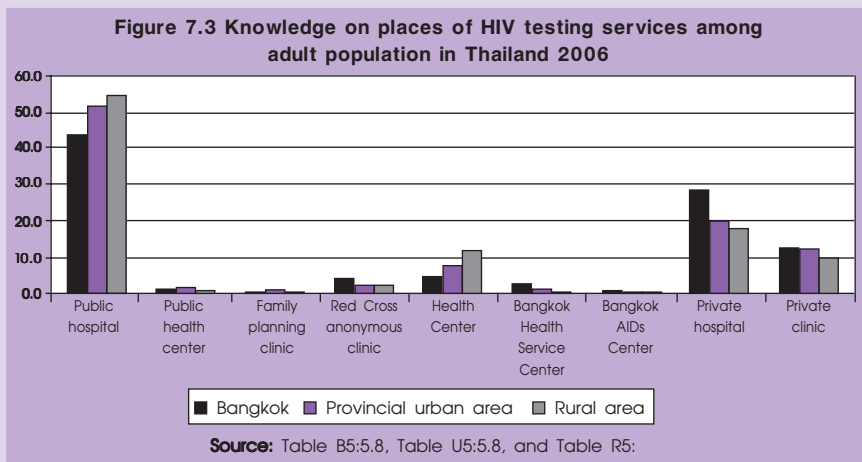
In order to plan for the delivery of VCT services, it is important to first assess the general knowledge of the public on the sources of HIV testing. Among those who intend to undergo HIV testing, a question was asked, without probing, on their awareness of

the places that can provide HIV testing for them.

Figure 7.2 reveals that public hospitals are the place most likely to be recognized by the general public as the site of HIV testing. Indeed 92% of the respondents know that a public hospital can provide HIV testing for them. This is especially true for the provincial urban and rural areas of the country. The second most (but far less commonly) cited place for testing is private hospitals. Bangkok residents were far most likely to cite a private hospital. About 55% of people in Bangkok know that a private hospital can be a source of HIV testing. Whereas only about 36% and 31% of the adult population in provincial urban and rural areas respectively, mentioned private hospitals. The third most frequently cited place is the private clinic which is widely recognized among Bangkok residents, provincial urban residents and the rural community respectively. In rural areas, the health center is also acknowledged by 21% of rural people. Residents in the provincial urban areas and in Bangkok also know about this place, but to a lesser extent, i.e., 15% and 10% respectively.

Apart from the above sources of HIV testing, other places are known or mentioned by the respondents to a much lesser extent, i.e., less than 10%. The Red Cross Anonymous Clinic is known to Bangkok residents (9%), and to some of those living in the





the target populations. They can be innovative and run unique pilot projects for the further development and implementation of new models of VCT services. In the end, multi-dimensional characteristics of different services outlets will probably enhance the success of the national programme for HIV/AIDS prevention in Thailand.

provincial urban (5%) and rural areas (4%). Bangkok Health Service Centers and Bangkok AIDS Center are also cited by some of respondents, especially in Bangkok, although the percentages are small. Lastly, public health centers and family planning clinics are mentioned by a very small number of the respondents.

Everything considered, the role of public hospitals in HIV testing appears to be by far the most significant in terms of its magnitude and its availability in all administrative and geographical areas. Further support on the scaling up of VCT programs to be available in all government hospitals nationwide is essential and relevant. However, equally important is the position of the private sector, including private hospitals and private clinics. The private sector would be able to contribute a great deal to the national VCT program.

In addition, although to a smaller scale, the role of non-government organizations and targeted services organizations cannot be neglected. For example, the Red Cross Anonymous Clinic, Bangkok Health Services Centers, and Bangkok AIDS Center can play a complementary role to the government programmes. As shown in this study, these organizations are already known among selected

7.4 Knowledge of STI

HIV prevention programmes have proven to be most successful when they are supported by, or implemented in parallel with, strong STIs programs being made available to target populations as well as the general public. In many contexts, the campaign against AIDS may surpass the conventional programmes on other sexually transmitted infections. It would be a mistake not to educate the public about sexually transmitted infections and only to alert young people about HIV. It is probable that young people know more about HIV than any other STIs.

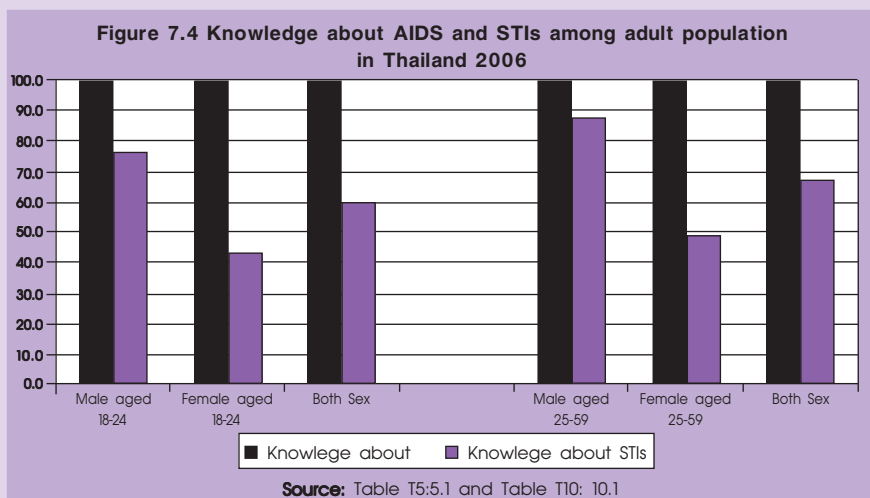
Table T10: 10.1 reveal the accuracy of the above hypothesis. Respondents were asked whether they had ever heard about any other sexually transmission infections apart from AIDS. Only two thirds, (66%) of the adult population had ever heard about other STIs, while, as discussed earlier, the knowledge about AIDS is almost universal. The gaps in STIs knowledge are also differentiated by age and sex (Figure 7.3). The younger generation, aged 18-24, know less about STI than the older peopled ages 25-59, i.e., 59% and 67% respectively. Ignorance on the part of women is striking. While 85% of men know about STIs, only

about half of women (48%) are aware of these infections. The rural population also lags behind their urban counterparts when it comes to knowledge of STI. Only 64% of the rural population are aware of STI as compared to 68% and 73% among urban people in provincial urban areas and in Bangkok respectively (Table R10: 10.1, Table U10: 10.1 and Table B10: 10.1).

Table T10: 10.2 shows that the sexually transmitted infections that Thai adults are most aware of is gonorrhoea (91%). Men have higher levels of awareness than do women (95% and 85% respectively). syphilis, lymphogranuloma /venereum and condyloma are known much less, i.e., only among 29%, 33% and 11% of the adult population respectively. Men are also more likely than women to know about these three infections. Other related infectious diseases are much less well known by the Thai general public, i.e., herpes (6%), candida (3%), and chancroid (3%). Young women aged 18-24, in particular, have greater awareness of candidiasis which involves infection of the vagina, than other groups (11%).

Although more investigation is needed, it could be true that this infection is particularly prevalent among young women at present time.

The sizeable gaps in STIs knowledge among different groups of the adult population probably point to the failure of the disease control programme in Thailand. Health education activities face numerous obstacles, not only in terms of public health management but also social and cultural barriers where communication on sexual issues is restricted among vulnerable populations, especially women and young people. Clearly the public needs to be much better informed about STIs, so that such awareness can reach the same level of knowledge of AIDS. This should help in reinforcing the process of learning and understanding about HIV and the importance of safe sex among the adult population in Thailand. To achieve the best results, the two programmes should therefore be more closely integrated.



7.5 Past Experience of STIs

More detailed information on the levels of STIs incidence and prevalence is very important not only for the STI programmes but also for its implications regarding the potential magnitude of HIV transmission through sexual intercourse. This study asked direct questions on whether the respondents have ever had any infection from sexual intercourse in the past 12 months. Thus it must be noted that the following findings are based on self-report in the absence of STIs testing, and may involve some under-reporting. Table T10: 10.3 reveals the incidence to be 1%, which is higher for men (1.1%) than for women (0.7%). The incidence is also revealed to be slightly higher among the younger population than their older counterparts (1.1% and 1% respectively). For the younger generation, both men and women suffer to the same extent, i.e., 1.1% for both young men and young women. It is shown in Table B10: 10.3, Table U10: 10.3 and Table R10: 10.3 that the incidence varies by the three geographical areas of the country. Provincial urban populations seem to be characterized by the highest incidence of STIs (1.9%). Rural people are the least infected with STIs (only 0.5%). In general, incidence in Bangkok is at intermediate level, i.e., 1.1%.

Variation by age and sex in the three areas is also interesting. The older population, aged 25-59, residing in provincial urban areas, report a higher incidence of STI than their younger counterparts. This is especially true among older men in provincial urban places who have the prevalence rate of as high as 2.3%. The opposite is true in Bangkok. Young men aged 18-24 who live in the capital city, are infected to a higher level than the older male population, that is, 1.8% as compared to 0.9% respectively. Factors underlying these discrepancies may include not only the uneven health education programme and available services but also exposure to sexual risk which probably varies among the people of the

three different rural/urban strata. Programmes to fight against STIs should take into account these geographical variations and a range of risk behaviour of rural and urban residents.

The infection that is most prevalent among men is gonorrhoea, accounting for 83% of men infected with an STIs in the past 12 months (Table T10: 10.4). Although the number of cases under this study is small and interpretation has to be made with care, for women who were infected in the past year, only a few women reported they had been infected with gonorrhoea in the past 12 months. Among the eight young women aged 18-24 who were infected in the past year, three of them were infected with gonorrhoea (Table T10: 10.4).

Apart from the names of infections discussed earlier, respondents were asked to describe the symptoms of STIs. Such symptoms include itching, pain, and unusual discharge from the genitals. The advantage of collecting such information on knowledge of symptoms related to STIs is that it may further reveal the extent of actual STIs incidence, that may have been under-reported when they were asked in previous question about infection from their sexual intercourse. Many of them might not know that, to a great extent, the symptoms are related to sexual intercourse. In addition, by asking about symptoms, a further step could be made to assessing the magnitude of the demand for services. A question was therefore asked to the respondents whether in the past 12 months, the respondents have any uncomfortable feeling at or around genital area such as itching, pain, or unusual discharge from genital.

Table T10: 10.5 reveals that up to about 5% of the adults in the general public had some uncomfortable feeling at or around the genital area, such as itching, pain, or unusual discharge, at least once in the last 12 months. Among this group who suffered from these experiences, the average number of times that they experienced the symptoms was 1.7 times

during the last year. This is especially true for women where about 8% of them reported their problem. Focusing on young women aged 18-24, the reported incidence of discomfort of the genital area is as high as about 10%. It must be stressed however, that many of the symptoms reported here relate to more common reproductive tract infections that are not transmitted sexually.

Regarding the variation by area of residence, Table B10: 10.5, Table: 10.5 and Table R10: 10.5 provide information on the report of discomfort of the genital area by age group and sex. The incidence of potential infection reported by the respondents is found to be higher in rural areas (5.9%) than the two urban areas, including provincial urban areas (5.5%) and Bangkok (only about 2.6%). This is in opposite direction when compared to the reported incidence of STIs from sexual intercourse, discussed in the previous section, and probably reflects higher levels on non-sexually transmitted reproductive tract infections in rural areas compared to urban areas.

Figure 7.4 compares results of the two inquiries. It is found that while Bangkok residents experience (or at least report) more STIs infection from sexual intercourse and less infection symptoms, the rural counterparts, in contrast, suffer less from STIs infection from sexual intercourse and more from the infection symptoms. This distinction is especially true for females. It should also be noted that in general, the provincial

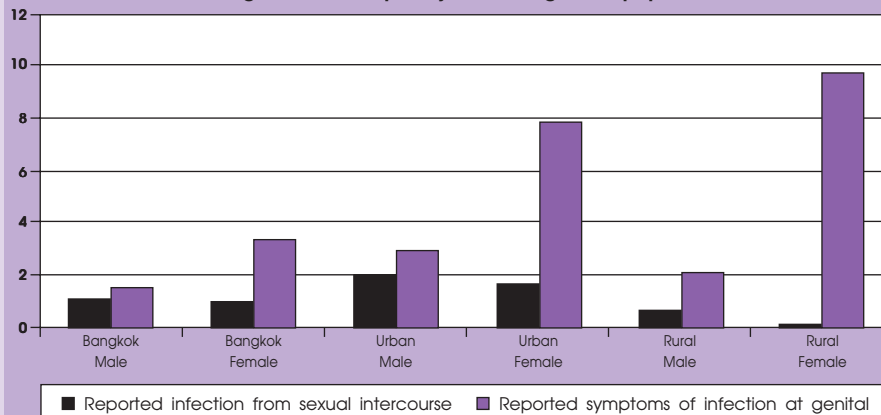
urban areas are characterized by consistently higher incidence of both STIs from sexual intercourse as well as infection reflected by the reported symptoms. Health programmes, including those focusing on non-sexually transmitted infections, targeting women in particular in the rural areas and provincial urban places probably need to be further strengthened.

7.6 Sources of STIs Treatment

In order to improve STIs control programmes, information on sources of STI treatment is important. Accessibility to treatment and barriers to treatment can be directly investigated. Community survey data, as in the case of this study, and in contrast to other data from clinical records or service statistics, provide useful information about both the users and non-users of different services. Data from the general public about their sources of STIs treatment is analyzed in this section.

Table T10: 10.6 reveals the places where respondents received treatment the last time they had an STIs or the last time they had symptoms potentially related to sexually transmitted infection. The most commonly cited place of treatment is public hospitals, which account for 32% of all respondents. Women receive treatment at public hospitals to a greater extent than men, i.e., 36% for women compared to 19% for men. The second most popular place of STIs

Figure 7.5 Reported STIs from sexual intercourse and reported symptoms of infections at genital in the past year among adult population in Thailand



Source: Table B10: 10.3; Table R10: 10.3; Table B10: 10.5; Table U10: 10.5 and Table R10: 10.5

treatment is private clinics, accounting for about 20% for both men and women. The third common source of treatment is the drug store. While some of the respondents buy the drugs themselves (14%), only one percent consult with the pharmacist before making the purchase. These practices are more customary for men than for women. About 27% of men (who report having had a STI) buy drugs by themselves but none of them consult with the pharmacist first before buying drug, in contrast to only 11% of women and 1.3% of women do so respectively. In any case, the fairly large proportion of men and women who buy drugs themselves need to be a major focus of the disease control programme since the practice may be very dangerous not only to the infected persons but also to the general public since drug resistant infections may emerge which can become a further public health problem.

Other places of treatment are found to be used by only a very small proportion of the Thai adult population. About 5% or less of the respondents receive treatment from other sources such as a private hospital (3%), health center (5%), public VD center (3%), NGO clinic (2%), village health volunteer (less than one percent), and friends (1%). It is encouraging to note that no one reports that he or she received treatment from a traditional doctor. However, almost 14% of the respondents who have had an infections or infection symptoms, state that they do not seek treatment from any source, but the majority of these people stated that they recover by themselves without treatment, washing their sexual organ with saline water, and taking medicine. This finding also points to the public health gaps that may be related to the inaccessibility of services as well as probably other social and cultural barriers of treatment, which need to be further investigated and addressed promptly.

7.7 Prevention of Subsequent Transmission

Similar to HIV, the public response to STIs, is firstly reflected by their demand or inquiries for STIs testing. Secondly, the public will respond by seeking treatment and access to the appropriate services. These two topics have been discussed in the previous sections. In addition, the reaction from the infected persons toward their partners and the community is of great interest. The issues of disclosure of infection to their partners and the prevention of infection of their partners, are important both as personal concerns and with regard to wider pandemic control. The partner relationship and communication related to the infection are principal public health concerns that need to be fully investigated. The sensitive matter of discordant couples and the nature of their relationships have to be thoroughly understood for the careful design and further development of appropriate and potentially effective programmes.

In this section, results from the questions asked to the respondents on partner communication and the disclosure of the infection to sexual partners are presented. The reaction of infected persons regarding the prevention against them infecting their sexual partners will be first investigated. The extent of temporary abstinence and safe sex, which are the central issues in this context, are measured. Lastly the intended practice or skill of protecting oneself from becoming infected from sexual partners or spouses who are HIV positive is also explored.

Table T10: 10.7 reveals the extent to which persons who report that they have STI from sexual intercourse or have symptoms related to infection, disclose their infection of STIs or the symptoms of infectious diseases that they experienced to their sexual partners. It is interesting to note that, only about 74% of the infected persons or the ones who have symptoms, report that they tell their sexual partners about it. The constraints or barriers to disclosure of their infectious

status are considered to be detrimental to public health control, and call for further investigation. It should be noted that these constraints and barriers pertain to sensitive matters, and need to be carefully addressed with rigorous but tactful programmes.

A sensitive gender dimension is clearly revealed in this study. Among those who reported having STIs or symptoms related to infection during the last 12 months, female partners are found to be more likely to reveal their condition than their male counterparts. Almost 82% of women would tell their partners about their infections or symptoms, but only slightly more than 45% of men would do the same. This is fairly consistent for both the older and younger groups of the population. Rural people are also more likely to disclose their infection to their sexual partners (79%) than are Bangkok residents (57%). There are only eight persons in Bangkok who answered yes in Q10.7 from 14 weighted cases who answered this question. The provincial urban population are characterized by an intermediate level, i.e., 66%. Again it is most striking to note that, for all areas, women are significantly and consistently much more open than men about their infectious status.

A question was asked as to whether the infected persons or respondents who have symptoms of infection do anything to protect their sexual partners from infection. Table T10: 10.8 reveals that about

66% of them do something about it. In general, women would try to protect their partners more than men (70% and 51% respectively). But this difference by sex also has an interaction with age. For the older generation, women tend to act much more positively (to protect their partner from their infection) than men, i.e., 71% of them do so as compared to only about 48% among men of the same age. For younger generation, the same is true although the difference is not as great. More than half of young men react positively to their partners, while 63% of young women would do the same.

It should be noted that the above result on the protection of transmission to partners on the part of the respondents is obtained from the spontaneous question, without probing. The magnitude of protection may be under-reported by the respondents who may not be aware that their natural reaction is also considered to be one method of protection. For example, stopping having sex may not be thought of as a means to prevent transmission. The analysis below is therefore carried out on the questions of protective acts which were directly asked to the respondents with probing for specific answers.

Three main acts to protect their partners are specifically investigated in this study. These include "stop having sex", "use condom" and "take medicine". The respondents were asked (with probing) about their actual experience in their last infection, whether they carry out these three items of action. Table T10: 10.9 shows that a large majority claim that they turn to temporary abstinence or stopping having sex. As is expected the magnitude of this response is higher than the answer from the earlier question

Figure 7.6 Percent respondent reported to protect partner from infection if they had that infection or symptom

Source: Table T10: 10.8



discussed in the previous section where only 66% stated that they did something to prevent their sexual partner becoming infected. Some of the respondents may not think that temporary abstinence, for example, is expected to be included as one of the important ways to protect the spread of the disease.

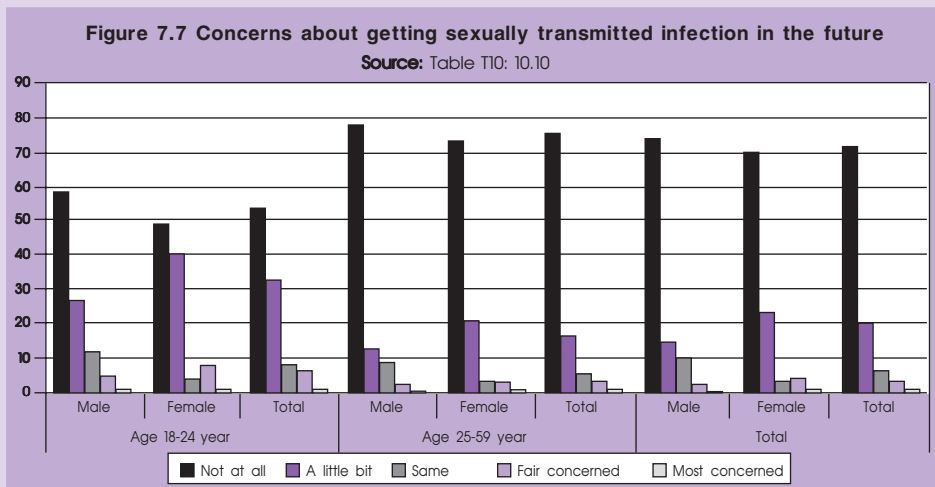
Among the majority of respondents who undergo temporary abstinence, significantly more women report their experience of this method than do men, i.e., 81% and 69% respectively. The second most popular choice is taking medicine. About 64% of the adult population who are infected with an STIs or who have symptoms of infection, state that they take medicine to protect their partners from infection. Again, more women try to protect their partners with this method than do men. The difference is significant, i.e., 66% among women as compared to 57% among men. Regarding condom use, it is discouraging to learn that only about 9% of the respondents have chosen this method of protection. Unlike the two methods mentioned earlier, significantly more men (28%) than women (5%) reported use of condom with their partners during their last infection.

Apart from the protection provided by the infected persons to their partners, the protection of non-infected persons from their sexual partners who are

infected is also equally important to investigate, if not more so. First a question was asked to all respondents, (either infected or non-infected), whether they are concerned that they may be infected from an STIs in the future. Table T10: 10.10 present the percentage of various degrees of concern among the public about such a possibility. About 72% of the general public were not concerned that they may be infected in the future. Others are a little concerned (about 19%), fairly concerned (3%) or very concerned (less than one percent). Therefore, only 28% expressed at least some concerns about their becoming infected. This proportion is fairly consistent for all the three areas of residence (Table B10: 10.10, Table U10: 10.10, and Table R10: 10.10).

This proportion however is not marginal or negligible, and reinforces the need for serious attention from programme and policy makers.

Again, such concerns are more prevalent among women than men. About 40% of women have at least some concerns, whereas only 26% of men express such concerns. The anxiety is highest among young women, slightly more than 40% of whom state that they are a little bit concerned, 7% of them are fairly concerned and almost one percent mentioned that they are very worried. This is substantially higher than their male counterparts. The perceived vulnerability among women is confirmed here. Special attention needs to be



given to this group of the population who are probably exposed to higher risk than others. Further research may be usefully addressed to these different levels of self-perceived vulnerability on the part of men and women. It probably relates to women's sense that their partners may have more risky sexual lifestyles than themselves.

Communication between partners seems to be the first and most important element of prevention of sexually transmitted infection. The investigation here directly focuses on this element. All respondents were asked if they suspect or know that their sexual partners have an STIs, whether they will talk about it with them. It is encouraging to reveal that the large majority of the respondents, or about 94%, report that they would talk about it with their partners (Table T10: 10.11). Differences by age and sex and places of residence are negligible (Table B10: 10.11, Table U10: 10.11 and Table R10: 10.11).

But when it comes to action taken, the picture is not as encouraging. The respondents were asked if they suspect or know that their sexual partners have an STIs, what they think they should do to protect themselves from infection. The question was asked without probing. Table T10: 10.12 indicate that 42% of the respondents would stop sex until the infection is cured, and about 44% would use a condom when they have sexual intercourse. The third option is also popular, i.e., suggesting their partner sees a doctor (33%). Other actions taken are only reported by a small proportion of the respondents, for example, taking preventive medicine (3%). Slightly less than 4% stated other actions, including having sex with other people without an STI, avoiding kissing on the mouth, not going out for fun at night, having a blood test, washing genitals with a water or solution etc.

Although temporary abstinence and condom use are effective and fairly commonly reported in these findings, it must be noted that less than 50% of the respondents would take such actions. Moreover,

these proportions are only the anticipation of action to be taken and not the reports of actions actually undertaken, which, as discussed earlier in the previous section, is found to be much lower. The infected partners are probably unlikely to actually undertake these prevention actions to the extent they predict. In reality, a much lower proportion (about 10% - Table T10: 10.9) will use condoms, for example, in the event of finding themselves infected with an STI.

7.8 Conclusion

This chapter has drawn upon a large body of analysis to derive findings that can assist the refinement of programmes concerning testing, treatment and behavioural change pertaining to STI as well as HIV infection. It is striking that nearly half of the adult population would appear to have been tested for HIV, with a higher level of testing in the urban than rural areas. Furthermore of those who had not been tested, fully a third (mainly from the younger age group), wish to be tested in the future, highlighting the need for ease of access to such services. HIV testing has clearly become an established and accepted aspect of life in Thailand. Whilst most of this testing has been associated with health service procedures, such as relating to pregnancy and health check-ups, a significant percentage of men (14%) have been tested for the sake of their own curiosity, probably relating to their engaging in risk behaviours. Overwhelmingly the reason most commonly given for never having been HIV tested was that they felt no risk. In terms of programme provision, it would appear that HIV testing is widely and easily available and accessed in Thailand. The vast majority of such HIV tests were provided by public hospitals, but findings indicated further scope for this to be complemented by higher levels of testing by private hospitals and clinics. Whilst virtually all women (98%) had received the result of their HIV test, only 87% of men had done so. The overall findings reinforce the need for continuing to build upon the coverage and quality of the VCT programmes throughout the country.

In striking contrast to the quite high levels of knowledge and testing for HIV, the findings reveal low levels of knowledge and testing for other STI. This is in contrast to the situation thirty years ago in Thailand prior to the onset of the AIDS epidemic, when levels of STIs were much higher. Indeed the younger generation know less about STI than the older age groups. Fully one third of the sample had ever heard of an STIs. Yet in prevention, minimizing STI is a first stage to reducing HIV transmission. Men are still more likely than women to have some knowledge of STIs other than HIV, yet the impacts and complications of many STIs are more serious for the female than the male. Clearly the study highlights the enormous need for better public education and treatment concerning STIs. This should be able to build upon the substantial de-sensitization to sexual communication and discussion that has been achieved by the Thailand AIDS awareness programme over the past twenty or so years. The survey found very low levels of experience of STIs or even symptoms of discomfort in the genital area, but this could reflect under-reporting or lack of awareness. This highlights the need for further more studies to explore the actual STIs prevalence in Thailand. The findings on reported symptoms of possible STIs suggest that STI diagnosis and treatment services need to be especially targeted and strengthened for women. Whilst again the public hospital is the most common place of STIs treatment, the survey also reveals a worryingly high degree of self-treatment and purchase (without expert advice) of drugs from pharmacies.

Some of the most intriguing and original findings from the survey pertain to matters of disclosure and protective behaviour within relationships, and HIV-discordant couples in particular.

A strong gender differential is identified wherein women (and rural residents) are much more likely to openly admit genital infection symptoms to their partner than are men. Furthermore, women are far

more likely than men to take practical steps to prevent their STIs from infecting their partner than are men. The most common reported protective response is temporary abstinence, followed by taking medicine and condom use. A similar pattern of responses is found for self-protection in the light of a partners possible infection. It is discouraging, in the light of Thailand's substantial condom promotion, that less than 10% would use a condom to prevent transmission of possible infection to their partner. What is most worrying is that a high proportion (just over 50%) would not pursue any protective action. This finding would benefit from further in-depth research. Approximately one quarter expressed some concern about their possible sexually transmitted infection in the future, again with the anxiety being more widely felt by women. This probably reflects the gender structuring of risk behaviour within the sexual culture. These different levels of self-perceived vulnerability between men and women may well warrant further research.

In final conclusion, there are still considerable gaps of HIV prevention which should be targeted. At the same time, a discrepancy still exists regarding how to promote self-protection among the non-infected persons from their partners who are already infected or suspected to be infected. The group which seems to be most vulnerable to infection from their partners seems to be women. Promotion of the use of condom particularly within a steady partnership is also a very complicated matter. The challenges of programme design are amplified by the extraordinarily sensitive issues including the concerns of human rights, family relations and gender considerations. While a 'gold model' of prevention among discordant couples still needs to be further considered and developed, programmes designed to provide numerous options of self-protection to the public may be the best way to address these sensitive concerns in the meantime.



The Sexual Risks

Chapter 8:

Sexual Risks

Chapter 9:

Sexual Behavior with Multiple Partners

Chapter 10:

**External Influences on Young Adults' Choices of
Sexual Behavior**

Chapter 8: Sexual Risks

This chapter analyses sexual risk of Thai people aged 18-59 years. Sexual risk is examined with reference to marital status, sexual orientation, sexual behaviour, partner numbers, and condom use by type of partner (including spouse/regular partner, casual, and sex workers). In addition, the history of sexual violence within and outside of marriage is described.

8.1 Sexual Orientation

Findings from Table 7.1 shows the self-reported sexual orientation of Thai people as overwhelmingly heterosexual, as nearly 100 % of both males and females reported that they are sexually attracted to the opposite sex. However, younger female are slightly more likely to report being attracted to their same sex than are young males. Young female homo/bi-sexual orientation is more common in Bangkok (3.8%) and urban (3.0%) than the rural (0.6%) areas. (See Table T7.1; Bkk7.1; U7.1 and R7.1)

8.2 Sexual Experience

Sexual experience in this study refers to people having ever engaged in sexual intercourse. Evidence from this study shows that overall 83% have had sexual intercourse. Among males, 89% have had sexual intercourse while for females 78% have had sexual intercourse. Thus the overall level of sexual experience is not very different for Thai males and Thai females.

Among the younger age group (18-24 year old), nearly three in four have had sexual experience (72%). More young males (80%) have had sexual experience than young females (63%) however, the percentage is less than it may have been thirty years ago.

When comparison is made of the levels of sexual experience among young people aged 18-24 years for the three types of residential areas it is found that young females in rural area are slightly more likely (67%) to have had sexual experience than young females in Bangkok (59%) and in the other urban areas (63%). This is opposite for young males, in that 83% of young males in Bangkok reported they had sexual experienced this drops slightly to 81% in the other urban areas and 76% in rural areas.

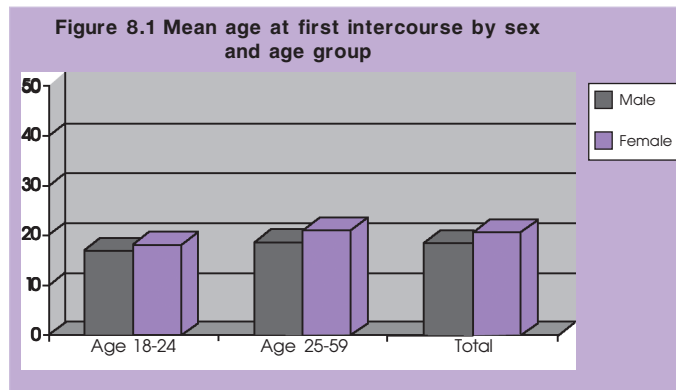
Among the older age group, it is found that virtually all males and females report sexual experience. (See T7.2; B7.2; U7.2; and R7.2)

8.3 Age at First Sexual Intercourse

Overall the average age of first sexual intercourse for males is 18.4, and for females 20.6 while in total, the average age is 19.6. In the 18-24 age groups, the average age for first sexual intercourse for males is 17.1, for females it is 18.2 while in total, the average age is 17.6.

In the 25-59 age groups, the average age of first sexual intercourse for males is 18.7, for females 21.1, while around, the average age is 19.9. Thus there has clearly a trend towards earlier ages of first intercourse in recent years. Furthermore this declining age of first intercourse is found in all three types of residential area.

As expected based on earlier studies of Thai sexual culture, males continue to have first sexual intercourse at significantly earlier ages than females, with approximately one in three males, but only one in ten females, in both urban and rural areas having first intercourse before the age of 15. These findings have clear implications for the timing of appropriate sex education in schools.



8.4 Sexual partners and homosexuality

As is found in most sexual behaviour surveys, the first sexual partners of respondents were overwhelmingly (99%) of the opposite sex, indicating a heterosexual culture. This pattern is replicated in terms of people's identification of their sexual orientation with 99% of males and 98% of females reporting as heterosexual. The main difference is that slightly more younger (4.5%), than older (1%), females in the total sample self-identified as not only heterosexual. Furthermore a higher percentage of younger females in the urban (4.5%) than in the rural areas (just over 2%)

identified as not purely heterosexual. This could indicate migration to, or a sense of more tolerant attitudes in, urban areas. However it is well recognized that large scale sample surveys are not the optimal data collection method to generate information on sexual orientation. (See TableB7: 7.4)

8.5 Nature of First Sexual Partner

For the total sample there are major variations in the nature of the relationship with the first sexual partner by both sex and age group. While most females (67%) report that their first intercourse was with their spouse (if not necessarily registered), for males it is reported as girlfriend, friend or acquaintance (72%). Given that there is some stigma involved in public knowledge of a woman's pre-marital sexual experience in Thailand, this finding could reflect different interpretations in reporting of spouse/girlfriend by sex.

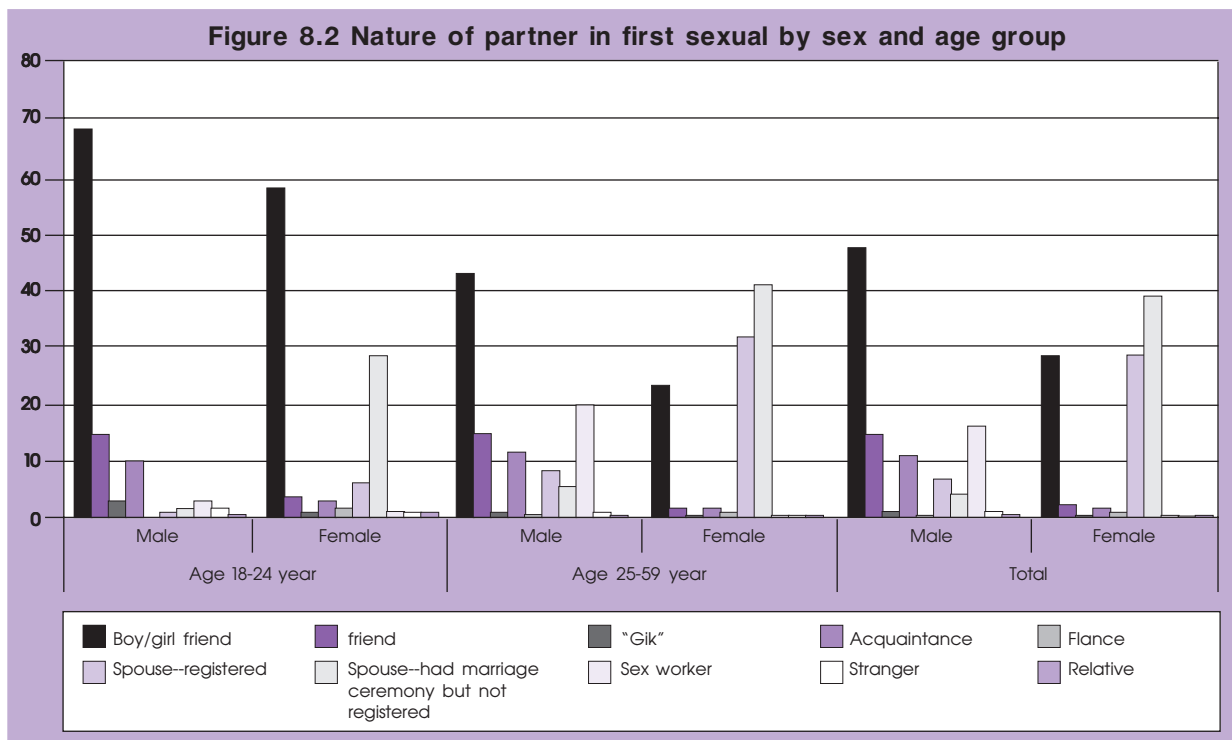
There are also major differences by age group for both sexes. Firstly much higher percentages of the younger age groups of both males (84%) and females (63%) report first intercourse with a boy/girlfriend, friend or acquaintance than the older age groups (68% males, 26% females). The second major

difference by age group is that a much lower percentage of younger males (5%) report their first intercourse as being with a sex worker (bar girl) or "gik" as compared to older males (19%). These differences by age group reflect the well-documented shifts within Thai sexual culture away from contact with sex workers sexual contact towards increasingly levels of intercourse within pre-marital relationships. This probably reflects some combination of gender liberalizing trends that make pre-marital sex less unacceptable for females, along with the high association of sex work with HIV in Thailand.

In epidemiological terms it is important to further explore the appreciable levels of casual, non-commercial sexual interaction, given the reported success of increasing condom use in the sex industry in Thailand. With respect to this it is notable that 12% of both younger and older males reported that their first sex was in a casual relationship, but not with a sex worker.

These broad trends are found in all residential areas. The only major difference is for younger females who report much higher levels of first sex with a spouse (40%) in the rural areas than for Bangkok (26%) and the other urban areas (23%). This suggests both higher levels of earlier marriage and more traditional sexual lifestyles for females in rural areas. This could well reflect both more traditional general values and greater familial control pertaining to the sexuality of women in rural than urban areas of Thailand.

The survey also asked respondents about relationship developments after first intercourse. There is a striking difference by sex with majorities of females of both age groups reporting that it led to marriage or cohabitation (more so for the older women), whilst a smaller majority of males state that it led to a relationship, but short of marriage. Thus the findings show the same divergence in males and females subjective reporting about sexuality, with females presenting an image of greater personal commitment. The finding that more older (42%) than younger (28%) males state that their first intercourse had no relationship implication reflects the fact that, many more had their first intercourse with a sex worker. These patterns were generally found across all residential areas, except a substantially higher percentage of younger women in the rural areas (76%) reported that first intercourse led to marriage/cohabitation than in Bangkok (64%) or the other urban areas (57%). Again this may reflect the greater social pressures in rural areas towards marriage in the light of sexual involvements.



8.6 Intention and Coercion in First and Later Sexual Experience

The survey explored the level of intention to have sex and coercion associated with first intercourse in terms of whether it was positively desired, unintended or forced. Whilst a majority of both sexes desired their first intercourse, this was higher for males (93%) than females (85%). It is of concern that while virtually no males reported that their first intercourse had been forced, this rises to 3% for females, of whom a further 4% reported it was not "not wanted". About 6% of both males and females described their first intercourse, somewhat ambiguously, as "happened but without an intention", presumably meaning it had occurred almost by accident but without any particular coercion.

It is notable that younger (18-24) women report higher levels (13%) of unwanted/forced first intercourse, than do older (25-59) women (8%). This may well indicate that the shift towards higher levels of pre-marital intercourse for young women is putting significant numbers of them under pressures within relationships. This pattern is found in all three residential areas thus pointing towards the need for the issue of the unacceptability of coercion to be addressed in national programmes on sex education and life skills.

The above findings on first intercourse are reinforced by the findings on ever having experienced (physical or mental) force in relation to sex. Whilst 2.6% of males report such force, this, rises to 6% for females. Furthermore, the level is 9% of the younger, as opposed to 6% of the older women. This further indicates, that changes in sexual culture, with increasing levels of pre-marital sex for young women, is leading to a situation where greater force or coercion may be involved in intercourse. It is notable that the highest level (15%) of reported force in sex is found among younger (18-24 years of age) women in Bangkok. (See Table T7.7, B7.7, U7.7, and R7.7)

8.7 Marital and Cohabiting Status and Frequency of Intercourse

Across the total sample a much higher proportions of the older than younger age groups are ever married (both registered and unregistered). Furthermore, among the younger age group, more females (53%) than males (20%) are ever married. Similarly, taking cohabitation into account, the divergence is even more striking with only 31% of males, but 81% of females, married or cohabiting. This confirms a pattern where young women have male partners somewhat older than themselves. Reflecting the pattern of younger women's more traditional sexual lifestyles in rural areas, there is a higher level (86%) of younger women in married and cohabiting relationships in rural areas than in Bangkok and the other urban areas.

In terms of the frequency of intercourse within married and cohabiting relationships, do the younger age group report intercourse as taking place more often than the older age group. Among this younger age group, the median level (40%) of intercourse is once or twice a week, while this (also the median) falls to 27% for the older group. The pattern of the frequency of intercourse within married and cohabiting relationships is broadly the same across the three types of residential areas.

8.8 Lifetime Numbers of Regular Partners

The majority of respondents (73% of the total sample) have had only one regular sexual partner in their lifetime. This is the case for nearly nine tenths of both the younger and older females. However only 52% of younger and 63% of older males report having one regular sexual partner in their lifetime, but for different reasons. For the young males this is because 28% have as yet never had a regular partner, and for the older males this is because 30% have had two (19%) or more regular partners in

their lifetime. Thus the pattern of the sexual culture would appear to continue to be one in which males have greater scope for having more than one regular partner in their lifetime (either serially or simultaneously), than do females. This reinforces the above noted findings that suggest that females steady partners are generally somewhat older than themselves. It would appear that age is more of a barrier to women than men in finding a second regular sexual partner in Thailand. These patterns are replicated across residential areas, but are most pronounced in Bangkok where 39% of the older (25-59 years) age group of males have had two or more regular partners, as compared to 31% in the other urban areas and 28% in the rural areas. This divergence may well relate to both greater wealth and number of contact opportunities in Bangkok than the other areas.

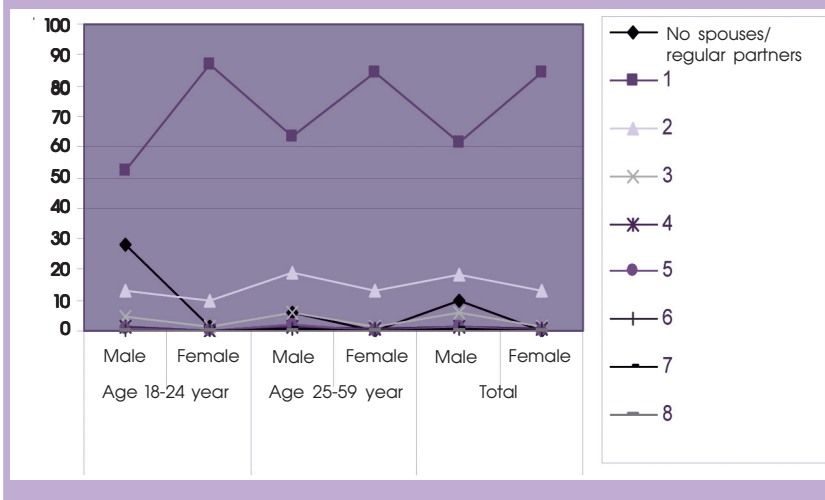
8.9 Levels of Casual (Non-commercial) Sex Partners in Lifetime and Last Year

Given the interest in the broad shifts within Thai sexual culture away from high levels of contact with sex workers towards higher levels of casual, but non-commercial, sexual contacts, the survey explicitly sought to address these matters. Sex with casual partners is predominantly reported by males, with 52% of the male sample reporting casual sexual experience, but only 3% of females doing so. However it is notable that this increases to 7% for females in the younger age group. Similarly while only half of older males report casual, non-commercial, sexual contact, this is reported by two thirds of the younger males, reflecting the trends noted above. When

reference is made to numbers of casual partners within the last year the pattern is found to be the same for both younger and older males. The general pattern is for nearly one half of those males, who have ever had a casual partner, to have had one sexual partner, one fifth two, just under one eighth three, and very small proportions four or more. These patterns are broadly replicated across the three residential areas.

In epidemiological terms, the implication of the large disparity in levels of casual sex in what is an overwhelmingly heterosexual culture is that there is probably a quite small proportion of (younger) women engaging in a fairly high level of casual sex (but their numbers

Figure 8.3 Number of partners in lifetime by sex, age group and residential area



are too small for them to be found in a general sample survey) and that more males interpret sexual contacts to be casual, whilst more females interpret the same encounters to be more personally meaningful. It would be useful to conduct further more qualitative research into this (demographically) small group of females engaging in high levels of casual sex.

8.10 Levels of Contact with Sex Workers

Given the international interest (Ankomah and Ford, 1994) in transactional sexual relations in which men provide material support in return for sex, the survey sought to examine whether there is evidence for such exchanges in Thailand. The survey findings found virtually no evidence for such practices. Either material or pecuniary transactions are not part of the Thai sexual culture or more sensitive methodologies drawing upon exchange theory need to be employed to develop a more nuanced analysis of the phenomenon.

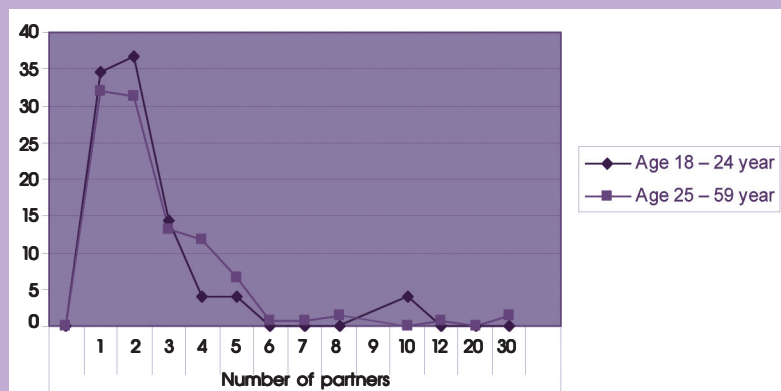
There is however continuing evidence in the survey for interaction with sex work. Across the total sample, 44% of older males report having ever engaged in intercourse with a sex worker, this is 24% of the younger age group. Furthermore for both age groups, of those who had ever had sex with a sex worker, around two fifths had done so within the past 12 months. Of these more than 80% had done so on no more than three occasions in the past year. Thus whilst sex with sex workers continues within Thai sexual culture, it is not an

especially frequent part of men's behaviour. The main places where these men met sex workers were roughly one third each in brothels, restaurants and karaoke bars. These patterns are an indication of the ways that sex workers are accessed through a variety of settings today.

With respect to variations by area, it is notable that male respondents in Bangkok reported somewhat higher levels of sex with sex work than did respondents in other urban and rural areas. This may reflect higher levels of disposable income and opportunity for contact with sex works in Bangkok than elsewhere in the country.

From comparing levels of contact with sex workers with those with casual, non-commercial partners, it is clear that younger males report more than twice as much contact with casual partners. These findings further reinforce the argument that there has been a major shift in the pattern of Thai sexual culture away from sex work towards more 'Western' non-commercial patterns of youth sexual relations. This shift is towards a more complex pattern of interactions and raises challenges for the practice of 'safer sex' in Thailand.

Figure 8.4 Levels of commercial sex by age group (Males only)



8.11 Condom Use

This chapter has provided an overview of the broad patterns of sexual interaction. However in epidemiological terms, with respect to the transmission of HIV and other sexually transmitted infections, the crucial factor is the extent to which condoms are consistently used. This final section of this chapter reviews levels of condom use in first intercourse, with current regular partner, with a casual partner, and with a sex worker.

Males report much higher levels of condom use than females, for, as noted in the previous sections, they report much more diverse patterns of sexual interaction than females (most of whose reported intercourse takes place within committed relationships). Thus for brevity, reference in this section is made only to males' reported condom use.

As depicted in Figure 8.5 there is a clear, and expected, pattern of increasing levels of condom use from regular partner (12%), through casual partner (47%), to sex worker (94%). It is also notable that the younger (18-24 years) age group reports much higher levels of condom use of first intercourse, and with regular and casual partners, than the older (25-59) age group. The lower level of condom use with regular partner (9%/33% last intercourse) by the older age group reflects the fact that they are more likely to be in stable, married unions than are the younger age group. The overriding reason (72%) for non-use of condoms with regular partners is reported here as "trust in and confidence in the safety of the partner", as has been reported in most such surveys of condom use around the world for the past twenty years.

Evidence for the success of Thailand's "100% condom use in the sex industry" policy is found in the 94% of both younger and older age groups who report that they always use condoms with sex workers. With respect to last sex with a sex worker, there is a

disparity between the age groups, with 96% of the younger respondents, but only 72% of the older respondents reporting condom use. This is probably because many of the older respondents have not visited a sex worker for many years, and their non-use of a condom could have occurred before the "age of AIDS" and the 100% condom use policy. There is concern that 4% of the younger age group report never using condoms when they have sex with sex workers. In the light of the levels of HIV prevalence in the Thai sex industry and the government's strenuous efforts to promote condom use this would appear to be almost pathologically perverse behaviour. It is possible that members of this small minority of respondents are probably already HIV infected and are infecting further sex workers. Some kind of qualitative in-depth research could well be gainfully undertaken among this epidemiologically crucial group.

A situation of greater ambiguity and uncertainty arises with respect to the findings on condom use in casual sex. This is an important aspect of the study given the major shifts in the sexual culture, with casual (non-commercial) sex appears, to be more common than encounters with sex workers. Most casual sex is engaged in by the younger age group, among whom a higher percentage (66%/42%) used a condom in their last casual encounter than did the older age group. Thus it makes sense to focus in some detail upon this younger age group's condom use in casual sex. Half report always using condoms, but about a quarter report never using condoms in casual sex. The reasons given for non-use are firstly (39%), confidence of safety of partner, secondly (31%), "not prepared/could not find a condom at the time", and thirdly (12%), just do not like using condoms' (reduced sensation). These patterns of levels of condom use and reasons for non-use are broadly similar across all three residential areas, with the small exception that levels of condom use in casual sex by younger people in the rural areas are somewhat lower than in Bangkok

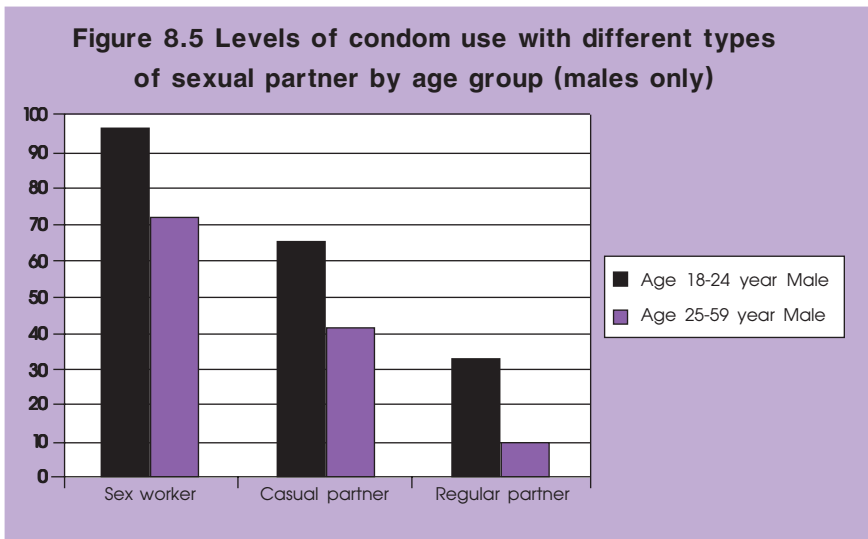
and the other urban areas. Perhaps in rural areas younger people are more likely to be socially familiar with potential casual sex partners and thus have a lower sense of perceived risk. However, the pattern of main reasons given for non-use of condoms in casual sex by the rural respondents is almost identical to that of the other areas.

The risks of HIV or other infections from casual sex in Thailand are very hard to quantify, as the nature of what is a casual sexual partner is highly subjective and necessarily varied. However as discussed in section 8.9 above, it is plausible to consider that given very few females report engaging in casual sex, those that do should be quite a small minority, some of whom will be having intercourse with numerous partners. Therefore their epidemiological risk is likely to be high. Yet the main logic on the part of the many males who do not, or only inconsistently, use condoms in casual sex, is that such women *do not* constitute a sufficiently high risk of infection to warrant protection from a condom.

sexual experience, younger females in the rural areas report higher levels of being sexually experienced than those in Bangkok and the other urban areas, which largely reflects their earlier ages of marriage. Comparison of the younger and older age groups shows a clear trend of declining ages of first intercourse in recent years, but with males still having first intercourse at significantly earlier ages than females. There are major variations in the nature of the relationship with first sexual partner by both sex and age group. While most females (67%) report that their first intercourse was with their spouse (if not necessarily registered), for males it is reported as girlfriend, friend or acquaintance (72%). Secondly the younger age groups of both males and females show higher levels of first intercourse with boy/girlfriend or friend than do the older age groups. This reflects a two-fold major shift in Thai sexual culture, towards higher pre-marital sex within relationships, and declining sex with sex workers. This probably reflects some combination of gender liberalizing trends that make pre-marital sex more acceptable for females,

along with the high association of sex work with HIV in Thailand. The higher levels of younger females first intercourse with a spouse in rural areas suggests both higher levels of earlier marriage and more traditional sexual lifestyles for females in rural areas. This could reflect both more traditional values and greater familial control pertaining to the sexuality of women in rural than urban areas of Thailand.

Figure 8.5 Levels of condom use with different types of sexual partner by age group (males only)



8.12 Conclusion

This chapter focused upon sexual behaviour and risk-taking. In terms of sexual orientation, the sample is overwhelmingly heterosexual. With reference to

The survey also asked respondents about relationship developments after first intercourse. There is a striking difference by sex with majorities of females of both age groups reporting that it led to marriage or

cohabitation (more for the older women), whilst a smaller majority of males are more likely to state that it led onto a relationship, but short of marriage. Thus the findings show the same divergence in males' and females' subjective reporting around sexuality, with females presenting an image of greater personal commitment.

The survey also explored matters of force (mental and physical) and coercion associated with sex. It is notable that younger (18-24) women report higher levels (13%) of unwanted/forced first intercourse, than older (25-59) women (8%). This may well indicate that the shift towards higher levels of pre-marital intercourse for young women is putting significant numbers of them under socio-personal pressures within relationships. It is notable that the highest level (15%) of reported force in sex is reported by the younger (18-24 years of age) women in Bangkok.

More females (53%) than males (20%) are ever married and at the younger age group. This confirms a pattern wherein young women have male partners somewhat older than themselves. It is also noted that the pattern of the sexual culture would appear to continue to be one in which males have greater scope for having more than one regular partner in their lifetime (either serially or simultaneously), than do females.

It would appear that age is more of a barrier to women than men in finding a second regular sexual partner in Thailand. These patterns are replicated across the three residential areas, but are most pronounced in Bangkok where 39% of the older (25-59 years) age group of males have had two or more regular partners, as compared to 31% in the other urban areas and 28% in the rural areas. This divergence may well relate to both greater wealth and number of contact opportunities in Bangkok than in the other areas.

Sex with (non-commercial) casual partners is mainly reported by males, with 52% of the male sample reporting casual sexual experience, but only 3% of females doing so. However it is notable that this increases to 7% of females in the younger age group. The implication of the large disparity in levels of casual sex in what is an overwhelmingly heterosexual culture is that there is both, probably a quite small proportion of (younger) women engaging in a fairly high level of casual sex (but their numbers are too small for them to be found in a general sample survey) and that more males interpret sexual contacts to be casual, whilst more females may interpret the same encounters to be more personally meaningful. It could be useful to conduct further qualitative research into this (demographically) small group of females engaging in high levels of casual sex.

Whilst the survey revealed virtually no transactional sexual relations of gift-giving in sex, there is however continuing evidence in the survey for interaction with sex work. While 44% of older males report having ever engaged in intercourse with a sex worker, this falls to 24% of the younger age group. Of these, more than 80% had done so on no more than three occasions in the past year. Thus whilst sex with sex work continues within the Thai sexual culture, it is not an especially frequent part of men's behaviour. Male respondents in Bangkok reported somewhat higher levels of sex with sex work than respondents in the other urban and rural areas. This may reflect higher levels of disposable income and opportunity for contact in Bangkok than elsewhere in the country

For transmission of HIV and other sexually transmitted infections, the crucial factor is the extent to which condoms are consistently used. There is a clear, and expected, pattern of increasing levels of condom use from regular partner (12%), through casual partner (47%), to sex worker (94%). The overriding reason (72%) for non-use of condoms with regular partners

is reported here as “trust in and confidence in the safety of the partner”, as has been reported in most such surveys of condom use around the world for the past twenty years. Evidence for the success of Thailand’s “100% condom use in the sex industry” policy is found in the 94% of both younger and older age groups who report that they always use condoms with sex workers. There is concern, however, that 4% of the younger age group report never use condoms when they have sex with sex work. In the light of the levels of HIV prevalence in the Thai sex industry and the government’s strenuous efforts to promote condom use, this would appear to be almost pathologically perverse behaviour. Some kind of qualitative in-depth research could well be gainfully undertaken among this epidemiologically crucial group

A situation of greater ambiguity and uncertainty arises with respect to the findings on condom use in casual sex. Half of the younger age group of males report always using condoms in casual sex, but about a quarter report never using condoms in such liaisons. The reasons given for non-use are firstly (39%), confidence of safety of partner, secondly (31%), “not prepared/could not find a condom at the time”, and thirdly (12%), just do not like using condoms’ (reduced sensation). These patterns of levels of condom use and reasons for non-use are broadly similar across all three residential areas. The risks of HIV or other infections from casual sex in Thailand are very hard to quantify, as the nature of what is a casual sexual partner is highly subjective

and necessarily varied. However it is plausible to consider that given very few females report engaging in casual sex, those that do should be quite a small minority, some of whom will be having intercourse with numerous partners. Therefore their risk is likely to be high, and may account for the recent increases in HIV incidence within the younger age groups. These findings, on the level of condom use and reasons for non-use in casual sex, lead onto what are probably the most important policy implications with respect to HIV prevention to emerge from this survey. In the light of the major shifts and increase complexity of the sexual culture, the Thai government needs to build upon the successes of the “100% condom use in the sex industry” policy to extend it to casual (non-commercial) sex.

Careful and extensive consideration needs to be given to the nature and directions of such a programme. However the findings provide three main suggests: firstly, the population needs to be better informed of the HIV/STI risks of engaging in casual sex without a condom. Secondly, people need to carry condoms when going out in nightlife venues, even when they may not intend to engage in casual sex. Thirdly, any perceived loss of sensation involved in condom use needs to be set off against the personal disaster of becoming HIV infected. Further research could gainfully consider working in the situations where casual (non-commercial) sexual encounters occur and (in Buddhist terms) seeking to enhance the mindfulness of risks in such places. (eg. Ford and Inman 1996).

Chapter 9:

Sexual Behavior with Multiple Partners

Numerous modeling studies have established the effect of those persons with large numbers of sexual partners in increasing HIV transmission. Persons with many partners not only have a higher probability of encountering a partner with HIV infection but also serve as effective disseminators of the virus to lower risk populations.

This chapter provides information about sexual behavior of respondents with multiple partners in the last 12 months. Information such as number of partners, relationship and partnering, places where they first met sexual partners, age, gender, types of sex act, whether their partners have other sexual partners, drinking alcohol, drug use, and condom use with the last five most recent partners are provided.

9.1 Numbers of Sexual Partners

Table T9: 9.1 present the numbers of partners that the respondents had in the last 12 months. The table shows that most of the respondents had one partner (male 75% and female 85%), indicating a fairly safe sexual lifestyle for a large majority of the population. Younger male respondents had more partners than the other groups (2.1 partners on average), 11% had two partners and 8% had three. There is the same pattern for all areas of residence (Table R9:9.1, U9: 9.1 and B9: 9.1).

9.2 Relationship and Partnering

Relationship with the first most recent partner

The relationship of the respondents with their most recent partner is presented in table T9: 9.2. The table shows that types of partners are different among the two age groups. Most of the younger male respondents had sex with boy/girlfriend (44%) or with a cohabiter (30%). By contrast most of the younger female respondents had sex with a cohabiter (67%) or spouse (18%) and only 14% with a boy/girlfriend (14%). Most older respondents had had sex with a spouse (male 56.8% and female 65.8%). The second main proportion of older respondents had sex with a cohabiter (male 29.7% and female 32.7%). There is the same pattern among the three residential areas.

Relationship with the second most recent partner

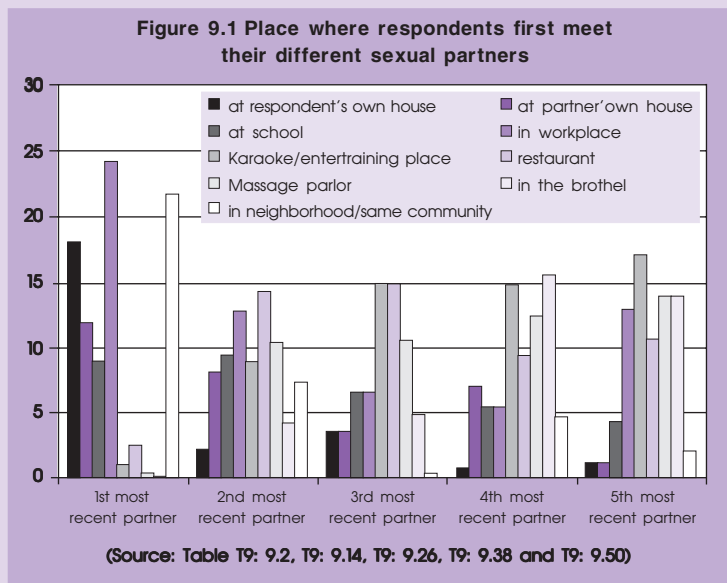
The group of respondents that showed the highest number of sexual partners before the most recent, is the younger males (34%) (Table T9: 9.13). Most younger male respondents with more than one partner had sex with a "Gik", that is a casual boy/girlfriend or acquaintance. Some of the younger males reported having sex with sex workers (T9: 9.14, U9: 9.14 and B9: 9.14). But younger male respondents

in rural areas were more likely to report having sex with a fiancé, boy/girlfriend, "Gik" and 'drink girl/beer girl' (Table R9: 9.14). While most older males in Bangkok and other urban areas had sex with sex workers (Table U9: 9.14 and B9: 9.14) and most of older male in rural areas had sex with a drink girl/beer girl (Table R9: 9.14).

For the quite small numbers of respondents who reported having sex with three, four or five recent partners the same broad pattern of findings as with the second partner is found.

9.3 Places Where Met Sexual Partners

Most respondents met their first partner in their workplace, school, neighborhood or community. By contrast places that most respondents, especially the older age groups, first met another partner, apart from the first most recent one, are entertainment places such as restaurants, karaoke, massage parlors and pub/bar/discotheques, as well as shopping malls. Brothels were reported mainly for some male respondents in rural areas. (Figure 9.1)



9.4 Gender Preferences

Whilst it is important to talk in terms of risk behaviour rather than risk groups, it is still of interest when seeking to identify the general nature of the sexual culture to outline the pattern of sexual orientation, which can be in turn related to data on prevalence of HIV infection across different groups.

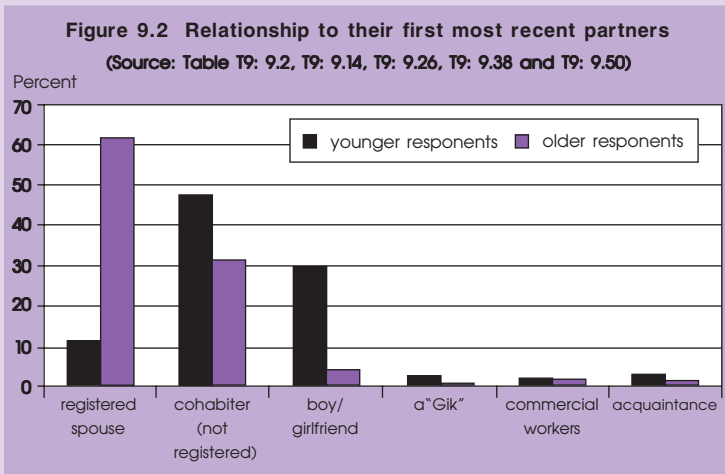
For sexual intercourse with the first most recent partner, the table shows that almost all of the respondents had sex with an opposite sex partner.

Slightly more younger respondents

(male 1.7% and female 2.1%) reported having had sex with a partner of the same sex than among the older age groups. More young respondents in Bangkok and the other urban areas than in rural areas had sex with a same sex partner. (Table T9: 9.4, U9: 9.4 and B9: 9.4).

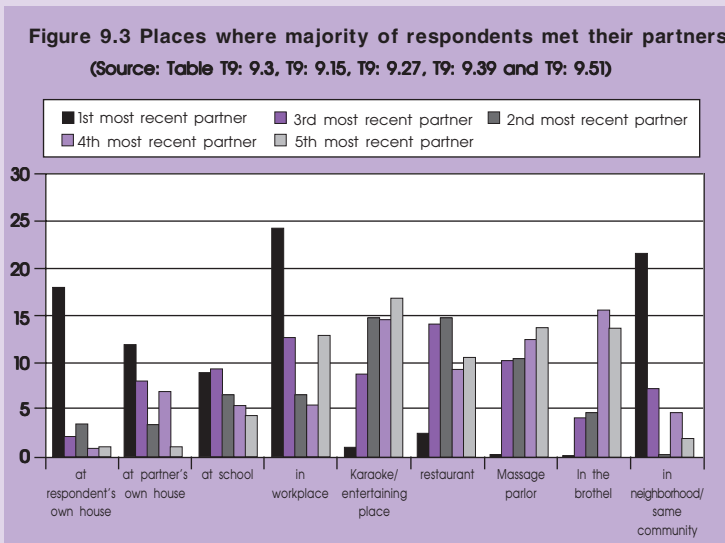
For sexual intercourse with the second, third, fourth and fifth most recent partners, the table shows the same pattern, with more younger respondents having had sex with a same sex partner than for the older respondents (second partner 2.9%, third partner 3.4%, fourth partner 2.0% and fifth partner 3.1%) (Table T9: 9.16, T9: 9.28, T9: 9.40 and T9: 9.52).

There are differences of types of sexual relationship between younger and older respondents. Larger numbers of younger respondents had sex with non-permanent or casual partners. This is especially young males in Bangkok and other urban areas. Most of the older respondents had had sex with permanent partners (Table U9: 9.2 and B9: 9.2). Having non-permanent or casual relationships seems to increase the likelihood of having another sexual partner and the result from this research shows that sexual relationship of the respondent with their second, third, fourth or fifth partners are mostly non-permanent relationships. (Figure 9.1 and 9.2)



According to this data the sample is overwhelmingly heterosexual. Although some researchers may raise questions of under-reporting it may be noted that most surveys of sexual behaviour report a similar pattern. Other types of methodology may well be more appropriate in being able to 'uncover' appreciable levels of non-heterosexual behaviour.

9.5 Age of Sexual Partners



For the most recent partner, the average age of younger male respondents' partners is less than that of the age of the females' partners (male 20.2 and female 25.8). For the older age group the average age of the male's partner is 35.9 years old while the average age of female's partner is 41.3 years old (Table T9: 9.5, R9: 9.5, U9: 9.5, and B9: 9.5). This shows the well documented pattern of males being slightly older than their female partners. This pattern is further reinforced when looking at the ages for second, third, fourth and fifth partners and is replicated across all three types of residential area. (T9: 9.5, T9: 9.17, T9: 9.29, T9: 9.41 and T9: 9.53). (Figure 9.5)

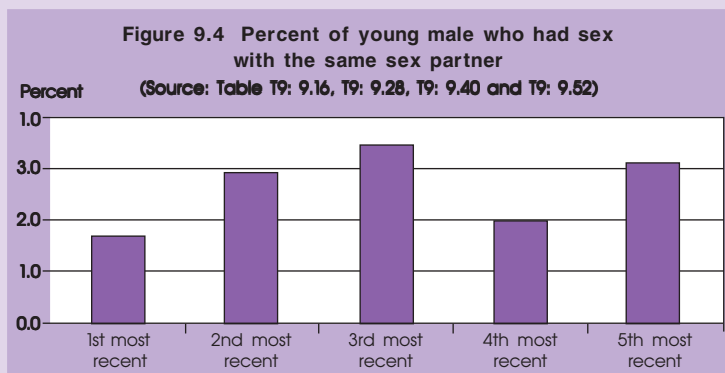


Figure 9.5 Average age of different sexual partners of young respondents
(Source: Table T9: 9.5, T9: 9.17, T9: 9.29, T9: 9.41 and T9: 9.53)

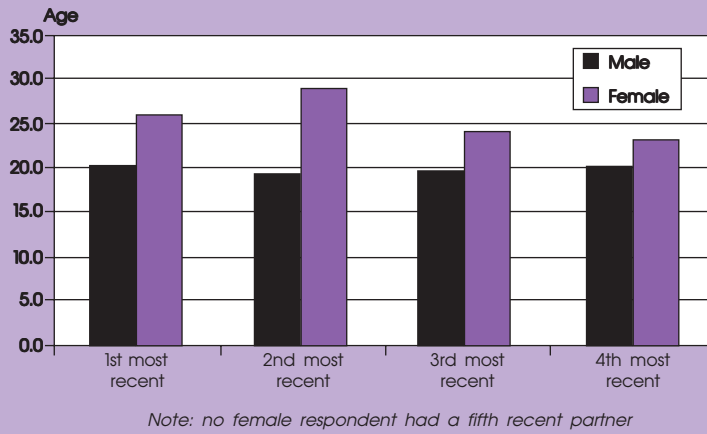
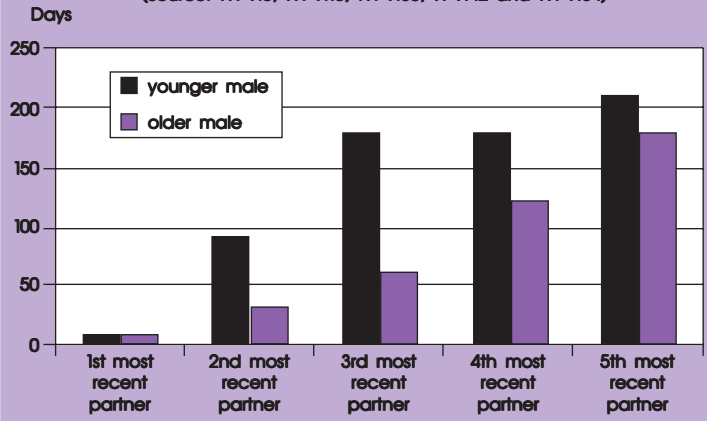


Figure 9.6 Duration since last intercourse for male respondents with different sexual partners
(Source: T9: 9.6, T9: 9.18, T9: 9.30, 9: 9.42 and T9: 9.54)



9.6 Duration Since Last Intercourse with Most Recent Partners

Younger and older age groups of respondents show similar (relatively short) durations since last intercourse with their most recent partner. However older males show shorter durations since intercourse with other partners, but it must be noted that fewer older male respondents report sexual contact with other partners. Also the data shows that for the minority of younger males who have other sexual partners (casual girlfriends, bar girls, sex workers and so on) it does not appear to be a particularly regular or frequent occurrence. (Figure 9.6).

9.7 Having Another Partner of Sexual Partner

The questionnaire asked whether (to the best of their knowledge) their recent partners had had another sexual partner before them. Most respondents said that their first most recent partner had not had another partner. It is interesting to note that a higher proportions of the younger than older age groups felt their most recent partner had another sexual partner before them. The figures are 29% for younger males and 40% for younger female respondents who said that their partner had another sexual partner before themselves, compared with only 18% of older males and 36% of older females (T9: 9:7). The same pattern is found in all three areas but the percentage of respondents in Bangkok who stated that their partner had another sexual partner before is higher than in other urban and rural areas (Table U9: 9.7).

From the data for the second to the fifth partners can be concluded that

there are more females than males whose partner had had another sexual partner before them and when comparing by age group, this is more the case for the younger than older males. (Table T9: 9: 19, T9: 9.31, T9: 9.43, 9: 9.55). This result is consistent with the results on places where they met these second, third, fourth and fifth partner, which were mostly at entertaining places. (Figure 9.7)

9.8 Alcohol and drug use

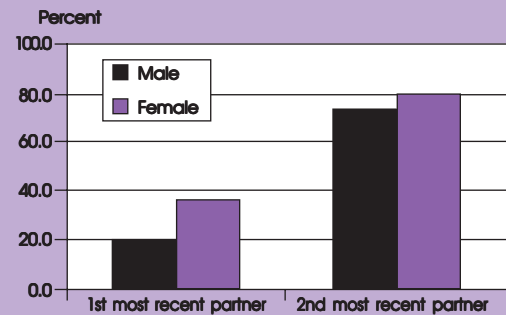
Responses on drinking alcohol when having sex, found that a small majority either sometimes (44%) or always (9.4%) drank some alcohol when having sex with their most recent partner (Table T9: 9.8). Most younger females never drink in association with sex but 14% sometimes do. A slightly higher percentage (47%) of older males sometimes drink in association with sex, while only 8.2% of older females do so. (Table T9: 9.8) (Figure 9.8)

In rural areas, a slightly higher proportion of younger males drink sometimes in association with sex rather than never. Younger females drink more in association with sex in Bangkok and in other urban areas than in rural areas.

Substantially higher percentages of younger males always and almost always drink alcohol when having sex than for their most recent partner (Table T9: 9.20, 9: 9.32, 9: 9.44, 9: 9.56). While in the older group, the percentage of respondents who drink alcohol when having sex is higher than for those who did not drink. The same pattern is observed in all three types of residential areas.

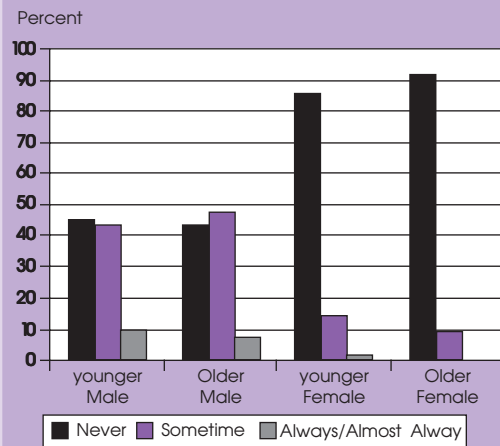
Almost all of the respondents never use drugs when having sex with their first recent partner (97%) (Table T9: 9.9). The percentage of respondents who use drugs when having sex is with the second to fifth most recent partner is slightly higher than with the first one. Thus drug use has been found to be less commonly associated with sexual relations with steady sexual partner, and more closely associated with sexual relations with casual partners and sex workers. When comparing by age, the table shows that there are much younger than older respondents who use drugs when having sex (Table T9: 9.9, T9: 9.21, T9: 9.33, T9: 9.45 and T9: 9.57). (Figure 9.9)

Figure 9.7 Percentage of respondents who report that their partners had another sexual partner before them
(Source: Table T9: 9: 19, T9: 9.31, T9: 9.43, 9: 9.55)



Note: numbers of respondents responded for the 3rd, 4th and 5th most recent partner are too small for analysis

Figure 9.8 Percentage of respondents who drink alcohol when having sex with their most recent partner
(Source: Table T9: 9: 8)



9.9 Types of Sexual Acts

Almost all of respondents had vaginal sex with their most recent partner, and only a very few respondents reported engaging in anal sex. A higher percentage of younger respondents had oral sex recently than older respondents. In Bangkok and other urban areas, oral sex was more common than in rural area (Table T9: 9.10, R9: 9.10, U9: 9.10 and B9: 9.10). (Figure 9.10)

Table T9: 9.22 shows that percentage of younger male who had oral sex with the second to the fifth most recent partner is higher than with the most

recent partner and it is the same pattern for older male respondents. This probably indicates that oral sex is more common with casual partners and sex workers than with steady sexual partners.

9.10 Condom Use

Frequency of using condom when having sex

Most respondents said that they never use condoms when having sex with their most recent partner (young male 33%, young female 54%, older male 75% and older female 76%), although significant numbers report using condoms sometimes (younger male 31%, younger female 36%, older males 14% and older female 20%). Only 26% of younger females report always using condoms when having sex with this partner. There is the same pattern in all three residential areas. (Table T9: 9.11, R9: 9.11, U9: 9.11 and B9: 9.11)

When having sex with the second to the fifth most recent partner, higher percentages (more than 60%) of both younger and older male respondents report always using condoms. This reflects the fact that people normally used condom when having sex with someone they met in entertainment places but used them less frequently with other types of partners. This means that they still have an opportunity for risk of HIV infection (Table T9: 9.23, T9: 9.35, T9: 9.47 and T9: 9.59). (Figure 9.11)

Using of condom at last time when having sex with sexual partner

On the last occasion that they had had sex with their most recent partner, most respondents did not use a condom (younger male 58%, younger female

Figure 9.9 Percentage of respondents who use drugs, either sometimes or always, when having sex with their sexual partner

(Source: Table T9: 9.9, T9: 9.21, T9: 9.33, T9: 9.45 and T9: 9.57)

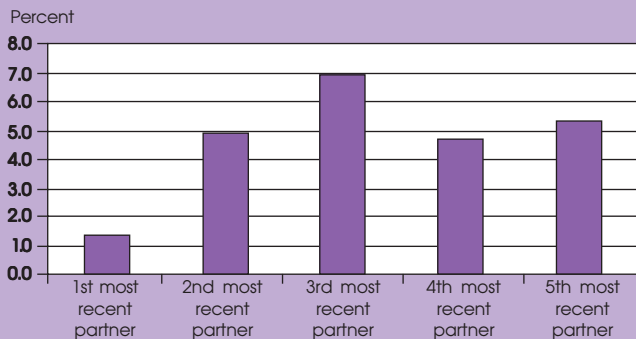
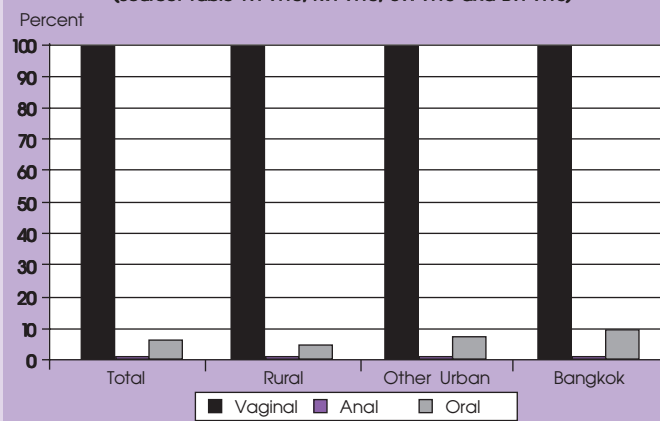
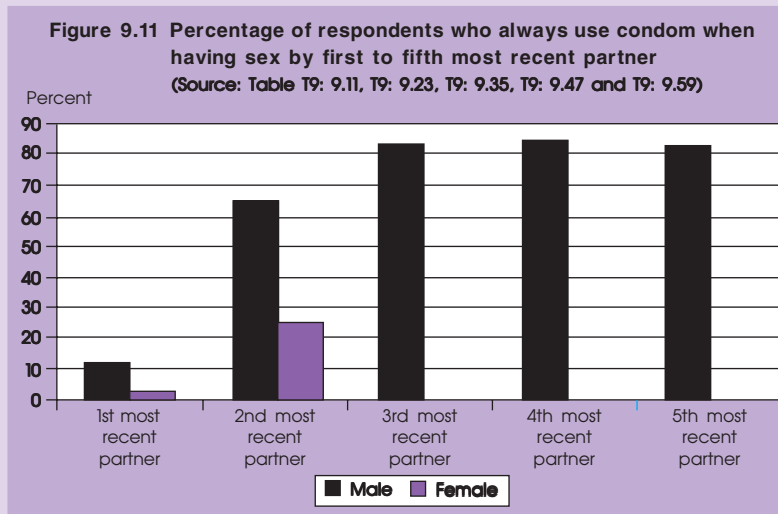


Figure 9.10 Percentage of respondents according to sex acts with their most recent partner

(Source: Table T9: 9.10, R9: 9.10, U9: 9.10 and B9: 9.10)



88%, older male 87% and older female (45%) (Table T9: 9.12). The main reasons for not using condoms are that they feel confident that they are safe and they trust their partner. The second set of reasons for younger males is that "they did not prepare for it" / "could not find it", while the reason for younger females is that "they use contraceptives or are sterilized". Older males explained their non-use of condoms in terms of being a husband and older females stated it was because they use contraceptives or have reached menopause. Some younger respondents reported not using condom because they do not like using it



In sexual intercourse with the second to the fifth most recent partners, more than 75% of respondents used condoms. Male respondents always used condom with partners they met at entertainment places (Table T9: 9.24, T9: 9.36, T9: 9.48 and T9: 9.60).

9.11 Conclusion

Most respondents had only one sex partner. The relationship with the most recent partner of young respondents is boy/girl friend and unregistered cohabiter, while for the older groups it is spouse.

Types of relations with the most recent partner are different from the second to the fifth partners. Most relationships with the first partner are permanent while the second to the fifth are non-permanent or casual partners who they had met at entertainment venues. This result relates to use of condoms, wherein it is found that male respondents are more likely to use condoms with partners they have met at entertainment venues than the partners they had met at another place. Female respondents rarely mentioned using condoms as a tool to protect against HIV or other STIs.

Chapter 10:

External Influences on Young Adults' Choices of Sexual Behavior

This chapter examines external influences that can impinge on young people's choice of sexual behavior. As reported by many previous studies, choices of sexual behavior among young adults are often influenced by the environment within which they live. These include living arrangements, family, peers, school, and public programmes and activities aimed at promoting sexual health, including HIV prevention. In this chapter 'young adults' include men and women aged 18-24 years, both unmarried and married. The national survey of sexual behavior, from which the data for this chapter are drawn, interviewed 3,024 young men and women. They account for 50% of the total sample (which includes people aged 18-59 years). Among the young adults, men and women are of equal number and are distributed evenly across the three strata types of area: Bangkok, other urban and rural areas. (See details about the sample in chapter Two)

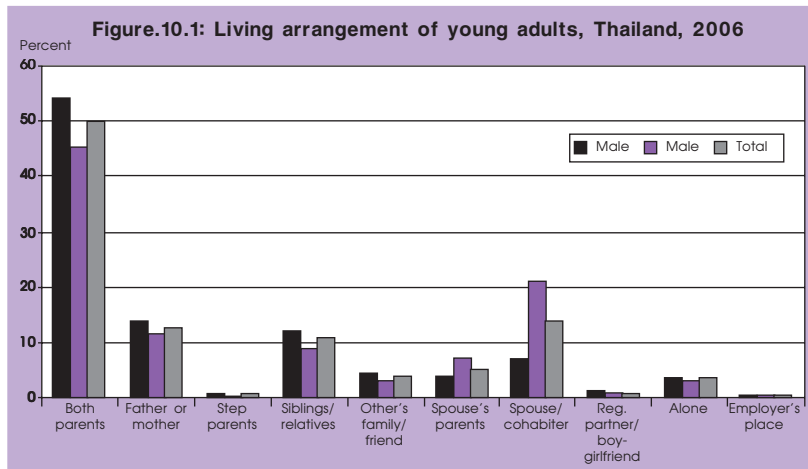
At the time of the survey (June - September 2006) nearly half of young adults in the sample (48%) were working, about 26 percent were students, while a small proportion (4%) engaged in both work and study simultaneously. The rest (22%) were neither working nor studying.

For comparison, the sample of young adults are classified into age-groups (18-19 and 20-24), sex

(male, female), and area of residence (Bangkok, other urban and rural areas). On the basis of this, each issue is considered with reference to similarity and difference that exist. The issues considered, by which this chapter is structured, are living arrangements, parental influence, peer influence, exposure to pornography and school and public AIDS education, and sexual values and sexual communication.

10.1 Living arrangements

Data on living arrangements of young adults in the overall sample are provided in Tables T12: 12.1-12.4 in the cd. Overall, about half of young adults in the sample lived in households with both their father and mother. Those who lived with only one parent (i.e. either father or mother) accounts for about 12%. Young adults who lived in households with their step father or step mother account for a small proportion of 0.5%. Living with siblings and relatives is also found among a small proportion of the young adults (10%). Those who lived alone or lived with employer account for 3.4%. About 14% of young adults reported that they were living with spouses or cohabiters, another 5% lived in households with their spouse's parents, while only about 1% lived with a regular partner or boy-girlfriend. (See Fig. 10.1)



Some variations in living arrangements are observed across age-group, sex and areas of residence. For example, younger respondents (aged 18-19 years) were more often found in households with both parents than older ones (aged 20-24 years) and more males than females were found in this type of household. Because they tend to enter into union at a younger age, more females than males were living in households with spouses, spouse's parents, cohabiters or regular partner. More rural young adults were living in households with both parents than their counterparts in urban areas and Bangkok. Among the three areas of residence, the proportion living with both parents is smallest in Bangkok, only 33% compared to 42% in other urban areas and 57% in rural areas. On the other hand, greater proportions living with spouse or cohabiter are found among young adults in Bangkok and other urban areas (19% and 15% respectively) than in rural areas (12%). Also greater in urban areas are the proportions who lived alone. The proportion is nearly one-tenth for Bangkok and almost 5% in other urban centers. To some extent, this reflects different ways of life between urban and rural young adults.

More than three-fourths of young adults in the sample lived in a house, but if other kinds of housing such as twin house, town house, apartment and condominium are included, the proportion is 85%. Other types of housing where young adults were

found include rented house or room (11%), dormitory (1.7%), shop house (1.7%) workers' lodge and military barrack (0.5%). There is only a small difference across age and sex in this regard, but differences among three strata (rural, urban, Bangkok) is more pronounced. For example, about 9 out of 10 rural young adults lived in a house proper, whereas less than two-thirds

of their counterparts in other urban areas and about two-fifths in Bangkok lived in the same kind of housing. Overall, about 4% of young adults owned the place in which they lived; owners of their residence are slightly greater among those in rural areas than in Bangkok and other urban centers. The largest majority of the sample of young adults lived in a residence owned by their parents, siblings or relatives. The proportion is 74% for the total sample, but 84% for the rural young adults.

Data on living arrangements show clearly that young adults in rural areas live closer to their parents than those in urban areas and in Bangkok. This information may contribute to understanding of different choices of sexual behavior among the samples of the three strata included in the survey.

10.2 Parental Influence

Parental influence is discussed here with reference to parental control, along with the more explicitly sexual matters of permissiveness towards sex, youth perception of their parents' awareness of their sex life, and discussion about condoms.

10.2.1 Level of parental control

Adolescence and young adulthood are a critical stages in the life course in which an individual goes through physical, social and psychological transitions.

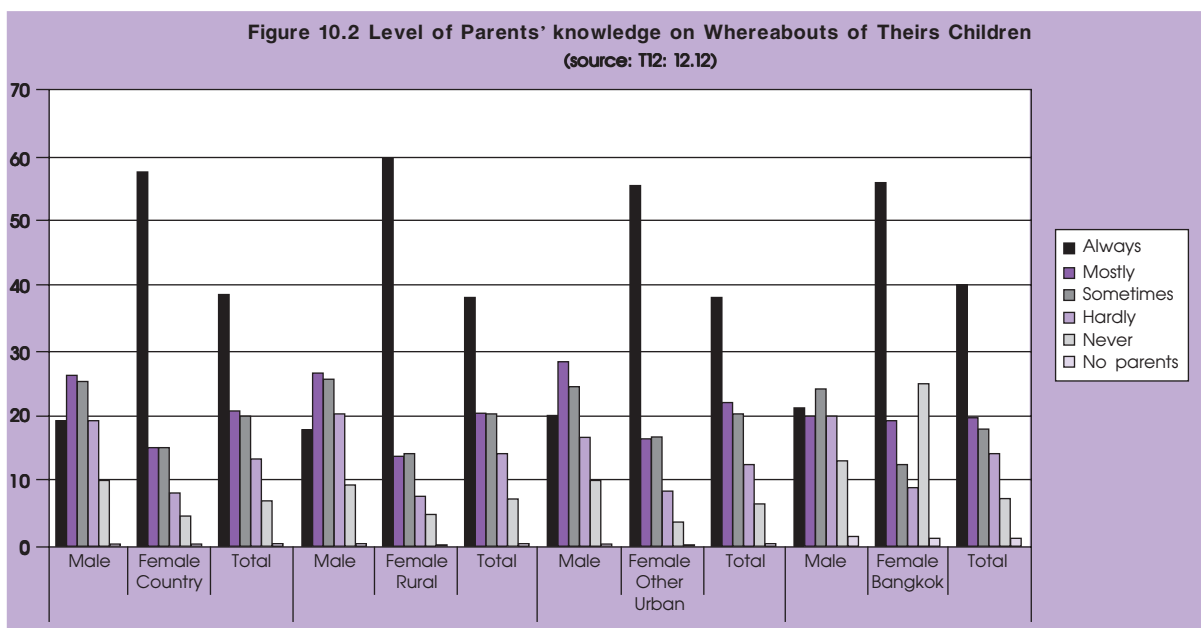
One of the important (social and psychological) transitions in this period is seen in increasing attention and interest given to people and relationships outside the family. Adolescents and young adults create their “new world” through networks of relationships with people outside, and through such networks they can engage in different activities, some of which may bring them into risk or bring harm to their lives. Sexual and reproductive health risk is one of the area of risk.

From the perspective of parents, the more they know about their children, the better, since such knowledge makes it possible for them to exert appropriate control when necessary. For example, knowing the where abouts of their children each day, knowing with whom their children are spending time, the kind of activities in which children are engaged, and getting to know their close friends are reasonable ways of “controlling” children’s behavior. In the survey, young adult respondents were asked questions about these matters. Overall results are provided in Tables T12: 12.12 - 12.13 in the CD.

A general picture that emerges from the data is that slightly more than one-third (38%) of young

adult respondents reported that their parents *always* know where they are, who they spend time with or what they do in each day. About 20% reported that their parents *mostly* knew about these aspects. If such knowledge represents close attention that parents give to their children, we can say that only about 59% (i.e. combining the first and second groups above) of the sample of young adults are under good care of their parents. Another 20% reported that their parents knew, but only sometimes, about where they were and what they did in their daily life. The rest, accounting for 20% or so, admitted that their parents *hardly* or *never* had any idea of their where-about of themselves in the day.

There is some difference in this regard between male and female young adults. Parents seem to be giving greater attention to daughters than to sons. The proportion reporting that their parents had knowledge of their whereabouts accounts for about 58% among females compared to only 19% for males. A similar pattern of parental ‘control’, where greater emphasis is on the daughter is observed in both younger and older age-groups. However, no substantial difference exists when comparison is made for young adults from the different areas of residence. (See Fig. 10.2)



Another aspect of parental control may be understood in terms of parental knowledge of the people with whom children have relationships, especially close friends. In this respect, reports from the overall sample tell us that, as with knowledge on where-abouts in daily life presented above, only slightly more than one-third (38%) of young adults' parents know *all* the close friends of their children. If those who reported that parents knew *most* of their close friends (17%) are included, the proportion that seem to be intimate with parents (in terms of being open by letting parents know about all close friends) is a little more than half (about 55%). About one-third reported that their parents knew only some of their close friends, whose among the rest, parents hardly or never knew about their close friends.

Again, greater emphasis seems to be on daughters than on sons since more female young adults reported parental knowledge of their close friends than did males. Parents seem to pay more attention to daughters in younger than at older ages. A similar pattern is found across all the three survey strata. Also there is no substantial difference among the sample from different areas of residence.

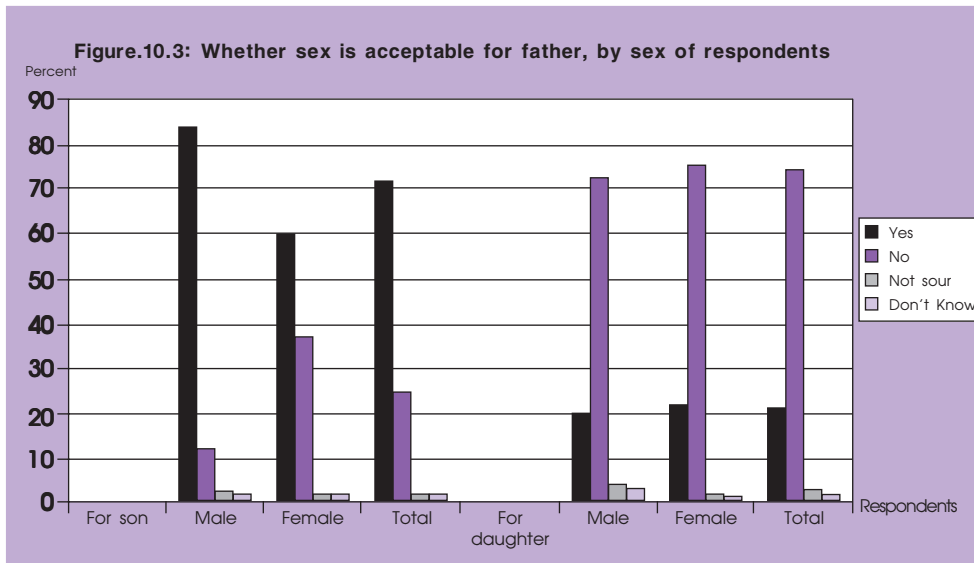
The data seem to point to a conclusion that about half of young adults in Thailand are not under the strict control of parents. Sons seem to enjoy more freedom in move around, make friends and engage in activities with people outside the family.

10.2.2 Parental Permissiveness on Sex

The degree to which premarital sex is acceptable to parents may have an influence on young adults choices regarding sex. This being the case, one can anticipate differences in sexual opportunities between young adults whose parents attitude toward premarital sex is permissive compared to those whose parents attitude is prohibitive. Where parents' attitude is permissive, young adults may feel less reluctant to engage in pre-marital sex, but with prohibitive parents they may feel differently.

There are at least two possible ways of measuring parents' attitude toward premarital sex of children. One is to ask parents directly whether premarital sex is acceptable to them. The other way is to ask children themselves if they know whether or not premarital sex is acceptable to their parents. This, in fact, measures children's perception of their parents' attitude rather than the actual attitude of the parents. However, it is considered valid since, regardless of parents' actual attitude, it is children's perception or awareness of it that has immediate influence on their choice of sexual behavior. In this survey the young adults were asked directly if, to the best of their knowledge, premarital sex was acceptable to their parents. Perceptions of father's and mother's attitudes toward premarital sex of sons and daughters were asked separately. Responses for the overall sample are summarized and presented in Tables T12: 12.14 -12.15.

It is of interest to note that: (1) young adults (both male and female) perceived that their parents attitude toward premarital sex for sons is much more permissive than for daughters; (2) that male respondents tend to perceive greater permissiveness of parents attitude for sons than female respondents perceiving parental attitude for daughters; and (3) that similar patterns of responses are observed in all three strata of the survey sample. It is clear that parents are perceived to use different sexual standards for sons and daughters. (See Fig. 3 for summary of responses of the overall sample regarding perception of parents' attitude)



10.2.3 Perception of Parents Knowledge on Childrens Sexual Behaviors

One way of obtaining an idea of how much young adults feel their sexual behaviors are under the control of their parents is to ask directly if they know that their parents are aware of their sexual life. In the survey we asked young adults who are never married: "Does your father/mother know whether you ever had sex?" Responses to this question may be an indirect indicator of young adults' assessment of the parental control. Note that responses may or may not reflect actual knowledge of parents. Also what is perceived to be parents' knowledge may or may not reflect actual behavior on the part of the respondents (as what is perceived to be parents' knowledge may or may not be true). Nevertheless, such perceptions reflect, to some extent at least, a respondent's assessment of the situation of control within the family. And this can have influence on choice of sexual behavior of young adults.

Overall responses to the above questions are summarized in Table T12: 12.16 where answers for the father and mother are separated. Young adults do not perceive different knowledge of their father and mother regarding their own sexual behaviors. In general, 61% thought that their father knew whether

they ever had sex, while 62% thought that their mother knew this. Difference of this response by respondents of different age-groups is not substantial, with the older respondents tending to perceive more parental knowledge than the younger respondents. Also female respondents tend to give more credit to parents as far as knowledge of their sex life is concerned. Respondents from different strata do not differ much in this regard, with those from urban areas showing higher proportions perceiving parents' knowledge of their sexual behaviors while Bangkok respondents show slightly lower proportions.

It seems fairly obvious that, regardless of whether or not they have actually ever had or never had sex, the majority of young adults in the survey (i.e. about 60% or more in most cases) did have the perception that parents knew whether they ever or never had sex. Unfortunately, a follow-up question was not asked here if parents' knowledge thus perceived was accurate or not. (Nevertheless, a question asked elsewhere in the same survey (See Table T7: 7.2) suggests that about 73 percent of young adults in our sample ever had sex.)

10.2.4 Condom Discussion

Discussion with children about sex and sexual health is a good avenue through which parental influence can have an effect on young adults choice of sexual behavior. In principle it does not matter who initiates the discussion, as long as there is such discussion in an open and friendly atmosphere it tends to be effective. But since parents are supposed to be more knowledgeable and with more experienced, they should be the ones who bring this up for discussion with their children with appropriate timing. In the present survey, young adults were asked whether their parents ever discussed condom use with them. Results are presented in Table T12: 12.17, where responses for father and mother are given separately.

Overall, relatively small proportions of young adults reported that their parents discussed condom use with them. Similar percentages of only 18% of fathers and 19% of mothers had discussed condoms with them. More males reported this than females in all three strata, with a substantially greater proportion among young adults from Bangkok and other urban areas than in rural areas. (See Fig. 10.4)

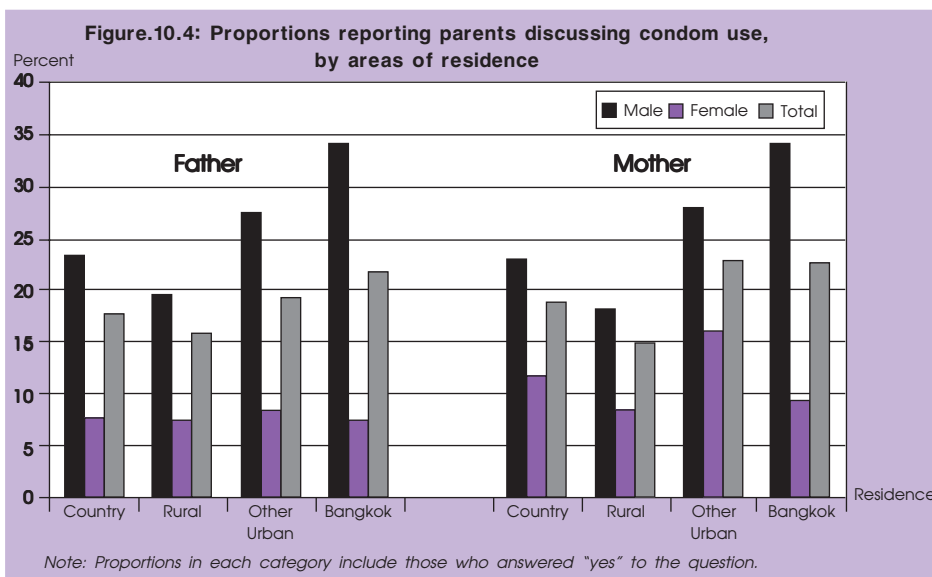
The results suggest that a relatively small number of parents discussed condoms with their children, despite the gravity of the HIV epidemic in the country. Perhaps discussion on sex and sexual health between parents and children has not been a norm in the Thai family. Adolescents and young adults often seek this knowledge from their peers or other sources.

10.3 Peer Influence

10.3.1 Knowledge of Close Friends' Sexual Experience

Numerous studies have shown that peers have a strong influence upon adolescents and young adults behavior, including risk behavior related to sex. For adolescents and young adults, members of the peer group tend to share similar values or prefer similar things. Members prefer to be like others in the group and thus be accepted by them. Such preference often leads them to engage in activities that may put them at risk. In the present survey we focus on perception (or knowledge in a general sense of the term) that young adults have with regard to their peers sexual behavior. A simple assumption here is that young adults sexual choice

may be motivated by knowledge of close friends sexual experience. More specifically, where all or most close friends have already had sex, it may be reasonable to assume that some may engage in sex just to be like them. But on the other hand, it may also be a motivation for them to avoid such behavior, especially where friends



experiences have caused some risks. We first focused on young adults' assessment of whether their male and female close friends ever had sexual experience. Results are presented in Tables T12.10 and T12.11.

It is appropriate to present results on sexual experience of male and female close friends separately since there are some differences in proportions reporting about this. Overall, less than one-third (28%) of the young adults reported that *all* of their male close friends had sexual experience, while 38% thought *most* of their friends had this experience. These two groups account for about two-thirds of the sample. Another 14% reported that *half* of their close friends already had sexual intercourse and only about 9% had *a few* friends who ever had sex. Those who reported that none of their close friends have ever had sex accounts for only 2%. Those who had no idea about sexual experience of their close friends are only a negligible minority.

Similar reports for female close friends are somewhat different. Only about 15% that *all* of their female close friends had sexual experience. About 29% claimed that *most* of their female close friends had had sex and 19% had about *half* of their friends with sexual experience, while 22% said only a few of their friends had sexual intercourse. As in the case of male close friends, respondents who claimed that none of their friends ever had sex, or who were not sure about it, or had no idea about it are a minority, accounting for 15%.

Across the three survey strata knowledge of close friends' sexual experience appears to be lower among young adults in rural areas than in urban areas and Bangkok, but the patterns by different response categories are more or less the same. Note that close friends who are the subject of our survey question on this issue include those who are unmarried as well as ever-married. Thus, interpretation of this result should take into consideration that some of the close friend reported to have had

sexual experience may be ever-married while others may be unmarried.

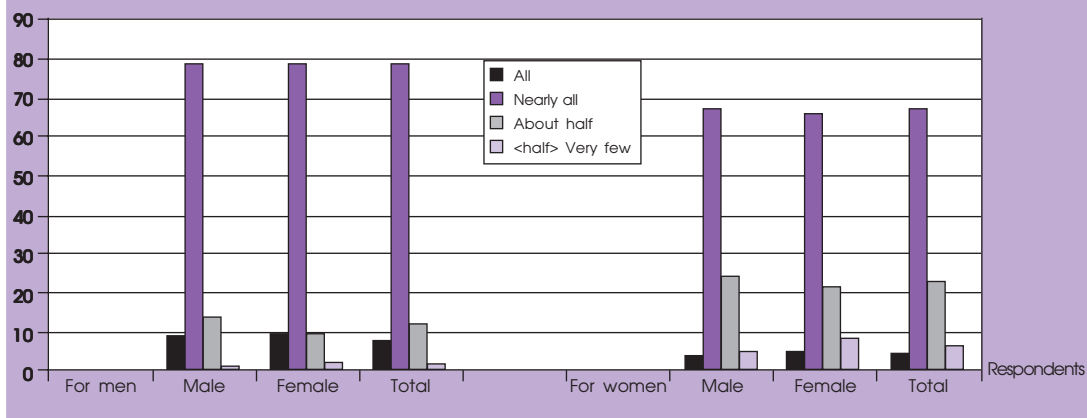
Putting the results on knowledge of sexual experience of male and female close friends together, sexual experience among young adults is perhaps not all that 'secret' or sensitive, at least it can be shared among close friends. This is confirmed by the fact that only a minority of respondents said that they had no idea about sex lives of their friends, which in effect means that most of the young adults have at least some ideas of their friends' sexual behavior. Even though the results presented here are based on perception of the respondents, they are valid and valuable for use on planning of intervention activities for this group.

10.3.2 Knowledge of Others' Sexual Experience

Assessment of sexual behavior of others in the same age-group can help young adults understand where they stand vis-à-vis others, whether they are 'in trend' or out of it. We asked young adults in the survey to assess to the best of their knowledge: "How many unmarried young men and women have had sex nowadays?" We also asked them to comment whether those who did have sex did so because of peer pressure. Overall results are presented in Tables T12.18-12.21

It appears that when it comes to others' behavior, the large majority of young adults in the sample (more than four-fifths in case of men, and well over two-thirds in the case of women) said that all or nearly all unmarried young adults of their ages have had sexual experience. Those who reported that about half, less than half, or very few of young adults today have had sex are a minority, less than one-fifth in case of men and around one-third in case of women. (See Fig. 10.5)

Figure.10.5: Assessment of the magnitude of sex among unmarried young adults, by sex of respondent



Across the three strata, patterns of responses on this issue are more or less similar, with the largest majority believing that all, or nearly all, young adults today have had sexual experience. Bangkok seems unique in this respect because the proportions reporting sexual experience for everyone or nearly all young adult males reaches 90% or more.

The overall assessment presented here seems high but available data do not allow us to comment on this. Nevertheless, accuracy of the responses aside, this information shows how prevalent sex among unmarried young adults is perceived to be in the view of the respondents. And this may have some influence on the decisions they make in terms of their own sexual behavior.

Given the level of sex among unmarried young adults as reported by respondents in our sample, what are the views on the motivations to engage in sex? Was this due to peer pressure? Respondents views are rather mixed, nevertheless they tend to support the idea that peer pressure plays a fairly important role over young adults choices. According to our results, peer pressure on young adult men seems to be somewhat stronger than on young adult women. But different views by age and sex of respondents are not substantial. Overall, about 22% of respondents thought that young adult men

engaged in sex because of peer pressure, whereas only 17% thought this was the case for unmarried young adult women. Other respondents gave indefinite answers, saying that this is most likely to be due to peer pressure (38% in case of men, 36% in case of women) or maybe this is the case for some people only (about 20% in case of men, 25% in case of women). Those who are of the view that this has nothing to do with peer pressure account for less than 10% of the sample of young adults. Similar patterns are observed in all three survey strata.

10.4 Pornography and AIDS Information

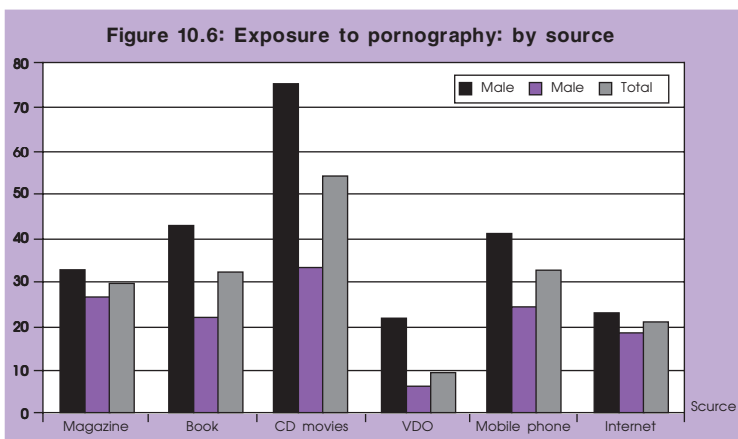
10.4.1 Exposure to Pornography

Pornography has been a popular source where adolescents and young adults seek sex information. It is also a source that often motivates sexual desire among people at young ages. Pornography can be accessed through several sources, ranging from magazine and books to VDO and CD movies, internet and even mobile phone which has been a common item of personal gear for adolescents and young adults. It is also available at a low, or no cost.

In the present survey various proportions of young adults reported viewing pornography from different

sources during the period of 12 months before interview. The most popular source, measured in terms of report by the largest proportion of respondents, is CD movies (54%), followed by mobile phone and book (33 and 32% respectively), magazine (30%), internet (21%), and VDO movies (9%). (See Fig. 10.6) Young adult males are much more active than females in viewing pornography from various sources. Across the survey strata the proportions who viewed pornography are more or less similar, except for those in Bangkok who seem to rely more heavily on CD movies and mobile phones than young adults in other areas.

With increasing accessibility of published and electronic media, pornography has become more and more available to adolescents and young adults. Hence, their sexual desires can easily be aroused leading to the risk of engaging in sexual behavior.



10.4.2 Exposure to AIDS Information

The value of AIDS information is that it provides correct understanding about HIV and AIDS. Such understanding is believed to be the basis for safe practice and hence reduces risk. In Thailand, AIDS information has been provided through several sources by both public and private organizations. In this survey, young adults were asked whether they ever received information, training or service related to AIDS in the period of 12 months before the interview.

Regardless of the type of information, the proportions who reported receiving any information related to AIDS are relatively small. More specifically, only 19% of young adults had received AIDS education through the school curriculum. Proportions of those who received other information/training are even smaller. For example, 18% for life skill training in a school programme, 12% for life skill training outside school, 7% for peer education, 17% for AIDS counseling and testing, and only 5% for workplace AIDS programme. In general, more males have exposure to this information than do females and the younger respondents are somewhat better off than the older ones. Respondents from rural and urban areas including Bangkok hardly differ in this matter.

In addition to AIDS related information and training, **small proportions** of young adults reported that they

ever received condoms in the past year up to the time of interview. For example, about 21% received free condoms from the condom distribution programme, 10% bought a condom from a vending machine, 25% from stores, 20% from friends, 10% from sexual partners, and 4% from places where they had sex (hotel, sauna, etc.). Differences across survey strata in this respect are not substantial. (Check, putting all sources together what is the proportion receiving condom in the past 12 months?)

10.5 Sexual values and sexual communication

10.5.1 Sexual Values

Sexual values provide a frame of reference for sexual behavior. The rationale is that people often behave on the basis of what they value as good or appropriate. Such values may or may not be consistent with social and cultural values and norms.

We may refer to these values as personal sexual values. In the survey we asked sample young adults whether they agreed or disagreed to certain value statements. Results are presented in Table T12: 12.5.

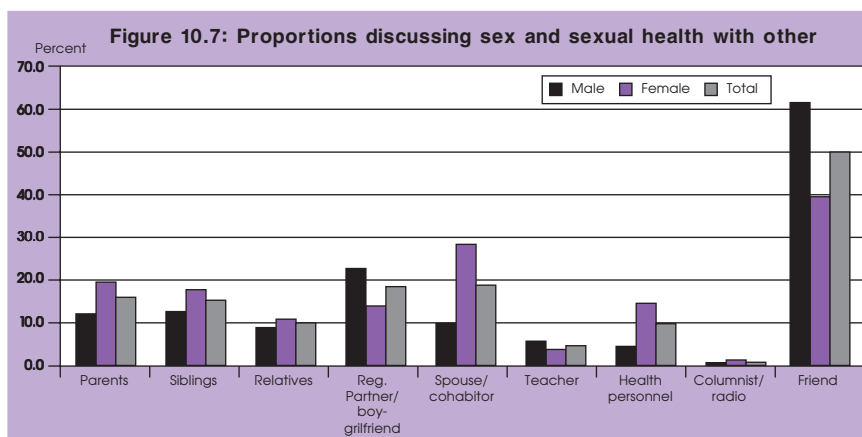
Overall, about two-thirds of young adults in the sample agreed that sex before marriage is common and acceptable for young boys and girls. Slightly more than one-third (35%) agreed that paying for sex is not a bad thing, while 29% agreed that sex with a partner of the same sex is safer in terms of AIDS, and 23 percent agreed that having a "Gig" (casual boy-/ girlfriend) is an indication of being "in trend". Men are more 'liberal' than women in all aspects and only a small difference is observed between respondents of younger and older age-groups. It is worth noting that respondents from the three strata are similar with regard to these sexual values.

10.5.2 Sexual Communication

Communication with others about sex and sexual health is an indication of individual concern about the matter. It is also an avenue through which knowledge on sex and sexual health is transmitted. People who are exposed to this kind of communication are at an advantage in that they tend to be more ready to take care of their sexual health. In the survey the sample of young adults were asked if in the period of 12 months before interview they had ever discussed sex or sexual health with different kinds of people. Results are present in Table T12: 12.9

Results show a relatively low level of communication about sex and sexual health among the sample of young adults. The proportions who discussed the

issues are well below 20% in most categories and for some the proportions are below 10%. The only kind of people with whom a substantial proportion of young adults (50%) discussed sex or sexual health is a friend. Some interesting differences between male and female respondents is noted: females seem to be more active than males in seeking information about sex and sexual health from family members (parents, brother/sister, relatives, spouse/cohabiter) and health personnel, while males seem to rely on people outside the family such as regular partner, boy/girlfriend and friend. (See Fig. 10.7) Young adults from the three survey strata are quite similar, with the exception that proportions discussing this issue among the Bangkok sample are lower than those from other strata. It may be the case that young adults in Bangkok generally have better access to the information from media or other sources so that seeking information from family members and other people are not very necessary, or that some young adults in Bangkok, for instance migrants, may be less socially integrated in friendship patterns.



10.6 School and Public AIDS Programmes

Young adults were asked a series of questions on various programmes related to HIV and AIDS. The aim was not only to obtain an idea of exposure to such programs or activities but to also know their

opinions about them. A summary of results from responses of the overall sample is presented in Tables T12: 12.22 - 12.32.

On sufficiency of HIV and AIDS education and campaign: A little more than one-third of the sample young adults thought that existing programs on HIV and AIDS education and campaign were sufficient. More males seem to have a positive opinion on the sufficiency of these programmes than females, and the Bangkok sample has a lower proportion with a positive opinion than the other two residence areas. Otherwise, variations across the survey strata are not substantial.

On life skills to prevent AIDS: Virtually all young adults (98%) in the survey support the idea that knowledge and skills to prevent HIV should be part of, and taught in, the curriculum of every school. More than three-fourths (77%) reported that such knowledge and life skills are provided in schools or colleges that they attended. Among those who reported having this programme in their schools, 43% said that the existing programmes in their schools/colleges were sufficient to protect them from HIV and nearly the same proportion (40%) reported that they had taken part in such life skill programmes. According to the respondents, knowledge and skills to prevent students from HIV should be taught at all levels of formal education, but the largest majority (95 percent) preferred teaching these as early as the primary and junior high school levels. Similar patterns of responses are observed in all three strata of this survey.

On peer education programmes: As in the case of the life skills programme, almost all young adults in the survey thought that a peer education program should be included as part of school/college activities. The main reasons are that such programmes can increase knowledge so adolescents and young adults can protect themselves from HIV. They also thought that such peer education programmes should be supported by the government.

On programmes in the workplace: About 90% of young adults agreed that HIV prevention programmes should be provided in workplaces, and virtually all thought that the government should support such programmes.

On provision of condoms in school: Provision of condoms in school (through condom vending machines) was a subject of public debate not long before the commencement of this survey. We asked young adults in the survey if they agreed with this. Results show that only 42% agreed, with slightly more males agreeing to this than females. Responses of young adults in rural and other urban areas are more or less the same, but in Bangkok the proportion that agreed is somewhat lower.

10.7 Summary

The study explored not only patterns of sexual risk-taking but also a range of key factors that impinge upon and influence such behaviour. An understanding of such factors can provide useful guidance for the development of interventions and policy that seek to promote safer practices. This part of the study focused solely upon the younger age groups, comparing findings for 18-19 and 20-24 year olds. This section was structured in terms of, living arrangements, parental influence, peer influence, exposure to pornography and school and public AIDS education, and sexual values and sexual communication.

With reference to living arrangements it was striking that a much higher proportion (nearly three fifths) of youth in the rural areas were still residing in households with both parents, than those in Bangkok (one third) or other urban areas (two fifths). Those young people in the urban areas contained higher proportions both, living alone, or with a spouse or cohabiter.

Parental influence was examined and discussed with reference to parental control, along with the more explicitly sexual matters of permissiveness towards sex, youth perception of their parents awareness of their sex life, and discussion about condoms. The degree of parental control was explored in terms of their knowledge of their children's whereabouts in the day, and with whom their children have relationships and friendships. The findings revealed that three fifths appeared to be under good care from their parents in this regard. Of concern, however, is that a fifth felt that their parents had very little idea of their whereabouts in the day. Not surprisingly, their parents seemed to be giving considerably greater attention to daughters in this regard. Interestingly there was very little difference in these matters with reference to area of residence. There was a similar pattern with regard to parents knowledge of children's friends. This survey seems to point to a conclusion that about half of young adults in Thailand are not under the strict control of parents. Sons seem to enjoy more freedom in move around, make friends and engage in activities with people outside the family

Regarding young people's sense of their parents permissiveness towards pre-marital sex the findings indicate that there is considerable gender structuring within Thai culture. It is of interest, although not unexpected, to note: (1) that young adults (both male and female) perceived that their parents attitude toward premarital sex for sons is much more permissive than for daughters; (2) that male respondents tend to perceive greater permissiveness of parents attitude for sons than female respondents' perceiving parental attitude for daughters; and (3) that similar patterns of responses are observed in all three strata of the survey sample. It is clear that parents are perceived to use different sexual standards for sons and daughters.

There was also evidence that the young people felt their parents had a general awareness of their level

of sexual experience. Regardless of whether or not they have actually ever had or never had sex, the majority of young adults in the survey (i.e. about 60% or more in most cases) did have the perception that parents knew whether they ever or never had sex. Unfortunately, a follow-up question was not asked here if parents knowledge thus perceived was accurate or not.

Safer sex has become a survival imperative in Thailand. However the results show that a relatively small number of parents discussed condoms with their children, despite the gravity of the HIV/AIDS epidemic in the country. Discussion on sex and sexual health between parents and children has not been a norm in Thai family. Adolescents and young adults often seek this knowledge from their peers or other sources.

Putting the results on knowledge of sexual experience of male and female close friends together, it appears that sexual experience among young adults is not all that 'secret' or sensitive; at least it can be shared among close friends. This is confirmed by the fact that only a minority of respondents said that they had no idea about the sex lives of their friends, which in effect means that most of the young adults have at least some idea of their friends' sexual behaviour. Furthermore, the perceived level of other young people's sexual experience was very high, especially for males. This suggests that pre-marital sexual intercourse has almost become the social norm among young people. This was found to be especially the case for Bangkok. A quantitative survey is perhaps not the ideal method to explore motivations behind sexual activity, but the most common reason given was peer pressure, more so for young males than females, reinforcing the sense of pre-marital sex having become a social norm. This impression was reinforced by the findings on sexual values, in that two thirds agreed that sex before marriage is common and acceptable today, and slightly more than a third agreed that 'paying

for sex is not a bad thing'. Young men were more liberal in all respects than the young women.

Young people receive images and information concerning sexuality and AIDS from a wide range of sources which may be expected to have quite different impacts upon behaviour. With increasing published and electronic media, pornography has become more and more accessible to adolescents and young adults. The levels of having viewed pornography were lower for females than males, but similar across the three types of residential area.

Given the continuing seriousness of the AIDS epidemic in Thailand, what was perhaps surprising was that the proportions who reported receiving any (official) information related to AIDS are relatively small. More specifically, only 19% of young adults had received AIDS education through the school curriculum. Proportions of those who received other information/training are even smaller, for example, 18% for life skill training in a school programme, 12% for life skill training outside school, 7% for peer education, 17% for AIDS counseling and testing, and only 5% for workplace AIDS programme. Furthermore, only about a fifth reported receiving free condoms from a distribution programme. In the light of this relatively limited level of young people reporting receiving AIDS information from official sources, it is not surprising that only about one third felt that existing AIDS programmes were sufficient for their needs. With regard to this deficiency, virtually all felt appropriate knowledge and skills pertaining to HIV prevention should be included in the school curriculum, but only two fifths felt that the programmes they had

attended in school or college were sufficient to protect them from HIV. These young (18-24 years of age) respondents were highly supportive of the government providing both peer educational programmes and in workplaces. The current limitations in formal channels of AIDS information were reinforced by the findings that show a relatively low level of informal communication about sex and sexual health among the sample of young adults, although about a half of the respondents had discussed sexual matters with a friend at some time. The similarities across the different types of residential areas in terms of perceived sexual norms, values and communication suggest that this reflects a common Thai youth culture.

Responses to questions on school and public programmes for AIDS prevention summarized above suggest that a majority of Thai young adults are aware of at least some existing programmes. Some had participated in, or benefited from, such programmes. Rural-urban differences do exist in certain aspects but they are not substantial. What is of particular interest is that the largest majority of young adults agreed that programmes aiming at enhancing the life skills necessary for safer sex and peer education programmes should be part of the school curriculum and receive support from the public. Similarly, most young adults agreed that AIDS programmes should be provided in the workplace. Although such programmes are available in some places, many more of them are still needed to meet the needs of Thai workers.



Other Risks

Chapter 11:
Substance use

Chapter 11:

Substance Use

This chapter explores substance use including alcohol and drugs, and also examine drug use practices, and the relationship of alcohol to sexual behavior. The chapter concludes with a description of sharing needles.

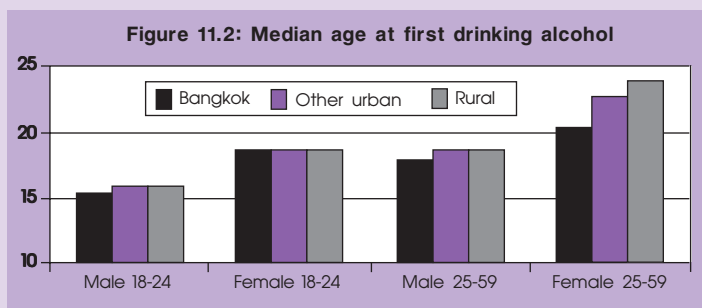
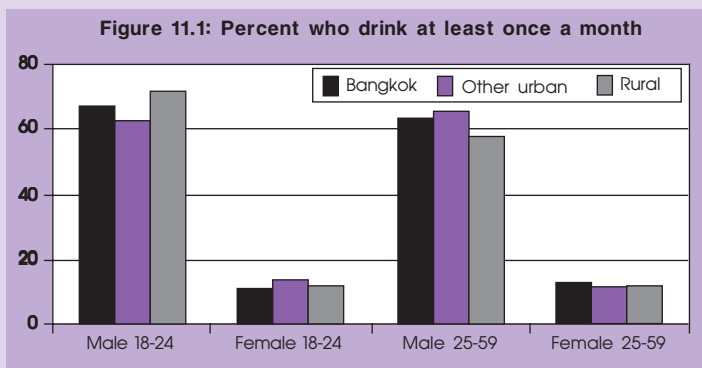
11.1 Alcohol use

Approximately two-thirds of respondents had ever drunk alcohol. However, among these persons, approximately one in two drank very infrequently—less than once a month. Females in all age groups, and in all places of residence, were less likely to have ever drunk alcohol, and among those that did drink, the frequency of drinking was much less than that of males. There was very little difference by place of residence in the proportion ever drinking alcohol and the frequency of drinking. In Figure 11.1, the proportion of respondents who drink at least once a month is shown. The results show that there is relatively little difference in the frequency of drinking among those aged 18-24 and those persons aged 25-59. For all three places of residence, 60 % of males aged 18-24 drank at least a month. This high level of alcohol consumption among young males should be a major concern of policy makers.

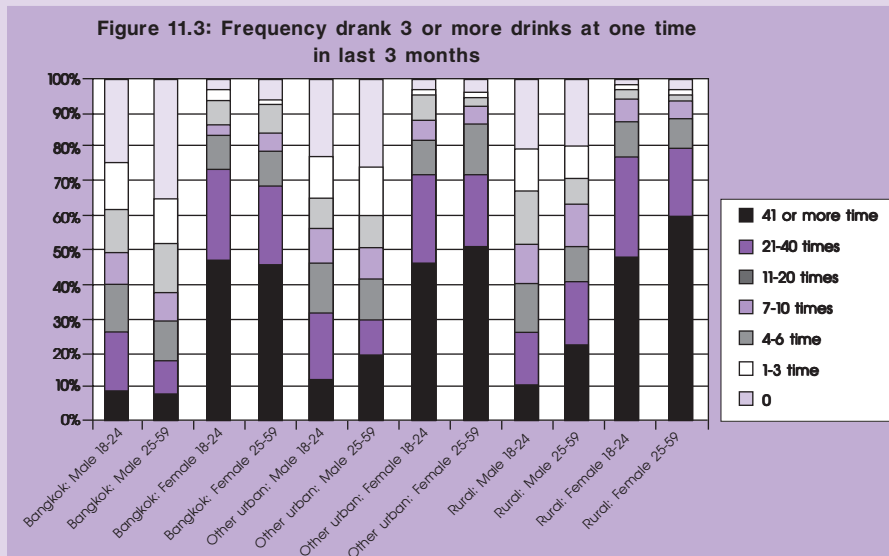
Among those persons who have ever drunk alcohol there is little difference in the median age at which they began to drink (see Figure 11.2). Males tend to start drinking at younger ages than females, and there is a tendency for persons in Bangkok to drink

at an earlier age than those in other urban or in rural areas. Male drinkers aged 18-24 commence drinking at young ages, with the median age in Bangkok is only 15.4 years of age.

Among those persons who had ever drunk alcohol, only 11% had not consumed alcohol in the three months prior to the survey. Thus approximately 89% of those persons with experience of drinking alcohol can be described as current drinkers. Among these

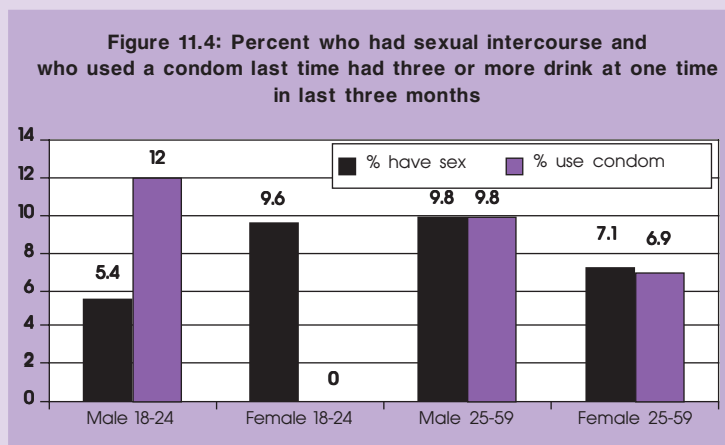


current drinkers, approximately 70% had drunk at least three drinks at one time in the last three months. In Figure 11.3 we show the percentage distribution of the number of times in the last three months that respondents had consumed three or more drinks at one time.



drinks at one time. For those aged 18-24, the proportions were highest for females and for those aged 25-29 the proportions were highest for males. There were only small differences among the three geographical strata. The percent who had sex and the percent of those having sex who used a condom at the time of sex are shown in Figure 11.4. Interpretation of these results must be

In all groups and all areas, 40% of women had not drunk three or more drinks at one time in the previous three months. This contrasts with less than 10% of males in Bangkok, between 10 and 20% in other urban areas and 10 to 22% in rural areas. Males aged 18-24 were especially likely to often drink more than three drinks a time. For example, over one-half of males in Bangkok aged 18-24 had drunk three or more drinks at a time more than 10 times in the last three months.



11.2 Sex and alcohol

For HIV prevention, the major concern about alcohol drinking is the possible relationship between the consumption of alcohol and sexual behaviour. In the survey, questions were asked about whether the respondent had sex the last time that they had consumed three or more drinks at one time in the three months prior to the survey and whether they used a condom at that time. Although the number of respondents who answered that they had sex at the last time they consumed three drinks is low, interesting patterns can be seen from the data.

Overall, almost nine percent of respondents reported having sex after the last time they consumed three

made with caution because of the very small numbers having sex.

The results suggest that young females are particularly vulnerable with regard to consuming alcohol and subsequent sexual behaviour. Although small proportions of women reported drinking three or more drinks at one time in the last three months, among those that had consumed this amount, 9.6% reported subsequent sex and none of these reported the use of a condom when having sex. Reported condom use subsequent to drinking was also low for other groups, with only males aged 18-24 reporting more than 10% (12%) condom use when having sex after the last time they had consumed three or more drinks.

The above results are confounded by marital status. In Thailand, as in most countries, condom use is low for persons who are married or who are in cohabiting relationships. The great majority (83%) of those persons who reported having sex after drinking were married or in cohabiting relationships. As expected, among the married respondents, only 1.8% used condoms the last time they had sex after drinking three or more drinks at one time. The corresponding percentage for those persons who were not married or cohabiting was much higher, but still less than one-half (44.4%). Among the nine women not married or cohabiting who reported sex after drinking three or more drinks only one said they used a condom.

11.3 Drinking and driving

A major cause of injury and death in Thailand is road accidents, and alcohol consumption is said to be a contributing factor to a high proportion of these accidents. Data from the survey show that among males who had consumed at least three alcoholic drinks at one time in the last three months, almost two-thirds of males aged 18-24 and 53% of those aged 25-59 reported that they had drove a car or motorcycle after drinking three drinks. Among women, the percentages are much lower, 33% of females aged 18-24 and 23% for those aged 25-29. These results clearly demonstrate that alcohol consumption and driving is a major issue for men, particularly young men.

The problems of drinking and driving are most clearly seen in other urban and in rural areas. In Bangkok, compared to other areas, a significantly lower proportion of males and females report drinking and driving. The difference among areas is greater for females than males. It is possible that the differences in drinking and driving between Bangkok and other areas may be a result of greater availability of public transport in Bangkok. Another possible explanation is more intense efforts by authorities in Bangkok to

convince people of the dangers of drinking and driving.

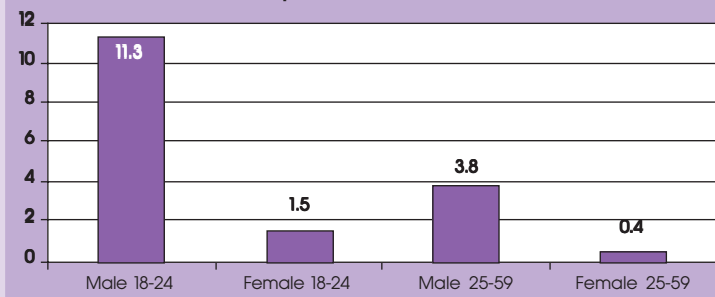
11.4 Drug use

Levels of reported drug use recorded in the sample are extremely low. Slightly less than 3% of respondents reported any drug use in the previous 12 months. The levels of use were much higher for males than for females and much higher for those aged 18-24 than those aged 25-59 (see figure 11.5). Only among young males, among whom 11% reported drug use, did more than 5% of the sample report drug use.

As might be expected, levels of drug use were much higher among respondents in Bangkok compared to those living in other urban and rural places of residence. Almost 15 % of males aged 15-24 living in Bangkok reported drug use, compared to only 11% living in other urban areas and 10% in rural areas.

Information about drug use was collected on a wide variety of substances. However, use of only three drugs was reported by more than a handful of persons. Of all drug use reported, 37% was the use of amphetamines and another 40 percent was marijuana use. Another 17% of drug use involved the use of 'mitragyna speciosa' which is made from the kratom plant and has a long history of being used in rural areas of Southeast Asia. This drug is not typically injected. Only two persons reported use of heroin. Young persons were most likely to use amphetamines and marijuana.

Figure 11.5: Percent who had reported any drug use in previous 12 months



Although a relatively small proportion has used drugs, almost one-quarter of drug use was associated with subsequent sexual intercourse. There is relatively little variation among drugs in the proportion engaging in sex after drug use. For example 29% of instances of amphetamine use were followed by sexual intercourse and this compares with 22% for marijuana use. The concentration of drug use in the young male population means that young males are the most likely to have an association between drug use and sex.

11.5 Sharing needles

Only 18 persons, or 0.3% of the population reported that they had shared needles or syringes in the last 12 months. The majority of this use (12 persons) occurred among older males while a further four women aged 25-59 reported sharing needles or syringes. Two-thirds of the instances of sharing needles were reported in rural areas. In addition, only one of the 18 persons who reported sharing needles also report drug use. It appears that most sharing of needles occurs among older man and women and is probably related to self-medication.

11.6 Conclusion

The survey reveals appreciable levels of alcohol consumption among younger males but with little difference according to type of residential area. In Bangkok, drinking begins at the young age of 15.4

years with implications for the focusing of appropriate health education. With respect to HIV prevention the survey revealed that although the number of respondents who engaged in sex after moderate drinking (defined as at least three drinks) very few took the precaution of using a condom, but this was confounded by marital status.

There is a much stronger relationship between alcohol consumption and driving. A quite worryingly high proportion of males, and especially young males (almost two thirds of those who admitted having at least three drinks on a single occasion) reported driving a car or motorcycle afterwards. Furthermore this is more prevalent in the rural and other urban areas than in Bangkok.

In contrast to alcohol consumption, other drug use is very low, and only among young males (11% of 18-24 years of age) did more than 5% report drug use. Drug use was found to be highest among young males in Bangkok (15%). There is however an association of drug use with subsequent sexual intercourse. Of the very low level (0.3%) who admitted sharing needles/syringes within previous the 12 months, the majority was among older persons in the rural areas and was probably related to self-medication. Perhaps the overall low levels of reported drug use should be viewed within the context of the government crack-down on such activity in recent years, although it may well reflect actual declining usage.



Conclusion

Chapter 12:

Conclusion and recommendations

Chapter 12:

Conclusion and recommendations

This concluding chapter provides a summary of the main findings of the analysis of the survey data. The chapter includes discussion of their general policy and programme related implications, and also makes some reference to the identification of some lines of potential further research.

12.1 Socio-demographic Characteristics

The broad socio-economic, cultural and linguistic characteristics of the sample were explored in order to provide a context for the subsequent analysis and to identify and introduce aspects of vulnerability of sub-sections of the population. This highlighted homogeneity in terms of the Buddhist religion and familiarity with the Central Thai language, but with significant minorities. Although there was generally a high level of education and literacy for a developing country, it was noted that around a quarter (highest in the rural areas) of the sample had a low level of education, with implications for information dissemination. The pattern of employment in Thailand was found to be broadly determined by age group, gender and urbanization. The study identified a high level of access to, and use of, the mass media, with reference to TV, radio and newspapers. The findings clearly indicate the scope for TV and radio to be used to transmit health information as they are almost universally accessible in all areas. The greatest variation in access to mass

media pertained to use of the Internet which was skewed to the urban areas and, above all, the younger age group. Thus there is increasing scope to use the Internet to provide health-protective information for the young

12.2 Knowledge and Attitudes Concerning HIV, AIDS and ART

Not surprisingly given the history of the epidemic in Thailand, practically 100% of the population has heard of AIDS. The study further confirmed that nearly half of the population have direct experience of personally knowing someone who is HIV infected or died from AIDS. However this figure drops to less than a third of the younger age group and may possibly contribute to the signs of increasing sexual risk taking within this group. There were still some misconceptions. For instance, 20% still did not believe that a healthy-looking person could be infected with HIV. This misunderstanding rises to a quarter among older women living in rural areas. There was generally very good understanding of sexual transmission of HIV and the means of prevention, although almost 10% of the sample had some reservations about the ABC components. Condom use was the most widely recognized means of preventing infection, followed by 'be faithful' and thirdly 'abstinence'. There may well be scope for the development of research to explore ways of giving more emphasis in the Thai HIV prevention

programme to 'being faithful'. There was also good knowledge of mother-to-child HIV transmission, although again nearly 10% of respondents had some misunderstanding. All of these findings were, consistent across all three residential areas (Bangkok, other provincial urban areas and rural areas) and by sex and age group.

A key dimension in theories and models of behaviour change is that of self-perceived susceptibility to HIV infection. Four fifths of the sample believed they faced no risk of HIV infection within the next 12 months. What is interesting is that among those who perceive themselves to be at some risk, the majority report that they have unprotected sex, engage in intercourse with sex workers, or are not faithful to one partner.

A section of the interview was addressed to knowledge of ART, by asking respondents whether and what they understood about drugs that could prevent HIV-infected persons from developing AIDS. Such information is especially important in terms of ensuring that misconceptions about ART do not encourage risk-taking behaviours. It was found that nearly half of the population has heard about these treatments. Television was by far the most common source of this information. Whilst similar proportions of men and women and younger and older age groups have this knowledge, awareness is highest in Bangkok (62%) and lowest (43%) in rural areas. This has with clear implications for programme targeting.

It is encouraging that of those who had heard of ART virtually all realize that it is not a complete cure for HIV infection or AIDS. Furthermore, awareness of the benefits of ART has not led to a lessening of concern about becoming infected with HIV. Among those who have heard of ART this correct understanding about the limitations of ART is found across all three types of residential area, as well as by age group and sex. There was also found to be good understanding of the procedures involved in

taking and adhering to ART, and continuing infectivity once a person has begun a programme of treatment. There was, however, considerable confusion on the part of many respondents regarding precisely when it is appropriate for an HIV-infected person to begin receiving ART. As many as 90% of those who had heard of ART believed that it should be taken as soon as HIV is detected, rather than when their CD4 count becomes low. Many were also unaware of the possible side effects of ART.

While respondents did not believe that their own awareness of ART had resulted in a more relaxed attitude to the threat of HIV, they did generally think that it would lead to greater sexual and drug-injecting risk-taking behaviour on the part of the general public. However the findings concerning individual's own feelings are probably most salient.

With regard to the important matter of possible stigmatization of ART-receiving patients, almost all respondents denied that they personally would behave in such a way. However caution in interpretation is needed here as people may well be unlikely to express stigmatizing views in a survey interview. There was a fairly balanced mix of views as to whether the government should pay for the cost of ART for patients, although most (81%) felt that it should be provided under the 30 Baht scheme.

In contrast to the awareness of ART to delay the onset of AIDS, only a minority (33%) were aware that drugs were available to prevent mother-to-child transmission of HIV, but almost all agreed that if such drugs exist they should be provided freely by the government.

In overall terms it is encouraging that there is already reasonable knowledge of ART in Thailand. However, ART information clearly needs to be more widely disseminated to the many who are still unaware of ART's potential. Much more needs to be done to generate knowledge and awareness of the PMTCT

programme. Finally although the survey revealed limited evidence of stigmatization of the HIV-infected, maybe different types of methodology could provide a richer understanding.

A further set of question were asked related to respondents general knowledge of HIV and AIDS, main sources of AIDS-related information, condom promotion and in particular the more widespread provision of condom vending machines. The general public's response to the AIDS pandemic was generally encouraging. However despite the high profile of AIDS in Thailand, less than half of the respondents reported receiving information about AIDS from any source in the last twelve months. Furthermore, there is a low demand for more AIDS-related information among the population residing in Bangkok compared to the rest of the country. Overall about two thirds would like to find out more information on AIDS, and this was especially observed among the younger population. There is potential for greater use of the mass media to disseminate further information on HIV prevention. Mass media especially television is the most popular source of AIDS information. The majority of respondents want to know more about AIDS. The most cited topic of interest is AIDS transmission. "Already have AIDS knowledge or know how to prevent AIDS" is by far the most (by two thirds) cited reason among those who do not want to know more about AIDS. Only about a third of those who did not want any more AIDS-related information gave reasons pertaining to not feeling themselves to be potentially at risk. The informational needs of the public are therefore not only considerable but also sophisticated.

Secondly, these findings revealed that the government's programme to promote the availability of condoms seems to be useful and appropriate for the young people in Thailand. Perhaps given the pattern of sexual scripting in Thailand, males have a substantially higher awareness of access to both low cost condoms and condom vending machines

than do females. The findings reveal that a substantial proportion of the population (30%) are aware of access to low-cost condoms in their community of workplace. But that level also indicates the scope for an increase in provision of this vital service.

The survey also revealed highly positive attitudes to the provision of condom vending machines. However, less than 10% of respondents report knowledge of such a machine in their own community or workplace, and only 5% report having actually purchased from one. The current level of popular support for condom vending machines is high. The potential use of these machines, especially by young males, seems to be quite significant and can probably be easily increased. Condom vending machines are clearly socially acceptable and could make a greater contribution to HIV prevention in Thailand. Further research could examine the economics underlying the wider provision of condom vending machines.

Overall, the survey findings indicate a positive social climate for the further expansion of the national AIDS awareness and condom promotion programmes. Whilst much has already been achieved in raising awareness of HIV prevention there is still considerable scope for continuing focused expansion of the programmes.

This survey also undertook analysis that can assist the refinement of programmes concerning testing, treatment and behavioural change pertaining to STI as well as HIV infection. It is striking that nearly half of the adult population appear to have been tested for HIV, with higher levels of testing in the urban than rural areas. Furthermore, of those who had not been tested, fully a third (mainly from the younger age group) wish to be tested in the future, highlighting the need for ease of access to such services. HIV testing has clearly become an established and accepted aspect of life in Thailand. Whilst most of this testing has been associated with

health service procedures, such pregnancy and health check-ups, a significant percentage of men (14%) have been tested on their own initiative, probably related to engaging in risk behaviours. Overwhelmingly the reason most commonly given for never having been HIV tested was that they felt themselves at no risk of HIV infection. In terms of programme provision it would appear that HIV testing is widely and easily available and accessed in Thailand. The vast majority of HIV tests were provided by public hospitals, but findings indicated further scope for this to be complemented by higher levels of testing by private hospitals and clinics. Whilst virtually all women (98%) had received the result of their HIV test, only 87% of men had done so. The findings reinforce the need for continuing to build upon the coverage and quality of VCT programmes throughout the country.

In striking contrast to the quite high levels of knowledge and testing for HIV, the findings reveal low levels of knowledge and testing for other sexually transmitted infections (STIs). This is in contrast to the situation thirty years ago in Thailand prior to the onset of the AIDS epidemic, when levels of STIs were much higher. Indeed the younger generation knows less about STIs than the older age groups. One third of the sample had ever heard of an STIs. Yet in HIV prevention programmes minimizing STIs is a first stage to reducing HIV transmission. Men are still more likely than women to have some knowledge of STIs other than HIV, yet the bio-physiological impacts and complications of many STIs are more serious for the females than for males. The study highlights the enormous need for better public education and treatment concerning STIs. This should build upon the substantial de-sensitization to sexual communication and discussion that has been achieved by Thailand AIDS awareness programmes over the past twenty years. The survey found very low levels of experience of STIs or even symptoms of discomfort in the genital area, but this could reflect under-reporting or lack of awareness. This highlights the need for further studies to explore STIs

prevalence in Thailand. The findings on reported symptoms of possible STIs suggest that STIs diagnosis and treatment services need to be especially targeted and strengthened for women. Whilst again the public hospital is the most common place of STIs treatment, the survey also reveals a worryingly high degree of self-treatment and purchase (without expert advice) of drugs from pharmacies.

Some of the most intriguing and original findings from the survey pertain to matters of disclosure and protective behaviours within relationships, and among HIV-discordant couples in particular. A strong gender differential is identified wherein women (and rural residents) are much more likely to openly admit genital infection symptoms to their partner than are men. Furthermore women are far more likely than men to take practical steps to prevent their STIs from infecting their partner. The most common reported protective response is temporary abstinence, followed by taking medicine and condom use. A similar pattern of responses is found for self-protection in the light of a partners' possible infection. It is discouraging, in the light of Thailand's substantial condom promotion, that less than 10% would use a condom to prevent transmission of possible infection to their partner. What is most worrying is that a high proportion (just over 50%) would not pursue any protective action. This finding could well benefit from further in-depth research. Approximately one quarter expressed some concern about possible sexually transmitted infection in the future, again with the anxiety being more widely felt by women. This probably reflects the gender structuring of risk behaviour within the sexual culture. These different levels of self-perceived vulnerability between men and women warrant further research.

Clearly, there are still considerable gaps in HIV prevention in Thailand. In particular the kind of information and that should be offered to infected persons and their partners could benefit from further systematic consideration and exploration. At the

same time, a discrepancy still exists regarding how to promote self-protection among the non-infected from their partners who are already HIV infected or suspected to be infected. The group in Thailand that seems to be most vulnerable to infection from their partners is women. Promotion of the use of condoms, particularly within a steady partnership, is a very complicated matter. These challenges to programme design are amplified by the extraordinarily sensitive issues including the concerns of human rights, family relations and gender considerations. While a 'gold model' of prevention among discordant couples still needs to be further considered and developed, programmes designed to provide numerous options of self-protection to the public may be the best way to address these sensitive concern.

12.3 Sexual Behaviour and Risk-Taking

Major sections of the survey focused upon sexual behaviour and risk-taking. In terms of sexual orientation, the sample reported as overwhelmingly heterosexual. With reference to sexual experience, younger females in the rural areas report higher levels of being sexually experienced than those in Bangkok and the other urban areas, which largely reflects their earlier ages of marriage. Comparison of the younger and older age groups shows a clear trend of declining ages of first intercourse in recent years, but with males having first intercourse at significantly earlier ages than females. There are major variations in the nature of the relationship with first sexual partner by both sex and age group. While most females (67%) report that their first intercourse was with their spouse, for males it is more generally reported as girlfriend, friend or acquaintance (72%). Secondly, the younger age groups of both males and females show higher levels of first intercourse with boy/girlfriend or friend than do the older age groups. This reflects a two-fold major shift in the Thai sexual culture, firstly, towards

higher pre-marital sex within relationships, and secondly, declining sex with sex workers. This probably reflects some combination of gender liberalizing trends that make pre-marital sex more socially acceptable for females, along with the association of sex work with HIV in Thailand. The higher proportion of younger females who have their first intercourse with a spouse in rural areas suggest both higher levels of earlier marriage and more traditional sexual lifestyles for females in rural areas. This could well reflect both more traditional values and greater familial control pertaining to the sexuality of women in rural than in urban areas of Thailand.

The survey also asked respondents about relationship developments after first intercourse. There is a striking difference by sex with majorities of females of both age groups reporting that it led to marriage or cohabitation (more so for the older women), whilst a smaller majority of males are more likely to state that it led onto a relationship, but short of marriage. Thus the findings show a divergence in males and females subjective reporting around sexuality, with females presenting an image of greater personal commitment.

The survey also explored matters of force (mental and physical) and coercion associated with sex. Unfortunately the survey questions did not differentiate between mental and physical force, nor the perceived level of force involved. It is notable that younger (18-24) women report higher levels (13%) of unwanted/forced first intercourse, than older (25-59) women (8%). This may well indicate that the shift towards higher levels of pre-marital intercourse for young women is putting significant numbers of them under pressures within relationships. It is notable that the highest level (15%) of reported force in sex is found among the younger (18-24 years of age) women in Bangkok.

With respect to settling down in committed sexual unions, among the younger age group many more

females (53%) than males (20%) are ever married. This confirms a pattern wherein young women male partners somewhat older than themselves. It is also noted that the pattern of the sexual culture would appear to continue to be one in which males have greater scope for having more than one regular partner in their lifetime (either serially or simultaneously), than do females.

It would appear that age is more of a barrier to women than men in finding a second regular sexual partner in Thailand. These patterns are replicated across the types of residential areas, but are most pronounced in Bangkok where 39% of the older (25-59 years) age group of males have had two or more regular partners, as compared to 31% in the other urban areas and 28% in the rural areas. This divergence may well relate to both greater wealth and number of contact opportunities in Bangkok than the other areas.

Sex with casual partners is predominantly reported by males, with 52% of the male sample reporting casual sexual experience, but only 3% of females doing so. However it is notable that this increases to 7% of females in the younger age group. In epidemiological terms the implication of the large disparity in levels of casual sex, in what is an overwhelmingly heterosexual culture, is that there is probably a quite small proportion of (younger) women engaging in a fairly high level of casual sex (but their numbers are too small for them to be found in a general sample survey) and that more males interpret sexual contacts to be casual, whilst more females interpret the same encounters to be more personally meaningful. It could be useful to conduct further qualitative research into this demographically small, yet epidemiologically important, group of females engaging in high levels of casual sex.

Whilst the survey revealed virtually no transactional sexual relations of gift-giving in sex, there is evidence

in the survey for interaction with sex work. Across the total sample, whilst 44% of older males report having ever engaged in intercourse with a sex worker, this falls to 24% of the younger age group. Of these, more than 80% had done so on no more than three occasions in the past year. Thus whilst sex with sex work continues within the Thai sexual culture, it is not an especially frequent part of men's behaviour. With respect to variations by area, it is notable that the male respondents in Bangkok reported somewhat higher levels of sex with sex work than respondents in the other urban and rural areas.

For transmission of HIV and other STIs, the crucial factor is the extent to which condoms are consistently used. There is a clear and expected pattern of increasing levels of condom use from regular partner (12%), through casual partner (47%), to sex worker (94%). The overriding reason (72%) for non-use of condoms with regular partners is reported here as 'trust in and confidence in the safety of the partner', as has been reported in most surveys of condom use around the world for the past twenty years. Evidence for the success of Thailand's '100% condom use in the sex industry' policy is found in the 94% of both younger and older age groups who report that they always use condoms with sex workers. There is concern, however, that 4% of the younger age group report never using condoms when they have sex with sex work. In the light of the levels of HIV prevalence in the Thai sex industry and the government's strenuous efforts to promote condom use this would appear to be almost pathologically perverse behaviour. It is possible that some members of this small minority of respondents are probably already HIV infected and are infecting sex workers. Qualitative in-depth research could well be gainfully undertaken among this epidemiologically crucial group

A situation of greater ambiguity and uncertainty arises with respect to the findings on condom use in

casual sex. Whilst half of the younger age group of males report always using condoms, about a quarter never use condoms in casual sex. The reasons given for non-use are firstly (39%) confidence in safety of partner, secondly (31%), 'not prepared/could not find a condom at the time', and thirdly (12%), just do not like using condoms' (reduced sensation). These patterns of levels of condom use and reasons for non-use are broadly similar across all three types of residential areas. The risks of HIV or other infections from casual sex in Thailand are very hard to quantify, as the nature of what is a casual sexual partner is highly subjective and necessarily varied. However it is plausible to consider that given very few females report engaging in casual sex, those that should be quite a small minority, some of whom will be having intercourse with numerous partners. Therefore their risk is likely to be high, and may account for the recent increases in HIV incidence within the younger age groups. These findings, at the level of condom use and reasons for non-use in casual sex, lead to what are probably the most important policy implications with respect to HIV prevention to emerge from this survey. In the light of the major shifts and increased complexity of sexual culture, the Thai government needs to build upon the successes of the '100% condom use in the sex industry' policy to extend it to casual (non-commercial) sex. Careful and extensive consideration needs to be given to the nature and directions of such a programme. However, the findings provide three main possible directions: firstly, the population needs to be better informed of the HIV/STI risks of engaging in casual sex without a condom. Secondly, people need to carry condoms when going out in nightlife venues, even when they may not intend to engage in casual sex. Thirdly, any perceived loss of sensation involved in condom use needs to be set off against the personal disaster of becoming HIV infected. Further research could consider working in situations where casual (non-commercial) sexual encounters occur and (in Buddhist terms) seeking to enhance the mindfulness of risk in such places.

The survey examined the broad picture of numbers of, and relationships with, sexual partners in order to provide some level of indication of sexual risk taking. Specifically the survey explored characteristics of sexual encounters with respondents' most recent (up to) five partners within the last twelve months. The characteristics explored included alcohol and drug use in association with sex, duration since intercourse with each partner, locations of meeting, and crucially, condom use.

As found in most such population-level sexual behaviour surveys, the findings showed a fairly safe pattern with the large majority engaging in intercourse with only one sexual partner within the last twelve months. The findings also show the customary pattern of males being somewhat (about five years) older than their female partners. The demographic group with the greatest numbers of partners (but still only 2.1 on average per year) were younger males. This has clear implications for the focusing of safer sex promotion activities. The sample identified as overwhelmingly heterosexual.

Typically the most recent sexual partner was within a relationship, being with a girlfriend or cohabiter for the younger male age group, but with a cohabiter or spouse for the younger females, and with spouse or cohabiter for the older age group. Among the minority who reported more than one sexual partner within the last year, the second (and up to fifth) partners were generally in more transitory relations. These additional partners typically spanned as well as some boy/girlfriends, casual partners and 'drink girl/bar girl' for the younger respondents, and sex workers for the older respondents. Unsurprisingly respondents had generally first met their main, first and more stable, partner in their school, workplace, neighbourhood or community, whilst the more casual and sex worker partners were encountered in entertainment settings, such as karaoke bars. Relatively few cited brothels as the venue.

Younger and older age groups of respondents show similar (relatively short) durations since last intercourse with their most recent partner. However, older males show shorter durations since intercourse with other partners, but it must be noted that fewer older, than younger, male respondents report sexual contact with partners other than their main partner (usually spouse). Also the data shows that for a minority of younger males who have other sexual partners (casual girlfriends, bar girls, sex workers and so on) it does not appear to be a particularly regular or frequent occurrence.

In the past there was a clear gender structuring of sexuality in Thailand (as in some other Asian sexual cultures), in that pre-marital sexual intercourse was considered an almost accepted part of male behaviour, but strongly prohibited for females. Thus the survey asked the question as to whether respondents thought (to the best of their knowledge) their partners had had a sexual partner before themselves. Most respondents stated that they did not believe their main most recent partner had had a partner before themselves. However, there are two points of interest: firstly, a substantially higher proportion of younger respondents believed their partner had sexual experience. Secondly, the difference between males and females appears to be less for the younger than the older age group. These findings reinforce those of earlier studies (eg. Ford and Kittisuksathit, 1996) suggested that there is a trend in Thailand for increasing levels of intercourse within steady, committed, pre-marital relationships, and that there are some indications of an erosion of the fairly extreme 'double standard' of the past.

In the more casual sexual relations of the minority who had had sex with two to five partners in the last year there was, not surprisingly, a high estimation that the women had had partners before themselves.

Just over half of males reported consuming alcohol in association with sex with their main partner, and substantially higher proportions reported doing so in more casual sexual encounters. Hardly any of the sample reported taking drugs in association with sex, although in the rare cases where this was reported it was by younger male respondents in sexual encounters with casual partners or sex workers.

Although vaginal intercourse was overwhelmingly the most usual activity and anal sex was very rarely reported, there were appreciable levels of oral sex. Interestingly, oral sex was reported as taking place more frequently with casual partners and sex workers than with main steady partners. This seems to support the contention argued by Tangchonlatip and Ford (1995) that for some men part of the motivation to visit sex workers was to experience a more varied range of sexual practice.

The survey findings on respondents (up to) last five partners showed the customary lower level of condom use within steady committed relationships, but higher levels in the more transitory encounters. Males mainly reported always using condoms with partners met in entertainment venues. However, condom use was not universally consistent in other casual, if not necessarily commercial, encounters. Thus it would appear that the 100% condom use in the sex industry policy has been highly successful. However the policy alone is not sufficient to protect against HIV infection in all casual sexual encounters. This important caveat needs to be viewed within the growing complexity of 'post-traditional' sexual lifestyles in Thailand, and may well, explain the recent increasing levels of HIV incidence within the younger age groups.

12.5 Key Factors Influencing Young People's Sexual Risk-Taking

The study explored not merely patterns of sexual risk-taking but also a range of important factors that impinge upon, and influence, such behaviour. An understanding of such factors can provide useful guidance for the development of interventions and policy that seek to promote safer practices. This part of the study focused solely upon the younger age groups, comparing findings for 18-19 and 20-24 year olds. This section was structured in terms of living arrangements, parental influence, peer influence, exposure to pornography and school and public AIDS education, and sexual values and sexual communication.

With reference to living arrangements, it was striking that a much higher proportion (nearly three fifths) of youth in rural areas were still residing in households with both parents, than those in Bangkok (one third) or other urban areas (two fifths). Young people in the urban areas contained higher proportions both living alone or with a spouse or cohabiter.

Parental influence was examined and discussed with reference to parental control, along with the more explicitly sexual matters of permissiveness towards sex, youth perception of their parents' awareness of their sex life, and discussion about condoms. The degree of parental control was explored in terms of their knowledge of their children's whereabouts in the day, and with whom their children have relationships and friendships. The findings revealed that three fifths appeared to be under close care from their parents in this regard. Of concern, however, is that a fifth felt that their parents had very little idea of their whereabouts in the day. Not surprisingly their parents seemed to give considerably greater attention to daughters in this regard. Interestingly there was very little difference in these matters with reference to area of residence.

There was a similar pattern with regard to parents' knowledge of children's friends. This survey points to a conclusion that about half of young adults in Thailand are not under the strict control of parents. Sons seem to enjoy more freedom in move around, make friends and engage in activities with people outside the family

Regarding young people's sense of their parents' permissiveness towards pre-marital sex, the findings indicate that there is considerable gender structuring within Thai culture. It is of interest, although not unexpected, to note: (1) that young adults (both male and female) perceived that their parents' attitude toward premarital sex for sons is much more permissive than for daughters; (2) that male respondents tend to perceive greater permissiveness of parents' attitude for sons than for female respondents perceiving parental attitude for daughters; and (3) that similar patterns of responses are observed in all three strata of the survey sample. It is clear that parents are perceived to use different sexual standards for sons and daughters.

There was also evidence that the young people felt their parents had an awareness of their level of sexual experience. It seems obvious that regardless of whether or not they have actually ever had or never had sex, the majority of young adults in the survey (i.e. about 60% or more in) had the perception that parents knew whether they ever or never had sex. Unfortunately, a follow-up question was not asked here if parents knowledge was accurate.

Safer sex has become a survival imperative in Thailand. However the results suggest that a relatively small number of parents discussed condoms with their children, despite the gravity of the HIV epidemic in the country. Discussion on sex and sexual health between parents and children is not a norm in the Thai family. Adolescents and young adults often seek this knowledge from their peers or other sources.

Putting the results on knowledge of sexual experience of male and female close friends together, it appears that sexual experience among young adults is not all that 'secret' or sensitive; at least it can be shared among close friends. This is confirmed by the fact that only a minority of respondents said that they had no idea about the sex lives of their friends, which in effect means that most of the young adults have at least some ideas of their friends sexual behaviour. Furthermore the perceived level of other young people's sexual experience was very high, especially for males. This suggests that pre-marital sexual intercourse has almost become the social norm among young people. This was found to be especially the case for Bangkok. A quantitative survey is perhaps not the ideal method to explore motivations behind sexual activity, but the most common reason given was peer pressure, more so for young males than females, reinforcing the sense of pre-marital sex having become a social norm. This impression was reinforced by the findings on sexual values, in that two thirds agreed that sex before marriage is common and acceptable, and slightly more than a third that 'paying for sex is not a bad thing'. Young men were more liberal in all respects than were young women.

Young people receive images and information concerning sexuality and AIDS from a wide range of sources which may be expected to have quite different impacts upon behaviour. With increasing advancement of published and electronic media, pornography has become more and more easily accessible to adolescents and young adults. The levels of having viewed pornography were lower for females than males, but similar across the three types of residential area.

Given the continuing seriousness of the AIDS epidemic in Thailand, what was perhaps surprising was that the proportions that reported receiving any (official) information related to AIDS are relatively small. More specifically, only 19% of young adults had received

AIDS education through the school curriculum. Proportions of those who received other information/training are even smaller; for example, 18% for life skill training in a school programme, 12% for life skill training outside school, 7% for peer education, 17% for AIDS counseling and testing, and only 5% for workplace AIDS programme. Furthermore, only about a fifth reported receiving free condoms from a distribution programme. In the light of this relatively low proportion of young people reporting receiving AIDS information from official sources, it is not surprising that only about one third felt that existing HIV and AIDS programmes were sufficient for their needs. With regard to this deficiency, virtually all felt appropriate knowledge and skills pertaining to HIV prevention should be included in the school curriculum, but only two fifths felt that the programmes they had attended in school or college were sufficient to protect them from HIV. Younger (18-24 years of age) respondents were highly supportive of the idea that the government should provide both peer educational programmes and those in workplaces. The current limitations in formal channels of AIDS information were reinforced by the findings that show a relatively low level of informal communication about sex and sexual health among the sample of young adults, although about a half of the respondents had discussed sexual matters with a friend at some time. The similarities across the different types of residential area in terms of perceived sexual norms, values and communication suggest that this reflects a common Thai youth culture.

In general, the responses to questions on school and public programmes for AIDS prevention summarized above suggest that a majority of Thai young adults are aware of at least some existing programmes. Some had participated in, or benefited from, such programmes. Rural-urban differences do exist in certain aspects but they are not substantial. What is of particular interest is that the largest majority of young adults agreed that programmes aiming at enhancing the life skills necessary for safer sex and

peer education programmes should be part of the school curriculum and receive support from the public. Similarly, most young adults agreed that AIDS programmes should be provided in the workplace. Although such programmes are available in some places, many more of them are still needed to meet the needs of Thai workers.

12.5 Alcohol and Drug Use

The survey reveals appreciable levels of alcohol consumption among younger males but with little difference according to type of residential area. In Bangkok drinking begins at the young age of 15.4 years with implications for the focusing of appropriate health education. With respect to HIV prevention, the survey revealed that although the number of respondents who engaged in sex after moderate drinking (defined as at least three drinks) very few took the precaution of using a condom, but this was confounded by marital status.

There is a much stronger relationship between alcohol consumption and driving. A high proportion of males,

and especially young males (almost two thirds of those who admitted having at least three drinks on a single occasion) reported driving a car or motorcycle after drinking. Furthermore this behavior is more prevalent in rural and other urban areas than in Bangkok.

In contrast to alcohol consumption, other drug use is very low, and only among young males (11% of 18-24 years of age) did more than 5% report drug use. Drug use was found to be highest among young males in Bangkok (15%). There is, however, an association of drug use with subsequent sexual intercourse. Of the very low level (0.3%) of admitted sharing of needles/syringes within the 12 months, the majority was among older persons in rural areas and probably related to self-medication. Perhaps the overall low levels of reported drug use should be viewed within the context of the government 'crack-down' on such activity in recent years. It may also reflect actual declining usage, and maybe also some under-reporting.

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.....Despite these successes, though, this survey now released by Mahidol University clearly demonstrates that the dynamics of HIV infection in Thailand continue to evolve and change, just as the dynamics of Thai society and Thai sexual behaviors are evolving and changing. Recent reports from the Royal Thai Government's Ministry of Public Health and other partners echo some of the more significant aspects of the evolving AIDS situation in Thailand highlighted by this survey...

Peter Piot
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It is indeed our hope that the results from this national representative sample survey will be useful to provide evidence for policymakers to ensure that our challenges are tackled effectively and will have impact to further reduce the epidemic in the country.

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ISBN : 978-974-11-0876-3