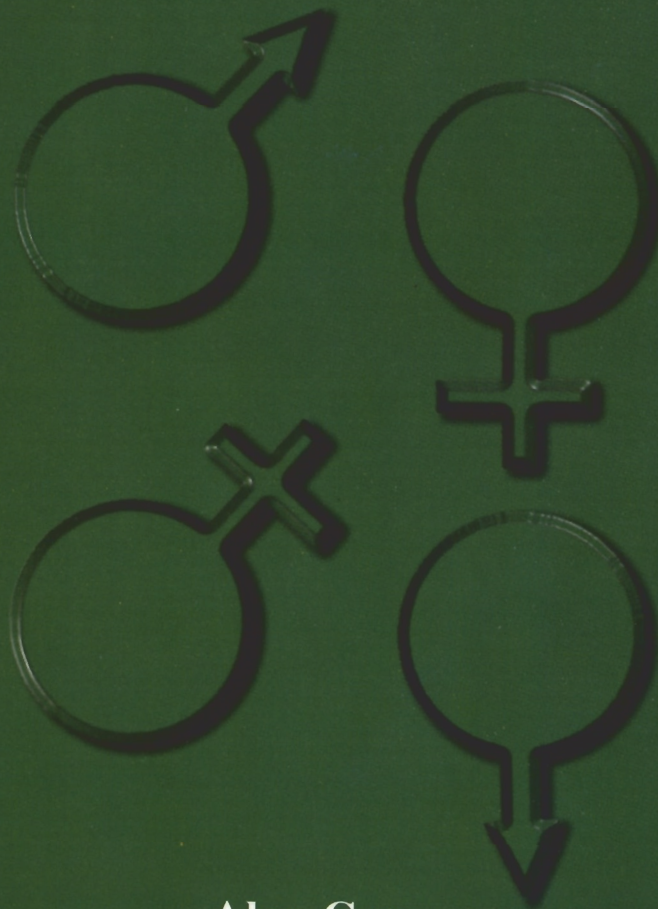
Gender, Sexuality and Reproductive Health in Thailand



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(Phase I: Compilation Study)

Supported by the United Nations Population Fund (UNFPA)

Final Report

Gender, Sexuality and Reproductive Health in Thailand

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Foreword

The importance of gender and sexuality issues in relation to reproductive health was discussed by the International Conference on Population and Development held in Cairo in 1994. In the period since the conference it has become increasingly clear that sensitivity to gender and sexuality is an essential component and a practical basis for reproductive health programs. In Thailand, government and other agencies recognize this, and the United Nations Population Fund (UNFPA) has lent its support to development of a gender-sensitive reproductive health programme.

This study is the first step towards this development. Essentially, it is a critical review of the research that has been done on gender and sexuality in relation to reproductive health in Thailand during the 1990s. While there have been some studies that have been focused on such issues explicitly, most studies that are relevant are actually focused on other issues, and the gender or sexuality perspective can only be discovered by inspection of the research reports. Moreover, few of the studies actually exist in published form. While published studies are often the most useful for the purpose of this review, other important results are much less accessible, in theses and unpublished reports of academic institutions and in government agencies. The study aims to expose the dimensions and content of all this research, and significant gaps..

On behalf of Mahidol University I would like to express sincere appreciation to the United Nations Population Fund for the support provided to this study. The University hopes that the knowledge gained from this study will be of use to policy and programme development of the government and private sectors, and inspire research efforts to fill the gaps that the report identifies.

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Preface

Increasingly, the civil service system in Thailand requires that administrative and technical staff do research and/or gain research qualifications before they can advance to middle and management level positions. Most university degrees at master level require a thesis or a significant research project. A by-product of the administration of government services is therefore a vast body of basic research on a wide range of topics. Much of this research does not filter through the processes of digestion into academic research papers, journal articles and books, and is not easily accessible. Some of the research does influence government administration directly in the ministries and departments when graduate students return to work; but generally speaking, there is no route for much of the research to have an impact on policy through the channels of advocacy and public awareness.

The Institute for Population and Social Research, Mahidol University, was requested by the United Nations Population Fund through the Department of Technical and Economic Cooperation to carry out a project to compile and consolidate all research reports, publications, documents and materials pertinent to the socio-cultural dimensions of reproductive health, gender and sexuality in Thailand. Alongside this volume, research teams based in the North (Chiang Mai), the North-east (Khon Kaen) and the South (Had Yai) will individually publish reports on research undertaken in each of these three regions.

For practical purposes, the scope of this national report has been restricted to the period since 1990, except where there was little recent research related to gender and sexuality on some of the topics. Generally, references to research that does not refer to gender or sexuality have been excluded, however important the research might be in other contexts related to reproductive health. There are relatively few studies that explicitly examine the links between gender, sexuality and reproductive health.

The aim was to include references to the most significant pieces of research in published format. It was also considered important to refer to as much unpublished material as possible, particularly theses. The most complete descriptions of pieces of research are for the less accessible material. We apologize very sincerely for the significant omissions that we are certain will be found in this volume, and we would be grateful to have omissions brought to our attention.

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The findings and recommendations of the project presented in this volume are the result of a wide collaboration. Research teams from the Institute for Population and Social Research (IPSR) at Mahidol University, Khon Kaen University, Prince of Songkhla University and Chiang Mai University worked on the project, collecting information about research which has been conducted on gender and sexuality in relation to reproductive health. It is essential for us to acknowledge, above all, that the volume could not have been produced without the extensive work contributed by all members of the research teams, who are listed on page iii of the volume. The level of cooperation which the team enjoyed in the few short months of this project is a testament to the commitment which all its members felt, to this first stage of a very important program of work.

In the latter stages of the project, consultative meetings were held in Bangkok, Hat Yai, Khon Kaen and Chiang Mai to obtain the valuable views of other experts working in the fields of sexuality, gender, reproductive health and related topics, especially about issues related to methodology of research in these topics. Lists of these participants are included in Appendix A, together with a schedule of the consultative meetings. We express our deep gratitude for the authoritative contributions of all the participants.

The results of the project were discussed at a seminar in Bangkok on 21-22 November 1998. At this seminar, the presentations for each region of Thailand, and for Thailand as a whole, were discussed by some of the most respected authorities on these topics in Thailand. We are extremely grateful to Dr Boonlert Leoprapai, Dr Churnruthai Kanchanachitra, Dr Chai Podhisita, Dr Ronachai Athisuk, Dr Wassana Im-Em, Ms Kanokwan Tharawan, Dr Kritaya Archavanitkul and Dr Napaporn Havanon for their insights and advice.

It is also important to recognize the value of the administrative support that was given by the staff of IPSR to enable this project to proceed smoothly to completion. We acknowledge our debt of gratitude to Ajarn Auraphan Hanchangsit and her capable staff.

Table of Contents

Foreword iii
Preface iv
Acknowledgments v
List of abbreviations x

1. Introduction
1.1 The reproductive health situation in Thailand 1
1.2 Dimensions of gender, sexuality and reproductive health 2
1.3 Gender relations and sexuality in Thailand 3
1.4 Organization of this volume 6

2. Review of Research: Family Planning, Maternal and Child Health and the Consequences of Unwanted Pregnancies 7
2.1 Family Planning 7
2.1.1 Men's roles in family planning 7
2.1.2 Unmet needs 8
2.1.3 Effect of family planning method choice on sexual desire and performance 9
2.1.4 Deliberations of consultative groups 10

2.2 Maternal and child health (MCH) and safe motherhood 12
2.2.1 Men's roles in maternal and child health 12
2.2.2 HIV/AIDS and maternal and child health 13
2.2.3 Maternal mortality and health after childbirth 14
2.2.4 Breastfeeding 15
2.2.5 Infant mortality 16
2.2.6 Deliberations of consultative groups 16

2.3 Abortion and Complications of Abortion 17
2.3.1 Legal situation in Thailand 18
2.3.2 Studies into occurrence of pregnancy termination 19
2.3.3 Attitudes towards termination of pregnancy 20
2.3.4 Deliberations of consultative groups 20

3. Review of Research: STDs and RTIs, HIV/AIDS, Infertility and Reproductive Tract Malignancies 23
3.1 Sexually transmitted diseases (STDs) and reproductive tract infections (RTIs) 23
3.1.1 Introduction 23
3.1.2 Condom use to prevent disease transmission 23

3.1.3 Service delivery for women with STDs and RTIs 26
3.1.4 Knowledge and behaviour of sex workers 26
3.1.5 Transmission of STDs to children 27
3.1.6 Deliberations of consultative groups 27

3.2 HIV and AIDS 28
3.2.1 Gender specificity in HIV infection in Thailand 29
3.2.2 HIV and marital relationships 29
3.2.3 High risk groups 30
3.2.4 Attitudes and knowledge about HIV/AIDS in the general community 33
3.2.5 Deliberations of consultative groups 34

3.3 Infertility 35
3.3.1 Clinical research 36
3.3.2 How infertility affects women's health 37
3.3.3 Deliberations of consultative groups 38

3.4 Reproductive Tract Malignancy 38
3.4.1 Cancer, gender and sexuality 39
3.4.2 Other research on reproductive tract malignancy 40
3.4.3 Deliberations of consultative groups 40

4. Review of Research: Sex Education, Adolescence, Menopause and the Elderly, and Sexual Abuse and Violence 43
4.1 Sex education 43
4.1.1 The gender dimensions of sex education 43
4.1.2 Sex education among students and factory workers 43
4.1.3 Education in condom use 46
4.1.4 Deliberations of consultative groups 46

4.2 Adolescent health 47
4.2.1 Adolescence, gender and sexuality 47
4.2.2 Experience of heterosexual intercourse, and safe sex practice 48
4.2.3 Other aspects of adolescent sexuality 52
4.2.4 Deliberations of consultative groups 54

4.3 Menopause and the Elderly 55
4.3.1 Sexual activity in menopause 55
4.3.2 Sexual activity in old age 57
4.3.3 Deliberations of consultative groups 57

4.4 Sexual violence and abuse 58
4.4.1 Gender and asserted power 58

4.4.2 Violence between husbands and wives 58
4.4.3 Other sexual violence 59
4.4.4 Suicide 59
4.4.5 An analytical problem 59

5. Methodology 61
5.1 The ideology of sexuality and gender in Thailand 61
5.1.1 Framework of research 61
5.1.2 Ideology of sexuality in Thailand 62

5.2 Limitations of method 63
5.2.1 Gender-sensitive analysis 63
5.2.2 Limitations of definition 64
5.2.3 Limitations of scope 66
5.2.4 Ethical limitations 68
5.2.5 Limitations of quantitative method 69
5.2.6 Limitations of qualitative method 70
5.2.7 Methodological innovation 71

5.3 Deliberations of consultative groups 72
5.3.1 Approaches to reproductive health research 72
5.3.2 Approaches to male involvement in reproductive health programmes and research 73
5.3.3 Regional perceptions about research gaps 74

6. Synthesis and Recommendations 75
6.1 Policy 75
6.1.1 A unified field of research and policy 75
6.1.2 Practical policy; practical programs 77

6.2 Future research 77
6.2.1 The scope of future research on gender, sexuality and reproductive health 77
6.2.2 Capability building and training 81
6.2.3 Priority research issues 81
6.2.3 Effective utilization of the results of research 82

6.3 Policy recommendations 82

References 85
Appendix 1. Participants in Consultative Meetings 103

List of abbreviations

AIDS	Acquired immune deficiency syndrome
BRAIDS	Behavioral Research for Prevention of AIDS in Thailand (project title)
Bt	Baht (unit of currency)
DTEC	Department of Technical and Economic Cooperation
FGD	Focus group discussion
FP	Family planning
HIV	Human immuno-deficiency virus
IEC	Information, education and communication
IPSR	Institute for Population and Social Research, Mahidol University
IUD	Intra-uterine device
KAP	Knowledge, attitude and practice
MCH	Maternal and child health
ml	Millilitre
MWRA	Married women of reproductive age
NGO	Non-government organization
pH	A measure of acidity or alkalinity
RTI	Reproductive tract infection
STD	Sexually transmitted disease
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1 Introduction

1.1 The reproductive health situation in Thailand

According to section IV of the Plan of Action of the 1994 International Conference on Population and Development (United Nations, 1994), countries should act to empower women and take steps to eliminate inequalities between men and women. Countries should eliminate all practices that discriminate against women and to assist women to establish and realize their rights, including those that relate to reproductive and sexual health. They should make it possible for women to combine child-bearing, breast-feeding and child-rearing with labour force participation. The degree to which this goal has been achieved in any country needs to be seen against the background of its reproductive health situation.

Thailand was among the first south-east Asian countries to achieve a fertility level below replacement level, with a total fertility rate of 1.9 children per woman in 1996 and for some years beforehand (Chamratrithirong *et al.*, 1997). This low level is the result of contraceptive prevalence for currently married women at 72.2 per cent, only slightly greater than the prevalence of 70.5 per cent which had already been achieved in 1987 (*ibid.*). The oral contraceptive pill is the most prevalent form of family planning, but female sterilization is almost as prevalent, and injectable hormonal contraceptives are also prevalent in rural areas. These three methods account for 85 per cent of method use.

Male methods of family planning are used at an almost negligible level. Vasectomy is used by 2.0 per cent of married women of reproductive age, condoms by 1.8 per cent, and the traditional methods of wihdrawal and the safe period by 1.6 per cent. These figures reflects a pattern of concentration by the health services on women as the target group for reproductive health services.

While there is considerable disagreement over the levels achieved (Tantiwiramanond *et al.*, 1996: 6-7) all estimates of maternal mortality indicate a substantial decline over a long period of time. In order of importance, the main causes of maternal mortality are hemorrhage, obstructed labour and complications following spontaneous or induced abortion.

A significant feature of the reproductive health situation in Thailand is the existence of a large, illegal commercial sex sector and high prevalence of STDs and HIV/AIDS infection. STDs have been on the decline since about 1990, while new HIV infections are also estimated to have been declining (Tantiwiramanond *et al.*, 1996: 10-13).

1.2 Dimensions of gender, sexuality and reproductive health

Concepts - Gender, Sex and Sexuality

- 'Gender' refers to the social roles that are ascribed to men and women
- 'Sex' refers to physical characteristics
- Distinction between the concepts of gender and sex is useful, because anything associated with gender is a social construction or a social perception, that can be modified or reversed in the interests of fair outcomes for both men and women
- Sexuality is sexual behaviour, attitudes and preferences
- It is 'a social construction of a biological drive' - Zeidenstein and Moore (1996: 2)
- It has elements of biology, gender and power relations (imbalance of power)
- A social construction can be altered

People in all societies seek intimate satisfaction of their biological drives, and they also seek advice and care for their health needs. Intersection between the two spheres is frequently minimal, and may be dysfunctional. The numerous interfaces between sexuality, gender and reproductive health are examined in this volume. The aim is to delineate the mechanism by which sexuality has been constructed conventionally in Thailand, the way this influences the reproductive health of the people, to identify gaps in the research that would bear on reproductive behaviour and health, and to discuss the methodology that has been used to analyse gender-associated aspects of reproductive health. The method used is review and analysis of the content and methodology of research that has been carried out, mainly during the 1990s.

The word 'gender' refers to the social roles that are ascribed to men and women within a social grouping, while the word 'sex' refers to the physical characteristics of the individual differentiated by anatomical and physiological features. The difference is in the emphasis that should be given to the fact that anything associated with gender is a social construction that is culturally ascribed, or a social perception, and it is capable of being modified or reversed in the interests of equality and equity for both men and women.

Sexuality refers to sexual behaviour, attitudes and preferences. Zeidenstein and Moore (1996: 2) refer to sexuality as 'a social construction of a biological drive', incorporating elements of biology, gender and power relations. They emphasize the central influence of gender roles in shaping a person's sexuality, and the imbalance of power that typically accompanies the gender roles that social organization ascribes to women and to men. They also refer to the fact that societally-ascribed roles can be altered, and that raising awareness through discussion and sharing of experience empowers people to make these changes to the social structures which they have inherited.

Sexual violence and sexual abuse are manifestations of the unequal power relations and gender roles that underlie the social construction of sexuality. Violence and abuse are parts of sexuality, however antipathetic to ideal behaviour. It can be difficult to locate information about how sexuality-related violence is dealt with by reproductive health service providers (Zeidenstein and Moore, 1996: 6-7). There are problems of definition inextricably bound in terms such as 'rape', which have legal, moral and emotive aspects. While all societies recognize that violence or the threat of violence as a means of enforcing compliance to sexual intercourse is unacceptable, in some countries the possibility of rape within marriage is not recognized by the law. This is true in the case of Thailand.

1.3 Gender relations and sexuality in Thailand

Do women in Thailand have high social and economic status?

- True (with exceptions) in education, economic activity, management of household
- False in personal relationships between the sexes

It has been observed (for example, Jones *et al.*, 1997: 17) that women in Thailand have high social and economic status, both within households and in the wider society. In most places of work, in the entire range of industries from agriculture to business and administration, there are women as well as men. Women with good education have achieved considerable occupational advancement, but many others remain concentrated in traditionally-ascribed low-paying occupations. In addition, women working in the informal sector are subject to exploitation (National Statistical Office, 1995a: 15). There are more women than men classified as unpaid family workers, and on average men get paid approximately 50 per cent more than women (National Statistical Office, 1995b: 58-60).

Thai women manage household budgets, by tradition. This gives women the power to decide on the allocation of funds for routine family expenditure, including the funds for nutrition and health care. Decisions about major expenditure must be made through agreement of all major contributors to the household's income.

Another factor contributing to the high status of women in Thailand compared with other societies is that marriage does not break them away from their parental families. On the contrary, they often maintain strong personal relationships and financial obligations toward their parents, and with married and unmarried brothers, sisters, uncles, aunts and cousins who constitute the extended parental family. Descent forms the primary family, and marriage secondary, for both men and women (Yoddumnern-Attig *et al.*, 1992).

In the north of Thailand, in Chiang Mai province, matrilineal ancestor spirit cults give rural women considerable autonomy in reproductive choice (Singhanetra-Renard, 1993). In the past, this reproductive choice included methods of induced abortion, such as purposeful falling or slipping, inserting a forcing object into the vagina, and squeezing the uterus. Such evidence strengthens the perception that Thai women have traditionally had autonomous rights and responsibilities.

Unequal power is nevertheless an extremely evident feature of relationships between men and women at the level of interpersonal relationships. It is mediated through expectations about acceptable behaviour of each sex. Women are expected to display submissive or passive characteristics, which can make it very difficult for them to assert rights or aspirations. Men from a village in the North viewed women as 'weak, credulous and indecisive' (Chayovan *et al.*, 1996), in a comprehensive set of focus group discussions of men and women in six locations from all over Thailand. Men also suppress the appearance of strong feelings and emotions, either positive or negative. A major difference between men and women is that men are given a high level of freedom in their personal lives, particularly in adolescence. These differences are infused throughout the construction of sexuality. (See, in particular, Soonthorndhada, 1991, 1996.)

Nowhere is this unequal power relation as evident as in the the context of tolerance of extramarital sexual activity of men, particularly casual relationships with sex workers. VanLandingham *et al.* (1995) observed that visits to sex workers are 'almost always undertaken as a social activity in the company of friends or acquaintances', and as a 'common form of entertainment [which] is morally unproblematic for many of our participants when undertaken in moderation'. While regarded by both men and women as normal for single men, acceptability of such activity by married men is conditional if accepted at all, so long as it is not frequent. Some wives tolerate their husbands visiting sex workers and others are less tolerant, but there is little awareness of what their husbands actually do on outings with their friends.

In marked contrast to commercial sex, extramarital sex with non-commercial partners is regarded by both men and women as a very serious concern, whether the liaison is casual or long-term in kind. According to VanLandingham *et al.* (*ibid.*), it was not regarded as uncommon, but seen as quite distinct from visits to sex workers. In particular, it was not subject to the peer group dynamics which usually mediate participation in commercial sex. Women were generally far more concerned about the implications of their husbands having non-commercial partners than they were about sex workers, and this was one reason for tolerating visits to sex workers.

Considerable emphasis was placed on the peer group dynamics of commercial sex (*ibid.*). There was diversity within the peer groups in attitudes and levels of

participation in the commercial sex activities; some married men were encouraged by the group to visit sex workers, drinking alcohol usually preceded the sex activity; the group itself provided a cover for the activity; and the group exercised influence in indirect ways as well as direct ways. There were opportunities in the peer group dynamic structure for modifying behaviour.

Bond (1995) used ethnographic, survey and network analytic techniques to explore the social and sexual networking of 39 men and 39 women in Chiang Mai. The study found that both men and women were exposed to risk in negotiating relationships and sexual practices, and that group norms also reinforced risk behaviour. Reinforcing the findings of VanLandingham and his co-authors, Bond found that networks or subgroups of either men or women could protect their members from risk, or they could act to expose the members to risk. Moreover, individual members of the network could influence the behavioural norms of the group either for good or bad.

Premarital relationships between young men and women are heavily influenced by the expectations of behaviour within ascribed gender roles (Tantiwiramanond *et al.*, 1996: 19-21). Passive behaviour limits the power of young women to negotiate avoidance of pregnancy or disease when sex is likely, and passive behaviour is encouraged by the need to avoid the appearance of being sexually experienced.

Homosexual and bisexual expressions of sexuality exist within Thai society, although there is a strong tendency to compartmentalize homosexual behaviour in a separate category from heterosexuality. While this separation is artificial, there is little specific attention in this volume to exploring the implications, except in the context of sexual transmission of diseases, including Human Immuno-deficiency Virus (HIV), and in the context of reproductive health during adolescence.

The studies reviewed in this volume build up a picture of a society in which gender roles exert a strong influence. When people express their biological drives in the sanctioned forms that exist in Thailand, they are acting out roles established within a heavily gender-based construction of sexuality. It is helpful to list some of the effects. The most pervasive effect is that men are discouraged from becoming active supporters in reproductive health care, for example in family planning and maternal and child health. In choosing methods of family planning, the methods that give least trouble to men are the most favoured. Condoms are neither promoted nor used for family planning, and vasectomy is seen as undesirable by women as well as men. Men have critical decision-making roles on major issues relating to pregnancy and child care, but these roles are not recognized adequately in the delivery of reproductive health services. The roles of husbands are very important in cases of HIV infection of pregnant women, in terms of support and decision-making. Women may be rejected by their husbands if they do not bear children, even when it is not their fault. Prescribed forms of behaviour for adolescents give very different roles and responsibilities to young men and women, and fail to recognize the changes that have been brought about in the actual behaviour of young people by the lengthening gap between menarche and marriage. Even so, young unmarried women who become pregnant can bear the sole responsibility. Social disapproval of discussion of sexuality and sexual behaviour has seriously limited the amount of sex education that can be given to young people. Following menopause, many women view continuation of sexual activity as neither appropriate nor enjoyable. The enforcement of power

relationships resulting from gender roles is also at the root of domestic violence and sexual assault. While it is evident that sexuality as expressed in sexual behaviour is the most critical issue in relation to the spread of HIV infection, the brief summary of other issues in this paragraph emphasizes the much wider importance of gender and sexuality in relation to reproductive health.

1.4 Organization of this monograph

A conventional list of categories was adopted in this report based on a listing by the World Health Organization for analysing different aspects of reproductive health. These categories are:

- Family planning
- Maternal and child health and safe motherhood
- Infertility
- Abortion and complications of abortion
- Sexually transmitted diseases (STDs) and reproductive tract infections (RTIs)
- Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- Sex education
- Reproductive tract malignancy
- Adolescent health
- Menopause and the elderly

A separate eleventh category was added:

- Sexual violence and abuse

These categories form three natural groups: family planning, maternal and child health, and the consequences of unwanted pregnancies; STDs and RTIs, HIV/AIDS, infertility and reproductive tract malignancies; sex education, adolescence, menopause and the elderly, and sexual abuse and violence.

The literature was searched for studies which dealt with gender and sexuality issues within the aforementioned eleven categories, and analysed in terms of content and methodology. This analysis is presented in Chapter 2 to 4, within the three topic groupings. There are also summaries of discussions conducted in consultative meetings with expert groups, on each of the above topics. These meetings were held in Bangkok (Central Thailand and Bangkok metropolis), Had Yai (southern Thailand), Khon Kaen (north-eastern Thailand) and Chiang Mai (northern Thailand), and attended by experts working in each of these regions.

Chapter 5 of the volume summarizes the methodological approaches in the studies. It was found useful to ask two complementary questions: How does the established view on sexuality in Thailand affect how research is done? How does the research reinforce the established views? In Chapter 5, gaps and deficiencies in the research are identified, including ethical issues. A synthesis of findings and recommendations for research, training and policy is given in Chapter 6.

2 Review of Research: Family Planning, Maternal and Child Health and the Consequences of Unwanted Pregnancies

2.1 Family Planning

Studies of Family Planning in Thailand

- Most research studies use cross-sectional population sample surveys of married women of reproductive age (MWRAs)
- Analysis is usually descriptive or retrospective
- Analytical methods are conventional
- While there has been increasing global attention to male roles in family planning and reproductive health, little attention was given in the studies
- The quality of family planning service delivery is considered a gender issue, but hardly addressed in the research

2.1.1 Men's roles in family planning

The major reason for contraceptive discontinuation throughout the world is the occurrence of side effects. There are few male contraceptive methods and their use is hardly promoted. In Thailand, there is a negative attitude towards vasectomy, in terms of perceptions about the man's health and sexual satisfaction. Women prefer to accommodate by choosing a female contraceptive method instead. Advocacy on the use of condoms in Thailand has mainly been for protection against HIV/AIDS rather than for family planning.

In the 1990s, there has not been much research on family planning in Thailand because the family planning programme has been viewed as highly successful, with no need of major modification. Three different features can be discerned among recent studies of family planning (Mattiko *et al.*, 1997). The first is focused on the fertility of married women and its demographic and socio-economic determinants. Secondly, there are studies concentrated on psychological and bio-social factors that are related to the use or non-use of contraception, for example, knowledge, attitudes, satisfaction, perception, decision and side effects. The third aspect is the determination of community factors, the roles of non-government organisations (NGOs) and value of social networks such as neighbours, relatives and spouses on family planning use or fertility reduction. Among community-level studies, Pardthaisong (1996) in a study of Pa Sang District, Lamphun Province, contends that low fertility leads to erosion of community infrastructure, increasing burden of care for the elderly (especially women), and anticipated conflicts between immigrants and Thais, as members of other ethnic groups move into the area.

Do men feel responsible for the family planning? Many studies indicate that most Thai men are not willing to use 'male' contraceptives, with the implication that the minority who are willing to use vasectomy or condoms are those who do feel responsible for family planning. Even then, there are reasons other than family

planning, such as using condoms for prevention of sexually transmitted diseases, including HIV, or using vasectomy because the wife does not want him to have children with other women (Yingchankul, 1983). The most recent quantitative information (Chamratrithirong *et al.*, 1997: 36) shows that both vasectomy and condoms are used minimally for family planning in Thailand, and with decreasing prevalence. In 1997, the prevalence of vasectomy dropped to 2.0 per cent, and for condoms it was 1.8 per cent.[i]

Most programs on family planning focus on the knowledge and attitudes of women toward contraceptive use and desired family size. While men are encouraged to use contraceptives through campaigns, little information about family planning is provided to men during the campaigns, except where some community leaders (usually males) are trained as part of the campaign. Moreover, women are more likely than men to continually improve their knowledge about family planning from health personnel.

The emphasis on women disregards the potential use of male methods. Purisinsit and Jirapattarapimol (1994) found in a study of 450 female factory workers in Chiang Mai, Lamphun and Lampang provinces, that the women sought guidance from their mothers, elder sisters and friends on the use of female methods without question or thought. The women would not use condoms because their husbands disliked them and found them inconvenient. Chokethavorn (1995) observed that women from Chiang Mai rejected the possibility of sterilization of their husbands (vasectomy) because they thought it would weaken their husbands' capacity to work. Similarly, Promkatkaew (1991) found unanimous support for the notion that women were the most appropriate to be sterilized, among sterilized women of the Hmong hill tribe.

Taken as a whole, these observations support the conclusion that complacency about family planning achievements in Thailand is misplaced. On the other hand, there is ongoing operations research on achieving greater male involvement in reproductive health in Thailand by influencing male adolescents, as reported by the Department of Health (1997).

2.1.2 Unmet needs

What are unmet needs for family planning? There are at least two concerns, the safety and effectiveness of contraceptive methods, and access to family planning advice and services.

The failure of contraceptive methods is measured in terms of the incidence of pregnancy while women are using the method. There is research that indicates failure rates of contraceptive methods (Wongboonsin *et al.*, 1993). The failure rate is theoretically zero for male and female sterilisation, very low for some other effective methods, and somewhat higher for the less effective methods, including condoms. Some research into failure and effectiveness of use consequently adopts a qualitative approach.

Similar studies examine the perceived and actual side effects of different methods and the perceived quality of each contraceptive method. The quality of family planning service delivery is a vital component of this analysis, and is often a gender issue,

when women are served by male providers who are equally uneasy about giving women detailed information on the method. There has been considerable research in Thailand on community-based factors affecting contraceptive continuation (Soonthorndhada *et al.*, 1991; Yoddumnern-Attig *et al.*, 1992), but further examination of the gender aspects is warranted.

2.1.3 Effect of family planning method choice on sexual desire and performance

Among the family planning methods frequently perceived to have an adverse effect on sexual and other relationships within marriage are the permanent methods, vasectomy for men and tubal ligation for women. The perceived effects include undesirability associated with barrenness, and physical weakness engendered by lack of sexual potency. However, Yingchankul (1983) found almost uniform satisfaction with both male and female sterilization among groups of 136 vasectomy cases, including 104 partners, and 167 tubal ligation cases, including 100 partners. It was noteworthy that every group recorded an improvement in sexual behaviour, and that the male partners of sterilized women appreciated the change.

A comprehensive study of sexual response among women using different types of contraceptive methods was undertaken by Pattaravanich (1990), using a national sample of 3,452 women included in a 1987 survey of the determinants and consequences of contraceptive use in Thailand. Overall, use of contraceptive methods increased sexual desire and frequency of intercourse, while sexual satisfaction was increased. Unlike Yingchankul, Pattaravanich found that tubal ligation had a negative impact on both sexual desire and sexual satisfaction among female respondents. However, she pointed out that the age of women undergoing sterilization was generally high. Vasectomy, on the other hand, was reported to increase sexual desire and satisfaction.

Pattaravanich (*loc. cit.*) reported that among all methods the use of injectables resulted in the largest negative impacts among all methods. This method decreased sexual desire, frequency of intercourse and sexual satisfaction. Another hormonal method, the oral contraceptive pill, also decreased sexual desire. Like vasectomy, condoms and IUDs increased sexual satisfaction of women.

An earlier survey, of 490 women who were admitted to a hospital in Bangkok and who had used oral contraceptives, injectables or IUDs, was undertaken by Suwansri (1983) to investigate reports of effects of these methods on sexual response. Three topics were investigated: sexual desire, orgasmic performance and dyspareunia (painful intercourse). For all three of these methods, the proportion reporting increased sexual desire was lower than the proportion reporting reduced desire. The disproportion was large in the case of injectables, with reduced sexual desire reported by 32 per cent compared with 2 per cent reporting increased desire. The difference was also large in the case of oral pills, for whom 23 per cent had reduced desire and 2 per cent increased desire, but for IUDs the disproportion was less, 13 per cent compared with 5 per cent. Orgasmic performance was also reduced more often than increased, for both hormonal methods. For pills, 17 per cent reported reduced orgasm compared with 7 per cent reporting increase. For injectables, 19 per cent reported decrease and 9 per cent increase. There was not much difference between gainers and losers in the case of IUDs, although many reported a change for the worse (12 per

cent) or better (15 per cent). While there was little effect on the incidence of painful intercourse with the hormonal methods, more users of IUDs reported increased dyspareunia (14 per cent) than reduction (9 per cent).

It can be surmised that reduction in sexual activity by men who had undergone vasectomy is associated with processes of maturation rather than the operation itself. Popuang (1980) found that the frequency of intercourse was approximately the same for those who were about to have vasectomies as for those who had already had the operation. Both groups had lower frequency of intercourse than they used to have, and libido declined with duration of marriage. The author concluded that in terms of frequency of intercourse, incidence of premature ejaculation and wives' assessment of sexual ability, there was no difference between men who had and men who did not have vasectomy. The study found that those with higher levels of education and employment, for example businessmen, had intercourse less and suffered more frequently from impotence.

2.1.4 Deliberations of consultative groups

Participants in the consultative meetings noted that studies on family planning continued to concentrate on married women, on the contraceptive prevalence rate, on knowledge, attitude and practice (KAP) studies, and on users' perceptions about the quality of family planning methods and services, using cross-sectional survey methods. There was no gender perspective in the family planning studies.

A significant issue raised by participants in the discussions was the way in which family planning side effects were evaluated. Trials of new methods were carried out in Thailand, with the evaluation concentrated on clinical issues and biochemical efficacy. A major ethical issue is the right of women to choose family planning methods, and the range and availability of family planning choices for women.

It seemed that women use family planning methods depending on government policies. Recently, the government has been encouraging women to use Norplant, from the private organization Population Council, while in the past the government encouraged women to use the pill and IUDs. It seems that as the side effects of each family planning method become known, the methods are replaced by other methods. It was also noted that there was still a lack of knowledge about Muslim attitudes towards the use of Norplant, and other methods for that matter.

On the topic of male involvement in family planning, there were prominent regional issues. In the south of Thailand, Muslim men had a high level of involvement in family planning, but their involvement was often perceived to be a general disapproval of contraception. The fact was that family planning for birth spacing, but not birth limitation, was seen as a valid component of maternal and child health and family planning programs in Muslim communities. In the North-east, men had a high level of knowledge about family planning, but were reluctant to submit to a painful procedure, as in vasectomy.

There was a particular problem with the way in which condoms had been promoted only as protection against disease, and not as a contraceptive method that could be used by men. Participants in the consultative meeting in Khon Kaen felt strongly that

condoms should be encouraged as a contraceptive method. They felt that as long as it was promoted mainly for disease prevention among partners, there would be a negative attitude to its use for family planning. In the consultative meeting in Chiang Mai, participants similarly referred to the belief that if a woman asks her partner to use a condom, it means she has had sexual experience.

Participants in the meetings felt that there was a need for further study of sexual behaviour following sterilization. It was necessary to allay men's and women's fears about the effects of vasectomy. More information about decision-making processes leading to female sterilization was required.

Consultative group summary -

- *Family planning studies are concentrated too much on married women, and there is no gender perspective **[Various regions]***
- *Studies take a conventional presentation and approach to examining contraceptive prevalence, knowledge, attitude and practice (KAP), and quality of family planning methods and services, using a cross-sectional approach **[Various regions]***
- *Use of Thailand as an experimental site for new contraceptive methods is unethical and detracts from quality of service delivery; the emphasis should be switched to contraceptive method choice and availability **[North region]***
- *There are not enough studies on male roles in family planning; better information about health and sexual behaviour after vasectomy could reassure both women and men about the procedure **[Various regions]***
- *Condoms had been promoted only as protection against disease, and not as a contraceptive method; women are reluctant to ask their partners to use condoms **[Northeast and North regions]***
- *Although Muslims see family planning as a valid component of maternal and child health care, Muslim men have been seen perceived as having a high level of negative impact on method use, and more information about Muslim attitudes towards family planning was needed **[South and Central regions]***

2.2 Maternal and child health (MCH) and safe motherhood

Gender Dimensions of MCH

- Who makes decisions in relation to pregnancy and child-care, especially among mothers with HIV/AIDS infection? Often it is men
- Most studies of MCH are based on hospital records of antenatal care and births. Some such studies are incomplete because they ignore men's' roles
- After birth, sexual relations are resumed too early by many Thai couples, causing health problems for women
- Men's roles in maternal and child health and safe motherhood are given insufficient attention in policy-related research in Thailand

2.2.1 Men's roles in maternal and child health

Taking responsibility for child care could be an enriching experience for men as well as women, but it has been denied to many men because child care has been ascribed as a female gender role. As modernization proceeds and many women take up occupations that conflict with child care, the traditional gender division of labor is eroded. Men can play important roles in maternal and child health by supporting women, especially working spouses. For example, when fathers help in household activities, breast feeding among working mothers can be extended. Among university students in Khon Kaen, Paibool (1995) found a satisfactory high level of perception of paternal roles, and it was highest among students of health sciences. Also in the north-east, Moleechati (1989) showed that information given on fathers' roles in the post-partum period had a positive effect, compared with a control group of fathers given no information. Research in southern Thailand (Wannaprasert *et al.*, 1994; Phiphatthanathiraphap, 1995) has shown that Muslim husbands are increasingly assuming supportive roles in fatherhood.

Everyone has a responsibility in avoiding transmitting diseases to their sexual partners, especially HIV. The majority of male partners in a study of HIV-positive women who had just given birth in a Bangkok hospital had a low degree of cooperation in HIV screening. This leads to an increased health risk for pregnant women and also new born babies, made worse because most HIV-positive female patients were young with low parity (Chintanadilok, 1995).

Chintanadilok's study on HIV-positive women who gave birth in a Bangkok hospital during the period January 1992 to December 1994 showed that among 202 cases, the prevalence rate increased year by year from 0.9 per cent in 1992 to 1.4 per cent in 1994. The risk was associated with sexual behaviour, because young women have relatively high frequency of sexual intercourse and have less knowledge and experience in preventing HIV/AIDS infection. Most of the women had normal vaginal deliveries. In spite of pre-test and post-test counselling services, few of the women underwent sterilization.

The patients were afraid to reveal the result of the blood tests to their husbands, and among those that did, some could not ask their husbands to be tested from fear of being abandoned and to avoid family marital problems. Among 52 husbands who had blood tests, 16 were not HIV-positive. In these cases, the women were likely to have been infected by other partners, before or after they were married.

Pregnant women with HIV have to decide whether to terminate the pregnancy. They also need to make decisions about care of the child in the future. In such matters, the husband is the main decision-maker. While women are more aware of the seriousness of HIV/AIDS than men, their decisions remain dependent on men, according to a study of the decision-making process on termination of pregnancy among women with HIV (Khongsakhon, 1994). One reason for deferring to men on the subject of continuing the pregnancy is that many women fear being abandoned if they cannot bear a child. The data were collected from twenty HIV-positive pregnant women who were patients of an antenatal care clinic at a hospital. The analysis was done through a qualitative approach using in-depth interviews and observation. Most of the women were housewives, and they had not been aware of their risk as they had sexual relationships with their husbands only. The situation worsened when they became pregnant without being aware they had HIV. In the decision about terminating the pregnancy, the couples decided together, but husbands had the final decision.

Khongsakorn (*ibid.*) found that although the decision was based on various reasons such as the desire for children, health status, health service, social and economic problems, religious belief, and mental health, pregnant women with knowledge of HIV/AIDS were more likely to terminate their pregnancies. Women with little or no knowledge of HIV/AIDS were likely to continue the pregnancy because they believed that it would not be too bad for them in the future and any problems could be solved.

In a study of 723 couples attending a fertility clinic at a hospital in Chiang Mai, Reaungsri (1997) found that more than half felt that they would be unable to make a decision to handle the situation without advice from a doctor. They felt that if they tested HIV-positive they should be advised to prevent conception.

2.2.2 HIV/AIDS and maternal and child health

Apart from the specific questions of male responsibility for transmitting HIV to their wives and possibly their children, and for decision-making about continuation of pregnancy, there has been other more general research on pregnant women with HIV/AIDS infection (Asdondecha and Danpradit, 1997; Kraisurapong, 1996; Nettip *et al.*, 1996; Phumboplab, 1994). These studies concentrated on women's role in reducing their reproductive health risk only. The husband's sexual behaviour has received little attention in these studies.

Both the physical and mental health of a woman are directly affected by an incident of which they were not the cause. This occurs particularly among pregnant women who find they are HIV-positive during a routine blood test. The mental health of women is a major concern because it affects not only the women, but also the children, their spouses and the community at large. Anxiety was the most common reaction to positive HIV tests among sixty women selected from patients of a hospital in

Bangkok for examination of the efficacy of counselling. They were most concerned about the possibility of transplacental transmission to the fetus, social avoidance and confidentiality about their conditions. Worries also centred on family life, survival, therapy, prognosis and employment. Besides anxiety, fear and denial occurred at high levels. Anxiety decreased after counselling and adaptation to the situation (Asdondecha and Danpradit, 1997).

The initial reaction to first birth was similar between HIV positive mothers and HIV negative mothers, according to a study of maternal attachment and adaptation to motherhood by Nettip *et al.* (1996). The study compared 30 mothers that had HIV with 30 who were not infected, using structured test scores. Although there were no statistically significant differences at the time the newborn babies were first returned to their mothers, after one month significant differences in both attachment and adaptation appeared.

Kraisurapong (1996) studied psychosocial aspects of HIV-positive pregnant woman during counselling. She interviewed 264 women from five provinces of the northern region and three provinces of the central region of Thailand. The questionnaire was designed to measure factors related to the decision on whether to terminate or continue the pregnancy, and their psychological status. It showed that almost half of the women wanted to terminate the pregnancy because they were afraid that their children would be infected. However, two in three women found that they were HIV-positive more than three months into their pregnancies, and could not undergo abortion safely. While reporting on the incidence of HIV among women delivering babies at a hospital in Bangkok from 1992 to 1994, Chintanadilok (1995) remarked that unregistered patients (meaning those who had not had antenatal attention from the hospital) had higher prevalence of HIV antibodies than registered patients.

2.2.3 Health after childbirth

During the post-partum period, maternal health is closely related to health behaviour. Taparuxs (1991) studied factors related to puerperal care of urban mothers who delivered at a hospital in Ratchaburi province. Applying a retrospective research method, she collected data from birth certificates and questionnaires from 457 mothers who gave birth during the period May 1 - October 31, 1989. It was found that the rate of puerperal care at 6-8 weeks was quite low, with 71 per cent of the women not attending the clinics. The reasons for this were: they thought that they were healthy, there was no appointment from the health centre, they did not have time, lack of child care and ignorance about the existence of the check-up. Factors increasing attendance were husband's education, husband's occupation, and social support from husband and relations. The study indicated that the husbands influenced the women's health care, but did not explain why and how men act to improve women's health. This study recommended that a post-partum health education and puerperal care program should be designed in order to promote the puerperal visit. In north-eastern Thailand, Anekwit (1991) examine questions of adjustment to parenthood among adolescent mothers, and found that a strong self-concept was associated with appropriate adjustment.

Sexual intercourse during the puerperium is avoided strenuously in many cultures but not in Thailand. The reproductive health risk for women from having sexual

intercourse during the puerperium emanates from medical problems such as pelvic infection and laceration of episiotomy wounds that have not yet healed. Chansmorn (1987) examined the occurrence of such problems among 520 women who attended a hospital post-partum clinic. Of these about one in five had experienced sexual desire and intercourse during the first six weeks after the birth. Among women who had early intercourse, 14.6 per cent had dyspareunia (painful coitus), lower abdominal pain, fever or laceration of episiotomy wounds. The lower abdominal pain and fever could have been associated with pelvic inflammatory disease and serious health consequences. The sample was highly selective and a more representative study of the population would have been desirable. Factors affecting the occurrence of sexual intercourse during the six weeks post-partum period are women's age, knowledge about the correct time to resume sexual intercourse, attitudes to sexual desire and sexual intercourse, the time of disappearance of lochia, complete healing of episiotomy, the perceived possibility of pregnancy, contraceptive practice, fear of pregnancy and the level of the husband's sex desire.

Life table methods were applied to the data of a large-scale survey of 2,989 married women aged 15-49, to determine the general pattern of resumption of sexual intercourse after birth in Thailand (Jethanamest, 1991). The study concentrated on the 19.3 per cent of women who resumed intercourse within two months, while the median time was three months. Rapid resumption of sexual relations was associated with low age at giving birth, short duration of marriage, ever-use of contraception, Buddhism, urban residence, residence in the north of Thailand, use of northern and north-eastern dialects of Thai, low economic status and participation in the agricultural sector. The study did not examine factors related to the men, who evidently are important players.

A study in north eastern Thailand conducted by Kiewying *et al.* (1993), through a follow-up of 400 women who had just given birth, showed that thirty per cent had sex within two weeks after giving birth, and few complained of dyspareunia. In general, sexual desire for these respondents had returned by the fourth week.

2.2.4 Breastfeeding

A long period of breastfeeding will benefit the physical and mental well-being of both mother and child. There are few studies which explore the gender dimensions of breast-feeding because it is clearly an activity for women only. However, men can support this activity through freeing the women from household tasks.

Concern about lack of breastfeeding is centred mainly on working mothers. Chicharoen (1994) used a sample of 150 working mothers who had children aged between 1 and 12 months, and had stopped breast feeding. Data were collected through face-to-face interviews with the working mothers and separately with their husbands. The study also used records of mothers and their children who attended various health service centres including hospitals, clinics, government services and private services. It was found that spouse support prolonged breast feeding. However, the recommendations concentrated on nurses in various setting being made aware of the factors that influence the working mothers' duration of breast feeding, such as the timing of introduction of bottle feeding, rubber nipple experience, and mother's perception of breast feeding. Nurses should prepare the working mothers to continue

their breast feeding before returning to work by encouraging spouses to support and assist in solving problems concerning breast feeding.

This single study of factors prolonging breastfeeding was flawed by the exclusion of women who were still breastfeeding their babies. This meant that all estimates of the duration of breastfeeding were negatively biased, and that women who breastfed longest were systematically under-represented. The same type of flawed analysis occurs in relation to other topics discussed in this volume. Fundamentally, survival analysis must be used with intervals of time when some of the intervals are not yet closed.[ii] It is not possible to correct the problem from the data collected, because the sampling method systematically excluded women who were still breastfeeding children less than 12 months old (the 'censored' cases).

2.2.5 Infant mortality

Infant mortality is the most commonly-used indicator of a country's health status. Vorapongsathorn *et al.* (1989) used a path model for explaining the direct and indirect effects of socio-economic and health service factors in reducing infant mortality. They used secondary data from various sources including the National Statistical Office, the office of the National Economic and Social Development Board, Mahidol University and the Ministry of Public Health. It was found that women's education had more potentially direct effects than the economic factors, on the observed decline in infant death rates during the 1970s and 1980s. Maternal health care, immunization and protein supplementation for children had direct effects on infant survival. Also, health personnel and the accessibility of health service delivery points had indirect effects on infant mortality.

The gender dimension of analysis of child survival is similar to that for other aspects of maternal and child health, namely paternal support for activities of the wife, and paternal sharing of activities that in the past have been attributed to mothers. These aspects of child survival have not been examined in recent studies in Thailand and are discussed further in Chapter 3.

2.2.6 Deliberations of consultative groups

The issue of anaemia was raised in the discussion among experts from the North-east, but not from the other three regions. It is perceived that anaemia is an important reproductive health issue which has been given insufficient attention. It has a prominent gender dimension, concerning nutritional standards perceived to be appropriate for the two genders, and access to and control of food resources, given the multiple burdens which women bear. Where malaria also contributes to the prevalence of anaemia, the problems are worse.

Another discussion point, on the gender dimension, was the stress that women experience during the post partum period, partly due to problems of the new born baby, such as disability or poor health. The women fear the development of family problems. In the North, it was noted that the hospitals even gave infections to mothers.

Also in the north, there was discussion about the relationship between high infant mortality and high fertility among the hill tribes. Discussion led to the recommendation that studies should look at the quality of children instead of the quantity. Quality is the opportunity to obtain the physical, social and educational nurture that will allow children to develop into healthy, well-adjusted, valued and productive members of society.

Consultative group summary

- *Anaemia has been given insufficient attention as a reproductive health problem, arising from perceived needs of males and females, and male control of food resources* ***[Northeast region]***
- *Women experience stress during the post-partum period, fearing family problems if their children are disabled or unhealthy, but the quality of care they receive is low and hospitals even give them infections* ***[North region]***
- *Studies into the reasons for high infant mortality and high fertility among the hill tribes were necessary, from a perspective of quality of children rather than quantity* ***[North region]***

2.3 Abortion and Complications of Abortion

Studies of Pregnancy Termination in Thailand

- The illegal status of induced abortion complicates possibilities for studies
- Substantial distortion exists in the statistical analyses from studies based on hospital presentations after septic abortions
- Many Thai adolescents resort to termination of inadvertent pregnancies. There are no direct studies
- More generally, studies of the consequences of unwanted pregnancies are also absent. Some information relating to HIV-infected women exists
- HIV testing is often too late in pregnancy for safe pregnancy termination
- Attitudinal studies concerning pregnancy termination are possible and some exist

2.3.1 Legal situation in Thailand

The term 'abortion' refers both to induced termination of pregnancy and to spontaneous abortion (miscarriage). These are different types of event. In common usage, the term 'abortion' without qualification is usually intended to refer to induced abortion. For clarity the term 'pregnancy termination' is used, except to refer to the concept of induced abortion as defined legally in Thailand.

Induced abortion is a crime under Articles 301-305 of the 1957 Penal Code of Thailand. Both the woman and the person terminating the pregnancy are subject to legal penalty. The woman can be sentenced to three years in prison and a fine of Bt. 6,000. Heavier prison sentences and fines are prescribed for the person conducting the pregnancy termination. However, attempted (unsuccessful) termination of pregnancy is not punishable under some circumstances, which allows women who have had unsuccessful illegal operations to be treated in hospitals. The other major exception to the law is that medical practitioners are permitted to terminate pregnancies in cases of rape or if continuation of pregnancy will endanger the health of the woman.

While illegal in Thailand, induced abortion in the legal sense is widely available. Asavaroengchai (1994) quotes informants who ascribe this situation to the prevalence of HIV infection, but there should be no doubt that pregnancy termination is more usually the result of premarital and other unwanted pregnancies. The issues surrounding its occurrence after unwanted pregnancies are described in detail by Achavanitkul (1995a).

2.3.2 Studies into occurrence of pregnancy termination

Analysis of pregnancy termination outside the framework of unwanted pregnancy is incomplete and unsatisfactory. Unwanted pregnancies have multiple ramifications that encompass the consequences of pregnancy continuation for marriage and family formation, education, economic opportunity and reproductive health, the decision-making processes involving men as well as women, and the availability of support and counselling for pregnancy continuation or termination.

There have only been a few studies attempting to describe the frequency and characteristics of pregnancy terminations in Thailand. Because of the legal situation, these studies face fundamental problems of data collection. A study by Chareonphat (1979) illustrates some of the problems. The sample for the study was 114 cases of induced abortion and 128 cases of spontaneous abortion treated in two hospitals in Bangkok. Hospital admission after induced pregnancy termination represents only a fraction of the cases, and a heavily biased 'accidental' sample (of septic abortions). Consequently, the study's findings regarding induced pregnancy terminations are unrepresentative. 'Most women induced abortion because of broken family structures', meaning that their husbands were polygynous, did not provide adequate money, or quarrelled with their wives. The people who carried out the procedure were said to be mainly women and not medical practitioners, and the most prevalent method was the insertion of a liquid or jelly through the cervix. Most of the cases were more than three months into pregnancy, and haemorrhage was the most common complication.

A similar study (Patikorn *et al.*, 1980), of 309 cases of women admitted to a Chiang Mai hospital in 1977-78 with complications from spontaneous or induced abortions, found that most of them came from the lower socio-economic strata. Among married women, the most commonly cited reason for inducing abortion was economic, while for unmarried women it was to continue education. Women with or without medical training usually carried out the procedure, often by squeezing and kneading the uterus,

then injecting liquid into the uterine cavity. Infection was found in 72 per cent of the cases, and in one in five cases, the woman had previously had an abortion. In another study of 109 women from the same hospital (Varalak, 1982), it was found that all of the induced abortion cases had haemorrhage, and often had fever and lower abdominal pain.

In another study of a method for late abortion, carried out in the south of Thailand, Kanchanaporn and Wetkikul (1990) noted that 5.6 per cent of women admitted to hospital after illegal abortion had undergone open-abdomen surgery. They found that this method caused serious complications when the woman was more than 40 years old, or had more than four pregnancies, or was more than 16 weeks pregnant at the time of the surgery. Because of the method of sampling for the study, none of the findings could be regarded as representative. Rather, the point is that some women undergo hazardous procedures rather than continue unwanted pregnancies.

Taengsingtrong (1990) detailed one case of a woman admitted to hospital with shock and internal haemorrhage after a very late incompetent abortion. At 4.5 months of pregnancy, her pregnancy had been terminated by curettage. Examination showed a perforated uterus and serious damage to the rectum. The woman was treated successfully. Such cases emphasize the gender dimension of access to safe services in cases of unintended pregnancy. It is women who suffer the physical damage, never men.

Contrast these results with studies of adolescents (Nucharnat, 1988, Suparp *et al.*, 1992, Srisuphan *et al.*, 1990), which investigated pregnancy termination as an outcome of unwanted pregnancy, in the full context of analysis of adolescent sexuality. These studies are described more fully in section 4.2, and put a very different perspective on the practice of pregnancy termination in Thailand. This more comprehensive perspective is preferable to narrow concentration on cases of septic abortion.

The context of reports of large-scale hazardous abortion methods by incompetent practitioners can also be appreciated more fully in the results of a study of methods employed by 756 sex workers from southern Thailand who took part in a study of intended abortion by Chan *et al.* (1995). Only 1.6 per cent did not go to qualified physicians. The rate charged by a qualified physician averaged Bt. 1,186 per month of pregnancy, almost twice the average rate (Bt. 609) charged by non-physicians. It can be observed that these rates seem very low.

The sexually-transmitted disease most commonly associated with pregnancy termination is HIV infection. Pregnant women in Thailand are tested routinely for HIV infection, and infected pregnant women may be advised to terminate their pregnancies. Auttagovit (1995) found that in a sample of 154 HIV-infected women in Petchaburi province, just under one quarter of the women terminated the pregnancy (38 cases). Both groups had a mean age a little higher than 23 years, were mainly giving birth for the first time, and were predominantly primary-educated, with less than fifty per cent classified as having a good knowledge of AIDS. A significant finding was that women whose husbands worked in agriculture were 2.4 times more likely to terminate their pregnancies than those whose husbands had other occupations. This confirms the finding by Koetsawang and Koetsawang (1984) that

most women who came to hospital after illegal induced abortions were married farmers.

2.3.3 Attitudes towards termination of pregnancy

While studies of incidence are difficult to carry out because of legal prohibition, attitudes towards pregnancy termination, and knowledge of its source, could be elicited in a study undertaken by Kamkom (1997) of 704 female vocational students in Bangkok, using self-administered questionnaires. While few of the students were favourable towards 'abortion', factors which they associated with terminating pregnancies were unwanted pregnancy, sexually transmitted disease, economic status and rape.

2.3.4 Deliberations of consultative groups

Consultative group summary

- *Legal and moral issues surrounding abortion make research difficult **[Various regions]***
- *Community-based data collection methods are possible to investigate the consequences of unwanted pregnancy, but there are cost considerations **[Central region]***
- *It is also possible to collect data on pregnancy terminations under the research topic of maternal and child health **[South region]***
- *Pregnancy termination is more common among certain types of women, such as factory workers, while among other groups unwanted pregnancies lead to early marriage **[Central region]***
- *The use of traditional herbs and medicines to terminate pregnancies requires further research **[Northeast and South regions]***

Much of the discussion focused on the legal and moral issues surrounding abortion. Participants in the consultative meetings also expressed interest in the use of various traditional medicines and other methods to terminate pregnancies.

In the central region, it was noted that pregnancy termination was more frequent among factory workers, because of their working conditions, than among 'ordinary' women, where premarital pregnancy is more likely to lead to early marriage. The consultative meeting in Bangkok also discussed methods of collecting information, with focus on the consequences of unwanted pregnancies. A community-based data collection is one possibility, but there are cost considerations.

The consultative meeting in the South region felt that it was possible to collect data on pregnancy termination, but it had to be under the research topic of maternal and child

health. Data could be collected by local health personnel. In both the South and North-east regions there was interest in the use of traditional medicines and unscientific methods to terminate pregnancies.

The consultative meeting in the North region concluded observed that the moral, legal and ethical issues of pregnancy termination were so great that it was almost impossible to find acceptable methods of collecting data.

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[i] Contraceptive prevalence is expressed relative to the number of women of reproductive age

[ii] Intervals that are not closed, or 'censored' intervals, contain a disproportionate number of subjects who have the longest intervals. If the censored intervals are excluded from the study, the sample under-represents subjects who have long intervals. Survival methods of analysis were developed specifically to overcome this problem.

3 Review of Research: STDs and RTIs, HIV/AIDS, Infertility and Reproductive Tract Malignancies

3.1 Sexually transmitted diseases (STDs) and reproductive tract infections (RTIs)

Sexual Transmission of Disease as a Gender Issue

- Most sexually transmitted disease can be prevented by use of condoms. There have been intensive studies of condom use by sex workers and their clients in Thailand
- Problems with these studies:

  - selectivity of sex worker samples (clinic attendance)
  - insufficient distinction between prevalence and consistency of condom use
- Further studies are required on the topic of sexual contact with regular partners after STD infection
- Service delivery for RTIs and STDs should be integrated with other reproductive health services
- There are no population-based studies on the issue and incidence of sexual transmission to girl children in Thailand (outside the context of trafficking and sex work). A hospital outpatient study indicates that a problem does exist

3.1.1 Introduction

The distinction between sexually-transmitted diseases and reproductive tract infections is an important one, even though the terms are often used interchangeably. Sexual transmission does not necessarily cause an infection of the reproductive tract, with some infections frequently manifesting themselves at other sites (for example, gonorrhea in the oral tract and eyes) and others, such as HIV, producing a generalized infection. Reproductive tract infections, on the other hand, are not necessarily contracted from sexual intercourse, as in the case of bacterial vaginosis.

The importance of integrating services for both RTIs and STDs with existing MCH and FP services is increasingly recognized, and there is awareness that RTIs are not only a medical but a social problem. Women's perceptions of their experiences should not be expected to fit biomedical models (Thongkrajai, 1996). Research in north-east Thailand has confirmed the existence of a distinct conceptual framework and language used by women to describe their gynecological experiences (Boonmongkon *et al.*, 1998). The framework describes different models of causation of reproductive tract infections and the terms used to describe the perceived pathways, most of which exclude infection by a sexual partner.

3.1.2 Condom use to prevent disease transmission

Most sexually transmitted diseases (STDs) can be prevented by the use of condoms. Condom use in commercial, casual or permanent sexual relationships is clearly a gender issue, requiring cooperation between both man and woman, or man and man.

At the start of the 1990s, condom use was far from universal in sex establishments in Thailand. From a sample of 4,801 men from 35 provinces who attended STD clinics in December 1990, 30.4 per cent had reported using condoms with sex workers in the month before they were interviewed (Chantcharas *et al.*, 1992). A sample of infected people is selective for risk behaviour, which would partly explain why the same study found that 65.2 per cent of 6,457 'direct' sex workers from 58 provinces, and 67.0 per cent of 4,296 'indirect' sex workers from 47 provinces reported using condoms. Such figures do not measure consistency of use, however. The study found that condom use had increased between June and December of 1990.

Another study, by Poonpipat (1991), reported on use of condoms by 80 female sex workers working in an establishment in Kanchanaburi province. Only 37.5 per cent insisted on their clients using condoms every time they had sex, and the others indicated that their clients mostly preferred not to use them. In this establishment the supply of condoms was enough for about one third of clients, highlighting that supply is as important an issue as demand.

Sawangdee and Isarabhakdi (1990) used focus group discussions and in-depth interviews with 61 low-income sex workers, their clients and the proprietors of the sex establishments, to evolve strategies for the promotion of condom use. The study concluded that the sex workers would not be able to adopt universal use of condoms unless all sex workers joined the scheme, and the management backed them up. The authors recommended targeting the proprietors and managers, and the provision of information to clients in the cafés annexed to many establishments.

Koetsawang and Ford (1993) were among the first researchers to point out the importance of distinguishing prevalence of condom use from consistency, in their study of 266 massage parlour workers and 87 workers from a low-income brothel, using qualitative and quantitative methods as well as HIV tests. They found that while condoms were used in 90 per cent of customer contacts in the massage parlours, one in three of the massage parlour workers and half of the brothel workers had engaged in sex without a condom with a customer in the last week. They found no evidence of sex workers successfully persuading uncooperative customers to use condoms.

It is important to emphasize that any discussion of condom use refers to a situation which has undergone rapid change, and it is always necessary to place the study within a time perspective. To avert disease transmission by sex workers, the Thai Government has established a program to encourage use of condoms in every commercial sexual encounter. This program is called the '100% Condom Program'.

An early evaluation of the 100% Condom Program was carried out in Ratchaburi province in 1991 (Sriphothong and Teansat, 1993). All female sex workers attending the Ratchaburi STD and AIDS Centre were interviewed and checked for STDs over a

period of twelve months. From 6,490 interviews, condom utilization was reported at 95.3 per cent, and gonorrhea prevalence decreased from 21 per cent in 1990 to 9 per cent in 1991. Among the few sex workers who did not use condoms, the main reason was refusal by their clients, and gonorrhea infection was present in almost half of these women. While the study concluded that the government program was highly effective in reducing the incidence of gonorrhea, and by extension other STDs including HIV, the study design selectively included sex workers within the government's program of disease prevention.

A more recent evaluation of the 100% Condom Program was carried out in Ayutthaya province to assess the attitude toward condom use of sex workers and their clients, the rate of condom use, and the impact of the program on the incidence of sexually transmitted diseases (Sudkasem and Poolprasert, 1997). While the main approach of this study was a cross-sectional survey, in 20 randomly selected sex establishments, the study employed careful cross-checking methods. It was found that the rate of condom use was 93.6 per cent reported by sex workers themselves, 90.0 per cent by volunteers pretending to be clients, and 96.6 per cent by clients. Interviews of sex workers revealed that non-use occurred with regular clients, and when service was provided outside the workplace, while removal of condoms occurred when intercourse was painful. The prevalence of STDs declined from 15.38 per cent in 1993 to 9.12 per cent in 1994 and 6.55 per cent in 1995.

In the northern province of Petchaboon, a study of 80 female sex workers attending the provincial Venereal Diseases Clinic (Chiancharoen *et al.*, 1995) found that most of the women had good knowledge about sexually-transmitted diseases and were favourably disposed to use of condoms out of fear of contracting HIV. About 87.5 per cent reported condom use during their last sexual encounter, but 51.3 per cent also mentioned that they serviced some clients who refused to use condoms. The contradiction reflects the unequal power relationship between sex workers and the men who temporarily control the women's bodies. This study illustrates how a high level of condom use can be associated with high risk if use is not consistent.

The importance of examining consistency as well as prevalence of condom use is emphasized in a study in northern Thailand by Nelson *et al.* (1993). In this study of 2,417 military conscripts, there was a high level of HIV infection despite widespread reported condom use. The authors concluded that control of infection 'will probably require more regular and effective use of condoms', as well as preventive measures.

After contracting a sexually transmitted disease from a commercial or casual encounter, a man or woman is at serious risk of transmitting the disease to his or her spouse or regular sexual partner. Behaviour during this period was examined by Karnthavorn (1998) in a study of 60 patients with sexually transmitted diseases who attended a hospital in Bangkok. It was found that the majority of the men had not practised preventive measures when they had sex with sex workers. They had also treated the occurrence of symptoms in stages, first by attempting to remove the discharge, then by purchasing drugs for self treatment, and next by going to a private clinic. After having intercourse with a sex worker, most of the patients delayed having sex with their regular partners, waiting to see if symptoms of STDs appeared. If symptoms did develop, they would refrain from sexual activities altogether, fearing more severe infection.

Apart from the general context of promotion of condom use to prevent sexually-transmitted diseases of all kinds, studies that concentrate more specifically on preventing HIV transmission are discussed in section 3.2.

3.1.3 Service delivery for women with STDs and RTIs

Issues of quality of care are prominent in the choice of avenues of service delivery for women infected with STDs and RTIs, because of the circumstances of infection by husbands. Thephusodin na Ayudthaya *et al.* (1997) examined the effectiveness of a participatory health education program on sexually transmitted diseases among women attending a family clinic at a hospital in Nakorn Ratchasima, following the recommendations of a cognitive study conducted by Thongkrajai *et al.* (1996) among women attending family planning clinics there. RTIs and, less prominently, STDs were found at a noticeable level by Thongkrajai and her co-authors: 6.4 per cent of the women had *candida albicans*, 3.5 per cent had bacterial vaginosis, 2.5 per cent had *chlamydia trachomatis*, 1.5 per cent had *trichomonas vaginalis*, 0.5 per cent had *herpes simplex*, and 0.5 per cent had gonorrhea.

Despite occurrence of these infections, and that 12 per cent of the women reported STD symptoms of their husbands, half of the women saw themselves at no risk of contracting STDs. The study recommended that health education and services concerning STDs and HIV/AIDS should be integrated into the existing maternal and child health and family planning programs. This would require preparation of personnel at all levels and the provision of laboratory and support services.

A concern is the true incidence of sexually transmitted diseases, which seems low in both selective and community-based samples (Thongkrajai *et al.*, 1996). Qualitative research by Boonmongkol *et al.* (1998) described women's experiences of STDs and found a rather higher level of self-reported cases than in clinical studies. This study described the linguistic terminology used to describe women's problems and their fears relating to reproductive tract infections.

3.1.4 Knowledge and behaviour of sex workers

The main program initiative to reduce sexual transmission of disease between sex workers and their clients has been the 100% Condom Program, described in section 3.1.1. A number of studies have investigated other strategies to improve the knowledge and behaviour of sex workers concerning STDs.

Phawanaporn *et al.* (1993) reported on improvement in the level of knowledge of male and female sex workers in Bangkok after education about sexually transmitted diseases, including HIV. Before the education was given, male sex workers had more knowledge than female sex workers. However, the men were 'less serious' about their practice of preventive measures. Seroprevalence of syphilis was 7.45 per cent for the males compared with 4.93 per cent for the females. The knowledge of both groups improved through the education given. Phanusopone and Narongvit (1992) prescribed the utility of the health belief model for interventions among sex workers in Thailand, after finding that there was a strong relationship between the health belief model and behaviours to prevent sexually transmitted diseases.

A high level of condom use does not necessarily imply consistent use. It leads to the paradox of increasing prevalence of HIV infection, which can occur if there is only one instance of sex without a condom, while at the same time the incidence of sexually transmitted diseases is reduced markedly.

Wongworapat *et al.* (1995) found that after twelve months of follow-up of 148 sex workers, from an original sample of 346 sex workers attending five STD clinics in northern Thailand, reduced prevalence of gonorrhea and chlamydia was observed with dramatic increase in HIV prevalence. The high level of loss to follow-up in this study does not reduce the impact of this observation. Its implication is that 100 per cent condom use is only effective if it is achieved at the individual level.

3.1.5 Transmission of STDs to children

Sirivongrangson and Pakdewongse (1995) reported the results of examination for STDs of 338 prepubertal girls who attended a hospital in Bangkok over a six year period to 1993. The girls presented for treatment of vaginal discharge. Active *Neisseria gonorrhoeae* (the organism causing gonorrhoea) was present in 15.4 per cent of the patients, non-specific genital infections were found in 5.0 per cent, and there were small numbers with syphilis, herpes simplex and other sexually-transmitted conditions.

Among girls with an identifiable history of sexual abuse the proportions with these and other infections were higher. The authors note that the proportions with sexually transmitted diseases are higher than among adults presenting with similar symptoms. They concluded that 'prepubertal girls present[ing] for evaluation of vaginal discharge may have STD and should be cultured for gonorrhoea whether or not sexual abuse is suspected'. They also felt that 'sexually transmitted diseases in children should have got more attention due to the possibility of sexual abuse'. The principal recommendation was to culture for gonorrhoea and chlamydia in cases of vaginal discharge in prepubertal girls.

The study refers to an invisible feature of the society. While trafficking in children is recognized and there are initiatives to combat its occurrence, like most societies Thailand maintains a state of denial about the occurrence of incestuous abuse of children by their parents and other close relatives.

3.1.6 Deliberations of consultative groups

The consultative meeting in Khon Kaen felt that this topic could be tied more closely to the topic of HIV/AIDS. Participants at the meeting in Bangkok stressed the importance of placing disease transmission within its behavioural context. The key issue was to study health-seeking behaviour in order to devise preventive measures.

Consultative group summary

- *It is important to place sexual transmission of disease within its behavioural context, and devise preventive measures from studies of health-seeking behaviour* ***[Central region]***
- *Studies of STDs need to be linked to studies of HIV/AIDS* ***[Northeast region]***

3.2 HIV and AIDS

HIV/AIDS in its Gender Context

- HIV does not discriminate between men and women, or the different modes of sexual behavior, in its effects on the immune system and eventual progression to illness and death
- Marital relationships can be severely disrupted by HIV infection
- Studies of effects of HIV on marital relationships and pregnancy have been conducted using patient samples. These studies have produced strong recommendations about support for affected couples
- Most early studies were on high-risk groups such as sex workers (men as well as women) and homosexual men. Other groups such as truck drivers and factory workers have increasingly been perceived as high risk groups
- Studies concerning bisexual behaviour are almost absent
- Studies are increasingly focusing on HIV transmission in the general community

3.2.1 Gender specificity in HIV infection in Thailand

Increasing prevalence among females relative to males is an intrinsic feature of the projections of HIV/AIDS cases in Thailand (Brown *et al.*, 1994). At the early stages of the epidemic, it was males who were affected more. While HIV prevalence has increased over time among both men and women in Thailand, the peak of new infections was in the early 1990s and HIV seroprevalence could have begun to fall within the last two or three years, according to the projections (*ibid.*).

One comparison males and females was done by examining prevalence among Thais who applied for work overseas in the early 1990s. Blood from all applicants was tested at a hospital in Bangkok. Keesukphan *et al.* (1994) reported changing trends among 98,154 male and 20,183 female applicants in three six-month periods from January 1993 to June 1994. It was found that while the seroprevalence of HIV

antibodies in male applicants decreased between the second and third periods, it was at that time continuing to increase among female applicants. Nevertheless, prevalence among women, at 0.40 per cent of applicants, was considerably lower than among men, at 1.03 per cent.

Once infection has occurred, HIV does not discriminate between men and women, or the different modes of sexuality, in its effects on the immune system and eventual progression to AIDS-related conditions and death in most cases. Pongsomboon (1996) examined health-promoting behaviour among 108 male patients and 52 female patients with HIV infection who were attending a clinic in an eastern province. The study found that HIV patients with good health perception and high education had better health-promoting behaviour, regardless of whether they were male or female.

3.2.2 HIV and marital relationships

Marital relationships between couples can be severely disrupted or otherwise affected by HIV infection. Kongsuriyanavin (1997) examined the effects among 24 married couples where the women but not the men were infected, selecting the sample by purposive and snowball methods from among outpatients at a hospital in Bangkok and using the techniques of indepth interview and participant observation to collect data. Couples were interviewed repeatedly and intensively, and home visits were made to observe interactions between the couples including their relatives. Kongsuriyanavin describes a process of reaction to discovery of infection, starting from fright and moving through further stages of ambivalence, denial, finding information and coping with reality. The women disclosed their infection to their husbands out of anxiety. Two groups could be discerned, the sympathetic or neutral families ('happy' group) and the unhappy or broken families. Changes in family and sexual relationships were mediated by a complex set of factors:

- the husband's perception of his wife's HIV infection
- the husband's perception of the cause of the infection
- the wife's perception of her husband's reaction
- pre-marital relationships
- post-marital relationships
- problem-focused coping
- knowledge about HIV
- the husband's acceptance of his wife's HIV infection

There were also supporting factors such as relationship with children, the husband's perception about the timing of the HIV blood screening, social support and the background of the couples.

Kongsuriyanavin gave strong recommendations toward a comprehensive health education program in educational institutions, support for married couples and a legislative statement of gender equality. It could be added that support for unmarried people is equally important.

Most of the studies of transmission of HIV to women have been conducted among pregnant women or those who have just given birth, and have been reported in section 2.2. The gender dimension is not often explored in these studies. An exception was a

study by Chintanadilok (1995), emphasizing the low cooperation of husbands in HIV screening, the reluctance of many women to inform their husbands about their HIV-positive status, and the absence of HIV infection among some husbands. A study by Khongsakorn (1994) examined the decision-making roles of men and women on the question of pregnancy termination.

Kiewying and Tungworapongchai (1998) used a survey approach to examine perceptions about AIDS and the caring roles of the spouses of people affected with AIDS in the north-east of Thailand. They found that women scored higher than men in their readiness to care for a spouse with HIV.

From a different perspective, Laojumpon (1996) found that housewives from Mahasarakham in the north-east recommended strategies of self improvement to promote 'being a good wife' and 'speaking out' on AIDS issues with their husbands. Personal strength of housewives could be enhanced using a networking strategy.

3.2.3 High risk groups

Attention to the impact of information about AIDS on the knowledge and behaviour of high-risk groups was brought about at an early stage of the epidemic in Thailand. Wangtira-Umnuay (1987) interviewed 312 sex workers and male homosexuals about the impact of information in the media on their knowledge and behaviour concerning HIV. The main source of information was newspaper stories, but advice from friends was an important source of information. More educated informants had higher knowledge, and the males had more knowledge than females. The most influential source on preventive behaviour was the interpersonal medium (friends, partners and relatives). Dissemination of information through health personnel who write columns in the popular press deserves to be examined and implemented to a larger audience.

A specific group, in this case gay bar men, was also the target for a condom education program reported by Tanasugarnl *et al.* (1989). A sample of 80 men working in gay bars in Bangkok was split into experimental and control groups. An educational intervention for the experimental group consisted of a videotape presentation followed by a pamphlet distributed three weeks later. The knowledge and behaviour of the experimental group was tested before and after the intervention, which was apparently successful because there was a statistically significant difference in favour of the experimental group after the intervention, and their AIDS knowledge and condom use both improved compared with the pretest. The participants who had the highest hopes about the efficacy of the intervention registered the greatest increase in condom use.

A collaborative project focusing on risk behaviours was carried out by the Institute for Population and Social Research at Mahidol University and the Center for Population and Family Health at Columbia University, under the umbrella title of Behavioral Research for Prevention of AIDS in Thailand (BRAIDS). This study used a combination of face-to-face interviews, focus group discussions and in-depth interviews with 678 female brothel workers, 330 truckers and 1,075 men aged 17-45. A number of studies carried out under this project focused on the behaviour of the sex workers. For example, Pramualratana and Podhisita (1994) reported qualitative results concerning the social context of AIDS awareness. They found that almost universal knowledge about AIDS went together with a 'seeming lack of urgency' in

taking steps to avoid risk. The attitude 'I don't know anyone with AIDS' was common, and the immediate concern of the sex workers was to make as much money as possible. The sex workers had a mature approach to obtaining knowledge on correct health practice but there was misunderstanding caused by wrong advice and lack of information from health personnel. The authors commented that health personnel worked under unclear guidelines. The same authors, with others (Pramualratana *et al.*, 1994) used similar methods to describe condom use by the sex workers. While practical problems such as getting clients to comply with condom use were mentioned, along with the discomfort and abrasion caused by the friction of constant use, the study also found that sex workers had persistent misconceptions, for example that nice-looking clients were less likely to carry disease.

Also as part of the BRAIDS project, Wawer *et al.* (1994) examined the backgrounds of sex workers to establish the consequences of this social context for HIV transmission. They argued that the home environments of sex workers from the North, the region from which most of them had come, accepted sex work and participated in its benefits. While women from the North-east region had less social support for engaging in sex work, both groups required motivation and opportunity to engage in other economic activities.

Recent studies of sexual networking and homosexual transmission of HIV and AIDS in northern Thailand have been notable for their methodological innovations. Spatial relationships were investigated by ethnographic and geographic methods in the investigation by Wijngaarden (1995) of homosexual networks in Chiang Mai. At gay bars, sexual establishments, public parks, commercial places and places of entertainment, he identified four types of linking mechanisms which formed the networks. These links were between male sex workers and their clients at each type of location, links between the types of location, places of entertainment as bridges between the different types of location, and sexual relationships with the 'outside' world. Wijngaarden noted a clear distinction between homosexual men who adopted homosexual identity and isolated themselves from heterosexuals, and the male sex workers, who adopted a male identity, had both male and female partners and considered themselves to have been made homosexual through their experience of youth, rather than born homosexual. It can be noted that Kunawararak *et al.* (1991, 1993) had found that most male sex workers in gay bars in Chiang Mai were heterosexual. The sex workers were divided into three groups, the most prominent being the Gay Queen group, while the Gay King group who were not really 'gay' were less easily identifiable. The third group were the real homosexuals, who were highly sensitive and difficult to approach. In another study in the lower northern province of Pitsanuloke, Preechaharn (1997) found that homosexuals other than the overt cross-dressing *kathoey* group were mostly government officials or graduates working in private enterprise, and one-third of them were married. This study provides a rare glimpse into the characteristics of bisexual behaviour, the existence of which in Thailand is often ignored and denied.

As described in section 3.1, Phawanaporn *et al.* (1993) found an improvement in knowledge of male and female sex workers about sexually transmitted diseases and HIV transmission after education on these topics was given. The authors expressed concern about the high risk for HIV transmission given high seroprevalence of syphilis among both groups. The study found that there had been a widespread belief

among the sex workers that routine checking of their blood and sexual organs could prevent disease transmission, rather than just detect the presence of disease.

In a study in the south of Thailand, Sinpisut *et al.* (1990) found a generally good level of knowledge about HIV, its modes of transmission, and methods for avoiding infection, from qualitative and quantitative research among female sex workers. In detailing the background of the 2,940 participants in a survey conducted as part of the study, the authors noted that nearly 40 per cent of the sex workers had come from unlucky marriages which had ended in divorce or widowhood. The observation reveals an important gender dimension of sex work, that it is often the result of difficult personal circumstances of women.

Truck drivers are often perceived as a high risk group for HIV infection. This was only partly confirmed in a study by Kamolphet *et al.* (1991) who found that 9 per cent of truck drivers in Nakhorn Ratchasima visited prostitutes and just over half of these did not use condoms. HIV prevalence was 0.7 per cent, and just under 3 per cent of the sample had syphilis, and the study found a high level of knowledge of HIV prevention and control. Sawaengdee and Isarabhakdi (1991) studied a small group of 60 truck drivers using qualitative methods, and found that frequent relationships with sex workers, and the taking of risks in these encounters, were associated with use of alcohol and amphetamines. The BRAIDS project proceeded from the assumption that truck drivers did represent a high risk group, by including a sample of them. At one level, the assumption appears to have been justified. Podhisita *et al.* (1994) reported that 15 per cent of the 330 long-distance truck drivers in the sample reported having had more than 300 sex partners in their lives, and a further 23 per cent reported having between 50 and 300 partners. In the previous year, 37 per cent had at least three partners. However, the study also found HIV prevalence, at 2.3 per cent, to be lower than expected. This was apparently because of a high level of use of condoms, and prompt treatment of other sexually transmitted diseases.

Other high risk groups have been identified in more recent studies, particularly factory workers in the north of Thailand (Buakamsri, 1997), who have been targeted for experimental education and intervention projects (Cash *et al.*, 1995; Chuamanachorn *et al.*, 1997). The project by Chuamanachorn *et al.* (*loc. cit.*) consisted of training for 138 group leaders and peer education among 1,440 men and women working in 12 factories in Chiang Mai. The objectives were to improve understanding of the reproductive system, sexual relations and sexual modes of disease transmission, to increase awareness of HIV/AIDS and its prevention, and to equip participants with problem-solving, negotiating, communicating and self-evaluation skills, in relation to sexually transmission of disease.

Prior to the peer education intervention, most men and women felt that mutual trust between partners should make condoms unnecessary, and most women were reluctant to discuss sexual relations with men. While 80 per cent of women were confident that their husbands or partners were faithful to them, the proportion of men who did not admit having more than one partner was less than 70 per cent. After the intervention, nearly half of the women had become uncertain about the risk of HIV infection by their husbands or partners, and both men and women saw the need to discuss condom use. Women were empowered to discuss safe sex and AIDS without causing conflict with men. While before the intervention, visiting sex workers on drinking sprees had

been perceived as part of male identity, after the intervention both men and women felt that this type of activity had been reduced among the men.

3.2.4 Attitudes and knowledge about HIV/AIDS in the general community

VanLandingham *et al.* (1995) remarked that much of the research related to AIDS in Thailand has concentrated on the high-risk groups, with relatively little attention to the general community. VanLandingham and his colleagues conducted a small number of indepth interviews and focus group discussions, with both men and women, to discern the social context of spread of HIV infection from sex workers through men into the general community. The study recommended that 'the risks of HIV infection from husbands' commercial sex partners should be made more salient for married women', and that the tolerance of commercial sex partners as a means of discouraging their husbands from taking up with non-commercial sex partners was 'obsolete in the AIDS era'. There was also a need to stress the increasing risks of having extramarital non-commercial partners, and married men should be encouraged to think more about the devastating impact of HIV infection on their families.

The study recommended further that the strong role of friends in groups of men going out for entertainment, often including visits to sex establishments as part of a package of activities, provided an avenue for intervention at the peer group level. Among these groups were men who did not participate in the sexual activities, and who were concerned about their friends. There was an opportunity to use media messages to encourage these men to tell their friends about the risks of spreading HIV infection.

Two earlier studies under the BRAIDS project (Morris *et al.*, 1994a, 1994b) also focused their attention on the spread of HIV infection from sex workers into the general population through 'bridging populations'. They found that younger men were more likely to be in sexual networks that bridged the commercial and non-commercial spheres, and that young men were also more receptive to condom use. Consistency of condom use was reported to be a major contributor to increased risk.

Earlier still, Havanon *et al.* (1993) had conducted in-depth interviews with 181 men who had sexual relations with at least two different women in the previous twelve months. Most commonly, these men had commercial and non-commercial partners. This study indicated that condom use was lowest among men who most frequently patronized sex workers. The study concluded that 'a program that focuses only on the closed commercial sex network will address only partially the real risk situations'.

Other studies conducted among members of the general community rather than high risk groups have also appeared in the last few years, although more restricted in scope (as distinct from size). A survey of AIDS knowledge and risk behaviour among 440 male factory workers in Samutprakarn Province near Bangkok found that a large majority (79.7 per cent) were comparatively well informed about AIDS, but 22.2 per cent were assessed as having relatively high risk behaviour. The study (Ittithumwinit and Jirarojwattana, 1995) used self-administered questionnaires. Younger and better-educated workers were most well informed about AIDS, but it was also found that higher income was associated with greater risk-taking behaviour.

Pitoonpong and Jirachai (1994) conducted a study of knowledge, attitudes and risk behaviours concerning AIDS among labourers in Ubon Ratchathani, and found a high level of risk behaviours including failure to use condoms, multiple partners and drinking, while 35 per cent of the sample had contracted STDs. Thongkrajai *et al.* (1992) proposed and tested the use of the health intervention model among factory workers in Khon Kaen province. While they found an increase in condom use, there was no significant difference in STD incidence between experimental and control groups.

Rojanarattanangkule *et al.* (1997) interviewed 21,270 people aged 15 to 59 in Sukhothai Province to measure their knowledge, attitudes and practice of prevention of HIV infection. Despite a high level of knowledge, many people (42.3 per cent) were not worried about the risk of contracting an infection, and only two out of every three adults (66.5 per cent) would definitely use a condom at the request of their spouse or partner. While almost ninety per cent of adults who had sexual experience said they would avoid sex with anyone other than their spouse or usual partner, it was also found that 6.2 per cent had contracted a sexually transmitted disease in the previous twelve months. One positive result of the study was that more than one third of the respondents (36.8 per cent) would treat HIV-infected relatives 'as usual'. As experience of HIV infection of relatives and acquaintances spreads throughout Thai society, increasing acceptance of people with HIV/AIDS is to be expected. However, the fact that more than sixty per cent of people in this study would not treat an infected relative in the same way as usual indicates that public education still has to contend with the problem of social denial.

Reference has already been made to three studies using networking approaches (Bond, 1995; Havanon *et al.*, 1993; Wijngaarden, 1995). Limanonda (1997) used a case study approach to investigation of sexual networking, presenting the results from in-depth investigations of ten villagers from rural Chiang Mai. She found that the dimensions of an intertwined and highly complicated sexual relations network had yet to be appreciated by the government agencies, to enable them to invent or formulate appropriate preventive measures against HIV and AIDS for members of the general community.

3.2.5 Deliberations of consultative groups

At the consultative meeting in Khon Kaen, participants felt that gender issues were given insufficient attention in the study of HIV/AIDS. From an ethical point of view, there were important reproductive rights, such as the use of the drug AZT by pregnant women, and the right to breast milk substitutes for babies born to HIV-infected mothers. A related issue of rights was raised in the Chiang Mai meeting, namely the issue of self-protection by hill tribe women whose husbands refused to wear condoms.

In Khon Kaen, questions were raised about the accuracy of projections of AIDS infection, on the grounds that the spread of the HIV virus could be wider than has been allowed for in studies so far. Discussion then turned to the need for parental preparation among men and women about to marry. Such interventions would emphasize the father's role in child rearing, building on existing programmes to educate men about women's reproductive health.

Most studies conducted on the topic of HIV/AIDS were KAP (knowledge, attitude and practice) studies. A more comprehensive approach would emphasize the triangle represented by the mother, father and child. For instance, decision-making processes affecting pregnant women were a key issue, especially with increasing incidence of HIV infection among pregnant women. In the south of Thailand, men were the main decision-makers concerning pregnancy termination. Counselling on this issue had to be directed at the couple, not just the woman.

Consultative group summary

- *Studies on KAP (knowledge, attitude and practice) were too limited; a more comprehensive approach would emphasize the triangle represented by the mother, father and child* ***[North region]***

- *Attention is needed to preparation for parenthood among men and women about to marry, emphasizing the father's role, and counselling about HIV/AIDS needed to be directed at couples, as men were the main decision-makers concerning pregnancy termination* ***[Northeast and South regions]***

- *Gender issues and rights are given insufficient attention in the study of HIV/AIDS*
  - the right to the use of the drug AZT by pregnant women
  - the right to breast milk substitutes for babies born to HIV-infected women
  - the right to protection against men who refuse to use condoms
  [Northeast and North regions]

- *The accuracy of AIDS projections needs to be examined,as the virus could have spread wider into the community than has been recognized so far* ***[Northeast region]***

3.3 Infertility

Infertility is a Gender Issue in Thailand

- Gender issues are prominent because infertility can result in family relationship problems:
  - guilt and blame
  - lack of harmony in marriage
- Most studies of infertility in Thailand have no social perspective, because they are based on patients seeking treatment, and laboratory studies
- Some of these studies reinforce the society's perception that infertility is a woman's problem despite the fact that men may be responsible

3.3.1 Clinical research

Most of the research that has investigated the occurrence of infertility among Thai women has been carried out on a clinical basis. This was due to clinical interest in the reasons for apparently low levels of infertility in Thailand. Infertility was estimated to affect 5.5 per cent of Thai women in the period before the 1960s, compared to 10 to 20 per cent in other developing countries (Sukhavachana, 1967). It should be noted that the evidence for female infertility in historical investigation was actually not specific to women. In most studies it could as easily have been male infertility that was observed, although it was reported as if it was for women.

For example, Sukhavachana studied patterns of 'female' infertility in Thailand by randomly selecting 1,875 women in nine provinces in the Bangkok, central, north and north-east regions. Data were collected from birth certificates. He also studied causes of 'female' infertility from 255 records of infertile women who were his patients. In these cases it was possible to determine cases of male infertility. Sukhavachana found that in many cases apparent infertility in women was actually caused by male seminal defects, which accounted for 25 per cent of infertility. The other causes were related to occlusion of the uterine tubes, physical uterine factors, and women's mental health. Although this is not mentioned in the report, occlusion of the uterine tubes is frequently a result of pelvic inflammatory disease induced by sexually-transmitted diseases.

Cheewadhanaraks and Surang (1990) classified 325 cases of infertility as 'male factor' (39.7 per cent), 'tubal factor' (28.6 per cent) and 'ovulatory factor' (20.6 per cent). The irony of ascribing female 'infertility' to male seminal defects and diseases transmitted to women by their husbands was not noticed by the authors of these studies.

The semen profile is an indicator of man's ability on having children. A low sperm count means a small chance of women getting pregnant. Chinsomboon *et al.* (1990a) studied the semen profile of 405 fertile men. The study involved measurement of seminal volume, sperm concentration, motility, progression, morphology and the pH of semen. It was found that the samples had an average volume of 2.66 ml., sperm concentration of 80.93 millions per ml., sperm motility 76.57 per cent with average progression 2.9, abnormal morphology 11 per cent, and pH was 7.8. There was no conclusion from this study about how these indicators related to infertility. Chinsomboon *et al.* (1990b) continued the study with semen analysis of infertile couples. The analysis was carried out among 1,000 infertile couples. It was found that azoospermia (absence of sperm) was encountered in 8.8 per cent of the couples, and oligospermia (a sperm count less than 20 millions per ml) in 26.1 per cent of the couples. The average seminal plasma volume was 3.84 ml., sperm density 49.5 millions per ml., sperm motility 74.4 per cent with average progression grading 2.9 and average abnormal morphology was 11.27 per cent. There is no recommendation from either study on what the couple should do to improve their fertility.

3.3.2 How infertility affects women's health

Having a child is one sign of love and bonding between couples. Infertility creates problems for women's mental health, as they can be blamed by the husband's family and society, and they may lose husbands and marital families (Boonmongkon, 1996). The blame can easily be placed on the wrong partner to the marriage, on the evidence of studies cited in section 3.3.1.

A study by Deeleau (1996) explored stressors and coping behaviour of 85 infertile couples attending an infertility clinic attached to a Chiang Mai hospital. The study utilized an infertile stressor scale and a coping behaviour scale. The women were found to suffer more stress than their husbands, and their stress came from internal rather than external sources. While the coping behaviours of men and women were at similar levels, among women the strategy was palliative coping, while men used confrontational coping.

A different perspective of infertile women is provided in a study by Sawadpanich (1993), who examined self esteem and spouse relationships in relation to coping behaviours and found that self esteem was the more crucial factor.

Another research study has shown how couples are affected by infertility at different life stages. The study was carried out at a Bangkok hospital in 1991 by interviewing 100 women who were clients at the infertility clinic. It was found that infertile women had problems of emotion, marriage adaptation, sexual identity and sexual ignorance. Using a standard form of personality evaluation, it was found that infertile women's personality including their behaviour deviated from 'normal', particularly in the pattern of anxiety and proneness to guilt (Anatavuthikanon, 1991).

Recognition that infertility can affect either partner to a relationship, and sometimes both of them, remains at a low level in Thai society. Mostly it is women who are blamed. Men and society should share the responsibility for solving problems of infertility and not leave women to face the pressure and suffer alone. Some women agree to accept treatment of dubious value, with uncertainty of future risk or harm to themselves (Achavanitkul and Boonmongkon, 1996).

Dealing effectively with the problem of infertility needs a lot of time and money. While only a small proportion of couples have infertility problems, treatment is disproportionately given to those with higher economic status. Infertility affects both the rich and the poor. The poor people of Thailand lack the opportunity to treat infertility as they cannot afford either the time or the costs. Boonmongkon (1996) suggests that there should be policies emphasizing the right of women to be informed about the problems of infertility that can affect their reproductive capacity, and their right to receive treatment if they are infertile.

Infertility can also be viewed as a single facet of the wider problem of sexual dysfunction. Sexual dysfunction creates an 'awesome toll in human suffering', according to Sanesak (1996), in an investigation of the characteristics of women who attended a hospital for counselling on sexual problems such as lack of sexual satisfaction, lack of sexual desire, painful intercourse (dyspareunia) and lack of orgasm. The women tended to be relatively old (mean age 37.8 years) and had been

married for some time (mean duration 11.9 years), although the author did not remark on the implication that perception of problems might stem from changes in physical capacities. The self-selected women in the study were also from backgrounds of relatively high income and high education.

3.3.3 Deliberations of consultative groups

The method of studies of infertility came under question in the consultative meeting in Chiang Mai. Those women who ask for treatment from clinics are not representative of all women. The meeting speculated that increasing infertility was associated with the pattern of increasingly late marriage. The general problem was that infertile women in the lower socio-economic classes (the poor) were ignored, as the treatment required a lot of time and money.

In the meeting held in the South region, a current study was investigating the hypothesis that infertility in factory workers had chemical origins. The study is not yet completed.

Consultative group summary

- *Clinic studies of infertility are not representative; infertile women in the lower socio-economic classes are ignored* ***[North region]***
- *There is an association between increasing infertility and late marriage* ***[North region]***
- *Relationships between infertility and exposure to chemicals are being explored in a current study* ***[South region]***

3.4 Reproductive Tract Malignancy

Cancer and Gender

- Cervical cancer is increasingly regarded as a sexually-transmitted disease
- Breast cancer is perceived to disfigure women
- There have been only a few studies in Thailand on the gender and sexuality dimensions of breast cancer, cervical cancer, and prostate cancer of men

3.4.1 Cancer, gender and sexuality

Cervical cancer is increasingly regarded as a sexually-transmitted disease because of its association with a history of multiple sexual partners and accompanying transmission of human papilloma virus (Polnikorn, 1990). Official statistics reveal cervical cancer to be the leading cause of cancer mortality among Thai women. Despite this, a study in rural northern Thailand found that women are shy to ask for the Pap smear test for cultural reasons; and the regularity of testing was low even among women who had previous tests (Theerawatsakul *et al.*, 1995). The province's campaign to promote the Pap smear test was inaccessible to the target population and failed to stimulate women to take the test. The study recommended that the health stations should put more effort into promoting knowledge and utilization of the test.

Sexual transmission of cervical cancer is only one of the gender and sexuality issues associated with reproductive tract malignancies. In addition, it is necessary to consider other conditions, including breast cancer of women, and prostate cancer of men. The effects on a person's sexuality of all these conditions can be far-reaching and traumatic. While the general principle of support from spouses can alleviate adverse effects, there has been little actual research into these topics in Thailand.

A study by Singkaeo (1986) examined the effects of reproductive system cancer on female patients' lifestyles. Eighty couples drawn from hospital patients participated in the study. Respondents and their husbands were asked to agree or disagree with items on a list. Typical responses were:

* The effects of this illness decrease my sexual desire. (Rated high.)

* I hope to recover from this illness and have the same sexual desire as usual. (Rated low.)

* I am bored and annoyed from treatment procedures and symptoms from the side effects of this disease which make me feel discomfort by anorexia, nausea and vomiting. (Rated high.)

Source: Singkaeo (1986)

The women and their husbands both felt effects at a high or medium level. Examples of items about which patients felt strongly are shown in the display. In contrast to Singkaeo's study, Wuttisupong (1998) found that women's perceptions about their quality of life remained high after receiving chemotherapy and operative treatments for reproductive tract conditions.

While not a reproductive tract malignancy, breast cancer is a disease of substantial concern in the context of gender and sexuality because of its association with a negative or impaired projection of female attributes, and consequent potential for effect on actual sexual behaviour. While there have been studies of factors associated with occurrence of breast cancer in Thailand, using a case-control approach, the gender dimensions have not been explored in most of these studies. An example is the study by Chariyalertsak *et al.* (1989) of 210 cases and 602 controls, which in a multivariate analysis found that increased incidence was present among women with agricultural occupations, those who had their first births at less than 20 or more than 30 years of age, and those who had entered menopause.

A study which explored the gender dimension of the anxiety caused by the disfigurement accompanying mastectomy was undertaken by Janmahasatian and Leksawadi (1995). The study investigated 60 patients from a Chiang Mai hospital who were having cancerous breasts removed. The women were anxious that the loss of breasts signified loss of female identity, that they would lose their status as wives, that their husbands would neglect them and dislike them and they would be unable to satisfy their husbands' sexual needs. The gender issue is evident; in the face of such anxiety, the husbands of women undergoing mastectomy should be counselled to allay their wives' fears. Another study that investigated some of the gender dimensions was carried out by Juangpanich (1993), who found that women's fears about mastectomy could be reduced using preparatory information.

3.4.2 Other research studies on reproductive tract malignancy

A study of 877 patients attending the Gynecological Tumor Clinic of a hospital in Bangkok led to the recommendation that married women should undergo a Pap smear every six months so that gynecological cancers (principally carcinoma of the uterine cervix) can be detected before they progress to a late stage (Paiwuti, 1989). The only social science dimension of this study was this recommendation.

In Thailand, there have been basic research studies into causation of cervical cancer. Following a speculative article by Jariyalertsak (1984), there were at least two scientific investigations of the relationship between oral contraceptive use and cervical cancer. One study involved 119 cases of invasive cervical carcinoma and 730 controls (Wongsrichanalai *et al.*, 1984). The authors found that after controlling for age and sexual behaviour, women who had used oral contraceptive pills for longer than five years were at greater risk of cervical cancer, at a 'slight' level of statistical significance.

A later study by Thanapatra *et al.* (1988) used a sample of 505 'promiscuous' women from an STD clinic in Bangkok and 519 'non-promiscuous' women from the National Cancer Institute, from whom cervical and endocervical smears were taken for cytological evaluation after pelvic examination. The 'promiscuous' women were found to have more abnormal Pap smears than the 'non-promiscuous' women, and this tendency was more pronounced if the women had begun to use oral contraceptives at younger than 20 years of age, but not at a statistically significant level. The study was inconclusive and the authors felt that a larger sample size was required.

3.4.3 Deliberations of consultative groups

All meetings stressed the lack of attention that has been given to this topic in research studies in Thailand. Most of the existing studies were on clinical issues. In the Southern region, there was continuing research on links between use of the contraceptive pill and cancer, even though research on this topic had been abandoned in other parts of Thailand.

Consultative group summary

- *There has been very little research into reproductive tract malignancy from a social science perspective in Thailand* ***[Various regions]***

- *Most research is on clinical issues* ***[Various regions]****, for example links between use of hormonal contraceptives and cancer* ***[South region]***

4 Review of Research: Sex Education, Adolescence, Menopause and the Elderly, and Sexual Abuse and Violence

4.1 Sex education

The Gender Dimension in Sex Education

- Lack of sex education in Thailand leads to unwanted pregnancies and disease transmission. The primary effect is on women
- Many studies of sex education have used students and factory workers as research subjects. Self-administered questionnaires are often used
- Several studies indicate that teachers are not considered by themselves or their students as appropriate sources of information about sex
- Specific attitudinal studies on topics such as homosexuality and condom use have been conducted

4.1.1 The gender dimensions of sex education

Given the degree to which socially-constructed gender roles influence individual sexuality in every society, it is important to reduce the prevalence of practices which involve risk of infection and unwanted pregnancy through appropriate education programs. The problem is to overcome societal taboos, which in Thailand restrict the adoption of sex education as a separate subject in national school curricula.

In Thai society, neither young men nor young women have the opportunity to learn about sexuality, and they are likely to be naive in their sexual relationships (Havanon, 1996a). The socialization process produces young women who are more submissive and less able to hold responsibility than men, yet expected to be responsible for the consequences of their sexuality. Unwanted pregnancies lead to problems such as unsafe abortions, forced cessation of education of young women, and alienation from their families (Havanon, 1996b). For these reasons appropriate sexuality education must be provided at an early age, and both young men and women should be motivated to take responsibility for their own sexual behaviour (*ibid.*).

4.1.2 Sex education among students and factory workers

Institutional populations such as students are not only convenient targets for educational campaigns, they can also be convenient sources of information about knowledge, attitudes and behaviour. Factors which predispose, enable and reinforce the use of condoms among young men were examined in a study of 310 male vocational students with sexual experience, at colleges in Bangkok (Mahuttano, 1996). Structured questionnaires were used to ascertain that while 75.8 per cent of the youths had used condoms, only 11.3 per cent always used them. Condoms were mainly used with sex workers and non-routine partners, seldom with routine partners. Nearly all of the sample had sexual experience with sex workers, and of these 89.5 per

cent said they always used condoms with the sex workers. Among factors which were associated with condom use were perception of susceptibility to STDs and AIDS and the seriousness of these diseases, the availability and cost of condoms, whether the partner was a sex worker or not, support from the partner, condom use among close friends and advice from parents or teachers. The study found that income, knowledge about condoms, STDs and AIDS, perception of the benefits of condom use, freedom and number of sexual factors were not associated with condom use. These findings could be used to improve sex education and counselling, and strategies for increasing condom use.

Consistent with the fact that young men use condoms mainly in their encounters with sex workers, a study of 670 university students from four universities in Bangkok (Sareethakun, 1994) found that male students had more knowledge about the use of condoms than female students. A study of the knowledge of vocational students about STDs and their attitudes towards STDs was conducted by Dinglim (1990). The sample consisted of 173 males and 207 females in the third year of vocational education in 12 colleges in metropolitan Bangkok. The study found no statistically significant difference between adolescent males and females in terms of knowledge, but females had better attitudes towards avoiding STDs than males, at a statistically significant level. Suntharasaj *et al.* (1994) carried out a study of 1,527 vocational students in the south of Thailand, using self-administered questionnaires. They found that 86 per cent of female students wished to avoid premarital sex while they were still studying, but only 41 per cent of males responded in the same way. The female students were found to be shy about using condoms and they did not know how to use them correctly.

Vocational students were also targeted in a study of sexual relationships, reproductive concepts and contraceptive use by Sakondhavat *et al.* (1986). The study used a pre- and post-intervention strategy, with 1,120 students included in the first round but most of them lost to follow-up in the following twelve months, with the result that only 502 students were included in the post-training interviews. The intervention was a health education program, and it resulted in great improvement in sexual attitude, contraceptive knowledge and sexual practice

A study of 250 male and 250 female secondary students, with a mean age of 14.9 years, was carried out using self-administered questionnaires by Tungphisal *et al.* (1989). The study found that the students had only a limited level of knowledge of STDs and contraception. Their main source of information was books and magazines. Nevertheless, 23 per cent of the male students had already experienced sexual intercourse with girl friends or sex workers, and only 42 per cent of them had used condoms. The finding underscores the need for early intervention through sex education well before students reach senior secondary level.

Unintended pregnancy, abortion, AIDS and STDs occur among unmarried women as a result of premarital sexual intercourse. Poonsanasuwansri (1997) conducted a cross-sectional survey among 400 adult learners study in Bangkok, who were drawn by multi-stage sampling. Data were collected through self-administered questionnaires. The results showed that the premarital sex was related to predisposing factors such as sex of respondents, attitude toward love, values about premarital sex and perception of the result of premarital sex, while the enabling factors were dating and touching.

The opinions and behaviour of the close friends, and receiving sex information from mass media, also played parts. The study revealed that sex education could play a major role in reducing the premarital sex. Poonsanasuwansri (1997) suggested that both the Ministry of Education and the Ministry of Public Health should work closely together in setting up policy and planning and implementing specific programs to reduce risks associated with adolescent sexual behaviour.

Kaewboonchu *et al.*(1993) used questionnaires to survey 539 female workers in eight large factories in Ladkrabung district, Bangkok. This study focused on sex education knowledge, sexual behaviour practice and preventive behaviour among factory women. It was found that more than half of the sample had knowledge about sexuality, and could explain about prevention of STDs. As would be expected, the married women had better knowledge than unmarried women. Because some women did not have the correct knowledge on sexuality, the authors recommended that more information and knowledge about sexuality should be provided by nurses or counsellors of the factory, or a project 'friends for friends' to share knowledge and experience among the factory workers should be set up.

Opinions and attitudes of high school teachers towards AIDS education were examined in a survey of 151 teachers in Bangkok by Phuttharangsri and Kupatachit (1996). The teachers' opinions were judged to be positive at a high level concerning the use of Thai values, culture and tradition in AIDS education, the environment which affects AIDS education, and the sex education component of AIDS teaching. They needed to add more time, more audio visual aids, especially videotape and slides, and also training for some techniques and strategies of AIDS teaching and learning activities. These attitudes have the potential to be exploited in school-based public health initiatives.

Negative attitudes towards male homosexuals were also found in a study by Pongthonkulpanich (1987) of 208 male students in the final year of high school. Two thirds or more of the sample thought that homosexuality was an emotional problem, that it created more exposure to sexually transmitted diseases, and that it was a social problem.

Yamarat *et al.* (1992) conducted research into the attitudes towards sex education of secondary school students and teachers, and found that among 4,377 students and 454 teachers in 21 secondary schools knowledge of sexuality was at a moderate level. Among students, 82.4 per cent agreed that sex education programs should be provided at secondary level, but 56.3 per cent of the student disagreed that sex education should be provided at elementary level. Moreover, 42.6 per cent agreed that sex education should be provided in the family, but 30.3 per cent did not agree.

There are some studies specific to adolescents concerning HIV and AIDS. A study of knowledge, attitudes and behaviour concerning HIV and AIDS was carried out among Bangkok college students by Phongsiri *et al.* (1993), using self-administered anonymous questionnaires from a stratified random sample of 608 male students and 42 female students. Nearly all of the students (94 per cent) had knowledge of what AIDS was, and 92 per cent knew about the major modes of transmission. The majority of students also knew that AIDS could not be transmitted in various casual ways or by mosquitoes, and that there were no vaccines to prevent infection. Almost

one-third of the respondents (31 per cent) thought that AIDS could not touch them and they practised no risk behaviours.

About 31 per cent of the students had unfavourable attitudes towards using condoms to prevent HIV transmission. While 62 per cent of the male students said that they would use condoms every time they had intercourse with sex workers, and 25 per cent said they would use condoms every time when they had sex with their girlfriends, the reported results refer to hypothetical questions and do not specify what the proportions were among students with actual sexual experience with these types of partners. The study also revealed that a sizable minority of the students held feelings of fear or aversion to the prospect of working with HIV-infected persons. Phongsiri and co-authors recommended that 'health education should be focused towards the special needs of selected target groups', and there was a need to develop 'suitable ways to monitor the impact of health education on the prevention and control of AIDS'

As discussed in section 4.2.2, at least one group of adolescents expressed a preference for obtaining information from health professionals rather than teachers (Suparp *et al.*, 1992). The reason for this is illustrated clearly in a study by Kanchanavasee (1992, cited in Yoddumnern-Attig, no date: 41), who found that lack of knowledge by health instructors was the most common barrier facing effective AIDS education in schools.

4.1.3 Education in condom use

It is sometimes felt that education in use of condoms would be beneficial. Vichajarn (1996) found that military conscripts were able to remember correct use of condoms two years after initial instruction. Not only that, an overwhelming majority reported use of two or more layers when they visited sex workers. However, Palapanya *et al.* (1996) found that 267 clients of 334 female sex workers in northern Thailand had less correct use than the sex workers, mostly because some of the clients failed to squeeze the tip of the condom or allowed exposure to contamination during removal.

4.1.4 Deliberations of consultative groups

Participants in most of the meetings referred to the bias caused by the fact that studies on this topic were based mainly on institutional populations (adolescents in educational institutions and factories). The studies neglected youth out of school, for example in the agricultural sector.

In both the Bangkok and Had Yai meetings, participants referred to the need for using health personnel rather than teachers as instructors on sex education. With sex education supposedly integrated into the school curriculum, and not taught as a separate subject, use of professional instructors was difficult. The issue, as mentioned in the Khon Kaen meeting, was that Thais are reluctant to talk about their sex organs, for reasons that stem from culture and the belief system. This applies to teachers as well as students. Even nurses, especially those without much work experience and unmarried nurses, are reluctant to discuss sexuality openly with their patients. A compromise solution to difficulties was for health personnel to train teachers to instruct school students.

It was noted that it was important to include a gender dimension in the school curriculum. Research on strategies to provide sex education to people was a priority, according to participants at the meeting in Had Yai. This was because of the past emphasis on providing knowledge to women. There was a need to concentrate on both male and female adolescents, but the question was what aspects to concentrate upon, and with what methodology.

Consultative group summary

- *Groups such as out-of-school rural youth are neglected in studies based on institutional populations (schools and factories)* ***[Various regions]***
- *Health personnel make better instructors for sex education than teachers* ***[Various regions]***
- *A gender dimension is needed in school curricula* ***[South and Northeast regions]***
- *Research on strategies to provide sex education to both male and female adolescents is a priority* ***[South region]***

4.2 Adolescent health

Gender Issues Affecting Adolescent Health

- There is a strongly defined gender construction of adolescent sexuality in Thailand
- Many studies implicitly accept constructed notions about sexuality, ignoring rapid change in the society. Increasingly young men have their first sexual encounter with a girl friend rather than a sex worker
- Researchers often use samples of students and factory workers, and self-administered questionnaires

4.2.1 Adolescence, gender and sexuality

There is no fixed definition of adolescence in the literature or common use, although the experience of puberty is frequently used to signify the beginning of what the World Health Organization calls 'the process through which an individual makes the transition from childhood' (cited in Soonthorndhada, 1991). Other more prosaic definitions, such as the ages 15 to 24, are often used. At no other stage of life are the issues of gender and sexuality as prominent as they are in adolescence, when young men and women adopt attitudes and behaviours which will shape their experience of life throughout its course. On the other hand, adolescents are perceived as having

generally good physical health, and they are sometimes considered as having a low demand for health services for this reason.

Data from censuses and surveys can be used to review the inter-relationship between sociocultural contexts and sexual attitudes and behaviour among adolescents in Thailand. Studies conducted during the 1980s among different groups of Thai adolescents revealed very little experience of sexual intercourse by adolescent girls, compared with European and American studies, while adolescent Thai males had considerably more experience than Thai females but not as much as American males at comparable ages (Soonthorndhada, 1991: 12-15). Soonthorndhada also cited studies showing that cohabitation of men and women before marriage was virtually non-existent in Thailand in the past (*ibid.*: 15-18). The observation actually applied more to urban areas than rural areas, where cohabitation was sometimes used as a conventional way to reduce bride price. Soonthorndhada then noted the existence of high ages at marriage for both men and women, describing a situation where women abstain from heterosexual relations throughout an extended adolescence, but many young men would have premarital sexual experience with sex workers.

Tantiwiramanond *et al.* (1996: 19-20) note in the same context that young men have few responsibilities and much freedom, including becoming sexually experienced, while young women have much less social freedom, and find it difficult to acknowledge their sexual feelings. Culturally-ascribed desirable attributes of young women make it difficult to negotiate for safe sex practices. The authors describe safe sex as a 'survival imperative for the current and following cohorts of young people in Thailand', and make strong recommendations about programs to support safe sex practices and remove the barriers which restrict access to reproductive health services. These barriers affect the entire mass of the youth population, although Tantiwiranond and co-authors referred in particular to young rural-to-urban migrants, and return migrants. A useful summary of the gender structuring of sexuality has been provided by Ford and Kittisuksathit (1996a:28), based on their analysis of the results of focus group discussions, and is shown on the following page.

4.2.2 Experience of heterosexual intercourse, and safe sex practice

A comprehensive study of the experiences and attitudes of Thai youth (Podhisita and Pattaravanich, 1995) demonstrates the extent to which this conventional construction had changed by the first half of the 1990s. A nationally-representative sample of 2,180 unmarried and married adolescents aged 15 to 24 were interviewed for the study. Among males, approximately 45 per cent of both the urban sample and the rural sample had ever experienced sexual intercourse, and more than 90 per cent of these had had sex before marriage. For female adolescents, the equivalent figures show that 28.9 per cent of the urban sample had experienced sexual intercourse, and 47.0 per cent of these had done so before marriage. In rural areas 37.5 per cent had ever had sex but only 17.2 per cent of these had done so before marriage. Among the adolescents who had sex before marriage, it was unprotected sex for 63.0 per cent of urban males, 49.8 per cent of rural males, 35.0 per cent of urban females and 13.2 per cent of rural females. The main reason for adolescent women agreeing to premarital sexual relationship, according to a study of secondary students by Tungphisal *et al.* (1989), was to gain experience and prepare themselves for marriage. This opinion was shared by 15 per cent of the female students.

GENDER CONSTRUCTION OF THE SEXUALITY OF YOUNG MEN AND WOMEN		
Dimension	*Young men*	*Young women*
Social acceptability of premarital intercourse	Commonly first sexual experience was wet dreams or masturbation. Pre-marital intercourse accepted and expected for young men. Young men who are virgins are ridiculed by their peers.	Masturbation uncommon, considered negatively. Pre-marital intercourse strictly unacceptable for 'respectable' women. Such activity considered to be highly damaging to the reputation of the young women and her family.
Attitudes to sexual feelings	Positive, open. Strong psychological sense of sexual drive which demands 'release' and justifies coercion occasionally. Sex is for enjoyment. A subject discussed with humour and much slang.	Generally negative attitude to sexual feeling. Great reluctance to admit having such feelings. In the rare admission of sex taking place, justified in terms of pleasing partner and sustaining relationship.
Actual sexual experience	Practically universal. Often first (and much subsequent) intercourse taking place with prostitutes. Belief that the level of non-commercial sex is increasing.	Very difficult to identify because of the extreme reticence on the part of young women to admit sexual experience. Articulate definite steps and limits in sexual interaction - holding hands, hugging, kissing.
Attitudes to condom use and contraception	Condoms used in varying degrees of consistency with prostitutes but not with (non-commercial) girlfriends. Contraception viewed as the woman's responsibility.	Would like to know more about contraception. Generally not considered seeking or requesting contraception because they would fear being stigmatized as sexually active.
Attitudes to negative consequences of sexual activity	The core of men's sexual freedom is that such activity has no impact upon their reputation. Mixed attitudes to the risk of HIV from prostitutes. Pregnancy is the woman's problem.	The greatest perceived harm revolves around the women's reputations. Pregnancy feared because shows evidence of 'sinful' behaviour. HIV/STDs not perceived as salient issues.

Source: Ford and Kittisuksathit (1996a: 28)

The major departure from the conventional view in this study concerns the first sexual partners of male adolescents. The most common type of partner for the first sexual partner was a (steady) girl friend or fiancee, and the next was a female friend or acquaintance. Together these two categories accounted for 82.2 per cent of urban males with sexual experience, and 70.1 per cent of rural males. For 13.7 per cent of urban male adolescents, and 22.3 per cent of those in rural areas, the first sexual experience was with a sex worker. Only a small proportion had waited until they were married before experiencing sex, 4.1 per cent in urban areas and 7.6 per cent in rural areas. Among adolescent women, the equivalent figures were 52.1 per cent for urban areas and 75.7 per cent for rural areas, and almost all of the remainder said that their first partners were steady boy friends or fiances. Podhisita and Pattaravanich conclude that their findings 'seem to suggest that the sexual tendency of young people today is toward early and premarital sex with a non-commercial partner'

In a study of sexual experience among final-year secondary school students in Suphanburi province, Nucharnat (1988) found that 40.6 per cent of male respondents and 6.6 per cent of female respondents had experience of coital sexual intercourse. Among the male students, more had experience with sex workers (27.5 per cent) than with girlfriends (19.0 per cent), while female students had only had coital intercourse with their boyfriends, and they had experienced sex once only while the male students may have had sex two or three times in a year. This study included comprehensive information about age at first intercourse, the place where it occurred, experience of sexually transmitted disease, causation of pregnancy and resort to abortion, knowledge and use of contraception, use of pornographic print and video material, and visits to places of entertainment. This study used self-administered questionnaires from 411 male students and 425 female students.

In a large sample of 1,981 secondary students (in all grades) from Sukhothai province, Paisalachapong *et al.* (1992) found 149 boys and 12 girls who had experience of sexual intercourse. More than half of these had used condoms in their sexual encounters. Of the 149 male students with experience of intercourse, 47.2 per cent had visited sex workers, and of these 22.4 per cent had contracted sexually transmitted diseases. The authors regarded it as crucial to disseminate AIDS information through the use of all types of media and the efforts of health workers, physicians and teachers.

A somewhat lower level of condom use (39 per cent) was found in a study of male university students in Khon Kaen by Thiramanus (1994). This study found that students living away from home had higher exposure to risk of HIV infection.

In earlier sections of this paper, there are references to other studies investigating patterns of condom use, much more frequent in sexual encounters with sex workers than in cases of intercourse between girl friends and their boy friends (Mahuttano, 1996). There are also references to the finding that adolescent males know more about using condoms than adolescent females do (Sareethakun, 1994; Suntharasaj *et al.*, 1994). Such findings are consistent with those of Ford and Kittisuksathit (1996a, 1996b), and emphasize the gender issue of unequal negotiating rights for safe sex.

Students in the non-formal education sector, for whom education is provided through a formal department of the Ministry of Education in Thailand, have also been

included in one study in northern Thailand (Sampantasith, 1992). Among 95 students, 6.3 per cent reported having had sexually transmitted diseases.

A study of electronic factory workers ranging in age from 15 to 24 in Pathumthani province (Suparp *et al.*, 1992) revealed a high level of premarital sexual experience among this relatively older group. Among the 157 males, 68.1 per cent had experience of sexual intercourse, compared with 21.0 per cent of 166 female adolescents in the sample. Most of the males who had sexual experience had visited sex workers, and 22.9 per cent of all the males had contracted sexually-transmitted diseases, compared with 0.6 per cent of the female adolescents. Among the married males, 27.8 per cent continued to visit sex workers. While more than 80 per cent of both male and female respondents with sexual experience reported that they used contraception, 9.2 per cent reported that premarital pregnancy had occurred and 5.0 per cent reported that they had terminated pregnancies in themselves or their partners by induced abortion.

A very similar proportion (4.15 per cent) of 966 male and female students at secondary, vocational and undergraduate levels in Chiang Mai had sought abortions for themselves (the girls) or their girlfriends (the boys) (Srisuphan *et al.*, 1990).

The study by Suparp and co-authors (*loc. cit.*) examined actual and preferred sources of information. While most sexual education had been given by teachers or instructors, the respondents thought that doctors and nurses gave the most 'valid' information. They felt that teaching or individual counselling by these professions was the best way to provide sex education. As with studies of students, self-administered questionnaires were also used in this study.

A study of factory workers in Bangkok and surrounding provinces was undertaken by Ford and Kittisuksathit (1996a, 1996b). They used a combination of focus group discussions, structured interviews and in-depth interviews among young, single factory workers aged 15 to 24, in-depth interviews with sex workers who were formerly factory workers, and interviews with factory owners and managers. There were 18 focus group discussions, 2,033 structured interviews and 25 in-depth interviews. The report of this study presents extensive evidence from the focus-group discussions and case studies. The objective of the study was to describe development of the sexual culture of adolescents working in factories, so as to derive policy and programme implications, within an explicit assumed context of threats to sexual health associated with rapid industrialization and rural-to-urban migration. The findings suggested the existence of 'a growing plurality and complexity in young people's sexual lifestyles and networking', but the main policy concern was a very low level of condom use within non-commercial premarital relationships.

In the north of Thailand, Buakamsri (1997) examined the hazards to health from the working and social environment for 49 migratory and 25 local factory workers in the Northern Region Industrial estate in Lamphun province. The health risks were mainly associated with the working environment, which produced health problems ranging from chronic headaches, exhaustion, strain, allergy, respiratory system disease, occupational injury, and motor vehicle accidents, to spontaneous abortion. During 1993-1995, at least 12 workers had died, but it was not clear whether HIV infection was responsible, or chemicals and other hazardous substances. The social

environment for the workers was a seedbed of sexual risk. Isolated from their families and communities in dormitories, young men sought entertainment in drinking and entertainment nightspots, while single females found lovers. From outside the factories, male students favoured factory workers as sex partners because they perceived lower risk of HIV infection than from sex workers.

Cash *et al.* (1995) also singled out peer culture as one of the most important influences on the behaviour of their adolescent factory worker respondents, whether male or female. They used an intervention approach in which they compared behaviour after use of information materials with a control group, and a separate intervention using health promoters and peer leaders. Peer leaders were found to be the most effective in influencing attitudes and behaviour. Similar findings by the partly overlapping research team of Chuamanachorn *et al.* (1997) have been mentioned in section 3.2.3.

Another study of factory workers was undertaken by Jariyawong (1996) in Nakorn Ratchasima. Approximately one quarter (26 per cent) of respondents accepted having heterosexual intercourse. Of those who did accept intercourse, the study found that 10 per cent of the respondents had contracted STDs, unplanned pregnancies had occurred in 23 per cent of cases, and 18 per cent had induced abortions themselves or by their girlfriends. These figures are comparable to the studies from central Thailand, after allowing for the fact that the figures refer only to sexually active students.

A comparative study of 250 unmarried female secondary school students and 250 unmarried female factory workers from Bangkok was undertaken by Soonthorndhada (1996), both groups being restricted to the age range 15-19. The study also included twelve focus group discussions with participants drawn from the same sample frame. While there was an explicit emphasis on using samples of comparable age from the two sample groups, the factory workers were almost a year older than the students on average (median ages 17.0 and 16.1 respectively). The main findings of the study were that 'conditional stimuli and environmental factors', such as drinking alcohol, viewing pornography and making friends with boys, were the main determinants of adolescent sexual interactions. There was a contrast between students and factory workers concerning contraception, with the students showing more awareness of the methods but the factory workers had greater awareness of where to obtain services. The study report makes effective use of statements from focus group participants.

Among the many studies of students and factory workers, there are relatively few of adolescents in other settings. One is the study of rural youth and AIDS prevention, conducted by Ayuwat *et al.* (1995), which found different preventive strategies and behaviour among adolescent males and females. The young men favoured the use of preventive measures in the sex act itself, by use of condoms. The young women favoured avoidance of intercourse, and a change of sexual attitudes and values.

4.2.3 Other aspects of adolescent sexuality

Two studies carried out in north-eastern Thailand add significantly to understanding of the socialization process for adolescents, by describing what young people find attractive and unattractive about the opposite sex. Thumakarte (1996) found that adolescent males and females had different standards, particularly concerning the

attractiveness of young people of the opposite sex from intact and broken families. Madsathan (1993) enumerated the specific characteristics of members of the opposite sex that were 'mostly liked' by adolescents in Khon Kaen. According to this study, the physical appearance of a member of the opposite sex should be good-looking, having a beautiful or handsome face, having a good figure and a nice complexion and using modern grooming. The person should be bright and intelligent, good at sports, have musical ability and good communication and artistic skills, and have the psychological characteristics of diligence, kindness, honesty, leadership ability, ability to follow, a good sense of humour, and punctuality. There is nothing surprising in this catalogue of desirable attributes, except perhaps the realization that the ideal is unattainable.

While all of the studies described in section 4.2.2 and the above parts of this section add considerable detail to the general situation that had been described by Soonthorndhada (1991), it should be noted that the definition of sexual relations that is implicit in all of the studies cited so far seems to exclude homosexual encounters.

Kunakorn (1989) examined homosexual behaviour and attitudes towards homosexuals among senior secondary school students, both boys and girls. There were about five times as many girls as boys among the 4.7 per cent of students who had engaged in homosexual behaviour, and the author estimated that 24.4 per cent of female students compared with 8.5 per cent of male students were at 'high risk' of homosexual behaviour. All-girl schools had the highest level of homosexual behaviour. Correspondingly, more girls had favourable attitudes towards homosexuality than boys. This study used a self-administered questionnaire among a sample of 470 male and 495 female senior secondary students in the three provinces of Nakhon Phathom, Pathumthani and Nonthaburi fringing the Bangkok metropolis on the west.

There is a suggestion here that the limitation of most studies of adolescent sexual behaviour to heterosexual behaviour is a deficiency in the social and cultural context of Thailand. Soonthorndhada (1996: 27) has pointed out that when the female focus group participants in her study were given free reign to define the terms of their discussion of sexuality, they explicitly limited the scope to heterosexual activity. However, a selection of statements from her focus group participants illustrate a strongly positive attitude towards lesbian sexuality (reproduced on the following page from Soonthorndhada, 1996: 28 - the first three statements are from students and the remaining three from factory workers).

As the perception that homosexuality is not part of adolescent sexuality in Thailand also informs most of the studies that have been discussed here, it raises a question about methodology for future studies. This is also the case for male homosexuality, because of the prominent public health issues.

Lesbian Sexuality is Accepted in Thailand

Statements from students

- I think those who are interested in the same sex do not always have sexual relationships. They might have similar interests, similar opinions.
- I think close relationships between women is much better than between men and women. You will never get pregnant or catch a disease. You are safe and secure.
- I think women liking women is much better than men liking men. It's disgusting, don't you think?

Statements from factory workers

- I know some of them in this factory. They live together and I can't see any harm.
- In this factory, many women behave like a man. I think it is a good thing so that no-one can interfere with you and exploit you, especially the men.
- I think women liking women is OK. They look lovely.

Source: Soonthorndhada (1996: 28)

4.2.4 Deliberations of consultative groups

An important issue raised at the meetings in the North and North-east regions was the extent to which modern living environments (for example, in factories) promote sexual risk. Having sex with multiple partners was widespread in the dormitories for both men and women.

In the consultative meetings held in Khon Kaen and Bangkok, participants directed attention to the issue of sexual behaviour that leads to a high level of early and unintended pregnancies. There was a need for research on the social support which is available to adolescents who become pregnant.

Consultative group summary

- *Modern living environments (for example, dormitories and factories) promote sexual risk and lead to high levels of early and unintended pregnancies* ***[Northeeast and South regions]***
- *Research is needed on social support for adolescents who become pregnant* ***[Central region]***

4.3 Menopause and the Elderly

Later Life from a Gender Perspective

- In Thailand, there have been several studies on sexual activity during and after menopause, using small-area population samples. Some of these studies have featured inadequate quantitative analysis
- Negative attitudes towards sexual relationships past menopause are described in some studies. There is a gap in research into associated risks among elderly people who then seek extramarital partners
- There is no research into the reproductive health needs of older people in Thailand

4.3.1 Sexual activity in menopause

Reproductive health needs during menopause and older ages remain a neglected area for research in Thailand. Chomputhawip *et al.* (1990) noted that when they carried out their study there were 'virtually no data on the age distribution of the menopause and no information on its sociocultural significance in the developing countries including Thailand'. They interviewed 2,371 women aged 45-59 in the Bangkok Metropolitan area, and of the sample 1,264 had already experienced menopause.

The factor found to be most strongly associated with higher age at menopause was a high number of children ever born, although there was also a significant relationship with later age at menarche, and marginally non-significant association with use of the oral contraceptive pill and body mass index of 19 or above. It should be noted that the analysis of age of menopause was done without allowing for selection effects. A survival analysis would have been more appropriate.

Of more relevance in the context of health issues is that women who had already experienced menopause reported significantly lower incidence of a large number of conditions which are often associated with the pre-menopausal phase of women's lives. These included dizziness, irritability, headache, fatigue, palpitation, insomnia, hot flushes, breathing difficulties, night sweats and depression. Only 13.1 per cent of women who had already experienced menopause reported that they had normal or increased sexual desire, with 27.5 per cent reporting that they still had sexual desire but at a decreased level, while 59.4 per cent said they had no sexual desire at all. The latter proportion corresponds closely with the proportion (60.8 per cent) who said they had stopped having sexual intercourse in menopause. Of the menopausal women who were still having sex, one in seven reported difficult or painful coitus (dyspareunia).

A somewhat different sampling strategy was used by Tungphisal *et al.* (1991) to select one hundred women who had stopped menstruating for at least twelve months and attended the gynecological clinic at a hospital in Songkhla from March to September, 1989. The study excluded women who were on hormone replacement, had endocrine disorder, or were in the process of being widowed or divorced. The purpose of this study was to examine sexual experience and responsiveness after

menopause. Of the 100 cases, 89 reported loss of libido, 78 orgasmic dysfunction, and 35 per cent dyspareunia. Only 5 women did not report decreased sexual desire. The authors commented that 'for older women with traditional gender role expectations, sexual activity may depend on large extent on partner availability and interest, partner competency, and socio-cultural expectations of appropriate sexual behavior of older individuals' (*loc. cit.*: 146). This study also featured biased estimates of age at menopause, that is, survival methods should have been used.

Another study of this type was conducted by Kamolchum (1997), using a sample of 384 post-menopausal women aged 45 to 59 in Ratchaburi province. Almost all of the respondents had experienced at least one health problem such as headache (reported by 57.8 per cent of respondents), weakness (49.5 per cent), palpitation (45.6 per cent), insomnia (42.4 per cent) and hot flushes (36.5 per cent). The study found that better nutritional status was associated with higher age at menopause, and smoking with lower age. As with the previous two studies, the analysis of age at menopause in this study could also be criticized on the grounds of selection effects. Decreased sexual desire was reported by 71.3 per cent of the married respondents, and most also reported decreased occurrence of sexual intercourse.

Also on the topic of sexual relations at the time of menopause, Isarangura na Ayudhya (1995) interviewed 283 women aged 45-53 from military dwellings in Rajtavee district of Bangkok. Besides personal interview, the study used measurements of hormone levels in the respondents. The author determined that factors significantly associated with adaptation during the period of menopause included the social factors of occupation, number of children living in the family and economic status, the psychological factors of satisfactory marital experience and good body image, and the physical factors of chronic disease and estrogen deficiency. Some of these factors (occupation, chronic disease and body image) were not significant in a multivariate analysis.

A study by Daengpiam *et al.* (1998) examined reported symptoms of menopause among 205 female staff of Chiang Mai University, and also the factors conducive to adaptation. The most common symptoms, in order of prominence, were problems related to bones and joints, menopausal syndrome, hot flushes, psychological symptoms, problems related to reproductive tract infections and sexual relations, and urinary tract problems. Positive socio-environmental conditions, and good relationships with family members and relations were factors conducive to adaptation. Previously good health status appeared to lessen the severity of symptoms of menopause.

In north-east Thailand, several recent studies (Imsudjai, 1997; Konsuntea, 1998; Sombutlah, 1998; Tonmat, 1996) have investigated the quality of life of women as they pass through menopause. It was found that women had not been concerned much for their health as they approached menopause, and they experienced stress and psychological disturbances without appropriate coping measures, when menopause occurred.

4.3.2 Sexual activity in old age

There have been few studies on sexual activity in old age in Thailand. Sawatpol (1990) found that most of his sample of 3,000 people aged 60 or more in Bangkok disagreed with having sexual intercourse, women more than men. Altogether 67.5 per cent of the sample had a negative attitude to sex. Just under half of the women thought that sexual activity should have stopped by age 60. A different way of looking at such figures is to note that they imply the existence of substantial minorities of elderly Thai people who continue to enjoy sexual relationships. What problems do they face in their sexual activity? What services or programs can be offered to rectify these problems? If some older Thais have negative attitudes to continuation of sexual activity into old age, do their partners look for other partners and expose themselves to risk? According to Thongkrajai (1997), the reason that the incidence of sexually-transmitted diseases increases with age of women is that husbands engaged in extramarital sexual activity are less likely to take precautions when their wives are no longer likely to get pregnant.

It is evident that studies on menopause and the elderly, concerning gender and sexuality issues, have been limited in scope so far. It is also evident that fundamental methodological flaws have affected some studies of menopause.

4.3.3 Deliberations of consultative groups

All regional meetings reported that there were only a few studies on this topic. For instance, participants in the Bangkok meeting could bring to mind only one study about sexual attitudes among the elderly. The meeting in Had Yai turned to the question of how couples cope when either partner wants to put an end to sexual activity. There was risk if extramarital sexual partners became involved. Another issue which had not been given much attention was that of unintended pregnancy during menopause, after abandonment of contraceptive protection.

Consultative group summary

- *There are few studies on gender and sexuality in menopause and among the elderly* ***[Various regions]***
- *Research is needed on what happens when one partner wants to put an end to sexual activity, because of the possibility of risk of exposure to STDs and HIV/AIDS in extramarital relationships* ***[South region]***
- *The occurrence of unintended pregnancy during menopause has been ignored in research* ***[North region]***

4.4 Sexual violence and abuse

4.4.1 Gender and asserted power

In Chapter 1, imbalances of power between men and women, and the accompanying occurrence of violence and abuse, were identified as integral components of the construction of sexuality within any society. Violence and abuse is perceived as a phenomenon accompanying contemporary society, in which women and children are the victims. On logical grounds the truth is that it is the perception of violence that has changed more than its prevalence. There are very few studies of violence between the sexes and generations in Thailand, and fewer that employ a gender perspective. In this section, the aim is to sift existing studies for context.

Violence as a Quintessential Gender Issue

- Power associated with perceived gender roles is asserted through abuse and violence, and it also attracts violent retaliation
- Neither the incidence of violence nor its causes have been described adequately in existing studies in Thailand
- Studies do show that
  - sexual abuse and violence exists in Thailand
  - women usually know the men who have abused them
  - sexual abuse affects sex workers
  - sexual harassment and favoured treatment of workers who submit to sexual relationships exists in factories and other workplaces
  - conflict can result in suicide attempts

4.4.2 Violence against wives and husbands

In the north of Thailand, in Mae Sot District of Tak province, Sawasdiwuthipong *et al.* (1994) incidentally studied the epidemiology of injuries in the year 1991. After excluding other sources of injury, there were 142 cases of assaultive injury. Among these were 10 cases of men assaulted by their wives and 4 cases of women assaulted by their husbands. There were no deaths. It can be observed that reported incidence might bear little resemblance to actual incidence, and depend on the ability to report cases, the seriousness of the assault and injuries received, and the willingness of the authorities to accept the reports. During the months July, August and September, 1998, the *Chiang Mai News* reported five homicides involving husbands and wives. Among these, four men had killed their wives with guns, sharp instruments or battery, while one battered hill tribe woman had killed her husband. Evidently, these cases also cannot be regarded as a representative sample, but they serve as counterfoil to the formal study reported above.

After searching documentary evidence, Thongkrajai and Anawatchapong (1996) noted that although women were frequently victimized violently by men, there were

times when women too were the agents of violence against partners who caused domestic stress.

4.4.3 Other sexual violence

A study of sexually abused women confined in psychiatric wards (Keowkingkaew, 1995) is hardly likely to be representative of all cases of sexual abuse, but it gives important clues into the patterns of abuse in the society. Almost one-third of the cases were former sex workers, most were unmarried, aged between 15 and 20 years, and poorly educated. Most of them knew well the men who abused them, and many of the men were relatives. The psychological characteristics of the women made them vulnerable to entry into commercial sex, since they considered that their lost virginity had been their most valued possession.

Nopkesorn *et al.* (1991) reported that more than one third of 202 new military conscripts in the north had had sexual relationships with school girls, and 4.6 per cent admitted to rape. These observations were incidental to their study of HIV infection.

Sexual harassment in the workplace undoubtedly exists in Thailand, at a high level. Buakamsri (1997) noted the occurrence of harassment by male supervisors and managers of female factory workers of Lamphun province. Sexual favours were requested in exchange for promotion or other benefits. However, the workers were reluctant to discuss these matters with the researcher.

4.4.4 Suicide

Sermpanich *et al.* (1994) interviewed 122 patients who had been admitted to a hospital in Chiang Mai after attempted suicide, and their relatives. The most prominent cause of attempted suicide was dispute between husbands and wives. Briefly, the study found that single men were more likely to attempt suicide than single women, and married women were more likely to attempt suicide than both single women and married men. However, women in the years of menopause aged 46-55 years were more likely to attempt suicide than men of the same age. The reasons for these patterns were not explored.

4.4.5 An analytical problem

Neither the incidence of violence nor its causation has been adequately described in the body of existing studies of sexual abuse and violence. Indeed, selective sampling could have produced quite misleading results in some of the studies reported here. The lack of worthwhile studies in this area is an impediment to the description of the characteristics of sexuality in Thailand, as manifested in relationships of power between the genders. At the consultative meetings in all regions, the central role of violence and abuse in reproductive health was affirmed strongly.

5 Methodology

5.1 The ideology of sexuality and gender in Thailand

- Almost all types of study design have been used in reproductive health research in Thailand, including descriptive, prospective, retrospective, and demonstration (or model) projects

- While valuable insights are increasingly being provided by qualitative research, the distinction between 'qualitative' and 'quantitative' is essentially misleading. The principle is logical research within a sound theoretical framework

- Research is often conducted without clear exposition of the theoretical framework. In reproductive health research, this means acceptance of the prevailing constructed ideology about sexuality in Thailand

- The ideology of sexuality in Thailand is usually interpreted in terms of a double standard allowing men sexual freedom and restricting women. This 'all-pervasive gender construction of sexuality' (Tantiwiramanond *et al.*,1996) limits analysis when rapid change is occurring

- There is limited recognition of the forms of sexuality, particularly adolescent female homosexual behaviour. Overlap between the homosexual and heterosexual spheres (bisexual activity) is also mainly ignored in studies in Thailand

5.1.1 Framework of research

Tantiwiramanond *et al.* (1996) and Bennett (1993) have described four major categories of studies on Thailand's reproductive health situation. The first and most common category consists of descriptive studies, which aim to describe the reproductive health, gender or sexuality issues affecting a population, group or individual. Descriptive studies have been useful in describing the situations of minorities or hard-to-reach groups, such as adolescents, intravenous drug users, sex workers and ethnic minorities.

While distinct, prospective studies and retrospective studies have similar intentions, to describe or measure the effect of a program of intervention affecting a defined population, group or individual. Usually, the research subjects will have already been described in previous descriptive studies, although a prospective or retrospective study also usually includes a descriptive component. A prospective study contains at least two rounds, one undertaken before an intervention, and the second after the

intervention. A retrospective study attempt to collect information about the situation before an intervention after the event, in a single round.

The fourth category of research consists of demonstration research projects (or model projects), in the areas of family planning, maternal and child health, HIV/AIDS and STDs. There is often a strong participatory element involving community or other non-government organizations in cooperation with the members of the target group for an intervention.

Both qualitative and quantitative methods can be described in terms of these four types of studies. As Tantiwiramanond *et al.* (1996: 15) point out, some of the most useful sources of information for intervention programs are qualitative studies that describe underlying social, cultural and behavioural processes. The distinction that is commonly made between qualitative analysis and quantitative analysis is essentially misleading, and that there is an over-riding principle of logical analysis within a sound theoretical framework or model. Both quantitative and qualitative methods have strong utility for different tasks within a logically-ordered research framework.

Research frameworks can be explicit or implicit, but they always exist whether or not they are set out. If not set out explicitly, the framework within which research is carried out often contains a set of assumptions about which not even the researcher might be completely conscious. These assumptions will actually comprise a model, partial or complete. The aim in this section is to identify some of the major components of this ideology as it has been actuated in the research studies that are catalogued here.

5.1.2 Ideology of sexuality in Thailand

Most research on sexuality in Thailand continues to be done within a traditional ideology, of which the main component is the assumption that there is a 'double standard' which allows men great sexual freedom, especially before marriage, and places strict limits on the sexual activity of women. There is no doubt that in parts of Thailand this 'main culture', as Hiranpeuk (1996) called it in a study of the southern part of Isarn (north-east Thailand), was male dominant. She encouraged all women to search for alternatives that would enhance their capabilities based on gender analysis of their human and material resources, to promote gender equity. Tantiwiramanond *et al.* (1996), citing Saiprasert and Ford (1993), describe this approach as 'an all-pervasive gender construction of sexuality'. They note that the assumptions engendered by this construction are unhelpful in a situation where rapid change might be occurring. Baewkeb (1992) noted that gender roles perceived as 'new', and adopted mainly by couples who married at older ages or had high educational attainment, produced more satisfaction within marriage in a study in north-east Thailand.

Recent research, especially by Soonthorndhada (1991, 1996), has pointed out other limitations of the traditional ideology, namely its assumptions about the forms which sexuality can take. It is sensible to define sexual activity within marriage to be mainly heterosexual (although evidently both women and men can have additional extra-marital partners of the same sex as themselves). It would be fallacious to assume that heterosexuality is necessarily the form of sexual relationships before marriage. In

Thailand, restriction of attention to heterosexual behaviour might be particularly misleading for women, because of the traditional restrictions on heterosexual relationships before marriage. A more complete framework for analysis would include greater recognition of lesbian relationships as an outlet for female sexuality in Thailand.

Recognition of the range of forms of sexuality is important not only for understanding behaviour before marriage, within marriage and outside marriage in Thailand, it is also extremely important for modelling disease transmission. It can be noted that female homosexual behaviour is not a major route of transmission of HIV/AIDS, unlike unprotected male homosexual behaviour and unprotected heterosexual intercourse. Moreover, lesbian relationships carry no risk of unwanted pregnancy. The more important point is that it is not so much the form of sexuality that results in disease transmission, rather it is having multiple partners. Homosexual men have no higher risk than other members of the population if they and their partners have never had other partners.

The traditional ideology emphasizes the permissibility of male sexual encounters with female sex workers, especially for unmarried men but also for married men with varying degrees of acceptance. This is identified as the major route of acquisition of HIV/AIDS by men and subsequent transmission to women. Homosexual transmission is identified as a separate non-overlapping sphere, although no such separation exists in the case of another high-risk activity, namely intravenous drug use.

Without dismissing the importance of a thorough understanding of Thai culture when undertaking research in Thailand, it is very evident from the reviews in Chapter 2 that the ideology has limited the understanding of important social processes which have intimate connections with reproductive health.

5.2 Limitations of method

5.2.1 Gender-sensitive analysis

- Three criteria can be used to detect whether a gender-sensitive approach has been used in a piece of analysis:
  1. Has the study considered the gender aspects of the topic at all?
  2. Have gender aspects of study design, conduct of the study or analytic method been treated properly?
  3. How has the gender content of the results of the analysis been presented?

- Besides lack of gender sensitivity, research can be affected by limitations introduced by definitions, limitations of scope, ethical limitations, problems affecting qualitative research methods, and problems of quantitative analysis

There are at least three different ways in which a piece of research can be judged against basic criteria of gender-sensitivity, first by examining whether the study has considered the gender aspects of a topic at all, second by assessing the study design, conduct of the study or analytic method, and third by analysing the gender content in presentation of the results of the analysis.

Omitting consideration of gender aspects of a topic is only rarely a matter of failing to collect information distinguishing the male and female sexes. It also includes limitations introduced by definitions and by the scope of a study. Limitations in conduct of the study can conveniently be divided into three groups: ethical limitations, problems affecting qualitative research methods and problems of quantitative analysis.

When a study has already been conducted, limitations of design, conduct and analytic method cannot be removed retrospectively, but different interpretations of results are frequently possible, using a gender-sensitive perspective different from that taken by the researchers presenting the results. Such differences in interpretation are the stuff of normal academic debate and consequent policy formulation. The existence of different interpretations does not necessarily signal that one interpretation is correct and another is not. It might simply mean that the information can be viewed from different perspectives, as is the case with information that has bio-medical interest as well as implications for reproductive health. It is also sometimes possible to re-examine the same set of data (in a so-called 'secondary' analysis) from a different, gender-sensitive perspective.

The review presented in Chapter 2 identifies a number of specific and recurring limitations which have affected analyses carried out in Thailand. In the following sections They are discussed according to their place in the sequence of designing, conducting and analysing a collection of information.

5.2.2 Limitations of definition

- Research studies are not value-free, although theory is not always explicit
- Definitions are prone to influence from gender ideology
- Clear definitions of the key terms 'gender', 'sex' and 'sexuality' are given in Chapter 1
- Other key terms are not defined, e.g. 'adolescence'

- Terms such as 'abortion' and 'rape' are loaded with legal, moral and emotive overtones
- Research into pregnancy termination should be conducted in the context of consequences of unwanted pregnancy
- The analytical context for rape is research into unequal power relationships and the assertion of power·

As has been emphasized in discussion of the ideology of gender and sexuality in Thailand, research studies are not value-free and they are carried out within a framework of theory, whether explicit or not. Definitions are particularly prone to influence from gender ideology, and some terms such as 'abortion' and 'rape' are so loaded with legal, moral and emotive overtones that their use in academic discourse becomes difficult. For example, research into (induced) abortion outside its context of analysis of the consequences of unwanted pregnancy is difficult to carry out, because of the illegal status of pregnancy termination in Thailand as well as the religious perception that it is immoral. Similarly, research conducted in the context of the legal definition is difficult to interpret. Like abortion, rape finds its analytical context in research into unequal power relationships and the assertion of power, whether inside or outside marriage no matter what the law states.

Other terms also carry overtones, which might sometimes interfere with conveying the message of a piece of research. In this volume there are clear working definitions of the key terms 'gender', 'sex' and 'sexuality', as discussed in section 1.1, but there are no precise definitions for other important terms such as 'adolescence' Even where the meaning which is ascribe to terms has been given, the definitions probably differ from those used by authors of some of the studies that are discussed.

An outstanding example of a definition confusing an important gender issue is the way in which infertility has been defined. For instance, Sukhavachana (1967) described infertility of women in Thailand with various cause, among them 'male seminal defects'. While describing male infertility as female would be merely amazing in a value-free context, female infertility is an issue of serious gender concern because it is the woman who is usually blamed when a couple does not succeed in having children. It is therefore invidious to treat a male condition as part of female infertility, especially when some women agree to accept treatment that is possibly dangerous (Achavanitkul and Boonmongkon, 1996). More subtly, genuine female infertility is frequently caused by diseases contracted from male partners. This happens when sexually-transmitted diseases such as gonorrhea, chlamydia and trichomoniasis cause pelvic inflammatory disease and scarring or occlusion of the fallopian tubes which carry the ova from the ovaries towards the uterus. The same condition sometimes results in dangerous ectopic pregnancies, where the blastocyst attaches to the wall of the damaged tube instead of the uterine wall.

Sometimes definitions are applied to women almost contemptuously. An example is a study of cervical cancer by Thanapatra *et al.* (1988), which used cases described as 'promiscuous' because they came from a sexually-transmitted disease clinic, contrasted with 'non-promiscuous' cases from the National Cancer Institute.

5.2.3 Limitations of scope

- Much of the knowledge that exists about reproductive health in Thailand was obtained from studies of students, factory workers and sex workers
- Significant groups within the population (out-of-school adolescents; agricultural workers; informal sector workers; retail and office workers) are almost invisible in the body of cumulated knowledge
- Client/patient samples are the basis of many other studies. Usually, such samples are self-selected or otherwise selective, even merely accidental
- In many studies there is a lack of attention to men where the male role is important

It is often convenient to limit the scope of a study to a particular geographic area or to a sub-group within the population defined by economic status or some other characteristic. The most convenient people to sample are those within institutions such as schools and factories. An outstanding impression from the review in Chapter 2 is that a very large proportion of knowledge about reproductive health in Thailand is actually derived from studies of students and factories (Buakamsri, 1997; Cash *et al.*, 1995; Chomputhawip *et al.*, 1988; Chuamanachorn *et al.*, 1997; Dinglim; 1990; Ford and Kittisuksathit, 1996; Ittithumwinit and Jirarojwattana, 1995; Kaewboonchu *et al.*, 1993; Kanchanavasee, 1992; Kunakorn, 1989; Mahuttano; 1996; Nucharnat, 1988; Paisalachapong *et al.*, 1992; Phongsiri *et al.*, 1993; Pongthonkulpanich; 1987; Poonsanasuwansri; 1997; Pudharangsi and Kupatachit; 1996; Sampanthasith, 1992; Sareethakun, 1994; Soonthorndhada, 1996; Suntharasaj *et al.*, 1994; Suparp *et al.*, 1992; Yamarat *et al.*, 1992). There are also many studies of sex workers.

By contrast, people who are out of school and working in agriculture, in the informal and casual sector, or in non-manufacturing industries are under-represented almost to the point of total absence, in the body of cumulated knowledge. This is not a limitation of any single study, many of which point out as a matter of course that the results are not necessarily applicable in a wider context. There is nevertheless a distinct possibility that significant patterns of behaviour in under-represented segments of the population remain unremarked, and conversely that apparently universal behaviours do not occur at all in some segments of the population. These limitations can be overcome by directing studies to more representative samples of the population, or to other population sectors.

The next most popular sampling method found in the studies which have been reviewed was the use of clients and patients attending health service delivery points. This sampling method can have proper application in studies of the experience of recipients of particular procedures, for example male and female sterilization as in the case of the study by Yingchankul (1983). A case-control approach is often used in clinical and epidemiologic studies, and could potentially be used in studies of reproductive health, but it is surprising to find little use of this approach. There was a study on breast cancer patients using the case-control method (Chariyalertsak *et al.*, 1989), and a study on giving information on fathers' roles in the post-partum period (Moleechati, 1989).

When a sample is self-selected, as in the case of most client and patient studies that have been reviewed, it is always necessary to ask whether the selected cases are representative of all members of the population with the condition for which treatment is sought. This is most likely to be the case with a life-threatening condition which causes pain and discomfort, for example reproductive tract malignancies. The studies on such patients are therefore likely to be valid for cases generally (Singkaeo, 1986; Paiwuti, 1989).

It is quite unlikely that patients with some other conditions could be representative of all cases in the population, as with clients of an infertility clinic (Anatavuthikanon 1991), clients with sexual dysfunction (Sanesak, 1996), patients seeking treatment for STDs as a source of information on behaviour to prevent onward transmission (Karnthavon, 1998), and prepubertal girls treated at hospitals for vaginal discharge (Sirivongrangson and Pakdewongse, 1995).

Many studies of HIV patients are also of this general type (Asdondecha and Danpradit, 1997; Chintanadilok, 1995; Kraisurapong, 1996; Kongsuryanavin, 1997; Nettip *et al.*, 1996; Pongsomboon 1996). In Thailand, there are many institutions outside the medical system's service delivery points that provide succour and traditional medical treatments to HIV patients, especially at temples. Even the standard sources of information about HIV incidence and prevalence are selective. Information about HIV infection is obtained routinely from pregnant women, and from military recruits in every province. Because the patterns of infection have been modelled, it is possible to use such data to estimate prevalence of infection in the general population, and the incidence of new infections. A similar self-selected source is men and women applying to work overseas (Keesukphan *et al.*, 1994).

Slightly different from self-selected samples are the accidental samples which occur in some studies. An example is a study comparing users of oral pills, injectables and IUDs using a sample of women admitted to hospital (Suwansri, 1983). Studies which involve anonymous HIV testing, as used for example in a study by Reaungsri (1997) of infertile couples, constitute another form of accidental sampling in the sense that the results of the HIV tests cannot be related to the individuals who took part in the study. Accidental samples can be heavily biased, as in cases of septic or failed abortions regarded as representative of all pregnancy terminations (Chareonphat 1979).

Among the many studies which used samples of sex workers, there were few which gave detailed descriptions of the sampling methods. When such details were given, it

was possible to determine that there was a likelihood that the sample was biased. For instance, when Sripothong and Teansat (1993) used interviews with sex workers at STD service delivery points to estimate prevalence of condom use in commercial sex, their sample was biased in two ways. First, it excluded sex workers who did not seek treatment from these points, and second the sex workers who were most health-conscious were over-represented.

A quite different aspect of limitation of scope affecting some studies was lack of attention to men in studies of conditions affecting women, when such attention was warranted. This applied most noticeably in research into reducing reproductive risk among women with HIV infection (Asdondecha and Danpradit, 1997; Kraisurapong, 1996; Nettip *et al.*, 1996), but it also occurred in a study into resumption of sexual intercourse after birth (Jethanamest, 1991). Usually this exclusion of men cannot be averted by the person analysing the data because the study's scope was restricted to women.

5.2.4 Ethical limitations

- It is usually difficult to tell from the published results whether a study has met ethical standards such as informed consent, and maintenance of confidentiality and privacy
- Attention to ethical standards seems to be lax in Thailand
- Strengthened procedures benefit researchers as well as subjects
- Ethics are very important for studies of some gender-sensitive issues

Ethical procedures are an important aspect of research with human subjects, and most research conducted in the 1990s is subject to ethical review to some extent. Ethical procedures typically require informed consent by participants concerning all intended uses of the data collected, maintenance of the confidentiality and privacy of all individual respondents, including such devices as secure storage of records, and separation of identifying information from information to be used for analysis. In many countries a single research proposal might need to satisfy the requirements of a committee within the research institution and another within a funding agency, and possibly other committees as well.

It is difficult to judge, from the published description of any piece of research, whether it has met ethical standards or not. The application of ethical clearance procedures appears not to be always strict in Thailand. Strengthened procedures would benefit researchers as well as providing greater security for people who become research subjects. Ethical considerations intrude heavily into gender-sensitive areas of research. This is the case with research into HIV and STDs, research into behaviour within the ambit of the criminal law, research into abuse and

violence, and research into marital relationships and other interpersonal relationships where any aspect of the research could be interpreted as interference.

A particular ethical issue which became evident, in the review of research that has been undertaken, was that names of hospitals were almost always included in the reports of research studies. Many of these research studies involved highly sensitive issues. However remote the possibility that individuals who participated in the studies could be traced, it is desirable to avoid providing any information that could be used for identifying individuals. In this volume the practice is to omit hospital names even where the names have been mentioned in the research reports.

In the course of this review, a particular matter involving considerations of medical ethics was noticed. This was that according to research by Kraisurapong (1996), testing for HIV often occurred too late into pregnancy, in Thailand, for pregnancy termination to be carried out safely. This involves the law as well as medical ethics.

5.2.5 Limitations of quantitative method

- Two common identifiable problems of quantitative method in studies of reproductive health in Thailand are

  - invalid, biased estimates when survival analysis should have been used in studies implicitly involving censored intervals

  - inadequate distinction between frequency and consistency of condom use

Making judgments about the adequacy of methods from results of research as presented in papers, theses, papers and books is often difficult. It is not intended to try to cover all the issues here. Rather attention is drawn to only two issues, one of major importance and one minor matter.

The major issue concerns failure to use survival methods (life table methods) when they should have been used. While there are some studies which do use survival methods, the problem occurs repeatedly in the studies that have been reviewed, in different contexts. For example, Chicharoen (1994) attempted to analyses length of breastfeeding using a sample of working mothers of children aged 1-12 months who had stopped breastfeeding. Because the study design excluded women who were still breastfeeding, all estimates of average length of breastfeeding are negatively biased. In a different context, there were two studies (Chomputhawip *et al.*, 1990; Kamolchum, 1997) which attempted to analyse mean age at menopause for different categories of women using samples of respondents aged 45-59 who had already experienced menopause. These samples systematically under-represented categories of women who experienced menopause later than average. What is more, the same data sets could actually be used to produce justifiable estimates, by re-including the excluded cases.

In yet another context, Podhisita and Pattaravanich (1995) included some estimates of mean age at first intercourse in their monograph on youth in Thailand. Again the estimates are subject to the same criticism that they are negatively biased, and again the same data could be used to produce more justifiable estimates using methods of survival analysis. There were similar problems affecting estimates of age at first intercourse in one or two other studies, but the topic was ignored in most studies. There is evident utility in being able to estimate, for example, what proportion of unmarried 17-year-olds of either sex who have not yet experienced heterosexual intercourse.

In the review in Chapter 2 there is only one example (Jethanamest 1991) of use of survival methods for analysing a topic in reproductive health. In that study it was the length of the interval before resumption of sexual intercourse after birth. These methods of analysis should always be the first choice for examining intervals of time or age such as the ones that have been mentioned here.

The minor matter of analytical method concerned estimates of condom use. The question can be divided into two parts, the first being the proportion of sexual encounters in which condoms are used, for example involving sex workers and their clients. The second issue is consistency of reported condom use, that is whether an individual condom-user uses them every time there is risk of infecting or being infected. A sixty per cent rate for encounters between sex workers and their clients can be achieved if only sixty per cent of sex workers use condoms but they use them every time, or the same rate can be achieved if all sex workers use condoms but they do not use them with four clients out of every ten. The truth is always going to be somewhere in between. While the two concepts tend to converge when usage approaches 100 per cent, the study by Chiancharoen *et al.* (1995) shows that relatively high incidence of use by sex workers, at 87.5 per cent, can still be associated with low consistency, at less than 50 per cent. There are studies in which the two concepts appear to be confounded (Chantcharas *et al.*, 1992). Poonpipat (1991) made the useful observation that inconsistent use could also be a result of inconsistent supply, even if the intention was to use condoms every time.

5.2.6 Limitations of qualitative method

- Care must be taken in preparing reports of qualitative research, which use only some of the material that was gathered in FGDs and in-depth interviews or by observation
- Self-administered questionnaires are used too often when qualitative methods would produce superior data
- There is an evident need for more multidisciplinary research and participatory research

As observed for reported results of quantitative analysis, it is also difficult to determine limitations of methodology using the reported results of studies using

qualitative methods. This is because reports based on qualitative research typically use only a tiny selection of the material that was gathered in focus group discussions and in-depth interviews or through observation. While it is not possible for us to comment on methods of qualitative research in a general sense, there is one particular observation that can be made.

This is that a considerable number of studies that have been reviewed, particularly studies carried out in education institutions, used self-administered questionnaires to obtain data from the research subjects. While this method of obtaining data is inexpensive and apparently efficient, it is markedly inferior to standard methods of qualitative assessment that could be used in the same situations. Havanon (1996a: 115-118) provides an account of how the personal insights gained from a qualitative approach in her study of sexual networking were enough to change her opinion of the status of women in Thai society, which she had formerly believed to be high. Insight like this would be inconceivable in a study using self-administered structured questionnaires.

Careful attention to qualitative method can be seen in some studies, such as those under the BRAIDS project, from which some of the publications deal specifically with methodological issues. For example, McNamara *et al.* (1994) discuss the internal consistency of qualitative evidence about the reported sexual experience of sex workers.

5.2.7 Methodological innovation

Methodological innovation has characterized much of the research into the changing patterns of sexual behaviour that have accompanied awareness about HIV and AIDS, particularly in northern Thailand. Among the quantitative techniques employed have been sexual and social relations network coefficient analysis with roster network data collection and ego network surveys, while qualitative studies have used linguistic analysis as well as the standard in-depth interview and participant observation approaches. Examples of studies using these methods have been discussed previously in this volume (Bond, 1995; Havanon *et al.*, 1993; Limanonda, 1997; Wijngaarden, 1995).

There are further methodological innovations which could be used to a greater extent than they have been in research projects which have been carried out so far. The value of insights from different disciplines is still recognized inadequately in many research projects on reproductive health issues, even though the topics of gender, sexuality and reproductive health quintessentially require a multidisciplinary approach. Participatory research, in which the members of groups within the community or the members of small communities become more than passive stakeholders, is an approach which recognizes that continuation of the capacity to deliver good research results depends heavily on the sharing of beneficial outcomes.

5.3 Deliberations of consultative groups

5.3.1 Approaches to reproductive health research

There was considerable discussion in the consultative meetings about the way that the emphasis of reproductive health research, policy and funding had shifted away from family planning towards HIV/AIDS. Three of the meetings (Bangkok, Khon Kaen, Chiang Mai) referred to the absence of research on reproductive rights (human rights, women's empowerment). The correct sequence was to talk about reproductive rights first, then reproductive health. In the Bangkok and Khon Kaen meetings, it was also felt that considerations of rights led naturally towards the principal of participatory research, in which, for example, women infected by HIV would also be the people collecting information about HIV infection among women. In every region, there was a perceived need to give more attention to the ethical issue of data collection strategies that preserved the respondents' rights.

Participants observed that there had been a trend away from quantitative research methods (including retrospective studies) towards methods that first involved a combination of quantitative and qualitative techniques and later just qualitative methods. However, there was a need to progress towards techniques including longitudinal studies, case studies, and mind and body mapping for the purposes of reproductive health research. In the Bangkok meeting, participants discussed the need for multidisciplinary research and the involvement of all stake-holders.

In every region, there was discussion about the relative merits of quantitative and qualitative methods. In the Bangkok meeting, it was noted that standard indicators applied to the components of reproductive health were still mainly quantitative. There was a need to create indicators that were more qualitative.

Participants in the consultative meeting held in Bangkok were particularly critical of research using self-administered questionnaires, where more appropriate methods could be used. There were circumstances in which use of this approach could be justified, as in the case of groups that have not yet been studies and are difficult to access, or where the topic is very sensitive. However, if the researcher is familiar with the circumstances of the group and the topic, the self-administered questionnaire should not be used.

In the Bangkok and Khon Kaen meetings, participants criticized the discontinuous nature of social science research. Research on reproductive health should be conducted within a program or agenda, and subject to evaluation and monitoring. In the Bangkok meeting and also in Chiang Mai, participants argued strongly that research on reproductive health should not be separated into components, as for example into the eleven topics discussed in this volume. While the structure of the report could be justified, there were obvious links between the discussion of various topics, and some themes had been assigned arbitrarily under headings. Research into any single component, however, always needed to be related to the larger unified topic. For example, there are clear relationships between family planning, maternal and child health and abortion.

In most of the meetings, there was discussion about the analysis of change, and the fact that most research has been done in terms of ideology. Under circumstances of change, traditional or old beliefs may no longer be applicable in current societies. There was need to reconsider the utility and validity of conventional approaches. A related issue mentioned in the Had Yai meeting was the religion and culture of people undertaking research projects in relation to the research subjects.

Questions of definition were a prominent feature of discussions in the consultative meetings. In the Northern and Southern regions, there was a need to recognize cultural issues, and therefore a requirement for a definition of culture. One definition was the way in which society manages itself to cope with the situations that arise within a given time period. Other definitions focused more on way of life, or on attitudes, beliefs, customs, traditions and religion. The way in which culture was conceptualized affected the way in which research was done and how it was interpreted. Similar observations about the importance of definitions were made in the Bangkok meeting, with reference to definitions of gender, sexuality and reproductive health, violence and rape.

5.3.2 Approaches to male involvement in reproductive health programmes and research

It was noted in every region that the target population for most reproductive health services and for research is women, and quite often the research was only on high-risk groups. This emphasis on the individual meant that most studies disregarded community or family influences in decision-making and other behaviour. The same applied to service delivery. Even though women were the target, there were doubts about how much gender sensitivity there was in service delivery. Health personnel needed to learn about gender sensitivities, for example how to treat pregnant women, or administer any treatment that was related to the reproductive health of women. It was instructive that in the North-east region, educated women always choose to get reproductive health treatments from female medical doctors. In the South, a husband will allow his wife to get reproductive health treatment only from female medical doctors. In general, women prefer female medical doctors.

In the North-east, the health department has started to implement programmes to promote the collaboration of men in reproductive health activities, for example by encouraging the husband to be with his wife while delivering. Unfortunately not many husbands like to do this. Men are also encouraged men to involve themselves in 'maternal' activities, such as in child rearing. These initiatives represented an improvement on previous programmes concentrated on the relationship between mother and child. Participants in the meeting in Chiang Mai referred to a premarital counselling programme involving men, and this programme extended to community level. The programme provides knowledge on reproductive health and also encourages blood testing before marriage.

Participants at the Bangkok meeting argued that research on men's roles have to be included in every aspect of studies of reproductive health. What do men think about women's reproductive health? How do they act responsibly for women's reproductive health? What is their perception about violence? These matters should be the topic of study.

5.3.4 Regional perceptions about research gaps

Turning to the nature of the research that has been conducted in Thailand, members of the team from the North-east region told the consultative meeting there that there was almost no explicit research linking gender or sexuality to reproductive health, and the research team had to read the links into the research studies under review. About half of the research being reviewed was thesis research.

The meeting in the Southern region felt that there was a strong need for research into some topics. Among these were:

- drug issues linked to reproductive health problems
- patterns of medicine use among Muslims
- the consequences of unintended pregnancy among Muslims
- the role of traditional midwives in a region where almost half of all women give birth at home
- a life cycle approach to the risks of HIV/AIDS, through the stages of babyhood, adolescence, marriage, menopause and old age
- a comparative study between the regions about the assistance given through volunteer organizations caring for HIV/AIDS patients (there are evident differences between the availability of volunteers in the south and the north of Thailand).

Among other specific research issues requiring attention, the effects of the current economic crisis on reproductive health status and on the delivery of services was mentioned at most of the meetings. The meeting in Bangkok also raised questions about research into the legal aspects of reproductive health, for example in relation to pregnancy termination. Laws needed to be reviewed in terms of their objectives and biases, leading into advocacy as necessary. More generally, research recommendations should lead to practicable programmes. In this regard, there was need for operational research concerning programme implementation, including programmes on reproductive health that are run by NGOs as well as government programmes. In Chiang Mai as well as Bangkok, participants said that we should be asking whom the research is for. Is it for the researchers, for the funding agencies, or for the people constituting the sub-cultures, classes, rural and urban locations, age groups or disadvantaged groups on whom the research is focused? In this context, participants at the Chiang Mai meeting mentioned the need for both class-based and culture-specific analysis of reproductive health issues.

On issues of sexuality, participants in several of the meetings argued the need for research about homosexuality, including female homosexuals (lesbians), and bisexuals. Specific action would be needed to bring gender issues into public consciousness, to overcome the cultural belief that men are entitled to hold power over women. Advocacy should be directed at students, but there was also a need for advocacy to lift issues that are now private, such as violence and sexual assault within the family, into public issues. The myths cannot be overcome unless they are confronted by the truth.

6 Synthesis and recommendations

6.1 Policy

- The various topics of reproductive health can be viewed in a unified way by adopting a life cycle perspective, in which men and women act out their gender roles, including sexuality, during adolescence and the subsequent stages of their adult lives

- Just as reproductive health is a coherent entity, policy and programs for all aspects of reproductive health should be integrated so that entry-level access to services for any one type of service will lead naturally into attention, as required, for any other service

6.1.1 A unified field of research and policy

In this volume it was convenient to consider issues of gender and sexuality across eleven topical areas of reproductive health. Ten of these topical areas were specified in the terms of reference for the study. An eleventh topic was added, namely sexual abuse and violence, because this topic did not fit well within any of the other topics and it was an extremely important topic in its own right. The question of violence is a central theoretic issue in the construction of sexuality, concerning the power relationships between the two genders and the way in which power is asserted and expressed.

There were various other discrete areas of research which could also have been placed into separate topics, and the fact that this report has adopted a conservative approach does not necessarily do justice to the potency of the case for separation of some other topics within reproductive health. Of these, it is possible that the topic of sexual identity, which has strong overtones of sexuality and gender, was the most difficult for us to handle within the pre-specified framework. While sexual identity is less directly an issue of reproductive health than some other topics, it cannot be ignored in any discussion of sexuality and gender. Within the framework of analysis in this volume there has consequently been less attention to issues of male and female homosexuality, and bisexuality, than might have been expected. Related topics such as transsexuality are discussed only in passing.

Despite its shortcomings, the topical approach has paradoxically served the valuable purpose of emphasizing the essential unity of the issues under discussion. Bozon and Leridon (1993, citing among others Foucault, 1976, 1984) explain how the history of discussion of sexuality has eventually resulted in a discourse, promoted by the medical and biological sciences, which puts the social and cultural construction of sexuality into a secondary role even though 'without [the construction of sexuality] no human desire could actually appear and express itself' in the translated words of Bozon and Leridon (*ibid.*: 1174). In this volume the parts are separated, according to the dictates of various scientific disciplines, and then they are united as a whole again

because the body of research comprised pieces which fitted neatly within a framework that was simple.

The basis of the framework is that the functions and malfunctions which appear as topics within the varied categories of reproductive health have their source within the experience of sexuality of individual Thais as they pursue gender roles throughout the stages of their lives. A life cycle approach to analysis of reproductive health issues is not novel (see, for example, Tantiwiramanond *et al.*, 1996). At a population level, it is possible to assign the various topics of reproductive health to one or more of the specific stages of the life cycle, such as: premarital adolescence; the experience of the early years of marriage; entry into parenthood; middle adulthood and the experience of raising a family; 'the golden age' (which is the Thai description for the stage of life during which men and women can hope to enjoy the fruits of their youthful work and enterprise, and women experience menopause); and finally, old age, which is perceived to begin at about age 60 in Thailand.

This life cycle approach to studies on gender, sexuality and reproductive health is recommended to individual researchers. A deeper level of analysis should be encouraged, in order to examine individual experience of the key periods of the life cycle. In adolescence, there is choice of sexual identity, entry into relationships, risk-taking behaviour (if any), assumption of permanent relationships, sexual activity within and outside permanent relationships, and the adverse consequences of risky choices. For men and women engaged in reproductive sexual activity, there is a spectrum of risks which can affect their reproductive capacity and the health of their partners and offspring. While multiple partners constitute an extrinsic source of risk, the processes of maturation and sexual function of men and women include intrinsic factors which have a bearing on health and well-being. The individual needs of older men and women are differentiated according to the sexual preferences and opportunities which they have, cultural constraints and the effects of aging. The analysis of individual histories through the stages of the life cycle in Thailand would provide valuable insights.

Strictly from a perspective of sexual transmission of disease, three critical stages of exposure to life-cycle risks can be discerned in Thailand:

- choice at a young age of a sexual identity and behaviour pattern which encourages risk-taking behaviour:
    - by young men following a culturally-accepted (but increasingly less typical) pattern of sexual behaviour including visits to sex workers;
    - by young men adopting any of a variety of homosexual and bisexual lifestyle choices which involve multiple partners;
    - by young men and young women following life styles that include premarital sexual activity and the possibility of multiple partners; and
    - (often without choice) by young women and men doing sex work
- extramarital sexual activity by men or women who are also engaged in reproductive sexual behaviour
- extramarital sexual activity during advanced years of age.

As will be clear from the discussion in this volume, these critical stages are specific to Thailand in the sense that they derive from the way in which the construction of

sexuality has occurred in Thailand. A similar individual life cycle approach can be taken to other aspects of reproductive health.

6.1.2 Practical policy; practical programs

Since the topic is much more unified than it appears at first sight, it follows that policy should also aim to address all of the topics in a unified way. To be completely clear about this, policy and programs for family planning, maternal and child health, safe motherhood, infertility, abortion and complications of abortion, sexually transmitted diseases and reproductive tract infections, including HIV/AIDS, sex education, reproductive tract malignancy, adolescent health, menopause and the elderly, and sexual violence and abuse should be integrated. They should be integrated so that entry-level access to services for any one of these types of service will lead naturally into attention, as required, for any other service.

While this is no more than a statement of the reproductive health agenda of the 1994 Cairo Conference on Population and Development, it is endorsed and the attention of policy makers to agreements already made under its auspices is recommended. It is practical and sensible to introduce a reproductive health approach into the delivery of services. The way in which this is done depends on the needs of each country as determined by the cultural construction of sexuality.

6.2 Future research

6.2.1 The scope of future research on gender, sexuality and reproductive health

There is nothing prescriptive in this volume, and it was not the aim to prescribe topics and methods of research. On the contrary, it would be encouraging to learn that someone had deliberated over the collection of information and set out on an innovative research trail that explored matters that are identified in this volume as under-researched. There are many gaps and limitations to the existing body of research, as detailed in Chapter 5 and in the text box on the next page. Some of these limitations refer to the content of research and others to methods of research.

Nevertheless, it is important to emphasize again that before embarking on any research study the researchers need to be aware of gender issues specific to Thailand, including the construction of sexuality. It is essential for researchers in every topic of reproductive health to ask themselves 'What are the gender issues related to this topic?', and then to make these gender issues explicit in their discussion of the research which they undertake. This can be done within the normal process of setting out the theoretic framework of a piece of research.

Research Gaps - National

Men's roles in reproductive health:

- Men's roles in avoiding pregnancy & disease transmission, including condom use with partners other than sex workers
- Men as carers of women and children and supporters of women's choices during health; male involvement in reproductive health and household responsibilities
- Reproductive health problems affecting men, including the gender and sexuality aspects of prostate cancer

The consequences of unwanted pregnancies

- Induced abortion must be placed within a wider perspective of analysis of the consequences of unwanted pregnancies. Who makes decisions? Was the partner consulted?
- Fundamental information on the incidence and distribution of unwanted pregnancies is not available, for adolescents or any other sector of the population
- Decision-making and its consequences, including unsafe terminations of pregnancies
- Counselling and service provision in cases of unwanted pregnancy; sex of counsellor and provider

Sexual activity of the elderly

- Existing studies have an inverted focus on avoidance of sex after menopause
- What risks are encountered when the elderly seek other partners? Is there a problem or not?
- Counselling and support services for elderly people who continue sexual activity

Research Gaps - National
(continued)

Sexual violence and abuse

- Studies into the imbalance of power between the sexes in Thailand
- Empowerment of men and women to share responsibility and decisions
- Health consequences of the imbalance of power:

— Incidence, distribution, causation and resolution of violence

— Reproductive health consequences

— Sexual abuse of children

Sexual identity

- The reproductive health implications of adolescent homosexuality (female as well as male)
- Bisexual behaviour and its impact on reproductive health, particularly for the case of married bisexual men

Reproductive tract infections

- Women's and men's knowledge of reproductive tract infections, at all socio-economic levels

Service Provision

- Attitudes and preferences related to contraceptive use and reproductive health management among providers of each sex

RESEARCH GAPS - REGIONAL

North-East Region

- Cultural differences within the north-east of Thailand and their implications for reproductive health, through gender and power relations in reproductive decision-making
- The use of traditional medicines in relation to sexuality in the North-East
- Conditions with high regional incidence, such as anemia and reproductive tract malignancies, and their impact on maternal and child health

Southern region

- Drug use linked to reproductive health problems
- Reproductive health focusing on gender concerns within an Islamic context, particularly medicine use and the consequences of unintended pregnancy among Muslims
- The role of traditional midwives in the south
- A comparative study with the North region about the assistance given through volunteer organizations caring for HIV/AIDS patients

Northern region

- Reproductive health and gender roles in the cultures of hill tribe minorities in the north
- Forms of sexuality other than coital contact, including male and female homosexuality and sexual networking
- Research into ways to make cervical cancer tests more acceptable and accessible

Central region

- The effects of the economic crisis on reproductive health status
- Legal issues affecting reproductive health (for example, abortion law)

6.2.2 Capability building and training

Before research on issues related to reproductive health can be undertaken in the regions of Thailand, it is likely that specific capability building activities will be necessary. The report has identified priority issues that can be addressed in the training of researchers, nationally and in each region. Research methodologies appropriate to the issues, including qualitative and/or quantitative approaches, now need to be incorporated into the design of training programmes accordingly.

Without prescribing a complete list of training requirements, There is a need for specific training related to the following areas:

Substantive -

- sensitization in the concepts of gender and sexuality in relation to reproductive health, for health and research personnel and the general population
- ethical issues in reproductive health research, including informed consent, discussion of sensitive topics, referral to appropriate medical advice, and the protection of confidentiality
- issues affecting the middle-aged and the elderly
- the reproductive health and sex education needs of young adolescents

Technical -

- appropriate qualitative and quantitative methodologies, including alternatives to self-administered questionnaires, and instruction in survival analysis
- innovative methodologies
- media practice for reproductive health advocacy

6.2.3 Priority research issues

The priority research issues will without doubt include some operations research, such as field testing strategies for male involvement in reproductive health services. Another project priority will be the development of monitoring indicators to assess the extent to which gender issues have been incorporated in programs.

The need for a national survey of reproductive health issues from a gender and sexuality perspective, incorporating qualitative and quantitative elements should be assessed and commissioned if there is a significant demand for comparative benchmark information. A well-defined quantitative objective of such a survey would be to determine the ages at which life cycle events, including the experience of puberty, first intercourse and menopause occur in the different regions, cultural groups and socio-economic categories in Thailand.

Research into the implications for reproductive health of adolescent homosexuality, both male and female, is virtually absent in Thailand. Ideally, the topic should be integrated into all studies of adolescent sexuality, because to ignore homosexual behaviour is to create a distorted impression of sexuality of adolescents. However, the level of knowledge about the topic is currently so low that it is certainly necessary to set down a basis of qualitative research into the topic. At a further stage, the research can be integrated into more general studies about the formation of sexual identity. This type of research is necessary for the eventual development of

appropriate sex education interventions, but sex education initiatives should not be delayed pending more complete understanding about the factors which contribute to the formation of sexual identity in Thailand.

Research into the consequences of unwanted pregnancies is a very under-researched area. Studies on this topic involve a change of emphasis away from the topic of illegal abortion towards a more comprehensive perspective in which pregnancy termination is one possible outcome of the occurrence of unwanted pregnancies. Why do unwanted pregnancies occur? What do women and men experience as a result of unwanted pregnancies? How do they make decisions about what to do? What improvements to services could be implemented to lessen the occurrence of unwanted pregnancies, to counsel and to assist the people affected?

There are many other topics for possible research discussed in these pages, some of which might well be considered to have higher priority than the selection given here.

6.2.3 Effective utilization of the results of research

Most of the research that has been discussed in this volume is locked away in musty libraries, in the form of volumes and volumes of scholarly journals, in master's theses, and in files of papers collected on the various topics. To become relevant, the research must be translated into advocacy inputs, information, education and communication (IEC) inputs and service delivery practices.

Stakeholders in the delivery of services and utilization of services, in the government and non-government (NGO) sectors, should be brought into a dialogue process at the earliest opportunity so that they can share the results of this project in a distilled form. Before this, there is a need to bring out the research issues that could input into programmes. The aim will be to alert all stakeholders to the necessity of developing a gender-sensitive set of reproductive health programs and to identify the mechanism for incorporating the gender dimension into reproductive health service delivery.

6.3 Policy recommendations

- Research, advocacy and training concerning the gender aspects of interactions between providers and clients in the delivery of reproductive health services is needed. Also, services provided to women should be extended to include men in supportive roles wherever possible, through the provision of information and encouragement to become involved. For this, a comprehensive information, education and communication (IEC) programme is called for.

- Measures are necessary to ensure that interventions are monitored and evaluated to assess their effectiveness and replicability.

- Limited perspectives on delivery of services involving reproductive health should be avoided in policy and programmes. For instance, public attention should be drawn to the role of men in causing infertility, to overcome adverse effects on women. Also, information and the means to make treatment for infertility

accessible to all levels of society should be brought into reproductive health programs.

- Abortion should be brought into the wider perspective of policy and programs to deal with the causes and consequences of unintended and unwanted pregnancies. Advocacy concerning the law in relation to pregnancy termination is needed in Thailand. Services should be available to manage the negative sequelae of induced pregnancy termination.

- IEC programmes for men and women should be conducted to inform them of preventive measures against unwanted pregnancies, for example family planning. Counselling services concerning appropriate contraception should be available to all women who undergo pregnancy termination.

- Attention should be given to social marketing strategies that can change the perception of condoms as devices used only for disease protection, to give men a greater role in family planning.

- Every effort should be made to administer HIV testing early enough in pregnancy to allow for the possibility of pregnancy termination, and, through service delivery points, to publicize the need for immediate testing as soon as women become aware that they are pregnant.

- Services for all aspects of reproductive health, including the treatment of STDs, RTIs and HIV/AIDS, must be integrated in accordance with agreements made under the ICPD Plan of Action, to provide seamless access to reproductive health services of all types as necessary.

- Research and policy attention to the transmission of STDs to children is required urgently.

- The focus of the 100% Condom Program should be strengthened to require consistency as well as frequency (use by 100% of sex workers with 100% of clients).

- Sex education should become a separate subject in the school curriculum in Thailand, with training provided by health personnel or by teachers who have undergone specific training themselves. Sex education should refer specifically to gender roles and seek to change attitudes to cultural beliefs and practices that establish unequal power between the genders.

- The reproductive health needs of older people in Thailand require specific program attention.

- Ethical procedures for the conduct of research and implementation of policy and programs in the area of reproductive health should be reviewed and strengthened.

- These policy and program recommendations cannot be envisaged without a comprehensive accompanying program on sensitizing service delivery staff to issues on gender and sexuality in relation to reproductive health.

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The references are drawn mainly from the period since 1990. Book, report and journal titles are underlined. Titles of theses are capitalized but not underlined. Titles of journal articles and conference papers are enclosed in quotation marks and not capitalized. Sub-titles are not capitalized regardless of the capitalization of the main title. Since it is difficult to distinguish published and unpublished reports, the same style is adopted for both unless it is clear that the report has not been circulated widely.

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Appendix 1. Participants in consultative meetings
(excluding members of the research teams)

Bangkok, 5 November 1998

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Garry Suwannarat
Kanokwan Tharawan
Kritaya Achavanitkul
Orathai Ruayarjin
Pimpawan Boonmongkul
Pornchai Suchitta
Ronachai Athisuk
Sasiporn Raitmahan
Tony Bennett
Tony Pramualratana
Vipan Prachumoa-Rufolo

Hat Yai, 7 November 1998

Arunporn Aitharat
Kulya Nitiruangcharat
Lamom Khomapat
Nualtha Arpakupakul
Praneet Songvatana
Suda Phutong
Thitiporn Engkatavornvong

Khon Kaen, 8 November 1998

Chintana Boonchan
Chintana Leelakraiwan
Chursi Koochaisith
Karoon Hongka
Napaporn Theeratanikanoon
Narong Winiyakul
Suchada Suwanakham

Chiang Mai, 11 November 1998

Bung-or Siriroth
Bussabang Chamroendararatsami
Chaladchai Rumithanon
Chavarith Nathprathan
Duangruithai Pongchengboon
Nunthawan Sophun
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