CHANGING SEXUAL BEHAVIOUR
AND WOMEN'S RISK FOR HIV/AIDS IN
CHIANG MAI, THAILAND:
THE FOURTH WAVE

BY

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A thesis submitted in conformity with the requirements
for the Degree of Doctor of Philosophy
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DEDICATED TO

RICHARD MORRISON

1939-1998

I Know You Are There
Abstract

The purpose of this dissertation is to explore the historical, socio-cultural, and economic context of sexual behaviour and sexual networking in Chiang Mai, Thailand, and specifically how these factors put women at risk for HIV. To address the potential for risk, several areas will be investigated including men and women's perspectives on sexual behaviour, their acceptance of pre-marital and extra-marital sex with commercial sex workers, and perception of risk for HIV.

By 1995, it was estimated that approximately 2% of all sexually active adults in the country were infected with HIV (Koetsawang and Auamkul 1997). The HIV epidemic in Thailand has been described as a succession of waves with the first wave sweeping through the drug injecting population, the second wave consisting of the commercial sex workers, with the third wave currently acting as the gateway to the general population through the clients of commercial sex workers (Ungphakorn 1993). These clients can potentially infect their girlfriends and wives, the fourth wave of the epidemic. Epidemiological studies in northern Thailand have confirmed the explosive nature of the epidemic among commercial sex workers with seroprevalence rates as high as 40% (Celentano 1994).

Thailand is in the midst of a social transition and undergoing economic
turbulence. This study will demonstrate that Western influence as well as the response to the AIDS epidemic has resulted in changes in sexual behaviour and gender role expectations. The retention of old traditions, such as commercial sex work visitations coupled with an increasing acceptance of pre-marital sex is fuelling the AIDS epidemic. Paradoxically, the emergence of HIV in Thailand has made individuals re-evaluate previously held socio-cultural axioms involving pre-marital and extra-marital sex with commercial sex workers.

Semi-structured ethnographic interviews, key informant interviews, focus group discussion, participant observation, educational material from public health campaigns, and archival data have been collected to contribute to the understanding of the epidemic in Chiang Mai. A model of transmission is proposed based on data analysis. Additionally, recommendations for future AIDS prevention programming and research are offered.
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1.0 INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) is a global pandemic comprised of a multitude of smaller epidemics shaped by local conditions of behavioural norms and practices. Attempting to counter the AIDS epidemic that has taken a stronghold in Thailand requires an understanding of the factors involved in predisposing certain norms of sexual behaviour. Chiang Mai, Thailand is currently the epicenter of an epidemic of explosive dimensions. This research is influenced by a critical medical anthropology approach which "...frames the local conditions in relation to macrohistorical forces, and focuses on the social relations..." as they affect health and conversely, ill-health (Leatherman 1996:476). The purpose of this dissertation is to explore the historical, socio-cultural, and economic context of sexual networking\(^1\) in Chiang Mai, Thailand, and specifically how these factors put women at risk for the Human Immunodeficiency Virus (HIV)\(^2\). To assess the potential for risk for HIV, several areas of investigation were pursued including women and men's perspective on sexual behaviour, the acceptance of pre-marital and extra-marital sex with commercial sex workers (CSWs)\(^3\), and perceptions of risk for the virus.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that, globally, in less than 20 years, over 40 million people have become infected with HIV (Piot 1998)\(^4\). It has been further estimated that 16,000 people become infected everyday, 90% of whom live in developing countries (Piot 1998). The latest epidemic update released by the UNAIDS and World Health Organization estimates that, as of

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\(^1\) Sexual networking is regarded as the sexual connections between individuals and the reasons for these connections.

\(^2\) For the purposes of this paper, HIV refers to HIV-1, the predominant strain found in Thailand.

\(^3\) Commercial sex worker (CSW) refers to a person who sells sex for money as opposed to the more ambiguous and stigmatized term of 'prostitute'. Unless otherwise stated, only women are referred to as they vastly outnumber male commercial sex workers in Thailand (Kammerer et al. 1995).

\(^4\) UNAIDS is the international body responsible for the global response to AIDS. The World Health Organization’s Global Programme on AIDS, created in 1986 and directed until 1990 by Jonathan Mann, has been replaced by UNAIDS.
December 1998, 5.8 million people have become infected globally in the past year. Half of all new infections are in the 15-24 year olds, a critical age group addressed in this dissertation. As has been documented in several countries of central Africa, the impact of HIV/AIDS has been particularly devastating socially, economically, and demographically (Heymann 1993, Caldwell, Orubuloye and Caldwell 1992, Schoepf 1991, Pela and Platt 1989, Carswell 1988). In many communities of the world, prevention has been hampered by limited funding, a refusal to acknowledge the epidemic, or rejected on ideological grounds because of its association with sex or marginalized populations.

It is estimated that worldwide, 75% of HIV transmission is through heterosexual contact (Mann 1992). The demographic impact of AIDS in Sub-Saharan Africa is critical where decreasing life expectancy and increasing infant and child mortality have already been observed (Armstrong and Bos 1992). As of December 1998, UNAIDS estimated that 34 million Africans have been infected with HIV and almost 12 million have already died. In 1987, 1 in 4 women visiting a pre-natal clinic in Kampala, Uganda was HIV+ (read HIV positive) (Carswell 1988). In late 1989, Kinshasa, Zaire reported that 15-20% of the sexually active population was infected with HIV (Schoepf 1991). HIV continues to have a calamitous effect in several countries in central Africa, which will continue to feel the economic and demographic effects well into the next century.

The virus strikes people in the reproductive and economically productive years of their lives. There is an increased mortality rate in the adult age group resulting in decreased fertility. Further, "...the aggregate loss of productive capacity these deaths represent is the principal economic concern" (de Zalduondo, Msamanga, and Chen 1989:180) as some African countries are 'top-heavy' with the elderly and 'bottom-heavy' with young children resulting in a high dependancy ratio (Carballo and Carael 1988). The situation in Africa is off-set somewhat by high fertility rates. This is not the case in Thailand where fertility rates have declined steadily since the 1960s (Knodel and Chayovan 1990). To address this area of concern, the future of children and HIV in Thailand is briefly reviewed in the "Women, Children, HIV, and the Future" section.
Women and AIDS

Nearly 5 million women worldwide are estimated to be either infected, ill, or dead because of the virus (Reid, 1992). The leading cause of death for women in major cities in the Americas, Western Europe, and sub-Saharan Africa is AIDS (Chin 1990). Similar patterns are currently emerging in Asia (Gould 1993, Chin 1990). Socio-cultural, economic, and historical circumstances culminating from gender discrepancies and inequities put women at greater risk for HIV than men (Morrison and Guruge 1997, Gorna 1996, Simmons et al. 1996, Schoepf 1995, de Bruyn 1992, Carovano 1991, Krieger and Margo 1991, Fletcher 1990). Until recently, few studies in the medical, behavioural, or social science disciplines targeted women to elucidate the gender differences that exist with regard to risk for HIV. Of interest are the specific social factors and circumstances that contribute to women’s lack of empowerment in sexual relationships.

In general, there is very little research on sexual behaviour, sexual norms (Herdt and Boxer 1991, Herrell 1991), and the social and cultural values that support these norms for women and men in each cultural milieu (Worth 1989). Social issues encompassing women worldwide such as basic inequities regarding employment, health-care, and disempowerment in social and sexual relationships put women at greater risk for HIV. The women of Chiang Mai are empowered in many aspects of their lives but the reality is that men have much greater sexual privileges and tradition dictates that women accept this.

Past studies on CSWs frequently depicted women as transmitters of the virus to men and children (Carovano 1991, de Zalduondo 1991, Krieger and Margo 1991, Overall 1991), but failed to incorporate the completion of the sexual network i.e. the clients. The clients of CSWs go home to girlfriends and wives and it is these women in the general population that are being neglected.

AIDS and Anthropology

The study of disease and its affect on populations is firmly imbedded within the anthropological paradigm. Classic textbook cases include references to malaria, kuru,
and schistosomiasis to illustrate the interactions of human behaviour, ecology, and disease (Ault 1989a, 1989b, Livingstone 1984, Grove 1980, Wright 1973, Mathews et. al. 1968, Gadjusek et. al. 1967). The impact of disease has been documented beginning with early hunters and gatherers exposed to zoonoses to the first city-dwellers exposed to a wide assortment of infectious diseases (Marks 1995, Baker 1989, Cohen 1989, Black 1978, Dunn 1977, Cockburn 1963). The main contenders affecting populations in the past were parasites and bacteria, such as *Plasmodium falciparum*, *Schistosoma mansoni*, or *Yersinia pestis*. The list is constantly expanding to include new emerging viruses such as the ebola and hanta viruses (Garrett 1994, LeDuc, Childs, Glass and Watson 1993), RNA-based influenzas (Palese 1993), and retroviruses such as HIV (Levy 1993).


Bolton (1995) encourages anthropologists to break with tradition, take risks, and delve into sexuality as a large part of human nature deserving attention. Goldstein's (1994:919) work in Brazil explored women's perspective on sexuality to determine their “… culturally scripted ideals for sexual behaviour.”. McGrath et al.’s (1993) study of Baganda women in Uganda found there were gender differences in approaches to risk reduction which were intricately tied to a woman's autonomy and economic independence. They concluded that women felt at greatest risk from their husband's
sexual activity, not their own. Similarly, in this work, Thai women’s world view on sexuality will be examined and how their view may affect their risk for HIV.

**Thailand: Traditions in Transition**

Epidemics occur due to a multitude of biocultural factors. Understanding women’s risk for HIV in Thailand requires a brief overview of the traditions within which Thais live and the socioeconomic and demographic transitions they are experiencing. Thai people are characterized by a strong and pervasive national identity. Thais are bound by a common language, the standard Thai dialect, and an adherence to Buddhism. Although a predominantly rural and agrarian society, trends towards urbanization are emerging.

In some regions of rural Thailand, residence is primarily matrilocal, with the youngest daughter staying with the parents. There is a deeply-rooted expectation that daughters will contribute as much as possible to support their parents (Boonchalaksi and Guest 1994). The nuclear family is the primary household structure, although newly married couples may initially reside with the bride’s parents for a short time (Knodel et al. 1987). Although women are expected to be virgins upon marriage, men enjoy far greater sexual privileges. In fact, pre-marital and extra-marital sex with commercial sex workers is regarded as a form of entertainment and a man’s prerogative (VanLandingham, Knodel et al. 1995). Men visit CSWs as part of a weekend social outing involving other male friends, usually preceded by drinking at a local bar (VanLandingham, Knodel et al. 1995, Berer 1994, Boonchalaksi and Guest 1994, Sittitrai 1993).

Poverty and filial obligation have led young women to migrate to cities like Chiang Mai and enter commercial sex work until the family is out of debt (refer to chapter entitled ‘Women, Buddhism, and Commercial Sex Work’ for a more in-depth discussion of the history of commercial sex work in Thailand and how it is woven within the social fabric) (Berer 1994, Boonchalaksi and Guest 1994, Gould 1993, Sittitrai 1993). Although visiting CSWs is a deeply ingrained cultural and economic aspect of Thai society, whether it actually is accepted by the women of Chiang Mai will be an
area of investigation.

Socioeconomically, Thailand has experienced remarkable and profound achievements since the 1960s while undergoing rapid modernization (Robinson and Rachapaetayakom 1993; Knodel et al. 1987). Thailand, like other less developed countries, is following the same trend of economically more developed countries that have undergone the demographic transition; from high levels of fertility and mortality to more modern, low levels (Wongboonsin 1995; van de Walle and Knodel 1980; see Omran 1971 for a full discussion of the various stages of the demographic transition). Due to the doubling of the population from 26.2 to 56.2 million between 1960 and 1990, the Royal Thai government implemented a rigorous family planning program to reduce fertility and population growth (Surasiengsunk et al. 1998, Mason and Campbell 1993). Hailed as an extremely successful program, the fertility rate dropped from more than 6% in 1970 to 2.7% in 1985 and may stabilize at less than replacement level (Surasiengsunk et al. 1998). The fertility rate of Thailand is declining so rapidly and pervasively (Hogan et al. 1987, Knodel et al. 1982) that it is referred to as a "reproductive revolution" (Knodel et al. 1987). The decreasing fertility rate is in part due to a relatively late age at first marriage (early twenties for women and mid-twenties for men) when compared to other less developed countries (Knodel et al. 1987).

The decline in fertility has been occurring in tandem with an overall increase in economic growth of 7% per year. This has led to speculation about an eventual labour shortage that could affect economic growth (Surasiengsunk et al. 1998). Additionally, the crude death rate has been steadily declining since the 1920s but experienced a perceptibly sharper drop since the 1960s due to advances in medical technology and public health services (Santikarn and Chusuwan 1982). Since that time, improved mortality has been due largely to a reduction in infant and child mortality (Knodel et al. 1987). The infant mortality rate declined from a high of 262 deaths per thousand live births in Bangkok in 1927, to 80 deaths per thousand live births for the whole nation by 1970 (Hongladarom 1979). This decline has been attributed to extensive public health facilities in rural and urban areas (Knodel et al. 1987).

Life expectancy in the 1980s was estimated to be 68 years of age which is
approaching levels observed in more developed countries, compared to an earlier figure of 55 years of age in 1970 (Mason et al. 1993; Robinson and Rachapaetayakom 1993). The annual population growth rate has fallen from 3% during the 1960s to 1.8% in the 1980s (Robinson and Rachapaetayakom 1993). In contrast to the emphasis placed on fertility and mortality, migration has received little attention, largely due the country’s geographical stability.

Thailand is fast-approaching a critical state in the epidemic and is regarded by some as the hardest hit country in the world (Gould 1993, Holmes 1993). HIV can potentially have devastating repercussions on population structure because, unlike many other diseases that infect the old and the young, HIV infects humans in their reproductive years (Anderson 1992) as well as affecting cultural perceptions, behaviours and attitudes (Caldwell, Oruboloye, and Caldwell 1992, Farmer 1992, Irwin et al. 1991). Mortality due to AIDS will aggravate an already existing labour shortage as well as challenge gains made in increasing life expectancy and decreasing population growth.

**AIDS in Thailand**

In contrast to other countries’ response to the epidemic, Piot (1998), the executive director of UNAIDS, points out that Thailand has been a notable exception due to its quick response in implementing prevention strategies using pre-existing surveillance methodologies and thorough mass communication campaigns. Unfortunately, the response came only after people with AIDS, the visible and symptomatic state of the epidemic, came to the attention of health professionals. Many people in the interim became, and continue to be, infected. The epidemic as it is occurring in Thailand has been one of the most extensively documented of any developing country (Phoolcharoen 1998). In order to address the issue of AIDS, one of the initial mandates of the National Epidemiology Board of Thailand was to establish a sentinel surveillance starting in 1989 to monitor HIV. By 1990, a commission composed of public health personnel and academicians proposed the promotion of condom use, especially in commercial sex work, blood donor self-screening system in
every blood bank, and availability of anonymous HIV blood testing (Somsak and Choprapawson 1990). The prevention strategies have been effective in slowing the epidemic but close to one million people have nonetheless been infected since the beginning of the epidemic (Phoolcharoen 1998).

The northern region of Thailand has been designated the epicenter of the AIDS epidemic with prevalence rates two- to threefold higher than elsewhere in Thailand (Surasiengsunk et al. 1998). Chiang Mai, the second largest city in Thailand, is at the center of the outbreak. At the beginning of the 1990s, the epidemic was largely confined to intravenous substance users and CSWs. It is now moving to the clients of the CSWs and potentially the non-commercial sex partners they have sex with.

In any area of the world where sexual behaviour is the primary mode of HIV transmission, the rate of sexual partner change becomes a crucial factor. The focus thus far in Thailand has been on CSWs as transmitters of HIV, rather than regarding them as a pool of infected individuals, leading to a more generalized dissemination of the virus. This approach fails to address by whom the CSWs were initially infected, and the other women with whom these men are also having sex. These women may include other commercial sex workers, in which case HIV transmission is bidirectional, or girlfriends and wives (see Appendix 1). In the latter case of transmission to girlfriends or wives, which is the focus of this dissertation, the flow of transmission is largely unidirectional as it has traditionally been unacceptable for women to indulge in pre-marital or extra-marital sex.

To date, CSWs and men’s perspective on commercial sex work has received thorough examination by a number of researchers in the Thai setting (Maticka-Tynedale et al. 1997, Wawer et al. 1996, VanLandingham, Suprasert et al. 1995, Lyttleton 1994, VanLandingham et al. 1993). Several such studies whose principal objective was to investigate men (Knodel et al. 1996, VanLandingham, Knodel, et al. 1995) incorporated women’s perspective on their partner’s commercial sex activity.

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5This is not to suggest that the flow of transmission is unidirectional from men to women but to give recognition to the fact that women are far more vulnerable to HIV infection physiologically due to the higher concentration of the virus in the semen. Added to this is the warm, moist environment of the vaginal canal where the semen is retained for a short amount of time after ejaculation.
This dissertation will complement and elaborate upon previous studies by exploring women's lives and perspectives with regards to sexuality as the primary objective, and secondly, how men's behaviour affect the women's risk for HIV. The result will be an overall awareness of the sexual networking in Chiang Mai and why it occurs in the manner in which it does.

The research will highlight the historical and cultural context of women's lives and sexual behaviour which is unique, and thus must be understood for appropriate preventive strategies to be developed. It is necessary to explore sexual relationships in their entirety to better understand the dynamics and determinants which influence people's sexual behaviour and sexual decision-making and the impact one gender has on another.

Additionally, two theoretical models are reviewed to elucidate and contextualize the sexual behaviour of Thai people: the Health Belief Model, a theory relating to decision-making and preventive health behaviour (Maiman and Becker 1974), which has been modified by other researchers and applied to inquiry on HIV/AIDS (Mahoney et al. 1995, VanLandingham 1993), and the AIDS Risk Reduction Model, developed specifically for HIV/AIDS and sexual behaviour. The models are similar, but it will be argued that the greater flexibility of the AIDS Risk Reduction Model is more appropriate for this data while retaining the relevant aspects of the Health Belief Model. It will also be demonstrated that both models are ultimately limited.

Women in the sex trade in Chiang Mai form an integral part of this work as they are inextricably tied to their sisters, the non-commercial sex partners. Their stories are presented using a critical medical anthropology approach which emphasizes the importance of political and economic factors, including the exercise of power in shaping health and disease (Baer 1996). This thesis begins with a macrosocial analysis providing a detailed overview of the situation in Thailand in the 'Background to the Problem' section. The context of AIDS and sexuality in Thailand must first be understood before the rest of the data can be presented and discussed.

The variability of the meanings of sexual categories and practices between cultures, historical periods, and among individuals within the same social setting has

This research has been influenced largely by past and current experience as an AIDS educator; that researchers are morally obligated to design research that is relevant and render their findings accessible and applicable to those outreach workers involved in prevention and education. Anthropologist Ralph Bolton's has also guided the approach to this research. He (1995:287) states,

Many of the publications to date consist of programmatic statements about what anthropology can contribute and few serious substantive contributions. There seems to have been too much effort devoted to convincing ourselves and others (most likely funding agencies) that we have something to offer and too little actual demonstration of the usefulness of anthropological approaches to AIDS.

He continues by stating that anthropologists should be accountable to themselves and to the people with whom they work; that is, the intended beneficiaries of the research. With respect to this corollary, suggested recommendations will be included in this dissertation for the practical application of this research towards educational purposes, public health initiatives, and policy-making.
2.0 BACKGROUND TO THE PROBLEM

A macrosocial analysis, in terms of understanding the pre-existing situation, is necessary to broadly contextualize Thai women’s life in Chiang Mai and their risk for HIV. Without setting the stage, the actors are operating in isolation. This chapter will review the epidemic as it is occurring in Thailand and more specifically in Chiang Mai. Additionally, an overview of the country, its history, and nationalism, are presented as key factors resulting in the homogeneity of the culture and the continuance of the commercial sex trade. Lastly, women’s roles in Thai culture are examined with particular attention to commercial sex work as an integral part of the HIV transmission cycle.

2.1 HIV/AIDS IN THAILAND: THE VISIBLE EPIDEMIC

Researchers describe the AIDS pandemic as having a "...high velocity in Southeast Asia" (Mann et al. 1992:99). In Thailand, HIV has multiple entry routes into this densely populated area of the world. The spread of HIV was originally attributed to injection drug use but heterosexual transmission is currently the main mode of transmission and closely linked to the consequences of commercial sex work (Holmes 1993; Mann et al. 1992). In less than five years, the male-to-female sex ratio for AIDS increased from 17-to-1 in 1986 to 5-to-1 in 1990 (Smith 1990). Although it was initially thought that Thailand would perhaps surpass the levels of infection seen in several central African countries, the turn of the millennium will bear witness to the shape of the evolving epidemic in terms of age-specific mortality and life expectancy. The rapid response by the Thai Ministry of Health may have averted calamitous outcomes.

The 1990s has been a critical decade for Thailand and, with hindsight from other countries, the public health response thus far in Thailand has been strong and informed thereby averting a similar outcome to that of Uganda and Zaire. At the time HIV was making its appearance in Southeast Asia, Thailand already had a solid infrastructure in disease control and surveillance especially pertaining to sexually transmitted diseases (STDs) (Weniger and Brown 1996). Hence, the integration of HIV prevention occurred very rapidly and successfully (Koetsawang and Auamkul 1997). Notwithstanding the
crucial prevention efforts, by 1995 it was estimated that approximately 2% of all sexually active adults in the country were HIV+ (Koetsawang and Auamkul 1997).

Mathematical modeling has been used to illustrate the magnitude of the problem. The modeling is based on relationships between biological, behavioural, and demographic variables. The predicted cumulative number of deaths from AIDS for Thailand will be 550,000 by the year 2000 but will not reach 1 million until the year 2014 (Surasiengsunk et al. 1998). These projection figures conform with the findings of the Thai National Economic and Social Development Board (NESDB) and population projections from the US Bureau of the Census (Surasiengsunk et al. 1998). Without the HIV epidemic, Surasiengsunk et al. (1998) estimate the population growth rate to be 1.3% per annum until 1995, with a predicted decline to 0.9% by 2005. Surasiengsunk et al. (1998) estimate that by the year 2000, there will 1% less people in Thailand than expected due to HIV and 1.6% less by the year 2010.

The first reported case and subsequent death from AIDS in Thailand did not occur until 1984 (Gould 1993; Shah et al. 1991). The Thai Ministry of Public Health estimated that by the end of 1993, a total of 500,000 to 600,000 individuals were infected with HIV. It has also been estimated that for every person with AIDS, there are an additional 25 to 100 persons infected with the virus (Shah et al. 1991). It is extremely difficult to obtain accurate figures as many people who have the virus may not realize it, may not want to know their status for a variety of reasons, or may not have access to testing facilities. People with AIDS, on the other hand, often come to the attention of medical personnel only when they become symptomatic. In Thailand, as in many countries, the visible epidemic is people with AIDS, whereas the invisible epidemic is people with HIV.

Ungphakorn (1993) describes the HIV epidemic in Thailand as a succession of five waves. The first wave swept through the intravenous drug using population, the second wave swept through the CSWs, and the third wave is currently the gateway to the general population as it is sweeping through the clients of CSWs. Ungphakorn foresees the fourth and fifth wave, the focus of this dissertation, sweeping through women in the general population and their potential offspring. Taking into account the
number of young adults of reproductive age becoming infected, Brown and Sittitrai (1996) estimate that by the year 2000, 63,000 children will be infected and 47,000 more will have died of AIDS. Although these are national figures, the northern region is foreseen to be more severely affected. These figures also give credence to the fourth wave, the increasing number of women becoming infected, giving rise to the fifth wave of the epidemic, the infants and children.

There are between three and eight million men who participate in the sex industry as clients (Ungphakorn 1993). Predictably, trends of increasing seroprevalence have been emerging among commercial sex workers attending sexually transmitted disease clinics and pregnant women attending antenatal clinics (Mann et al. 1992). Having unprotected sex with a male partner could potentially put the average woman in Thailand at high risk for HIV.

Widespread industrialization that is attracting young men and women from rural areas to cities like Chiang Mai for employment, increased accessibility to education for women, delaying marriage until an older age, and an increasing rate of pre-marital sex between young people, are contributing to a changing social environment for Thai people (Weniger and Brown 1996). These are but a few of the factors that are contributing to the epidemic in Thailand and in particular, Chiang Mai (see next section for further elaboration). In fact, national AIDS cases are peaking in the 20-24 age group for women and 25-29 age group for men.

Thailand's rapid response to the epidemic was, in part, motivated by the significant impact on the economy of other countries with a reliance on the tourist industry (e.g. Kenya and Haiti). The HIV/AIDS Prevention and Control Program was established as soon as the epidemic became apparent in Thailand. The primary goals of the program were to raise awareness of AIDS, reduce risky behaviour, and provide care for people living with HIV/AIDS (PLWHAs) (Rojanapithayakorn and Hanenberg 1996). Prevention efforts involved initiating AIDS education within the school setting and providing funds for quantitative and qualitative studies on risk behaviours (Phoolcharoen 1998). By 1989, Thailand embarked on a '100% Condom Campaign', one of the most unique and innovative programmes that has met with tremendous
success (Hanenberg and Rojanapithayakorn 1996).

The two main thrusts of the 100% Condom Campaign are; to encourage brothel owners to support a 100% condom policy in-house, while launching a mass advertising campaign promoting the use of condoms with CSWs (Rojanapithayakorn and Hanenberg 1996). Public health officials supplied the brothels with free condoms. Government-sponsored STD clinics also promoted condom use within the commercial sex setting. Both CSWs and their clients were encouraged to use condoms without exception. In those cases of non-compliant clients, the commercial sex worker had the right to refuse services and had the support of the brothel owner in enforcing that decision. If brothel owners did not cooperate, sanctions were imposed by the police. This is a tremendous feat considering that prostitution remains illegal in Thailand, but government and public health officials are willing to overlook this technicality in order to decrease HIV transmission. By the end of 1994, the number of sex acts with CSWs using condoms rose to 90% from a low of 14% in 1989 and STDs decreased by 85% (Rojanapithayakorn and Hanenberg 1996).

From an international perspective, the 100% condom campaign in Thailand is the most successful of its kind (Rojanapithayakorn and Hanenberg 1996). As a government initiated response, it is quite unprecedented. The achievement is perhaps due, in part, to a clear-minded and singular goal of decreasing HIV rather than eliminating commercial sex, which has not has not proven successful historically or geographically. Culturally, Thais have long been solicitous of their technocratic government. As well, their non-confrontational attitude in most circumstances including those involved in the political system made it more amenable for agencies to cooperate for the greater good (Rojanapithayakorn and Hanenberg 1996). In conjunction with the '100% Condom Campaign' and the mass media advertising were changes in some school curricula. Greater efforts also made within the workplace by non-government organizations (NGOs) focusing on raising awareness through education and building decision-making skills (to be discussed in the chapter entitled 'HIV/AIDS Local Social Support Services'). Their success notwithstanding, compliance, which is guided not only by rational thought but by human nature, is inconsistent. The inconsistencies and
the reasons for it will be addressed in the results section entitled 'On the Compatibility of Men, Condoms, Commercial Sex Work, and Alcohol'.

A study conducted in Lamphun province, also in the north, found a very high compliance among CSWs using condoms (Rugpao et al. 1997). Many CSWs were using multiple condoms at the same time to enhance their protection against STDs and HIV. The suggestion to use at least two condoms was generally accepted by the clients and very few refused using condoms at all. In such cases, they were refused sexual services. The impetus for such high condom compliance has come from the '100% Condom Campaign' and an increasing awareness of the high rates of HIV seropositivity. By the mid-1990s, a large number of people were becoming ill with HIV-related illnesses (Weniger and Brown 1996). Men may also be motivated to use condoms as more of them are becoming personally affected by knowing someone who is sick or dying of AIDS (Weniger and Brown 1996).

In addition to behavioural risk factors for HIV, there are epidemiological factors which have contributed to the explosiveness of the epidemic in Thailand. The first of these is the already high rate of STDs, which are co-factors to HIV transmission, and the actual subtype of HIV found in Thailand, which has a greater propensity for sexual transmission than do subtypes found in Europe or North America (Soto-Ramirez et al. 1996). In Thailand, HIV-1 subtype E is found in 90% of people who acquired HIV sexually, whereas subtype B is found in 75% of injection drug users (Weniger and Brown 1996). Excluding the hill tribes peoples who have traditionally smoked opium and continue its use, the drug and method of choice in Thailand is the injection of heroin for the majority of users, most of whom are males (Celentano et al. 1998). Because of the genetic diversity of the HIV genome, it has left an evolutionary trail. It appears that subtype E found in Thailand is of Central African origin where subtype A predominates and that the recombination occurred before its spread to Asia (Gao et al. 1996). The actual genetic constitution of the virus is not pertinent to this work except to illustrate that the two areas of the world undergoing an explosive epidemic that is heterosexually generated have closely related viruses.
2.2 HIV/AIDS IN CHIANG MAI

To assess whether women in Chiang Mai are at risk for HIV, culture patterns promoting the epidemic need to be discerned, especially in this unique setting of a prevalent commercial sex tradition. The province of Chiang Mai, part of Asia's drug producing 'Golden Triangle', has gained media attention because of the increasing incidence and prevalence of HIV, especially within the city of Chiang Mai. The spread of HIV in Chiang Mai province through commercial sex work was documented as early as 1988 (Rojanapithayakorn and Hanenberg 1996).

During military induction, 6.9% of twenty-one year old males (n=1115) chosen by lottery for conscription in northern Thailand were found to be HIV+ (Nopkesorn et al. 1993). Among a smaller sample in the same survey of men from the upper north subregion of Thailand which includes Chiang Mai, the rate of seropositivity was 15.3%. Almost 75% of the sample reported having had sex with a commercial sex worker. Men from the upper north subregion were found to be at greater risk for HIV compared to men from other provinces due to higher rates of STDs, higher frequency of commercial sex patronage, younger age at first intercourse, and greater occurrence of that first intercourse being with a CSW'. Less than half the total sample reported using condoms. Sex with a 'casual' partner was also reported by more than half the sample.

Studies on commercial sex work in other parts of northern Thailand have confirmed the explosive nature of the epidemic among CSWs especially in the late 1980s and early 1990s. In confirmation of the risk of HIV, an epidemiological study found a 40% seroprevalence rate among CSWs in Chiang Mai (Celentano 1994). Rates of STDs and HIV have declined substantially due to increasing condom use; researchers nonetheless highlight the need for continued STD management and protected sex for both the CSW and client (Gray et al. 1996).

Condom-use was low during the first wave of the epidemic and continues to be so in some circumstances. Some men are slow to perceive themselves to be at risk

\* Studies of army conscripts found that in contrast to vaginal sexual transmission, anal sex with men, injecting drug use, and tattooing was not a substantial contributing factor to HIV transmission (Celentano et al. 1993; Nopkesorn et al. 1993).
(Weniger and Brown 1996) while other men screen partners for risk rather than practice safe sex (Havonon, Bennett, and Knodel 1993). This screening involves assessing how a woman looks and smells as well as feeling for her skin temperature. Additionally, if a woman is less attractive men may think she may not have had as many partners and the man will feel safe in not using a condom. Perception of risk is also deduced by assessing the cleanliness of the brothel or the price of the woman. The higher the price of the CSW, the less likely the man is to use condoms since she would also have less clients. CSWs must also submit to weekly STD examinations which may contribute to a false sense of security. The pink cards confirming a clean bill of health can be falsified or may not accurately reflect a newly acquired infection.

Lack of condom use on the part of the CSW may be related to the greater number of clients a woman can see. Men will occasionally offer a woman more money to not use a condom. Condom use often results in delayed ejaculation which increases the duration of penetrative intercourse. If men using condoms take longer to ejaculate, this may result in fewer numbers of potential clients for the day (Ford and Koetsawang 1991). Further, although latex condoms are widely available, water-based lubricants are not. The absence of lubrication can cause mild to severe irritation of the vagina making intercourse, the preferred sex act among Thai clients, a very painful undertaking. A woman may not be able to take on as many clients as usual leading to a loss of revenue. The alternative is to not use a condom, but if the irritation is still present, it may increase efficiency of HIV transmission.

Men may view their risk behaviour as a test of their fate or good fortune. Accidents, whether vehicular or from mishap, contribute greatly to mortality, and the perception may be that there is a greater risk of dying from a car accident or house fire than from having sex. Others believe that HIV/AIDS erupts in acute outbreaks, perhaps like many contagious and infectious diseases such as malaria and dengue fever. This is perhaps reinforced with the cyclical public health campaigns on AIDS.

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2The fact that penetrative intercourse is the preferred sexual activity is worth mentioning because of its increased risk for HIV. I have found that, in sharp contrast, commercial sex work in Toronto tends to be of a manual or oral nature which presumes less inherent risks for HIV.
People may think that campaigns appear when AIDS is ‘acute’ subsequently subsiding when the disease is no longer a threat. This would typify the disease experience in a tropical setting.

Poverty is the most important factor in risk-taking (van Kerkwijk 1995). Not using a condom may have greater appeal as a short-term survival strategy versus a long-term possibility of dying of AIDS. Women do not have full control over their bodies or lives. This may be particularly the case for CSWs, especially those at the lower end of the commercial sex hierarchy. Ford and Koetsawang (1991) view the primary factors in the pace and level of HIV transmission in Thailand to be ‘the pool’ and ‘polypartnerism’. The ‘pool’ signifying the growing number of infected individuals and ‘polypartnerism’ signifying the number of unprotected sexual contacts, both of which are very high in northern Thailand. For these reasons, male infections were much higher at the beginning of the decade (1990s) because there were more clients than CSWs. Once sex began occurring outside of the ‘pool’, rates of HIV among women in the general population began escalating and are now occurring at comparable rates to those of men (Brown and Sittitrai 1996).

For women who are non-commercial sex partners (e.g. housewives, girlfriends, or any women employed in the non-commercial sex sector), the risks are very different. If they are married or within a relationship, they will not have as many partners as a commercial sex worker who may have several male clients per night. Further, women in the general population usually have lower rates of STDs, a co-factor which facilitates HIV transmission. Conversely, condom use within a relationship tends to be very low, putting women at higher risk for HIV. Ultimately, it is the unsafe sex that puts them at greatest risk for HIV. The national AIDS campaigns have focused primarily on HIV transmission within the commercial sex work setting. This may have lead to an initial low perception of risk by both men and women who are in a relationship but this dissertation will show that women definitely perceive themselves to be at risk through their male sexual partners.

Confirming the movement of the virus to the fourth wave of the epidemic, Nopkesorn et al. (1993:1238) state that “As more young men become infected with
HIV-1, more women, both commercial sex workers and regular sex partners, including wives, and eventually their children, will also be infected. In fact, according to the sentinel surveillance of the upper North, 5.1% of pregnant women in urban areas, which includes the city of Chiang Mai, were HIV+ as of June 1993 (Rojanapithayakorn and Hanenberg 1996). Koetsawang and Auamkul (1997) feel that despite the initial outbreak occurring in injection drug users followed by sex workers, young married women are now at greatest risk.

Although Thailand has been very aggressive in its public health efforts towards decreasing rates of HIV, that the decline is largely due to increased education and condom distribution is being contested. Other plausible explanations being put forth include the decline being due to the natural course of epidemics i.e. the decreasing infectivity of the virus (Brody 1996) or that the overall number of contacts with sex workers is declining (Lawless 1996). The nature of this research tends to support the latter suggestion but the decline is occurring in conjunction with education and prevention.

Two important trends emerging from the 1991 and subsequent 1995 studies of the Thai military conscripts include the decrease in commercial sex patronage and the increase in condom use when CSWs are sought (Phoolcharoen 1998). Overall changes in sexual behaviour may have slowed down the epidemic but Phoolcharoen (1998) feels that HIV is becoming an endemic situation that will affect the social infrastructure of Thailand. The economic burden of AIDS-related deaths, the increasing number of infants with AIDS or orphaned because of AIDS, and an increasing number of HIV-related illnesses, such as tuberculosis, are coinciding with a pervasive financial crisis affecting all of Asia. The economic crisis has resulted in a decrease in the national AIDS program from 2 billion Baht (50 million US$) in 1997 to 1.3 billion Baht (26 million US$) in 1998 (Phoolcharoen 1998) directly affecting the services provided by NGOs. The anticipated effect is of increasing unemployment disproportionately affecting women and children putting them at greater economic disadvantage (Phoolcharoen 1998). Issues of empowerment have been the root cause globally of the high rate of HIV found among women, a basic tenet of this dissertation.
2.3 THE COUNTRY AND ITS PEOPLE

The AIDS epidemic, coupled with a prevalent commercial sex industry, is not a unique situation when viewed within a global framework. What makes Thailand's situation distinctive are the factors which shaped the present day occurrence. Thailand is unique in that it has never been conquered but had to acquiesce to certain Western influences to preserve its identity. Thailand and its people are guided by a strong sense of nationalism, a deep and all-encompassing adherence to Buddhism and its patriarchal forces and, to a certain degree, a history of feudalism. In the last three decades, Thailand was dramatically affected by the Vietnam War later followed by an economic surge experienced throughout the country. Tourism flourished with commercial sex work as one of its main components. These historic factors have set the stage for the AIDS epidemic.

The Setting

Thailand is a tropical country in Southeast Asia measuring 514,000 square kilometers, bordered by Myanmar, Laos, Vietnam, and Cambodia in the north, and Malaysia in the south (see Figure 2). The shape of the country is said to resemble "...the head of an elephant - a Thai symbol of good fortune" (Thomlinson 1971:17). Rivers and mountains divide the country into 4 natural regions; the mountainous north, the northeast, the central region (consisting of the Bangkok metropolis), and the peninsular south. The city of Chiang Mai is the second-largest city located in northern Thailand with a population of 170,269 (Chiang Mai Provincial Statistical Office 1993). It sits in a valley surrounded by hills.

Figure 2. Map of Thailand

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3It may be argued that this practice of feudal obligation was passed down to the daughters of Thai families who remain indebted to their parents. This point is elaborated upon in a later section on women's role in Buddhism and commercial sex work.
Thailand was known as Siam prior to 1939 and between 1945 and 1948. It has never been colonized by a foreign power and is currently ruled by a constitutional monarchy (Knodel et al. 1987). The monarchy is a symbol of unity, and is deeply revered, with portraits of the King and Queen adorning all households, shops, and places of business. Administratively, the country is divided into 73 provinces (changwats) each of which is further subdivided into districts (amphurs).

Culturally, the Thai people are homogeneous maintaining a strong national identity facilitated by the small number of migrants and ethnic minorities. The Chinese population in Thailand constitutes the largest minority, however, it is located mainly in Bangkok and involved largely in commerce. Although there are several major dialects, standard Thai is widely spoken and understood, further unifying the country. Ninety-five percent of the population Theravada Buddhism. Approximately 4% are Muslim and found mostly in the south where they have close cultural ties with Malaysia. Christianity and other religions comprise the remaining population which is less than 1%. Although current trends are towards urbanization, Thailand is predominantly rural and agrarian.

History And Emerging Nationalism

The remains of ancient cities and temples give evidence to Thailand’s long history. Lamphun, which exists today and is in close proximity to Chiang Mai, was the first town founded in 750 C.E. (Common Era) (Penth 1995). Within 500 years, the first of four Siamese empires was established. It was during the Sukhothai empire (c.1240-1351) that Thailand became a distinct nation in culture and character with the origin of the ‘Thais’ as a people and the spread of Buddhism (Sharp 1956, Busch 1964). The economy was based on rice agriculture which remained in place for many centuries.

Chiang Mai, founded in 1296 C.E., was very well-established by the end of the 15th century. City-states in the North fell under the leadership of Chiang Mai. Because of its importance, it was fortified by a rampart and moat, the remnants of which exist today. The old fortification remains significant, particularly Tapae Gate,
which is a refuge or 'hang-out' for lower-class CSWs, many of whom are under-age or in the country illegally.

The germination of Western influence in Thailand became evident with the influx of missionaries, merchants and diplomats. This influence was enhanced and formalized in 1855 with King Mongkut’s signing of an Anglo-Thai treaty officially opening up trade with the West (Sharp 1956). This was to be the model for future treaties which influenced the modernizing of Thailand. Thai economy expanded under King Chulalongkorn who also implemented numerous administrative reforms. One of these was the commutation of the corvee, or feudal, obligation into a system of taxes achieved through the creation of wage-labour occupations (Batson 1984, Kirsch 1975).

Although the strong nationalism exhibited by Thais has been recently shaped, in part, as a response to the fear of communism from its neighbors, China, Laos and Vietnam, nationalism has a long tradition in Thailand (Sharp 1956). Except for brief periods, Thailand is the only country in Southeast Asia to successfully resist colonial rule (Grabowsky 1995). This is due to a long historical pattern by the reigning monarchs of strengthening national identity within the country. By the 19th century, the northern region was vassal to Siam and involved in trading teak wood with the British. Motivated by a possible British threat to subjugate the North, Bangkok - the capital city of Siam - strengthened its own economic interests and re-enforced its geographical and cultural ties to rule the North before the British did (Abhakorn and Wyatt 1995; Charoenmuang 1995).

The 'West' was regarded as being progressive which aided the colonization process that was occurring in Southeast Asia. Thailand acted upon this fear of colonization in a unique and innovative manner by acquiring the best of what the West had to offer while retaining the essence of what it was to be Thai. The threat of

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4King Mongkut was popularly known from the novel and movie entitled “Anna and the King of Siam”. This novel is, in a sense, one of the earliest ethnographies written about Siamese life among the royalty in the mid-1800s. A very dramatic event in the book is the execution of one of the king’s concubines and her lover, a Buddhist monk. Such an infidelity, particularly with a monk, was considered a fatal transgression (Leonowens 1873).
colonialism was initially met by King Chulalongkorn (1868-1910) who strategically increased relations with the West to maintain independence at a time when Thailand was surrounded by colonial rule (Charoenmuang 1995, Sharp 1956). Solidifying these relationships involved adopting some of the West's legal, economic, and administrative procedures. By 1892, Thailand began centralizing administrative control over each province (muang), including Chiang Mai. For example, Western standards were used in developing government ministries and communications, including road, railroad, and postal systems. These reforms and changes augmented the centralization of power. Incorporating Western ways to counter assimilation by a foreign power was a successful strategy in maintaining independence. The government convinced the populace that they were given only what was most useful and appropriate of the Western ways to ameliorate their lifestyle while retaining their national identity.

The last vestiges of feudalism were abrogated. On one level, families were no longer constricted by a form of serfdom to their lords but within families, the expectation remained that the daughter, often the youngest one, render her services and financial contributions for the support of her parents. Filial obligation continues today to the extent that some young women are turning to commercial sex work to fulfill these expectations (Boonchalaski and Guest 1994).

In the first half of the 20th century, Siam encouraged a strong integration of the country by de-emphasizing local traditions and emphasizing national ones. Some of these national traditions were fictitious or spuriously constructed to give the populace greater similarities rather than emphasizing the previously existing differences (Abhakorn and Wyatt 1995). The 1930s were marked by a strong nationalistic fervor everywhere in Asia (Reynolds 1991). In 1932, there was a coup d'état instigated by young officers and civil servants which abolished absolute monarchy. The King of Siam was forced to adopt a Western-style constitutional system and many of the local elites, for example in the north, were replaced by

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5 The colonial rule referred to include the French in Laos, Vietnam, and Cambodia, the English in Myanmar and Malaysia, the Dutch in Indonesia, and the Spanish in the Philippines.
Bangkok appointees (Abhakorn and Wyatt 1995). The following year, national and structural reorganization was completed. In 1939, Siam changed its name to Thailand (Grabowsky 1995). For some countries, the name change indicated a shrugging off of the last vestiges of the colonial period. For Thailand, it involved strengthening the national identity to ward off colonialism and newly emerging communism. The rising influence and close proximity to China was not lost on the Thais who viewed communism as ‘anti-Thai’.

Nationalistic mandates reflected a channeling of loyalties to the national flag and to the national and royal anthem. Phibun Songkhram (1938-1944), who was very instrumental in implementing many changes, came to power on a platform of modernization and homogeneity (Morris 1994). The use of terms like ‘northern Thai’, ‘northeastern Thai’ and ‘southern Thais’ was discouraged while using the central Thai dialect was rigorously encouraged. Even a dress code emphasizing Western styles was mandated. For example, men were to wear shirts and pants while women could not wear sarongs but donned skirts, blouses, hats and gloves (Morris 1994, Reynolds 1991). Sivaraksa (1991:43) evocatively states “…we had to understand the West and to change our outward identity in order to preserve our inner strength to cope with the West”. Reflecting on gender issues, Morris (1994:34) feels that the mandates were not only implementing political changes but were in actuality leading towards “…prescriptive gender formation...”. Western influence changed and exacerbated pre-existing gender differences. Defining and mandating gender behaviour also sets a precedent for men and women to follow political dictum in terms of individual behaviour.

Language is a strongly unifying factor for the nation. Due to the intense pressure to integrate by the turn of the century, only central or Bangkok Thai was taught in school. The northern dialect, although still widely spoken, is not being taught in school in the written form. Many children can now only speak standard Thai, which must be spoken fluently to enter first year university (Charoenmuang

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6Name changes were seen elsewhere in Asia during the 20th century; Ceylon became Sri Lanka, Malaya became Malaysia, and Burma became Myanmar.
1995). In the late 1970s, attention continued to focus on national identity. The Office of the Prime Minister issued a monthly magazine entitled "Thai Identity" which enforced a strong national culture for independence and sovereignty in addition to the implementation of the National Culture Commission to preserve and promote Thai culture (Reynolds 1991).

The consequence of the cultural mandates did not only affect people's behaviour and language use but entailed the subordination of local traditions. There was more freedom under the pluralistic 'Siam'. Government officials essentially constructed and enforced a national identity (Reynolds 1991). By World War II, Thai nationalism increased in tandem with the rising supernationalist states of Japan, Germany, and Italy (Terwiel 1991, Sharp 1956). Other countries were increasingly nationalistic perhaps indirectly influencing and supporting Thailand's nationalism.

For the last two centuries, the influence of Bangkok over the northern region has been, and continues to be, powerful and pervasive. Compared to surrounding countries such as Myanmar and Laos, national integration in Thailand has been very successful for the following reasons: 1) the Thai/Siamese kingship is a unifying national symbol; 2) the modernizing policies of the monarchy and ruling elite; 3) the resulting homogeneity of Thai people; and 4) the quick assimilation of foreign nationalities (Grabowsky 1995).

The country continues to be solidified by internal and external forces. By 1961, Thailand became largely integrated in the global economic system due to the implementation of the National Economic and Social Development Plan coupled with foreign investment promotion (Charoenmuang 1995). As a consequence of nationalism, the Thai economy increased rapidly in the last two decades. The country is regarded as one of the five East Asian 'tigers' and fast approaching the status of a 'Newly Industrialized Country' (NIC) alongside South Korea, Taiwan, Hong Kong, and Singapore (Charoenmuang 1995; Grabowsky 1995).7

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7Some of the research was conducted in 1998 after the 1996-97 economic collapse which severely affected Asia and the Pacific rim. The repercussions were palpable in everyday interactions in Thailand.
The Vietnam War had a significant impact in the expansion of the Thai economy by establishing the sex industry as a major component of tourism after the end of the War. There remains today a heavy reliance on the sex industry to bring in foreign tourist dollars (see the following section on 'Women, Buddhism, and Commercial Sex Work' for a more complete discussion). By the late 1980s, there was a huge influx of foreign investment. Tourism subsequently increased catering to patrons from other NIC countries including Japan, Taiwan, Hong Kong and South Korea (Charoenmuang 1995).

After the War, the mountainous North was singled out by the tourist industry as a main attraction. Since the 1970s, tourism in this region has been growing partially due to a resurgence of northern cultural traditions which had been overshadowed by the centralization from Bangkok (Grabowsky 1995). Tourism has had a significant effect on Chiang Mai resulting in a tremendous growth spurt in the last two decades and an emerging middle class of entrepreneurs and business-oriented people. Chiang Mai is surrounded by hilltribes which constitute one of the main tourist attractions to the city. Reynolds (1991:15) states that "Like many developing countries with rich heritages, Thailand sells itself abroad by commodifying its culture and tradition". Thailand's recent history reflects a certain amount of subordination to Western ideology. This may have once saved it from colonialism but is now at the expense of the present-day daughters of Thailand.

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*Reynold's statement is a harsh one but contains an element of truth. His inaccuracy is in restricting that opinion to developing countries. Developed, or industrialized countries, have long exploited the cultural traditions of their aboriginal peoples.*
2.4 WOMEN, BUDDHISM, AND COMMERCIAL SEX WORK

Women's risk for HIV has been linked to social and sexual inequalities. The following sections offer an examination of what influences Thai women's lives, the issues they face, and the role of commercial sex work. Commercial sex work is addressed in this thesis because of its pervasiveness as an employment option for women and because of the high rates of HIV among those women.

Women's status in Thailand is difficult to decipher as they have traditionally had a strong economic role which gave them some autonomy (Boonchalaksi and Guest 1994). The surge in economic development since the 1980s has resulted in fewer opportunities for women in the agricultural sector, but has increased economic opportunities in urban settings where women are valued labourers and the demand for them sometimes surpasses that of men (VanLandingham 1998 pers. comm., Boonchalaksi and Guest 1994, ). Less economically advantaged women are often involved in construction work as hod-carriers and masons. Women can be seen working side by side with men in industrial and construction settings in Bangkok and Chiang Mai.

Women's financial astuteness and industriousness is, nonetheless, countered by the distinct emphasis on beauty being the main asset (Boonchalaksi and Guest 1994). A cursory look at the media such as television commercials, billboards, or taking a short walk through a department store in Thailand gives evident support of beauty being a predominant feature in young women's lives. Close-up shots of glamorous young women selling various products in revealing and suggestive clothing abound on the highways of Thailand. Beauty, previously culturally constructed, is also falling under Western influence. Women wear make-up to make their skin appear lighter and in some cases are opting for plastic surgery to modify their features to look more 'western'. This is more evident in cities such as Bangkok and Chiang Mai.

The expanding labour force and the lure of the excitement found in cities provides a definite incentive for young women to leave their agricultural settings to migrate to urban areas. Unfortunately, many of these employment opportunities do
not provide a sufficient wage to live on and remit money home. Added to the lack of employment is the incentive of commercial sex work coupled with the lack of constraints in the absence of family members (Boonchalaksi and Guest 1994). For some women with few options, living in a society that commodifies their bodies so easily, commercial sex work may provide a quick and viable option for increasing revenue. In other circumstances, the lack of parental guidance and supervision also provides the opportunity for young women to enter into relationships with young men which may become sexual.

**Women and Buddhism**

Buddhism, as it is found in Thailand, is much more than a religion; rather, it reflects a way of life and a manner of thinking that guides behaviour on a daily basis. Buddhism underlies the Thai political and cultural identity (Jackson 1991). Buddhism provides norms for individual and collective well-being. The phrase "...to be Thai is to be Buddhist" exemplifies the distinctive Thai identity, or *eekalak Thai*, which is at the core of everyday living and conduct (Jackson 1991:192). The traditional Buddhist view accepts personal suffering as *kamma* (karma), the consequence of immoral acts in previous existences (Khantipalo 1994). Gaining merit or merit-making is absolutely central to Buddhism. For Thai Buddhists, maintaining, and perhaps improving, their relative position in the social hierarchy may affect the outcome of their next life (Kirsch 1975). Giving alms, whether it be food, money or objects, to the monks and their temples is the most common way of merit-making.

Becoming a monk is the most profound act a man can perform to gain merit (Kirsch 1975); an avenue not pursuable by women. Under both state and ecclesiastical law, women cannot become ordained as Theravada monks. Their only option is to enter the nunnery which is clearly an inferior status to that of monks in rank, social prestige, and benefits, such as receiving an education at a minimal cost (Klausner 1997). When becoming a monk, a young man not only gains merit for himself but for his family as well. It is very prestigious for a family to have a son.
enter the *sangha* (the monkhood)*^9^, and they are very well respected by the public at large as they wander through the city in their saffron robes. In contrast, nuns are less visible in the streets of Chiang Mai than in Bangkok. The ramifications of this unequal access to merit-making and prestige leaves young women with fewer options to fulfill familial and secular (or societal) obligations. Young girls who are brought up to be docile and obedient can easily fall into the path chosen by many other girls, that of commercial sex work, to fulfill their obligation to make merit (Klausner 1997, Boonchalaksi and Guest 1994).

Karma is a consequence of action. A person’s karma is based on their activities in their past and present incarnations. Further, it is thought that signs of suffering are an outward indication of ‘bad’ karma. This would include sexually transmitted diseases, and HIV infection in particular, because of its lethality. The *wat*, or temple, has always had multiple purposes in that it has traditionally been the school, hospital, home for the aged, asylum and community centre. Presently, with the growing epidemic and lack of adequate medical care or hospices, people with AIDS are often taken care of in Buddhist temples where others will donate money and gifts for their own merit-making. Therefore, HIV+ individuals are not necessarily scorned but their affliction is regarded as their fate in life due to bad karma, or due to deeds done in a previous or current life.

Kirsch (1975) looks to Buddhism to explain the sexual division of labour of women. Men, in their lifetime, can alter and elevate their social status by entering the *sangha*^10^. As monks, men can aspire to attain the ultimate Buddhist ideals. In contrast, women, unable to be ordained and join the *sangha*, have very ill-defined and poorly developed roles in Buddhism. Buddhism has a greater impact in shaping

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^9^The *sangha*, a monastic order, is also falling under the scrutiny of a more discriminating public due to publicized infractions and violations by the monks such as rape, theft, and fraud (Klausner 1997). The *Bangkok Post*, a national English newspaper, printed stories of monks violating their vows of celibacy and at least one key informant mentioned the increasing rate of HIV among monks due to sexual liaisons with men and women.

^10^It should be noted that while entering the *Sangha* is highly encouraged, not all men do so and many men stay only for a brief period thus limiting their merit.
a male's life than a female's. On the other hand, a woman can achieve increased merit through her economic activities, which may include commercial sex work, enabling her to give merit-making donations to the wat.

Muecke (1992) sees the linkage of Buddhism and commercial sex work through concepts of karma and merit-making. She argues that the increasing economic growth of Thailand as a Newly Industrialized Country, has provided the impetus for the continuance of a thriving commercial sex trade. The growing participation in the sex trade has actually allowed women to continue to fulfill basic social and religious obligations of society. It allows daughters to realize their economic obligation to the family as well as accrue merit, a vital aspect of Buddhism allowing improvement in the next life. As well, a commercial sex worker can fulfill her role as a good Buddhist and improve her karma by making donations to temples (Muecke 1992). Her ability to donate to the temples supersedes the methods by which she makes her money. Therefore, the more money she has the more she can increase her merit.

CSWs are exploited for their enormous contribution to the economic growth of the country. These young women are able to accomplish what their mothers accomplished through food-vending but on a grander scale (Muecke 1992). Young men can ameliorate their social status by joining the monkhood or the military whereas women do not have comparable options. Muecke (1992) states that approximately a decade ago, on a per capita basis, twice as many women were CSWs as men were monks. Muecke (1992 892) says that "For Thai Buddhists, this ratio starkly juxtaposes daughters and sons as moral opposites....". This is not to suggest that Buddhism is responsible for commercial sex work but it also does not, on the other hand, provide a refuge for young women. There are obviously stronger incentives for a woman to enter the sex trade.
Commercial Sex Work

"To be with a man takes minutes; to plant rice takes hours in the broiling sun"

CSW in Thailand

The above quote illustrates the powerful economic incentive and stark reality of some women's lives. Until recently, AIDS was largely thought by Thais to be a disease of the farangs, or foreigners. Although the sex industry has long been used as a tourist attraction and caters to tourists from all over the world, most clients are actually Thai (Kammerer et al. 1995). The economic pressures since the Vietnam War have amplified and exploited commercial sex work. Ubiquitous and deeply embedded within the culture, the sex-industry serves millions of Thai men and tens of thousands of foreign tourists (Ungphakorn 1993:56). To understand sexual behaviour and HIV transmission in Thailand, a comprehensive overview of commercial sex work and the role it plays in the transmission cycle is necessary.

The estimated number of CSWs in Thailand varies dramatically. In 1990, the Center for the Protection of Children's Rights for the National Commission on Women's Affairs (NCWA) estimated that there was close to 3 million CSWs in Thailand, including 2,000,000 adult females, 800,000 girls under the age of 16 and 20,000 young males (Sittirak 1996). For that same year, the Ministry of Public Health more conservatively estimated that there were less than 87,000 CSWs (Sittirak 1996). Gould (1993) states there are approximately 500,000 to 800,000 CSWs in Thailand, or roughly 10% of 15 to 24 year-old women. After intensive study in this area, Boonchalaksi and Guest (1994) feel that an estimate of 150,000 to 200,000 women involved in commercial sex work is more plausible and realistic given the population of young women between the ages of 15 and 29. Brown and Sittitrai (1996) concur with Boonchalaksi and Guest with an estimate of 100,000 to 150,000 CSWs nationwide. Brown and Sittitrai (1996) make the significant observation that the number of CSWs is relatively small in contrast to the number of male clients which, in 1990, was estimated to be over 3 million. If the average CSW
has unprotected sex with 5-10 clients per day, HIV can spread rapidly throughout a network of numerous partners.

The estimation of CSWs is extremely difficult and fraught with frustration partly because commercial sex is illegal\textsuperscript{11}. Additionally, many women who occasionally sell sex for money often have legal employment in low-paying jobs. Throughout Thailand, there are direct and indirect commercial sex establishments including brothels, bars, hotels, go-go bars, massage parlors, tea rooms, the street, restaurants, discos and karaoke\textsuperscript{12}. More importantly, as Jeffrey (1997) points out, the debate on the number of CSWs, which has reached international proportions, focuses not only on the methodology of the count but the purpose of the count. She suggests that the government and non-government agencies which publish these counts may have underlying motivations affecting policy implementation and foreign aid.

Regardless of the count, by mid-1989, HIV infection had reached epidemic proportions among CSWs (Celentano et al. 1993). High rates of infection were found along the main transportation routes leading to the major cities where there are many truck-stop brothels. The city of Chiang Mai has been the focus of the epidemic for many researchers due to its particularly high rates of HIV. As of June 1992, the Thai Sentinel Survey, conducted bi-annually, found an HIV prevalence rate corresponding to fee structure of 40.8% among low charge ($2-$5) CSWs and 8.9% among high-charge ($20-$40) CSWs (Batterink et al. 1994).

The above studies have targeted only the CSWs. The common reductionist approach of regarding CSWs as being the locus, or reservoir, of HIV, has ignored the sexual network in which they operate. Figure 1 illustrates the bi-directionality of HIV transmission from the CSWs to the men and back again to the CSWs. Two

\textsuperscript{11} The Prostitution Suppression Act of the early 1960s was enacted due to pressure from the United Nations. The client is not liable to punishment, only the person selling the sexual service or one profiting from it. The maximum imprisonment is six months. Very few offenders are prosecuted (Bootchalaksai and Guest 1994).

\textsuperscript{12} "Indirect" commercial sex refers to establishments where sex is sold but whose primary function is to sell food and drink.
factors put them at far greater risk for HIV than men. These are the physiological factors which put women at greater risk and the number of sex partners they have in a day. To develop an appreciation for this network, some questions need to be addressed:

a) why commercial sex work exists to such an extent
b) what is the role of commercial sex in HIV transmission as part of a greater sexual networking,
c) how fluid is their labelled identity: for example, are the identities of being a woman and being a CSW mutually exclusive,
d) who else are the clients of CSWs having sex with i.e. their girlfriends and wives,
e) and how do these women, the girlfriends and wives, feel about their male partners having pre-marital and extra-marital sex with CSWs.

These last two issues will specifically be addressed in this dissertation.

The existence of commercial sex work in any community of the world is multifactorial. The historical and cultural context of sexual networking in northern Thailand that has sustained its existence and acceptability in society is complex. Sexuality in Asia varies from the artistic sexual depictions of India’s Kama Sutra and temple statuary to a form of puritanism that is found in Thailand but is reserved for the non-commercial partners. Sexuality in Thailand is contradictory and deserves more elaborate treatment. The following section will highlight the outcome and focus on those issues most relevant to this dissertation.

History of Commercial Sex in Thailand

HIV has thrived in Chiang Mai due to an historical precedent of having more than one sexual partner, and a long-standing tradition of the exchange of sex for economic incentive. Commercial sex in Thailand dates back to at least the 14th century when women serviced commoners. Wealthy, elite men had numerous wives, concubines, or harems (Van Esterik 1992). By the 15th century, women were
bought and sold for sexual services (Kammerer et al. 1995). During this time period, male peasants often had to work away from home throughout the year in a corvee system and were provided with the sexual services of women (Wawer et al. 1996). The migration of Chinese labourers to Thailand in the 17th and 18th centuries generated greater sexual demands, thus creating a thriving brothel market (Boonchalasiski and Guest 1994).

Commercial sex proliferated on a large-scale during the urban growth of Thailand in the late 19th century with the concomitant migration of young men to the big cities (Phongpaichit 1982 cited in Ford and Koetsawang 1991). It was, at that time, legal for a man to sell his wife or daughter or for either to be given as an exchange for unpaid debts or as a gift to a superior (Muecke 1992). Although the laws have changed, this sets an important historical precedent whereby men can sell women for economic gain as well as buy sexual access in the guise of generosity (Muecke 1992). Buying sex is socially and culturally supported because it fulfills a man's sexual need while he, in turn, can 'help' a young woman and oftentimes her family by contributing financially to their upkeep. It should be noted that a moral issue is not implied and the transaction is purely a financial one in which numerous parties benefit.

In more recent history, wars have had a tremendous impact on commercial sex work. Muecke (1992) has noted the correlation of the increased availability of CSWs in Thailand with the onset of World War II due to the presence of military troops. The sex industry further expanded during the Vietnam War (Kammerer et al. 1995). It is estimated that U.S. servicemen enlisting during the Vietnam War pumped one million dollars into the local economy at each of the military bases (Glasser 1995). It was during this war that American soldiers acquired mia chaw, or rented wives. These were women bought for longer periods of time and provided

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13 The moral context in Thailand is very different than that found in the West where selling sex has strong negative religious and social connotations.

14 Sittirak (1996:87) states there were 6 military bases in Thailand directly accessible from Vietnam.
more than sexual services (Sittirak 1996, Boonchalaksi and Guest 1994). The practice of acquiring a mia chaw continues today among the tourists. Some even carry on long distance relationships with their 'wife' and continue to remit money to them. By the same token, these mia chaw(s) may have several 'husbands' remitting money to them at the same time.

Certainly during this time period, daughters born in the most impoverished parts of the country had a greater chance of being contracted into commercial sex. This was supported by local officials who had a vested interest in bars and massage parlours. The enlisted men, who were the primary beneficiaries, justified it by assuming they were contributing to the well-being of a young girl and her whole family (Glasser 1995). Since the Vietnam War, the tourist industry in Southeast Asia has generally been built upon the infrastructure established by rest and recreation (R&R) centers created at that time. The infrastructure has since been taken over by the tourist industry and expanded.

The sex industry certainly existed before the war, but the infusion of money had an explosive effect as well as being the vehicle for the introduction of new forms of sexual entertainment. Although Thai men continue to play a vital and critical role in the maintenance of commercial sex work, in terms of sustenance through foreign dollars, the Vietnam 'troops' have been largely replaced by the tourist 'troops' (Sittirak 1996:87). Travel agencies in Europe, North America, the Middle East, Australia, and other parts of Asia offer sex tours to Thailand. The 'land of the many smiles', as Thailand is touted in too many tourist pamphlets and handbooks that are produced nationally and internationally, clearly states its willingness to offer its young women as part of the tourist pleasures. VanLandingham (1998, pers.comm.) counters that presently commercial sex work derives greater subsistence from the increasing availability of discretionary cash flow among young Thai men.

Coinciding with the economic expansion of Thailand in the 1980s that

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15Although the mainstay of the sex industry at present is largely local with the addition of tourist dollars, there is still periodically the influx of wartime troops. In the recent Persian Gulf War, go-go dancers of Pataya in southern Thailand, greeted 7,000 American troops shortly after their victory (Sittirak 1996).
emphasized tourism, commercial sex work exploded on a national and international scale. Today, commercial sex work is extremely diverse and can be found at high class call girl agencies, go-go bars, karaoke, restaurants, tea houses/coffee shops, massage parlours, brothels, and among streetwalkers (Ford and Koetsawang 1991). Morris (1994:23) states very eloquently and accurately,

Few nations have been so thoroughly subject to Orientalist fantasies as has Thailand. Famed for its exquisite women and the pleasures of commodified flesh, the Thailand of tourist propaganda and travelogues is a veritable bordello of the Western erotic imaginary.

Economics of Commercial Sex

The spread of HIV is linked to the rapid industrialization of Thailand which led to economic and social disparities, accompanied by the disintegration of rural life (Ungphakorn 1993). By 1961, Thailand became largely integrated in the global economic system and grew at an unprecedented rate as a result of the implementation of the National Social and Economic Development Plan coupled with foreign investment (Charoenmuang 1995). As a result, overall poverty has decreased but the disparity between the rich and poor is widening. Families cannot survive solely on their rural income which needs to be supplemented. This has led to a migration to the big cities by the young for work and in many cases, to commercial sex work for the young women. Similar to Africa's migrant trade labour, young men, separated from their wives and girlfriends in their rural towns, frequent the sex establishments in the city (Jochelson et al. 1991). The North and Northeast have been particularly subject to the effects of modernization in the agricultural sector. This has benefitted males who have tended to be employed more often than females, leaving the latter with even less opportunity to contribute to the family or access consumer goods (Boonchalaksi and Guest 1994).

It is Chiang Mai, in the northern mountainous part of Thailand, where the tourist industry has burgeoned dramatically in the last twenty years, that has particularly high rates of HIV/AIDS (Mann et al. 1992). The revival of northern traditions in the form of crafts, dress, and food, long forgotten with the powerful
centralization of Bangkok, has attracted many tourists bolstering the economy. This has provided the financial incentive for young people from the countryside to migrate to the city (Grabowsky 1995). Few options exist for female employment that are financially rewarding. They can either remain in the rural countryside making a meagre living through agriculture or migrate to the city to join numerous other women in the textile industries where the hours are long and the conditions in the factories are dangerous (Muecke 1992, Ford and Koetsawang 1991)\textsuperscript{16}. The lure of commercial sex work to attain material goods and status symbols, as well as the ability to fulfill familial obligations and gain merit in the process, may perhaps be too overwhelming to resist. As Wawer et al. (1996:456) states

Commercial sex work remittances thus may secure the subsistence of the rural household, provide consumer goods, educate siblings, upgrade family economic level and status in the village, and thereby satisfy traditional female responsibilities for the domestic economy.

For many living a traditional lifestyle, it becomes next to impossible for young women to fulfill familial and societal obligations to support their parents (Wawer et al. 1996). Boonchalaksi and Guest (1994) suggest that this deeply-ingrained sense of obligation by the youngest daughter, coupled with a social and economic structure that not only supports commercial sex work but rewards those who enter the profession, provide the motivation for many young girls to become commercial sex workers. Commenting on a child’s debt to his/her parents and the social environment he/she lives in, Klausner (1997:6) states,

In such a hierarchical society, the individual is constantly under an obligation to sublimate his or her expression and rights to the larger interests of family and social and community solidarity.

Understanding the extent and depth of this obligation and hence, subordination, leads to a greater understanding of the wide acceptance at the familial and individual level of young women entering commercial sex work.

Young women entering commercial sex work generally come from the North

\textsuperscript{16} Women and children dying in factory fires because of locked windows and doors have gained media attention in the last several years.

37
and Northeast and are from agrarian backgrounds (Odzer 1994). In these regions, it is not uncommon for young rural girls from poor families to be systematically recruited to enter commercial sex as a temporary financial arrangement that is often orchestrated between the girl's family and a broker (Wawer et al. 1996, WHO 1994, Berer 1993, Gould 1993). Even after paying out the financial prerequisite to the bar or pimp, CSWs usually make enough money to send home to build a new house or alleviate the outcome of a bad crop year. The typical two to three year stay in the sex industry is characterised by high mobility between establishments (Odzer 1994, Celentano et al. 1993, Ford and Koetsawang 1991). The young women who come to Chiang Mai work until the family is out of debt to then return to their village and marry (Gould 1993, Sittitrai 1993). Because many of the young women expect to return to their rural life afterwards, Wawer et al. (1996) feel this is an indication that perhaps they never would have left had there been other financial options. Very little stigma is attached to commercial sex work and in fact, if material well-being has been achieved, women are respected and may very well be regarded as an attractive marriage prospect (Ford and Koetsawang 1991). If parents' initial reaction is anger or rejection of the daughter involved in commercial sex work, it often is alleviated by the monetary benefits received (Wawer et al. 1996).

The increasing disparity between rural and urban areas intensifies the attraction for many young women to migrate to cities such as Chiang Mai to work in the service and entertainment sectors (Batterink et al. 1994, Muecke 1992). Recruitment of young women is also conducted by sisters, cousins and aunts (Odzer 1994, Skrobanek 1994). There are some women who are duplicitously led into thinking they will be working in restaurants enabling them to remit money back home. The demand is such that some villages in the North and Northeast are almost barren of young women. Brokers are now going to hill tribes to get younger and younger women who will be "AIDS-free". There are some women who are forced into the sex trade, such as Shan and Burmese women, who are illegal immigrants and, similarly to hill-tribe women, are marginalized. They are also at a disadvantage because of their inability to speak Thai. Corruption in the police force is far too ubiquitous to
offer these women any assistance. In fact, Brown and Sittitrai (1996) state that in some cases, the police have returned runaway CSWs to their brothel owners; an apparent contradiction of some basic Buddhist tenets of kindness and merit-making.

The end result is that Thailand, a vital and fast-growing nation caught in the global economy, has at many levels relied on its young women to bolster its economy. This is particularly the case in Chiang Mai, the second largest city in Thailand, which has a thriving tourist industry and, concomitantly, a thriving sex industry. Its rural areas have suffered numerous economic hardships which has forced many young women to come to the city for employment. In desperation, some turn to commercial sex work as a viable means to fulfill their financial and familial obligations.
2.5 CHANGING SOCIAL ENVIRONMENT OF PRESENT-DAY THAILAND

The young people of Chiang Mai are developing their own culture. Respect for teachers and professors is still very evident in high schools and universities. In both Chiang Mai and Bangkok, students tend to wear school uniforms as it is a sign of status and prestige. The girls are modifying their attire to give it a more fashionable look while other students have disposed of the uniform entirely. The majority of young men and women have their own motorbikes giving them tremendous freedom to come and go as they please including Friday nights at the local disco or karaoke. In fact, the young women of Chiang Mai seemed to enjoy a greater sense of freedom sitting astride their own scooter through the streets of the city whereas in Bangkok they use a scooter taxi service whereby they sit side-saddle while the man drives.

The pervasive belief in karma as defining and explaining one’s existence is being challenged especially by the younger generation who are more interested in self-gratification (Klausner 1997). Buddhism, and the belief in karma in particular, has not only provided solace and explanation for those occurrences in life but has also been used as a coping mechanism to explain the inexplicable. Drugs and alcohol are now becoming the coping mechanism of choice (Klausner 1997). As of 1998, there was more of street culture apparent. Artisans with long hair, tattoos, and motorcycles display their work in store front spaces and in the Chiang Mai Night Market. Hemp stores are sprouting up on the main streets.

Klausner (1997) refers to individualism and egalitarianism weaving its way through the Thai social fabric as the double standard is challenged especially with regard to sexual freedom. As exemplified by this data, more women are becoming aware of themselves as social and sexual equals. Additionally, a gay and transvestite sub-culture is clearly evident in Chiang Mai and its visibility has increased markedly from 1995 to 1998. Katoeys, male transvestites, are seen in the streets and in bar performances that are eye-catching extravaganzas. Gay resorts, bars, and escort services have proliferated in the last three years. Klausner (1997), after spending many years living in Thailand, says that Thais are less judgmental of
the sexual diversity found in their country than their Western counterparts due to their belief in karma. Through personal observations and interviews, Thais do not attach any negative judgements to katoeys (transvestites), CSW, or PLWHA. This may not have always been true with regards to people with AIDS as some of the key informants have spoken of the stigma they encountered.

There is a growing trend in Thailand of changing societal values due to the influence of commodification and availability of goods and services. Evolving industrialization concomitant with, or as part of, westernization has resulted in a high value placed on consumer goods symbolising rising social status. Klausner (1997) speaks of a past when men and women wore dull gray and black colored sarongs and shirts. Today, the Thais are attired in brand-name jeans and shirts that can be purchased at the local markets where they can also acquire high technology items as well as the latest plastic items. Klausner (1997:48) ponders whether “... the urban Thai of today will be able to preserve their identity, besieged and beguiled by teleshopping, telecommuting and cybercafes, as well as Western music, brand name attire, luxury cars, hair styles, cable TV, movies, and even language.”

Not only are local street vendors cornering the market on brand-name clothes and electronic gadgets, but supermalls are flourishing outside of Bangkok and department stores can be found in various locales in Chiang Mai. The historical on-going shift to materialism, and perhaps even Western ideology in terms of status symbols, is particularly prevalent in Thailand at this time. Portable phones are highly visible in Chiang Mai. Couples seen together in restaurants are carrying on separate conversations on their individual phones. Ironically, those products used as status symbols are often mass-produced in Asia. People speak nostalgically of Chiang Mai in the late 1980s when the main mode of transportation was via sanglor or bicycle. Now the noisy 3 wheeled motorised tuk-tuk has replaced the manually pedalled 3 wheeled sanglor and bicycles are a relic of ancient times. People already reminisce on the quietness of the city and the breathability of the air.

A more palpable change has been in an increase in violence between the 1995 and 1998 field trip amongst Thais and towards foreigners. This is no doubt
exacerbated by the plummeting economy experienced throughout Southeast Asia in 1997-1998. The economic decline benefitted the tourist whose dollar had more buying power, but not the Thais, whose prices remained the same. The Thais, who are suffering financially, are surrounded by cheering tourists at foreign exchange counters lining the streets. The violence in the last 3 years manifested in various forms from rioting workers to increased rape, assault, and murder of Thais and foreigners. Although Thailand remains without question one of the most hospitable countries, there is a discernible change in attitude. The ‘Land of the Many Smiles’ is not as eager to offer as many smiles as in the past. Klausner (1997) attributes this change in attitude to the stresses suffered from an insufficient time to adjust and adapt to a rapidly changing economy heralded by a growing consumerism and materialism. He posits that the increase in violence is possibly due to accumulated stresses within individuals, especially those on the lower end of the social hierarchy, of always having to be subservient in action, speech, and body language to those above them. Being under such constant constraints in a changing climate, which is beginning to espouse individualism and expression, may lend itself to internal conflict resulting in eruption on occasion.

Thais are verbalizing their needs more than before. Thais are becoming more vocal and in some cases more confrontational in having their voices heard and needs addressed, especially as it impacts on their survival. During both stays of fieldwork, strikes were not uncommon and in some cases became quite heated. The last decade has witnessed the rise of NGOs, essentially grassroots organizations established to facilitate and coordinate the voices of the people for various issues. This dissertation has attested to the dedication of numerous NGOs in Bangkok and Chiang Mai in addressing HIV/AIDS. It is a radical shift from the emotional distance and lack of community involvement that has previously characterized Thai culture (Klausner 1997).

A powerful symbolic analogy to the changing social environment in Thailand culture is a comparison to food preparation and consumption (Klausner 1997). Food availability, processing and preparation have undergone a marked change due to
improved transportation and widespread electrical usage including refrigeration.

External forces, including the influx of tourists and food imports from all over the world, has also had an impact on the changing menu.

Western influence is all too apparent in Chiang Mai where one can obtain wiener schnitzel, bagels and cream cheese, the finest Italian pasta, and a cold English beer at the Irish Pub all within walking distance of Tapae Gate. In the 1998 trip, cake and bread type products were ubiquitously available throughout Chiang Mai either in actual bake shops or in stalls in the local markets. This was an evident change from the previous 1995 trip. As well, milk and milk products such as yoghurt are also widely available in convenience stores modeled after the Seven-Elevens that have popped up complete with neon signs flashing their names along Chiang Mai’s main thoroughfares. Interestingly, national elections were occurring during the 1995 field trip at which time one of the political platforms was to encourage young people to drink more milk. The fluorescent-lighted convenience stores with clean metal shelving offer a wide variety of goods displayed in wonderful arrays often at better prices than the local family-owned shops that were more the norm in the past. The neon lights of fast foods such as McDonald’s, Kentucky Fried Chicken, and Dunkin Donuts initially made their crass presence in Bangkok but can now easily be found in Chiang Mai along with Baskin Robbins.

Thailand, a country that was once resilient to colonization, has an historical pattern of incorporating aspects of the West while maintaining its strength of character as a nation and its integrity as a culture. Caught in the momentum of globalization, the changes occurring throughout Thailand, including Chiang Mai, have been rapid and continuous. The changes, whether they be in the form of foods, clothing styles, or sexual behaviour, are pervasive and widely accepted. Klausner (1997:84) echoes a familiar sentiment "...there is little doubt that food, like every aspect of Thai society, is undergoing dramatic change."
3.0 METHODS

Researchers from various backgrounds including demography, epidemiology, and the social sciences recognize the unequivocal contribution of qualitative data to research design (Bacon 1993). Anthropologists, in particular, have long used qualitative techniques such as participant observation and interviewing techniques in the field. Large-scale surveys do not provide the same insight into the cultural landscape which is garnered from qualitative research techniques (Bacon 1993). It is evident that HIV is a major contributor to morbidity and mortality, but the transmission of the virus is a behavioural issue. Bogue (1993: 24-2) opines that mortality is "... based on ..... customs and cultural practices, on environmental circumstances, and on individual and group beliefs, attitudes, and motivations.". He further emphasizes the importance of trying to understand the world of those we observe, which cannot be done solely through demographic research or large-scale surveys. Quantitative data separates knowledge and information from women's behaviour, identity, and the cultural context of their lives (Emi 1998). These are essential factors in understanding the epidemic in Chiang Mai and how it affects women.

Epidemiology, in measuring the dependent variables such as morbidity, mortality, incidence, and prevalence of HIV/AIDS still requires the integration of meaningful, independent variables which are the causal or explanatory factors and can be derived from qualitative research (Bogue 1993). Without such knowledge, it is very difficult to explain why epidemiologic events such as HIV/AIDS occur. The context of HIV transmission must subsequently be investigated to provide the why; the causal explanation. Quantifiable surveys have been conducted in Thailand and demonstrate considerable knowledge concerning HIV transmission (Shah et al. 1991) but they do not, and cannot, because of the limitations imposed upon mass surveys, tell us why Thais continue to have unsafe sex. For example, what are the social, cultural, and personal factors that contribute to the epidemic. It is not just Thais having unsafe sex, but people everywhere, with shared similarities and dissimilarities due to the context of their sexual behaviour, beliefs, and attitudes. The qualitative data gathered for this dissertation has resulted in a broader cultural contextualization of the epidemic as it is
occurring for those people interviewed in Chiang Mai Thailand.

The contributions of the medical anthropologist is well-suited to this type of investigation. Because of the open-ended nature of anthropological inquiry, the approach makes use of the unexpected and contextualizes it as appropriately as possible (Scrimshaw et al. 1991). In contrast to quantitative research which is context-free and driven by the researcher, qualitative research is context-specific providing a richness of information, and is respondent driven since the answers are spontaneous rather than provided (Aboud 1997). As theory develops, subsequent questions may arise that are pertinent to data collection. The preferred strategy is to maximize the variation in data gathered to obtain the broadest range of information regarding a particular topic. Having a variety of data challenges or confirms any preconceived or developing ideas (Kuzel 1992).

Qualitative research has been described as being holistic, an approach that studies humans in all their complexities, and naturalistic, meaning that the approach is undertaken without the constraints or controls imposed by the researcher (Polit and Hungler 1993). It is a systemic inquiry used by the anthropologist to explore people's lives and their interactions with each other and their surroundings. The qualitative and descriptive nature of this study is designed to examine process, not outcome (Daly and McDonald 1992), to enhance the understanding of sexual dynamics and peoples' experience in sexual encounters. In this particular study, it is the process of change regarding a specific phenomena; sexual behaviour in the context of HIV/AIDS. This methodology allows maximization of information collected on pivotal issues regarding those factors which influence people's sexual decision-making and networking and, ultimately, their risk for HIV. The narrative material becomes the voice of the participants regarding, in this case, a social and epidemiologic phenomena.

The research began with a simple yet profoundly pertinent question: Are the women of Chiang Mai at risk for HIV and what is the socio-cultural, historical, and

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1 From a nursing perspective, Polit and Hungler state that qualitative research is particularly useful in areas of inquiry looking at decision-making processes and people's adaptation to critical life experiences, issues pertinent to this dissertation.
economic context of their lives that may put them at risk? In-depth interviewing and participant observation is used to describe social phenomenon. Typically, there is no explicit *a priori* hypothesis. The emphasis is on theory development which tends to be generated from and grounded in the empirical data either through the collection process or by the end of the analysis (Polit and Hungler 1993). It is not preconceived by the researcher and represents an integration of themes found throughout the data. The theory developed by this research is illustrated in Appendix 11 and explained in the 'Summary of Findings'.

There are several qualitative research traditions including 1) ethnography, used by anthropologists, 2) phenomenology, with its roots in philosophy, and 3) ethnomethodology, aligned with sociology (Polit and Hungler 1993). The former two are of greater import to this piece of work. The aim of the ethnographer is to understand the world view of the people or culture they are studying from an emic perspective. The result of qualitative research methods is the provision of rich and detailed information about a community and its individuals and the context within which they function (Aboud 1997). For example, what are Thais' sexual behaviours, practices, and attitudes. From a phenomenological perspective, the guiding question is “How do people experience and understand a certain phenomenon?” (Polit and Hungler 1993, Miller and Crabtree 1992). In other words, what are Thais' experience with AIDS and how does that fit in with their world view and their sexuality?. What activities put them at risk, and how do they, thus, interpret this phenomena? In essence, how do they talk about it, what is their construction of the epidemic, and what does it mean to them? The data gathered will be put back into the historical, political, and sociocultural context to gain a better understanding of the experience (Miller and Crabtree 1992). As such, the analysed data is presented within the 'Results and Discussion' chapter and embedded within a historical and socio-cultural context.

The HIV/AIDS Rapid Anthropological Assessment Procedures (RAP), as well as my work as an AIDS Educator, guided the data collection in terms of the respondents and key informants who were selected and the questions asked of them. The RAP guidelines were developed by the World Health Organization's Global Programme on
AIDS to collect meaningful and culturally appropriate data to be used in prevention and educational efforts (Scrimshaw et al. 1991). The RAP guidelines consist of applying anthropological methods of observation, participant observation, informal and formal interviews, focus group discussions on AIDS-related beliefs and behaviours, and accessing data from secondary sources including published and unpublished research, government and community records. Because of the urgency of the HIV/AIDS epidemic, it became necessary to develop tools to collect data rapidly and yet maintain validity and reliability (Scrimshaw et al. 1991). My experience as an AIDS educator affirms that qualitative information is absolutely essential to decipher the factors that drive the epidemic, and how they can be used in prevention efforts. The guidelines were designed to be modified within each cultural context. The following most relevant areas of research to this study were extracted from the RAP guidelines and slightly modified.

A) Sexual Behaviour

1) Beliefs related to marriage and extra-marital sex and pre-marital sex.
2) Contraceptive use in various relationships and different stages of the life cycle.
3) Local patterns of migration and travel and their associated sexual behaviour for those who travel and those that stay at home.
4) Extent of sex in exchange for money, drugs, shelter, favors including frequency or regularity of such transactions and their social acceptability.
5) Sexual practices including penetrative and non-penetrative behaviour and the context of those behaviours e.g. are certain practices part of the sexual repertoire with wife/husband or performed as an exchange for money.
6) Discussion of sexual matters, with who and under what circumstances. Whether birth control and condoms are part of that discussion.
7) Barriers and supports to HIV prevention.
B) Knowledge, Attitudes And Beliefs

1) People's awareness of HIV/AIDS.
2) Causes of AIDS; biological (virus) and/or metaphysical (punishment from God, supernatural, etc.).
3) Recognition and progression of AIDS and whether symptoms are recognizable and manifest differently in men, women, and children.
4) Whether people know how to protect themselves and their families.
5) Attitudes and reaction to knowing someone close with HIV or AIDS, reaction to illness and death, social consequences, and official responses to an AIDS death.
6) Local treatment for PLWHAs including health services, social services, and hospices.

Analysing people's knowledge and attitudes regarding HIV/AIDS can be useful in a) identifying which groups of people are at risk, b) identifying the gaps in the biomedical knowledge of transmission of HIV in the target population, and c) assessing the appropriateness and effectiveness of current educational messages (Scrimshaw et al. 1991). The RAP guidelines were closely adhered to in data collection, especially the HIV/AIDS knowledge, attitudes and beliefs guidelines, which is reflected in the subsequent chapter entitled 'Results and Discussion'.

Data Collection

The objective of data collection is the elicitation of explanatory factors that will contribute to the understanding of the impact of HIV/AIDS on women in Chiang Mai and how it has affected sexual behaviour. The impact is evaluated in terms of the acceptance of CSW, the women's perception of risk for HIV, and changes in their own sexual behaviour. More specifically, if sexual behaviour has changed, what are the driving forces that are prompting the changes. In addition, gender or age differences in changing sexual behaviour are of great import in an individual's decision-making, communication and negotiation skills as well as affecting the formulation of public
health programs. Semi-structured ethnographic interviews, interviews with key informants, focus group discussion, participant observation, educational material from public health campaigns, and archival data have been collected to contribute to the understanding of the epidemic in Chiang Mai.

The semi-structured ethnographic interviews were based on people between the ages of 16 and 40 in the city of Chiang Mai. The respondents were interviewed to elucidate the context within which people live and have sex to determine whether individuals in the general population, and women in particular, are at risk for HIV. Because of the dyadic nature of sexual relationships, assessing women alone would be too limiting. Men were thus included in the research design to examine how they affected women's decision-making and understand their world view of sexuality and perception of risk for HIV. Specific areas of research include gender and age differences regarding family obligation and responsibilities, dating and relationships among young people, marriage, pre-marital sex, extra-marital sex, CSW, condom use, and perception of risk for HIV/AIDS through knowledge, attitude, and behaviour.

The interviews were anonymous to increase the comfort level of the respondents due to the sensitive nature of some of the questions. They were conducted at locations and times that were of comfort and convenience for the respondents. See Appendix 2 for the explanation the potential respondents received from the researcher and/or interpreter. Respondents were also told they could end the interview at any time or refuse to answer any of the questions. See Appendix 3 for a review of the ethical protection of the respondents.

A rank order test of sexual behaviours was another technique used in the interview process to diminish possible embarrassment or imposition on the respondent. Although these have generally been applied to analyze taxonomies regarding plants or to categorize diseases (Bernard 1988), in this context they were modified to obtain information regarding sexual behaviour and at-risk behaviour. When asking respondents which behaviours may put people at risk for HIV, verbalizing sexual behaviours may generate discomfort but viewing pictographs and pointing at them may ease this. Therefore, what I have termed 'flash cards' have been designed to depict
various sexual behaviours in such a way as to be as gender- and culture-neutral as possible. The respondents were asked to sort the cards into 'high', 'low', and 'no' risk behaviours for HIV transmission. This technique has allowed for the elicitation of information that is essential in determining people's knowledge with minimal discomfort or imposition by the researcher onto the respondent.

Data collection is guided by the desire to illuminate the research question or phenomenon by collecting representations of multiple realities (Kuzel 1992). It is not guided by representativeness as is quantitative sampling. The issue of representativeness in qualitative research can be addressed by a careful selection of sub-samples of participants as heterogeneously as possible, for an in-depth analysis (Scrimshaw et al. 1991). Non-probability quota sampling was used to collect the data to ensure that the sub-populations of interest for a particular phenomenon e.g. sexual behaviour, are represented in the final sample (Uche 1990, Bernard 1988). Based on an extensive review of the literature of risk factors for women, the 'sub-populations' include women between the ages of 16 and 40 in 5-year increments i.e., 16-20, 21-25, 26-30, etc. Males were also included in the sample to gain an understanding of their views of sexuality and how this may impact on women's risk and decision-making powers (see Table 1).

<table>
<thead>
<tr>
<th>Gender/age</th>
<th>16-20</th>
<th>21-25</th>
<th>26-30</th>
<th>31-35</th>
<th>36-40</th>
<th>TOTAL</th>
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<td>TOTAL</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 1.

Thai culture is very homogeneous but respondents from diverse ages and occupational

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2 The flash cards were previously used in a similar study in the Sri Lankan Tamil community of Toronto where they were extremely useful in decreasing discomfort and promoting discussion.
backgrounds were, nonetheless, selected to ensure as much heterogeneity as possible. The respondents included marketwomen, tuk-tuk drivers, receptionist, college and university students, teachers, bar owners, *mamasans* (brothel owners/madames), and librarians, to name but a few.

An opportunistic and convenience sampling strategy was followed. The former refers to following new leads and taking advantage of opportunities as they presented themselves (Kuzel 1992) and the latter refers to simply fulfilling the age/sex criteria combined with immediate availability while paying attention to geographic area. Typically, sample sizes of people interviewed are kept small as the narrative data is very rich and insightful. A larger sample size would render unwieldy and impractical amounts of data (Polit and Hungler 1993). The data collection followed a maximum variation approach by using numerous sources such as key informants and archival material to complement the ethnographic interviews. Data collection ceases when a point of saturation is attained meaning the new data would not yield new information and thus be redundant (Lincoln and Guba 1985). While it is recognized that each individual has different life experiences leading to unique thoughts and opinions, those individuals are nonetheless bound and shaped by the culture within which they live and formulate opinions, values, and lifestyles. It is to be expected that there will be similarities among the responses. The point of saturation was reached much more quickly with men than with women perhaps due to more stringent male behavioural expectations. For this reason, and because the focus of this dissertation is primarily on women, twice as many interviews were collected from women before saturation was reached.

The use of key informants is intrinsic in deriving information regarding a particular culture (Pelto and Pelto 1983). As with the ethnographic interview, key informants were asked their thoughts and opinions on the cultural and social factors that predispose Chiang Mai inhabitants to high rates of HIV transmission and the impact of the disease (see Appendix 4 for a listing of key informants).

Several of the key informants were from non-government organizations (NGO’s) working in the area of AIDS prevention, education, treatment, or hospice care. They
were asked more in-depth, specific, and highly focused questions pertaining to the organization or institute they were with. Having worked with similar AIDS service organizations in Toronto, information was exchanged usually in the form of posters, pamphlets, and workshop formats. This was particularly the case with Thai Youth AIDS Prevention Project (TYAP) whose members conducted workshops in local high schools in Chiang Mai. Several of the workshops were attended. The information from the key informants was cross-referenced and triangulated with the data from the ethnographic interviews as a check on validity. One focus group discussion with 12 to 15 university students was conducted. The majority were from Chiang Mai university and many were from out-of-town. The discussion took place in a house shared by several young men and women. The focus of the discussion was on sexual behaviour, sexual networking, and risk for HIV.

Two language mediators were used, one male (Yoishi) and one female (Nong), who were paid on an hourly basis. The bulk of the data was collected and entirely transcribed by Nong, the female mediator. As part of their training, several practice runs were conducted before officially commencing. Nong was more experienced as a research assistant, was fluent in central Thai and the northern dialect, taught Thai to western students and had a strong facility with English, and easily established rapport with both men and women candidates. All interviews were tape-recorded. Nong translated the tapes at a later time by listening to the original tape and recording the information onto a second tape. All interviews were translated while in Thailand. Any discrepancies were quickly rectified thus ensuring the collection of accurate material. Over 40 ethnographic and key informant interviews were collected in the city of Chiang Mai resulting in approximately 120 hours of translating and an additional 200 to 240 hours of transcribing.

Participant observation consisted mostly of night-time work at go-go bars and

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3"Mediator" is used rather than the traditional "translator" in recognition that they do far more than translate. Although I provided a brief introduction of myself and the purpose of the study in Thai, it was largely left to the mediator to build rapport with the respondent for the success of the interview. Further, the mediator had to be very adept and essentially memorize the areas of interest and the probes used to derive the appropriate information.
restaurants in Chiang Mai. Attention was given to the latter locale because in some cases, female waitresses sold sex for money or the restaurant was simply a 'hang-out' for other CSWs. A brothel visit was also arranged where the layout of the brothel was sketched, customers and the CSWs were described as well as the steps involved in procuring certain sexual activities over various designated time periods. Condom availability and usage was also observed.

The educational and archival material was gathered in Bangkok and Chiang Mai from the Ministries of Public Health, various institutes, universities, and NGOs such as Education as a Means of Protection of Women Engaged in Recreation (EMPOWER) and Thai Youth AIDS Prevention Project (TYAP). Public health campaigns focussing on HIV/AIDS have been found to have an impact on people's attitudes and behaviours. Many countries, including Thailand, initially used scare tactics in their propaganda often resulting in the stigmatization of certain groups. Approximately 50 photographs of posters and pamphlets spanning the last 5 years were taken. Archival material was collected from Chulalongkorn University's Social Research Institute and Thammasat University in Bangkok and Chiang Mai University in Chiang Mai. The educational and archival material was used to document events or conditions of the past and contribute to reconstructing the phenomena under study (Massey 1993).

**Data Analysis**

From the moment the researcher begins to collect data, analysis is on-going. It is necessary to impose order on the resultant large amounts of data. Numerous systems of analysis have evolved but universally accepted rules do not exist (Polit and Hungler 1993). Data pertaining to the culture of Thais in Chiang Mai including the ethnographic and key informant interviews, focus group, participant observation, and the educational and archival material, underwent the same process of content analysis, to varying degrees. For the sake of brevity, this section will largely focus on analysis from the ethnographic and key informant interviews as they provide the greatest bulk

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4This aspect of the research was conducted by my male traveling partner. My presence there as female would have been far too obtrusive whereas his entrance, since it was with a 'regular', went unnoticed.
of the data. All interviews were transcribed and duplicated numerous times for final analysis to begin. The end product for analysis resulted in approximately 600-800 pages of raw data. Some of the information perceived to be less essential, especially incidental questions posed to 'warm-up' the respondent before more difficult questions, were temporarily excised.

The nature of qualitative analysis is the search for patterns (Bernard 1988) "...to arrive at categories, relationships, and explanatory models which fit the data" (Bogue 1993:24-7). It is guided entirely by the research question i.e. what is the context of women's lives in Chiang Mai that may put them at risk for HIV. Perceiving patterns in the initial phases of data collection and incorporating those areas into subsequent interviews follows what Strauss and Corbin (1990) refer to as grounded theory approach. "The knowledge thus inductively derived from perceiving patterns in the data which are repeated and reinforced by a number of informants is said to be 'grounded in the data', and hence the theories (non-mathematical models which fit the data) are said to be grounded theories" (Bogue 1993:24-3).

Analysis begins while data is being collected and continues after fieldwork. Particular attention was given to potential patterns in responses within (single-site analysis) and between (cross-site analysis) the various age- groups and sexes (Huberman and Miles 1983). The analysis began with a broad coding of the data into general categories which eventually lead to underlying themes and sub-themes (Turner 1981; Huberman and Miles 1983; Berg 1995). Appendix 5 outlines the modified framework by Turner (1981) which was adhered to for this research. Coding can be done either manually or with the use of computer software such as Ethnograph (Seidel 1988). For the purposes of maximizing in-depth familiarity with the data collected for this dissertation, the coding was done manually. As expected, many of the categories generated other categories whether they were opposite, or more specific, categories (Turner 1981). Appendices 6,7,8,9, and 10 illustrate the categories used in schematic format, which were developed to guide the analysis. The two schemata

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5This data will be put in a different cluster by age and sex of respondent. This will allow for later retrieval if deemed necessary for more complete analysis. No data shall ever be completely deleted.
(appendix 6 and 7) depicting sexual relationships and HIV/AIDS represent the basis of this dissertation, are thus the most complex. The categories found in the smaller schemata were used to enhance the understanding of the overall picture portrayed in the larger ones.

Acknowledging the dynamic properties of the data, coded data moved from one category to the next in relation to other data and the overall refinement of coding and development of categories and emerging themes (Kirby and McKenna 1989). The analytical process is never static but represents a continuous flow of changes and refinement. Coded data is cross-referenced before being placed in categories. Each piece of coded data, whether it be 2 lines or ten lines, should make sense when read out of context. The data was initially colour-coded by gender, then age, then placed in categories. Once the coding was completed and each piece of data was placed within a category, they were then linked and physically placed on a huge surface area according to the flow charts developed during analysis. These schemata illustrate the categories used and how they were linked. The schemata were constructed to guide the analytical process but were re-configured during the analysis to accommodate changing categories and links based on emerging themes. After reflection on the data, it was re-analysed, new links developed with the emergence of new categories and the collapse of others. The dynamic and on-going nature of this process cannot be over-emphasized. It continues until some measure of fluidity and coherence occurs (Kirby and McKenna 1989).

Saturation occurs when new pieces of information do not add new information or understanding about the area of interest. The existing data has a density and richness that will not be enhanced by further data collection or analysis. The following chapters are comprised of the richest examples of data while maintaining the representativeness of the sample. Pieces of data that are unique or aberrant are sometimes referred to as satellites and presented as such in the ‘Results and Discussion’ chapter (Kirby and McKenna 1989).

In presentation of the data, direct quotes are used to support themes and sub-themes. Multiple comparisons of different types of data will ensure full exploitation of
the categories and aid in the refinement of emerging theories (Hammersley 1981; Turner 1981). Following this approach, the categories and themes established using interview material was cross-referenced with data collected from participant observation, and the educational and archival material to confirm or contradict initial findings. Finally, a causal matrix was developed to display the relationships between the categories and sources of data and how they are relevant to the theories (Hammersley 1981, Huberman and Miles 1983).

After numerous iterations and the completion of the coding, the analysis moved into a more interpretive stage where the themes were established and an explanatory framework constructed (Miller and Crabtree 1992). The themes will be addressed in the following chapters where the results are integrated within the text. Each section and sub-section represents the themes that have emerged with supporting data, background information, and discussion. Recommendations based on the data gathered and analyzed are also provided.
4.0 RESULTS AND DISCUSSION

The purpose to this section is to examine the process of change in sexual behaviour, especially as it affects women, and the factors affecting that change to explain why it is occurring. HIV/AIDS, as it affects sexual behaviour, is the phenomena under investigation. To examine the changes affecting Thais and how these complexities are intertwined to foster risk for HIV, a number of issues were explored and analysed, including: marriage, family obligations and responsibilities, dating and relationships among young people, sex before marriage, sex outside of marriage, commercial sex work, sexuality, condom use, and lastly, knowledge, attitude, and perception of risk regarding HIV/AIDS.

The findings are presented in two broad sections. The first section is comprised of all aspects of sexual behaviour as experienced perhaps differently by gender or age group. The second section will be strictly on HIV/AIDS with a detailed examination of the social support services and the implication of HIV/AIDS for women and children. Both sections contain the most illustrative and pertinent excerpts taken verbatim from the in-depth interviews with respondents, key informants, and focus group discussion.

4.1 CHANGING SEXUAL BEHAVIOUR AND GENDER DIFFERENCES

The Thais are experiencing social and economic changes, due to internal and external forces, which are occurring at the same time as the AIDS epidemic. Thai tradition in many respects remains strong but the following data will show that Western influence, in terms of less restrictive sexual behaviour, and the AIDS epidemic have had a profound affect on gender roles, educational and employment opportunities, and family structure and obligations. For example, more women are now entering university coupled with the freedom of living away from home, but yet still bound by

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1Gender (F=female, M=male) and the age of the speaker are provided. In some cases, a sub-code appears in lower case letters to further differentiate respondents. For example, 'F28o' indicates the statement came from a female respondent, 28 years of age, and the 'o' differentiates her from another 28 year old female respondent. Statements taken from the focus group discussion of university students (F or M focus group) and the New Life Friends Center (NLFC) are also indicated.
tradition. The social changes are invariably affecting attitudes and behaviour towards sex. Many Thais are in transition with respect to sexual behaviour, family patterns, and acquisition of material wealth, which presents conflicts. The changes experienced by Thais, such as the increasing acceptance of sex before marriage among young people, has left individuals at risk for HIV. Paradoxically, the emergence of HIV in Thailand has made individuals re-evaluate previously held axioms such as the acceptance of pre-marital and extra-marital sex with CSWs.

This section will begin with the presentation of data on marriage and the family to lay the foundation for the more relevant aspects of behavioural change regarding sexuality. To be highlighted is the fact that Thais are in transition, the first indication of which is presented with the conflict young women face towards their family obligations.

4.1.1 Marriage, Family Responsibilities and Obligations

The nuclear family is the primary household structure with newly married couples residing with the bride's parents for a short time (Knodel et al. 1987). It is the basic social and economic unit and the locus of values, loyalties, and associations. Thai women perhaps have greater equality in contrast to some of their Southeast Asian counterparts because they can choose their own mates and have more autonomy within the marriage (Hogan et al. 1987, Richter et al. 1992). Arranged marriages may no longer be prescribed although having parental approval is still very important.

A man may legally take more than one wife but that privilege is not extended to women; having more than one husband is not allowed under Thai law. Women do not have equal rights under laws governing marriage. For example, if a Thai woman marries a foreigner, she loses her right to purchase land as it is presumed to be for her husband's benefit (Klausner 1997). Until the last few decades, divorce was non-existent and minor wives were common (Klausner 1997). As well, legally it is 'impossible' for a man to rape his wife (Klausner 1997).

Women are very active in business affairs and usually handle the family budget and in some cases allot the husband an allowance (Klausner 1987). Previous anthropological work in the North depicts the dominant role of women in managing the
household economics and their responsibility as financial contributors (Muecke 1992).

Marriage, Men and Desirable Qualities

Thai women have historically accepted that their husbands will have extra-marital sex with CSWs (later sections will actually explore whether this is so on an individual basis). Since fidelity is not expected, qualities that are attractive or desired by women in a potential husband-to-be, were explored. Women respondents were asked which characteristics they looked for in a man as a potential husband. Of paramount importance to them is a husband who is responsible and takes care of the family. Conversely, gambling or drinking too much is considered grounds for divorce. Maintaining the relationship by pleasing the husband, in addition to taking care of the family and household, was considered to be very important by the women.

F20: I think that a good husband should know how to be responsible to the family and they also know how to take care of the family and me... and they have to know how to not make any problems for us.

F37: A good husband should be responsible for everything in the family. Like money, or take care of the family, love the family. (laughing) Romantic as well.... the man is not good if he drinks too much, he likes to gamble.

The growing concern with materialism and a gender double standard is evident in some of the women’s responses in which they indicate that men are not working as hard as themselves but still want the monetary benefits in addition to being taken care of.

F25g: Right now many men are selfish. If they see the girl has money, they are looking for the girl who has money like this. And then the second thing, he has to be responsible to the family and love the family.

F25b: Most women take care of men, give him money, feed him some good food like this. Most men don’t work. Women work and give men money. One of my friends, she is responsible for everything, but her husband doesn’t work. If I marry, I don’t think that one will be rich but I think it’s better that I get a good person, like he has a
high sense of responsibility.

**Daughter’s Obligation: Tradition in Transition**

The birth of a daughter is greeted with celebration due to their potential future market value or commodification (Ford and Koetsawang 1991). When a young woman marries, the bride’s family receives a gift from the groom’s family. Similar to bride-wealth, it is called ‘milk-money’ to compensate the family for the cost of rearing a daughter (Sharp 1956). Traditional Thai society used to be strongly matrilocal with the youngest daughter staying at home with the parents. The obligation to care for the parents is being challenged with young women leaving home for employment or to attend university. In the past, daughters would inherit their parent’s land but current transformations in inheritance rules state that the land must be equally divided among the sons and daughters (Boonchalaksi and Guest 1994). Nonetheless, there still exists a strong expectation that daughters will contribute as much as possible to support their parents and other siblings (Boonchalaksi and Guest 1994).

Regardless of a woman’s occupation, the support takes the form of buying the parents a new house, or supplementing their daily existence. Young women are having to contemplate the juggling of traditional responsibilities vis-a-vis their families versus opportunities to attend college and university and potentially have a career. In some cases, the responsibility to support the family not only falls on the daughters but on the sons as well, perhaps accommodating women’s greater mobility. There is also an obligation to help younger siblings, especially with their studies. For example, F20b/w wants to continue studying but must also work because,

I need to help my father to pay for the house, then I think that it’s better that I study and work as well... because right now I have to support my younger brother as well.

F25g: I wanted to help my older sister as she had no money to study, so I had to work... I send a little bit [of money] to my mother.

F34: I have a younger brother and sister, everybody gives money to mother. I also give money to mother. And food and drink we bring.
M33's parents live very far away and he can only visit them once a year. He states,

I have one brother, one sister. They live in Chiang Mai so I give them money and to my father too but I don't earn a lot of money (laughing).

M19 is in a different situation in that he lives with his girlfriend's family and helps them financially like her other siblings.

I buy food for everybody in the family. This month we have a problem in the family because we will buy a house for my girlfriend's grandmother...only my girlfriend's grandmother's kids collect money, but I use my own salary to buy things for the family also.

4.1.2 Young People: Challenges in their Changing World

It is not only young women who are confronted with conflict. Young people in their late teens and early twenties, are now influenced globally, or on a macro-level, whereas in the past, they were influenced on a micro-level, by their parents who taught them traditional Thai morality and values. Historical sources suggest that Thais were very modest (Blanchard 1958). Until recently, public touching and embracing was not common and women were expected to be virgins at marriage. Klausner (1997), an anthropologist who has spent the last 40 years working in Thailand, noted the prohibition of dating without chaperones and the restriction on hand holding between young girls and boys.

From this data, one of the more discernible changes in Thai culture can be observed in young peoples' behaviour as they are developing relationships which sometimes includes sexual intimacy. Young women are enjoying a freedom different from that known in the past by going out with friends and boyfriends. They often go out in big groups and, depending on the outing, drinking is often involved. The composition of groups varies according to activity be it studying, going shopping, or dancing and drinking. This is in sharp contrast to the past when women did not generally drink or go out with mixed groups. Those in university, in particular, feel a
certain sense of freedom and go to discos, pubs, and kariokes. Nonetheless, women emphasize that their priority and obligation is to study hard and honour their parents. Several young women indicated the reason they go in groups is because discos are not safe due to a criminal element.

F18: About teenagers who like to go to discotheques, its no good when they go there they have to drink alcohol.
I: So you don't go?
F18: Sometimes (lots of giggles) but if we go, we go in a group with girlfriends and boyfriends.

F25g: All the staff in the shop, everybody here, we go out together. After working sometimes we went to discotheque to drink whiskey and come back at four in the morning.

Young women are crossing a barrier by seeking fun in discos and pubs, places traditionally reserved for men where they accessed CSWs. In later sections, male respondents describe targeting discos to pick-up girls. Young women may feel they look 'available' and therefore seek the security of travelling in a large group. Demarcating themselves as somewhat different perhaps legitimizes the infraction. This is reminiscent to earlier North American culture when 'good' girls did not smoke or go out drinking.

The Embodiment of Tradition: Parental Influence

Young women will fervently state that their studies are more important than having boyfriends or going out. The commitment to their studies may be motivated by an obligation to their parents to do well in school and to keep their trust even if they are away from home; that they are maintaining the values with which they were raised in the face of a changing world around them. There is an increasing awareness of young people having sex which may be exerting pressure on some young women. Having respect and honour for the parents, as well as fulfilling an implicit understanding between them about what is right or wrong, is an extremely important aspect of Thai society and is likely a motivating factor for young women not to have sex.
F20: Mostly I'm more interested in studying than to have a boyfriend....because of Thai culture, and my parents are also quite old fashioned. If Thai boys and girls do the same as foreign boys and girls, its not good...

F20r: Most of them [students] are from other provinces because Chiang Mai University is the only one big university in the north so they are quite far away from their parents. There is no one to control them so sometimes they can do this and this with other people. There is no big brother watching them. I really study hard because my parents send me to study. If I not study, I am not good Thai.

F22: The girls and boys, they go to the pub and when I am drinking I smoke too.

When F22's boyfriend goes out with his friends she hopes he drinks so much he will just go home rather than go to a CSW.

Regarding her boyfriend, F23 states

Living together before marriage is not acceptable, not good. Because of my parents, everybody knows them very well in the society. If I do that, maybe they lose face.

The data suggests that parental proximity acts as a check on behaviour regarding boyfriends and sex before marriage. Some of the young women are more concerned with making money before getting married. They are perhaps experiencing conflicting pressures of fulfilling family obligations of honouring parents and financially supporting them while feeling the pull of establishing themselves and having relationships.

F23b: It [pre-marital sex] is a little bit acceptable, but mostly the parents don't know because they are from outside Chiang Mai.

It is with respect to pre-marital sex that respondents note differences between themselves and their parents generation. The current, younger generation of 17-25 year old people are in transition as they are becoming more sexually active than was previously acceptable. They are the most exposed to western influence and
materialism and have the opportunities to acquire and exploit them.

M28o: Mostly teenagers right now follow friends. They imitate friends. Thai culture or tradition, teenagers don't know much about Thai culture. Mostly they imitate western people. Like to have sex. In the past, in Thai culture, we didn't have sex before but right now girls are free, they can do what ever they want.

I: Do men and women have sexual relations before marriage?  
M28: I think about 80%. Because right now society is changing. In the past, they were old-fashioned...

That Thai society is changing was echoed by numerous respondents. Increasing sexual freedom juxtaposed with the risk for HIV and diminishing parental influence could conceivably result in dilemmas for young people's decision-making process. Would it be worth the pursuit of sex to contract HIV? And would that risk coupled with the transgression of traditional mores and values make the decision that much more complicated?

4.1.3 Sex Before Marriage: Challenging the Status Quo

There exists very little data on pre-marital sexual activity outside the commercial arena. Studies that have been conducted based on illegitimate births indicate that anywhere between 5% and 17% of women gave birth before or within 8 months of marriage (Knodel et al. 1982). Knodel et al. (1982) caution that there are such serious difficulties in assessing pre-maritally conceived births that the results are questionable. This leaves us with the vague assumption that pre-marital sex in all probability did occur but perhaps very infrequently due to stringent cultural constraints.

Writing in the late 1950s, Blanchard (1958) states that men who were in the army or on a drinking spree, had sex before marriage, often with CSWs, but they did not have sex with a potential mate. The purpose of these outings is for men to bond with each other. The tradition of bonding through drinking and commercial sex work visitations continues today but is being challenged by changing social norms and values. Risk for HIV is also a critical factor in threatening men's traditional sexual
Sex before marriage is becoming more common among young people. It is not unusual for a young woman to have had 2-3 boyfriends before getting married. Male respondents also indicated they were going out with women in large mixed groups and were also involved in committed relationships with girlfriends. Several of the respondents were involved in long distance relationships with boyfriends at different universities. The implications for HIV transmission is evident if practising unsafe sex with other partners while away from the primary partner.

I: Is there anything else you feel is important about how young people are changing?
F17: Yes, I feel that they have more sex before marriage .... so the effect is that they got the disease from the boys.

F22 does not have sex with her boyfriends because

Mostly we become girlfriend and boyfriend for 5-6 months then we change. If I have sexual relations with every boyfriend [nervous laughter]....

This situation of serial monogamy involving sexual activity would be unacceptable to her.

F23: Right now we are very new, high technology. Its very little that men still expect the woman he will marry to be a virgin. Everything is changing.

M21: Right now, teenagers, mostly they have sex before marriage and most of them live together before. In the past, they are forbidden to have sex before marriage, but right now the society changed.

M28o: Mostly they [men] have sex with friends more than prostitutes.

One of the respondents, F26, had a very unusual experience in contrast to the other women. She knows her husband had many women before marrying her as well as a previous wife, probably common-law which is not unusual in Thailand. In addition, her first sexual encounter with this man was at 15 years old when he raped her.
She states

I worked in the shop, it was quite late and I worked alone. He came to me and spoke to me like a sweet way...then I allow him to take me home because he used to take me home three or four times...and on the way there was construction. There was nobody. He pulled me into the construction and raped me.

Fear of punishment made her remain with him and eventually marry him. She had a child by him and now says she loves him.

A Place for Freedom: University Students

University students are probably the most exposed to external forces including Western influences because of the academic setting. The faculty are often educated in the West and use textbooks written and published in Europe or North America. For these reasons, university students are presented as a specific sub-group of young people.

Brown and Sittitrai (1996) postulate that AIDS may have a detrimental impact on higher education as more students and staff become infected or families already financially overburdened cannot afford to send their children to university. Further, if younger children are taken out of the school system to help with family obligations, the cohort of young people entering university will dwindle.

My first encounter with HIV/AIDS in Thailand was as an AIDS educator working at Ryerson Polytechnic University at a time when there was a collegial relationship established with Chiang Mai University (CMU). By the mid-1990s, faculty at CMU were already concerned with the escalating rates of illness and absenteeism among students, staff and faculty due to AIDS. Since an AIDS education programme had already been developed and implemented at Ryerson, we were approached to provide guidance and training to implement a similar peer education programme at CMU.²

²I was employed by Ryerson Polytechnic University from 1991 to 1997 to obtain funding and develop and implement a peer education programme among students, faculty, and staff. This involved a staff of part-time students, social work and nursing placement students, and volunteers. The project gained much attention in North America due to its innovation and was presented at the XI International conference on AIDS in Vancouver in 1996.
The most notable change in attitude regarding sex before marriage came from the university-aged respondents. This generation of young people are in a unique and non-traditional situation. Both young men and women are away from home and parental guidance. Like university students everywhere, there is a new-found sense of freedom which includes drinking, going out, and a variety of living arrangements including dormitory living, shared accommodations, and even co-habitation. Women are having sex with boyfriends and men are now having sex with their girlfriends as opposed to primarily with CSWs.

The extent to which pre-marital sex is prevalent in Thailand is unknown. Young people in university change partners every 5-6 months. Whether they are sexually active with each partner is unclear, but there is the predisposition for serial monogamy. This is a risk factor for HIV/AIDS since in those situations, safer sex is often not practised. There is also an indication that men in university tend to like having relationships with first year “freshie” students. In contrast to the growing acceptance of pre-marital sex, for some of the young respondents, not having sex was an issue of honour.

A woman from the focus group states,

I think if a boy and girl love each other they pay respect to each other. Therefore, in Thai case to pay respect is very necessary to be a virgin so it’s honour for both sides.

A young man in the focus group states,

Absolutely not [no sex before marriage] because we should give the honour for wives.

I: Is it acceptable for young men and women to have sexual relations when they are girlfriend and boyfriend?
F19: In university I think they do but they don’t show it because if they are open it’s not very acceptable ... they rent dormitory or rent rooms outside Chiang Mai University and they stay together, they live together ... and when they go to sophomore second year then the men can find someone that’s younger, the one that replace you ... mostly the freshie, when they first come to study at the university they are very innocent. They don’t know anything and the boys they feel they have
more seniority and they take care of them and after that they are close to each other so the boys, they feel, hmmm, she is young so it’s better.

F21a: They think it’s good to study each other by living together first and sometimes some couples feel it’s fun if they stay together.

M39: every man should have experience before [marriage].

He also thinks that 80% of university students have sex before marriage... because they are close to each other, and they are also independent so they have more freedom.

Commercial sex work visitation was not only accepted by the general population, it was institutionally supported at Chiang Mai University. Part of the traditional initiation for ‘freshies’ or first year male students was to visit a brothel. With faculty knowledge, senior boys would take their juniors to brothels. The faculty of engineering was particularly prone to this practice. With growing awareness of AIDS throughout Thailand and the universities, this tradition is no longer condoned.

Focus group: They still take the freshie out. They don’t force him to go but if someone want to go they still take them.

F19: It’s hard to forbid boys to have sex before marriage...... I heard that most boy students they go to prostitutes. It is very popular for them sometimes sophomore or third year or fourth year take a freshie to go and see prostitutes.

The respondents alluded to Western influence being the cause of changing sexual behaviour among university-aged people. Men have traditionally gone out drinking but now women also go out to pubs and discos. Some men seem to be aware of the changing gender roles in Thailand, but the double standard still exists. Attending university has provided for women the ability to live on their own away from parental and community scrutiny further enhancing their independence. Whether it will eventually lead to the breakdown of filial obligation remains to be seen. The next decade will perhaps be one of many changes in Thai society.

Professor Suwatchara of Thammasat University in Bangkok, who is also an
advisor for the AIDS Hotline in Chiang Mai, fears that many students do not perceive themselves to be at risk for HIV. She feels that class differentiation accounts for their lack of internalization of the problem because university students tend to be middle and upper class. In a hierarchical society, these students may in fact perceive themselves to be better than lower class or village people with whom they may associate HIV. Dr. Suwatchara and her colleagues consider universities as playing a critical role in the dissemination of HIV/AIDS education to the public at large. This is in contrast to Canada, where public health plays the primary role in education and universities are relegated a research role.

**Gender Differences of Sexual Expectations**

Gender inequality regarding sexuality continues to exist. For example, even though women are known to have sex before marriage, it is still not as accepted and certainly not expected, for them to do so as this is a privilege largely reserved for men. This view is changing, especially with the influx of western influence in terms of materialistic goods, values, and lifestyles. These are explicit in the media and through tourism. Female respondents noted an increasing acceptance of women having sex before marriage but many said that personally it was not acceptable. This may indicate that there is the perception among peers that sex before marriage is happening, but to what extent is difficult to establish (everyone seems to be doing it but who is actually doing it?). For men, pre-marital sex is a common occurrence although sex with friends is being initiated more than in the past.

Women expect their boyfriends and husbands to have had previous sexual experience. Some of the women do not perceive their partner's sexual experience to have any consequences for them. There is the implicit belief on the women's part that the need for men to have sex, whether it is before or during marriage, is 'in their nature'. It was assumed that the boyfriend or husband would have taken responsibility by having safer sex in his past encounters. Since it is not discussed between partners, the women do not really know for sure. It should be pointed out that discussion does not imply honesty but clarifies assumptions and expectations between partners.
Overall, there are clearly gender differences of sexual expectations.

I: Would you ask a boyfriend about his past sexual experience?  
F18: Maybe I ask him about how many girlfriends he has had but I don’t ask him about his sexual relations.

F20w: In my opinion, I think that most men need sex, so it’s not strange that they have [sex] before marriage.  
I: What do you think if girls your age have sex with men?  
F20w: If they know how to protect themselves, it’s fine.

But, she explains further that Thai society, unlike foreign societies, really do not accept that women have sex before marriage.

I: Who do you think your boyfriend has sex with?  
F27: Maybe with the services.  
I: Do you think your boyfriend protects himself.  
F27: Probably.

I: What do you think about men who have sex before marriage?  
F40: Right now I’m very worried about Thai society. Before they marry, they should go and check blood, you know, and have a blood test before they married.  

Knowing that pre-marital sex has always been acceptable for men leaves young women with a dilemma in choosing partners or boyfriends. The young women state that they pass judgement on young men’s character in terms of their ‘worthiness’ as a boyfriend. Examples given include whether the man will listen when she says no or whether they understand each other.

I: Have you asked him about his past experience?  
F21a: He has told me most of it …..and if he’s not sure of the person he won’t have sexual relations with [her] and also he gives me honour.

I: Does he ever try to convince you to have sex?  

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3The issue of blood tests to ensure neither partner has HIV is a particularly heated debate among health advocates and researchers.
F22: ...before we became girlfriend and boyfriend, I had to judge and choose what is best for me ...we have to understand each other and if he tries to, I say no.

Focus group: Before I have sex with him, I should know his background first. Before I have sex, I have to choose that man and consider it a lot. I will decide by his ideas, education, family and friends.

**Women's Dilemma, Men's Prerogative**

The male and female perspectives on pre-marital sex varied significantly. Women are more concerned with not disappointing their parents by remaining chaste. If they make the decision to have sex, they want to ensure that the man will have an honourable character. Males, on the other hand, have a more self-oriented view of their sexuality as they are not held accountable to anyone. Their sexuality is very separate from other spheres of their lives. Because having sex is such a strong expectation of men, it is far less of a dilemma for them to make the transition from having sex with CSWs to having sex with girlfriends. VanLandingham (1993), in studying the sexual activity of never-married men in the North, found that 53% of men were having sex with a girlfriend, indicating a change in traditional pre-marital sexual behaviour usually undertaken with a CSW. In fact, men perhaps consider it safer thus providing the impetus for them to do so.

Except for one respondent, M37, all the men had sex with their girlfriends. M33 indicated that although women could have sex before marriage, they would be regarded as 'unclean' if they had too many boyfriends.

I: Do you have sex with people other than your girlfriend?
M19: No.
I: Why not?
M19: It's dangerous because I have my girlfriend so it's not good for me to have sexual relations with others. I'm also afraid of AIDS.

Regarding young women who have sex he states,

Maybe the girl, when they have already had sex with boys, after that the girl goes out with friends and if she knows someone else maybe she have someone new.
Because it's easier for her to have boyfriends. Also because they [girls] drink.

I: How about women or girls...after drinking alcohol, do they like to have sex?
M21: It's possible, but mostly women can control herself.

Alcohol impedes sexual decision-making especially among young people leading to decreased inhibitions and enhanced sense of invincibility. The feeling that men have stronger sexual needs than women and are thus less able to control themselves appears among female respondents in later sections.

M33: ...maybe you have 3-4 girlfriends before you marry. In Thailand we can have many girlfriends. For example, if woman has many boyfriends the people say you are not clean girl, you are not clean so we don't want them because you have many boyfriends so they don't want to marry you but for me, no problem.

I: Who are the women men have sex with? Are they friends or someone else?
M39: Mostly they are not friends....they can be like the woman who loves to have sex with any person. The woman who loves to go to discotheques, and also the men who love to go to discotheques. Men and women, when they go to discotheques, the drink and they talk to each other, and after that they go together....because some men don't like to go to the brothels so they try to flirt with the girls in general and they have to try their hardest. But they have sex, so I'm not sure how the women feel. In my opinion, it's a sin to force the woman to have sex. Suppose they are virgins, if you force her to have sex, we are not being responsible to her, so it's not good for her.

With regards to past inequality in terms of freedom of movement and opportunity to have sex, M37 states,

In the past, only Thai men would go out and work, earn some money to support family. Females stay at home and do some household chores so she cannot, she would not have a chance to interact with other people outside, so the man can go to...everywhere. So that's the reason why a man can go to the brothel, can do these kinds of things and females cannot.

In response to young people living together he states,

Sure, that is the influence from the Western culture, so maybe the teenager, they prefer to stay together before they get married, 'let's just try'... the teenager now is maybe influenced from the Western culture and so, especially in the big city, they
prefer to go to McDonalds, KFC, or Dunkin Donuts.

It is not inconceivable that as AIDS continues to be associated with CSWs and mia noi's become a financial and practical impossibility, that men will increasingly have sex with casual acquaintances. Sexual networking is changing, and its effects would be monumental in the context of the misperceptions of risk, which views having sex with one kind of woman as somehow safer than another.

**New Thoughts on Old Traditions: Gender Perspectives on Commercial Sex Work**

In traditional settings, pre-marital sex was thought to offend the ancestor spirits unless the male compensated the female's family (Wawer et al. 1996). The loss of virginity is a loss in market value for the woman in terms of her marriageability. Some women recognize the strong market value placed upon their sexuality by their society and opt to exploit it through commercial sex work (Boonchalakksi and Guest 1994). That commercial sex work is pervasive in Chiang Mai and is part of the HIV transmission cycle is indisputable. The factors challenging this long-standing tradition need to be explored from both the male and female perspective.

The majority of people living in cities in Thailand have migrated from rural areas. Part of what they bring with them are their mores, values, and traditions. Lyttleton (1994) notes that in village life, sexual transgressions are punishable by fines. This perhaps is one of many factors establishing the precedent for regarding sex as a form of financial transaction ie; that sexual contact with a female has a monetary value. Different types of sexual contact warranted varying amounts. As the severity of the sexual transgression increased, so did the amount paid. The fine was to compensate the family of the woman involved.

**Women, Commercial Sex Work and its Acceptability**

The literature review conducted before undertaking this research indicated that commercial sex visitation was very ingrained in Thai lifestyle. The degree to, and conditions under which it was accepted by Thai women was examined with particular
attention to the impact HIV may have had on changing opinions.

Gaining experience is the predominant reason given for men’s sexual freedom by both men and women but was verbalized more frequently among the women. A fear of AIDS emerged in the responses but there was an assumption that men would protect themselves. The acceptance of CS visitations as a long and historical practice by men has not changed but AIDS has added a new dimension and has forced men and women to re-evaluate the basis on which they will accept this. Some of the women would find it unacceptable if their partners continued to see CSWs while with them. For many women, the past was relegated to the past without further ado. Knowledge of past commercial sex encounters would not inhibit them from having sex with their male partners nor would they insist on condom use. They do not perceive themselves to be at risk since they believe the men will protect themselves. Practicing safer sex is tied in to honour, for the men themselves and the non-commercial sex partners they will be with. Additionally, the younger women seem to assume that their male counterparts will be too afraid of AIDS to go to CSWs.

I: Is it acceptable for men of your age to have sex with prostitutes?
F20b/w: Right now, we are afraid of AIDS but in the past it’s acceptable. But in my opinion, I think that I don’t care....because they [men] need this. If they know how to protect themselves, that’s fine.

Interestingly, this respondent realizes the impact of AIDS and yet she still feels that a man’s sexual needs nonetheless supersedes all else including the risk for HIV/AIDS. She qualifies her statement with the realization that protection is necessary.

I: Do you think men go to prostitutes before they marrying?
F25b: Yes, sure. Because they are teenagers so they think maybe they get more experience, so they went to prostitutes. At that time, there was no problem, but right now, AIDS is the most popular disease so they have to know how to protect themselves. ....right now, the radios and information always tell how to protect themselves about AIDS, so if they don’t know....maybe they get HIV one day.

The respondent, F27, says she is quite sure her current boyfriend went to the sex services when he was young. When asked how she would feel if she found out he still
went, she said,

That's okay, it doesn't bother me....but if he goes to that place very often, it's not good.

With regards to men in general, she continues,

Maybe their age, they need to, it's their need. They need to go and to see and to try.

F31: Mostly the men, they love to go out and have sex with the prostitutes or friends, whatever.

F34: ...they are bachelors so they have to go to the brothels... because we can avoid rape ... but it's quite dangerous right now that there is AIDS.

Only one female and one male respondent mentioned rape in this context although it is becoming a concern in Thailand.

F40: Right now, prostitute is not very important for men. Most of them have sex with the one they work with because they have close relationship. Maybe they thought that this woman has no disease...

This response as well as others in subsequent sections may indicate an increasing trend for married men to avail themselves of their female co-workers rather than CSWs.

Men, Sex Before Marriage and Commercial Sex Work

This section was divided by gender due to widely differing responses. Since women are beginning to have sex before marriage, the need or desire for commercial sex work visitations is declining. Men using sex services throughout their lives is still

4Newspaper articles in the Bangkok Post and The Nation seem to indicate an increase in violence and sex crimes. In fact, while walking along a soi (road) in Chiang Mai in the vicinity of several brothels, a young Thai man jumped off his motorcycle and masturbated in front of me. When I mentioned this to one of my key informants from an NGO, she stated that numerous other women had complained of similar incidents but nothing official was ever undertaken. Apparently, word has been conveyed enough to make some women uncomfortable about walking around Chiang Mai.
recognized as a longstanding Thai tradition. The potential for HIV infection is challenging this tradition. Men are recognizing their risk for AIDS via commercial sex work and it is affecting their attitude towards it as well as their behaviour. Although women respondents talked about honour and respect with regards to the men in their lives and how they expected to be treated by them, these issues did not occur spontaneously among the male respondents.

Most men described drinking with friends often resulting in brothel visits. It is becoming apparent that this pattern is beginning to change as men are increasingly dating women and becoming involved in relationships. Men may not go to CSWs once they have girlfriends but what is of concern is their exposure before the girlfriend and in between girlfriends. As well, it cannot be assumed that every girlfriend is willing to have sex. Therefore, do the men still go to CSWs while with their girlfriend?

I: Do your friends go to prostitutes?
M19: No ...because they have girlfriends and also the ones who don't have a girlfriend, they still don't go. We love to go out and have a drink or go to a restaurant, something like this. Sometimes we just want to go out for fun. It doesn't mean that we go to prostitutes.

A male respondent in the focus group, in discussing sex with CSWs, stated he did not go...

...because of disease we can get from prostitute like VD or AIDS.

Although M21 does not have a girlfriend, he still does not go to CSWs because ...

...I'm scared of AIDS.

Brothel visits among his friends does not occur as most of them have girlfriends but he could not comment on what they would do if they did not have girlfriends.

Once M23 became engaged, he stopped going to CSWs, his reason being ...

...I was afraid I would get some disease and bring it home to my wife or
something like that.

**M**focus group: When I study as freshie, mostly the seniors take us and I also wanted to try. I stopped going because I am very sympathetic with ladies because I work within the society. So when I work with the women workers I am very sympathetic to them. Lots of men think the same as me because we work in the same job. I have been five times and every time I talk to them... the last 3 times I didn’t want to go but I felt lonely so that’s why I went.

The issue of having a greater understanding of what these women’s lives are like was reiterated by another key informant who was a graduate student at Chiang Mai University. He spent 10-12 years of his life going to CSWs until social activism coupled with conducting research in the villages the young women came from led to a greater understanding of their situations.

Peer pressure among men to go to brothels is quite strong (see ‘Commercial Sex Work and the Male Peer Group’ for a more in-depth discussion of peer pressure).

**M37** says: Some friends go ‘oh, why you don’t go blah blah. You are not man.. 

He continues to say that because of AIDS, that attitude is changing, especially among the more educated. He says his parents and elder brother taught him right from wrong and about consequences of actions like getting an STD from a CSW. He also explains the long tradition of men going to CSWs at least once when they are growing up. They are influenced not only by the tradition but also by the friends with whom they will be able to share something with, a bonding of sorts.

...if they’ve never been there to a brothel or massage parlour, they would like to know, and then they would have a topic to talk to his friend about and say ‘oohh, I’ve been there’.

**M39:** In the past we went to brothels because there was nothing except brothels so it’s bad if we rape someone so we should go to the brothel. I think that if we buy sex, it’s better.
If a man has a special woman in his life, M40 states,

Mostly they won’t go [to the brothels]. Even if they go with friends, they still don’t want to go to prostitutes. Even if they have a chance to go, they don’t have to go because they will wait for friends downstairs...

In the focus group discussion, four young men had differing opinions regarding commercial sex work visitations.
The first young man states.

For men, its normal if they drink and go to prostitutes.

Another man counters,

No, no, no, if the man has a girlfriend, they don’t go.

The next man states,

I think that it is common that everybody goes.

And lastly, the fourth man says,

No, it’s unusual. I have a girlfriend so when I get drunk, I never go see prostitutes.”

Women, Commercial Sex Work and the Threat of HIV

The women interviewed were very aware of the men’s penchant for going to CSWs and assumed condoms were being used. There is some ambiguity as to whether the very expensive or less expensive CSWs are more likely to use them. Some of the respondents involved in sexual relationships with partners they know had either previously seen CSWs or continue to go, do not perceive themselves to be at risk for HIV. Under any topic of conversation, female respondents did not consider themselves part of the sexual network nor was it a part of her reality to suggest using
condom use.

There is the recognition that going to CSWs is part of an evening’s regalia that does not involve pre-meditation; that the focal point of the evening is actually getting together and drinking. Perhaps as a further enhancement to their sense of security, many of the female respondents felt that men did not go to CSWs as often because of the fear of AIDS.

F17: ...right now there are a lot of diseases so they [men] try to stop [going to CSWs].

I: Why are you so sure he [the boyfriend] doesn’t go out with other women?
F23: Because since I’ve known him, he has no habit like this. He works all the time, just sometimes he goes out with men friends. But his friends, they do go out with other women. But he himself will leave.

Her response is interesting and not unusual. Like many people who rationalize their situation as being somehow different from others, she does not perceive herself to be at risk even though she knows he went to brothels before they became a couple and his friends continue to go. Perhaps her assumptions based on his character are correct and he no longer goes to CSWs but having said that she continues:

If the man has a girlfriend already, he should give her the honour and not go to prostitutes. So if that man decides that he will have a girlfriend, he should stop going to the prostitute. But if that man cannot stop going to prostitutes, it makes his girlfriend very sad.

She thus realizes that a commercial sex visit is a possible outcome to which she would react with sadness. The immediate response is not anger at the transgression or fear of STDs because sex is seen as such an inevitable part of being a man and the inevitable part of being a woman is to accept it.

F25g: From my experience of hearing the bar girls, they talked and told me. They say that they have to have condoms with them all the time. Sometimes even in the bedroom, and when they have sex with the men, they will give condoms to the men.
F26 feels that all men go to the brothels but when asked whether they know how to protect themselves, she states,

Some of them, they don't protect themselves because they say they are not afraid of AIDS. They are afraid to stop having sex. A lot of them die. I think most prostitutes, they work in a bar or club, most of them have condoms for men. But prostitutes who are much cheaper, like 150 or 200 baht ($4-$6), actually some in Chiang Mai, sometimes men can use condoms or don't use condoms, that's okay.

She reiterates that she feels that men are more afraid of not having sex than of using condoms.

F34 describes what she knows about commercial sex work in the following statement,

Mostly the construction workers go to the brothels. For the student, I don't see it as much, but for the white collar, mostly they go to the karioke, the pub, or a night club. The karioke and escorts are more expensive but the massage parlours is the most expensive. It's about 1,000 to 1,200 baht ($28 - $34) per hour. But if men go to the brothel, it costs 50 or 100 baht ($1.50 - $2.80) .... I heard someone say that when they go to a massage parlour men take showers with the lady. The massage parlour is close to the train.

**Men and Commercial Sex Work: An Evening Out**

From the male perspective, extra- and pre-marital sex with commercial sex workers is regarded as a form of entertainment and a male privilege. Men and women feel that men have stronger sex drives which need to be satisfied. To have sex with a CSW is a male expectation. Havonon, Bennett, and Knodel (1993) state the most common network pattern for men, regardless of social strata, is to have sexual relationships with CSWs as part of a social occasion usually preceded by drinking (VanLandingharn et al. 1995). It is the getting together and drinking that forms the central or dominant aspect to male socialization.

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5The price is given in Canadian dollars based on an exchange of $.35 to 1 baht. The exchange rate varied significantly between the 1995 and 1998 trips.

It does not always inevitably lead to brothel visits but it does occur with regular frequency and is recognized as a strong part of male social life. Male friendships have traditionally been based on mutual interests in drinking, gambling, cockfighting, marijuana smoking, and brothel visits (Blanchard 1958, Celentano et al. 1993). Solidarity is gained through shared experiences. Not only does it seem to be the average male’s prerogative to seek commercial sex workers but it is in particular “...for the most masculine of men, police, military, and government officials, to patronize the sex service industry.” (Muecke 1992).

The majority of men start going to brothels in their teenage years. Many go 2-3 times per month as part of a pay day celebration preceded by drinking. There is a strong sentiment among some of the respondents that all men must go (M28). The variability of commercial sex work is recognized; different venues of accessing women include brothels, massage parlours, pub, karioke, nightclubs, and discos.

The respondents indicated that commercial sex work visitations are on the decline partially due to the fear of AIDS. What is actually replacing the traditional sexual outlet is alluded to but not explicitly stated. As has been previously suggested is that sex outside the commercial arena is possibly increasing. The male respondents presumed that sexually active men knew how to protect themselves, especially younger teenage or university aged men.

In recognizing their need for money, CSWs were not spoken of derogatorily. Commercial sex work is viewed as an ingrained part of Thai life, not an ‘other’ or marginalized life as is often depicted in western countries.

M23: There are many kinds of places like nightclubs, discotheques, karioke, or the pub, they can go inside and look for girls. They are mostly high price girls.
I: How often did you go?
M23: Two to three times a month

M25: When I was drunk I planned to go. I had an idea to go. With friends. I went once in 2-3 months.
I: Why do men go to prostitutes?
M25: Because we go and drink. It is common to go. We don’t think about it ... but now I give up because it is not good ... because we have AIDS and there are many
diseases like AIDS.

M28o: Mostly I can say all men have to go see prostitutes. It's very common for men to go. If they don't go, sometimes they say that we are homosexual or transvestite (laughing). ... I think [men go less] because of AIDS....

M33 works in the tourist industry and therefore has much opportunity to go to sex services with farangs. He stated that before he was married he went to CSWs alone and with groups of friends but his visits currently are restricted to business interactions with farangs.

Mostly farangs. Thais are easy. They know where to go, where to contact the people. Farangs don't know, like in a restaurant, whether they can buy sex or not or just buy food.

His attitude towards commercial sex work is very non-judgmental and practical. It is recognized as a legitimate way to make money. He states:

We believe that usually the country people believe in prostitutes for money. Or your job forces you to do. You don't like but you can make a better life, make money so we don't care.

M39: In the past, when there was no AIDS, they [men] loved to go. Bachelor, married, they still go to prostitutes... right now they still go so they use condoms.

He talks about the changing culture and that in the past liking a girl did not mean having sexual relations with her. But now things are changing and girls go out more often.

M40: The age when they go out to see the prostitute is when they are in high school. Maybe 16 years old .... if you are a student, mostly you go to brothels but if we have a lot of money, we will go to massage parlour because it's more expensive, but to go to brothels, we use less money.... to go to massage parlours, they have more services than brothels. Women at massage parlours are more beautiful... presently, if we go to brothel, it's about 200-300 baht ($6 - $8.50). If I go to massage parlour, I will go to Pinpayong Hotel, it's about 700-800 baht ($20 - $23).
4.1.4 Sex Outside of Marriage: The Gender Double Standard

In a culture that is predisposed to extramarital sex for the men only, the choices or expectations married women can realistically have are few. The husband, if wealthy enough, can choose to have a mia noi or, can seek out commercial sex workers as part of an evening’s regalement with friends. The two options are not mutually exclusive and either situation would put the wife at risk for HIV and other STDs. If a husband chooses to have a mistress, this would not only put the wife at risk but lower her status and bring shame and dishonour upon her. Because of the incessant barrage of information on HIV/AIDS in the last several years which focused on CSWs, a man may actually be more likely to use a condom in a liaison with a commercial sex worker than in a non-commercial liaison.

To gain a greater understanding of the gender double standard as it pertains to freedom of sexual expression, both men and women were asked about women having sex outside of marriage in general and both genders were asked specific thoughts and opinions regarding men having sex outside of marriage with a mia noi, friend, co-worker, and with CSWs.

Establishing the Threat

Except for a consensus of the unacceptability of women having sex outside of the marriage, women’s opinions were few and comments were vague. None of the respondents mentioned any personal experience either directly or indirectly through family or friends of a woman having sex outside the marriage. The topic did not seem to be one of past or present discourse which may be the reason why strong sentiments did not ensue. The closest experience was F36 reading about a married woman having a lover in the newspaper.

In commenting about women having sex outside of marriage F20 states that she does not pass judgement but,

...our culture does not accept this.
F26 hints at sexual equality however, her situation seems to be uncommon due to her past history with her husband. Additionally, it is unclear what the extent of her relationships with other men were. Therefore, her response, although valid may be atypical.

F26: ....most men, if they go out, if they go to a prostitute, they don’t care about wives. But when I went out, I care about my husband a lot. It’s only my body that goes, but my mind doesn’t follow.

Later in the conversation she says she only goes out with other men for food and drink and to cheat them. She puts pills in their drinks so they will fall asleep and she can avoid having sex with them. She alludes to the double standard and that there should be equality

If he thinks he can do so, I can also.

With regards to men having sex outside marriage, women did not like it but seem to accept it as an inevitable part of a man’s need for sex and variety. The recognition of a double standard was non-existent to the extent that women’s sexual needs are subservient to men’s needs. Some women are very aware and frightened of AIDS. There is a definite growing perception of risk for HIV but as with other issues dealing with sexuality, for instance, sex before marriage, it is assumed that the man will be responsible by not financially hurting the family or by bringing a disease home. F20 states that women should accept the fact that men will have extra-marital sex because they get tired or bored with the same woman. In contrast, F30 says her husband is not the type because he does not like to go out. It is uncertain whether there is a certain stereotype or genre of man that does not have sex outside the marriage or how that man is perceived or operates within the male domain. If he does not go out at all does that also entail a lack of a male peer group or is there another type of group.

F20’s views are radically different with regards to men having sex outside of marriage; for women it is unacceptable. She states,
...is only for fun, it's not very serious....but it means that they have to know how to protect themselves...

She also feels

.....women should be open-minded about this...because we are the same thing all the time. Sometimes its boring (for the men).

The perceived male need for sexual variety has appeared in other studies (VanLandingham et al. 1995) and will be addressed further in this chapter.

I: Is it acceptable for men to have sex outside marriage?
F20b/w: It's acceptable because it's the need of the men, it's the nature of men. But before they get married, they have to check themselves. As long as they do not have any diseases, that is fine.

I: Is it acceptable for men to have sex outside the marriage?
F22: No, I don't think so but at the same time, if I marry I have to accept that he will have sexual relations with someone else.

In commenting on her husband's previous sexual experience, F30 states,

Maybe, because it's very common for men. I believe that my husband doesn't go out after marriage ... because his habit, he doesn't want to go out, ... [about drinking] right now he gave it up but in the past yes.

F40 says men having sex outside the marriage in the past was okay but now there is AIDS and she finds it very scary. Nonetheless, having said this she continues to say that she would rather not know if her husband is having sex with somebody else

....if my husband doesn't let me know, that's fine but if I know it's not very good, I will be angry.

The interviewer clarifies,

It's okay or fine if men have sex outside the marriage?
She states,
It depends. If wives, they have more work and they’re tired so men can go out, because the nature of men, most of them have more sex than women.

She feels that this is acceptable as long as it does not affect the family, especially her daughter. Therefore, the fear of AIDS exists but is secondary to the acceptance of extra-marital sex based on the condition that it not have a negative impact on the family.

The male respondents were not as vocal about the topic of extra-marital sex. Their reticence is perhaps due to the fact that commercial sex work is such an ingrained part of the lifestyle that it does not merit any particular attention. Its acceptance and frequency makes it an unremarkable event. Those respondents who were unmarried gave their future projections about how they would comport themselves in the midst of a changing sexual environment. In some cases, such as M21, who does not think he will have sex outside the marriage, it could indicate an individual choice or be part of greater collective change in attitude regarding sexual behaviour. Overall, there is a tendency for the younger respondents to indicate that they will mostly have sex within a relationship whether it be a marital or pre-marital one. Sex occurring within a relationship in contrast to within a commercial sex work encounter has different dynamics pertaining to condom use.

M21 thinks a married couple would definitely quarrel if the wife were to have extra-marital sex. When asked whether he thinks he will go outside of his marriage for sex, he states,

I won’t because at present I won’t go either.

M25 does have extra-marital sex and says his wife knows and does not get angry.

M37 feels that sex outside of marriage is an indication of the lack of resolution to problems couples may be experiencing. He states that,

... some people, they just keep getting a problem, and ignoring it. That is the
reason why males like the minor wife.

M39 succinctly summarizes the general behaviour of older men. His wife was very pro-active in her urging him to use condoms. He describes the conversation in the following,

She didn’t say directly to me. She said something like this, ‘Oh, be careful, because I didn’t see that you have any condoms.’ (Laughing). She also said other songtaew (taxi drivers) have condoms (laughing again). But she didn’t know that I also have condoms with me.

Her perception of risk to HIV is clear when the respondent was asked why he thought she would bring up the topic of condoms. He explains,

It means that she doesn’t want me to go to the prostitute, because if I go to prostitutes and I don’t use condoms it means that I will transmit a disease to her. But she doesn’t know that I always have and I am careful about this.

Her use of peer pressure is very creative. It is unknown whether she actually did speak to other songtaew drivers or is just telling him so, but the effect is the same - your peers are using condoms, you should too. The discussion with this respondent about extra-marital partners and his wife’s feelings continued further.

I: Suppose you go to the prostitute or you have the minor wife, what happens?
F39: Wives mostly say that to go to prostitute is better than to have minor wife.

He later says that both venues of extra-marital sex are unacceptable to the wife,

....both are bad. If I go to the prostitute, it seems like I look down upon her, like she is not good about sexual relations.

He seems to justify his actions by saying that,

Some women, they love the taxi driver. It’s impossible that a wife can stop the husband from going to prostitute or to have minor wife.

He finishes by saying that one must think of the diseases they can get after
sexual relations. His response addresses numerous issues including that of honouring his wife. Although the intention is not to make his wife 'look bad', the sexual availability poses a dilemma. His wife is very realistic about the situation and uses peer pressure quite effectively in her insistence that he use condoms.

This could be a strategic tool for women in terms of prevention and equally important as a communication tool. She is letting her husband know that she is aware of disease transmission and vocalizing this fear as well as her expectation of his responsibility which may have an impact on his behaviour. Regardless of their personal feelings, none of the women would actually ask their husbands to stop having extra-marital sex. The social acceptance of extra-marital sex for men is so pervasive that women may not feel that they can challenge the tradition on an individual basis. Rather, the primary concern was their health. Perhaps by discussing HIV and other STDs, it forces men to be more aware of their actions and take responsibility.

The Mia Noi, Friend, and Acquaintance

Polygamy also has a long history in Thailand. Males from wealthier families in particular would take a second wife, called a mia noi, to help with the chores (Blanchard 1958). Only the first wife has any legal standing including inheritance rights and usually exerts authority over the second wife (Klausner 1997, Blanchard 1958). For a husband to take a mistress, as opposed to visiting a CSW, would lower the wife's position and status as she cannot exert control over this other woman. A non-commercial sexual liaison with a woman outside of marriage is considered a threat to the well-being of the family in contrast to a commercial sex encounter (VanLandingham et al. 1995).

The knowledge that their husband's will likely have extra-marital sex, coupled with the advent of AIDS, wives are contemplating financial security versus long-term health outcomes. The concept of a mia noi is derived from an older Thai tradition when men could afford more than one wife. Currently, the practice of having a minor wife is not as prevalent and yet it was remarked upon spontaneously by several of the women respondents. Women's feelings towards the mia noi are ambiguous and based on
conditions and context. For example, a *mia noi* is accepted only if the husband can support everyone without it being a financial detriment to the first family. Although there is fear of AIDS if men go to CSWs, the wives will not lose face as they would if their husbands had minor wives. Sex with a CSW is regarded as being fun and obligation-free whereas the appropriation of a *mia noi* is serious and can result in financial repercussions for the family. The women who responded did not seem to regard AIDS as being as much of a reality in comparison to suffering financial consequences.

I: What do you think if the man has a minor wife?
F32: Actually, it's not good but if that man is very responsible than it's fine.....don't leave real wife and children. He also must take good care of them. I saw someone in my village, her husband has the minor wife but the real wife, she is better wife so the real wife didn't work for money because her husband will give her a lot of money. He also gives to the minor wife but the difference is that real wife doesn't work.
I: What do you think is worse, your husband go see the prostitute or to have minor wife?
F32: Right now, I think that is the same. Is not good because if man go to see prostitute right now they have AIDS [minor wife?].... it hurts the feelings of the real wife.

F36 gives her opinion,

Just once is fine but if two or three times, the man feel good if they have minor wife and they start missing that girl or lady and the man may separate from the wife.

When asked about whether she is afraid her husband has a *mia noi*, she exclaims,

I will be angry with him....[she will say to him] I don't have time for you and if you want to shame me okay, you can do, I will stay alone...

I: What do you think if men have sex outside the marriage?
F37: In general, it's fine. I disagree if men have minor wife and mostly, men, they go to the brothel. It's very very simple.

F40: If they do [have sex outside the marriage] just for fun, it's fine. But if they do
like minor wife, it's not very good for family. Mostly Thai women should accept for husband that they have to go out and to have sex with someone else, but if he supports them, something like this, it’s not acceptable.

The topic of extra-marital sex was addressed in the focus group discussion. One woman, speaking hypothetically as she was not yet married, said in response to how she felt about her future husband going to CSWs,

No, I would get him a mia noi.
I: What else could you do?
Focus group: I don’t know but I don’t like it if he goes.

She then said she would ‘improve’ herself by having more sex with her husband at which point one young man rambunctiously yelled out that it was sexual techniques she should improve. This was not meant as an insult as both the men and women laughed but there is the recognition that non-CSWs are perhaps more demure sexually that their commercial counterparts. In a similar study in Thailand on extra-marital sex, VanLandingham et al. (1995) found their female respondents to assume it was their responsibility to keep the men satisfied within the marriage to prevent them from seeking sex elsewhere.

The men have a slightly different reality and the women do not seem to be aware of it. Mia noi’s are not as common as in the past and presently a privilege for wealthy men who can financially afford to support more than one wife. Men are now seeking their extra-marital sex with casual labourers or acquaintances rather than with CSWs. The risk for STDs is perceived to be substantially less and the financial burden is obviated.

M25: Oh, I didn’t go to the prostitute but I had sex with a working woman.... I met her many times .... and stopped because my wife knows. I went to work in Bangkok and my wife stayed in our home town. So, during about 4-5 months of work, I have sex with worker friends, about 4 girls.
These women were dressmakers or shoemakers. He would normally meet them after work. Drinking was usually part of the encounter.

M25's wife knew he went to CSWs before they got married. When asked what he would do if his wife forbade him to go to out and have sex, he states,

Yes, I would give up going because of what I feel for my son. I would give up having sex with the girl who sells vegetables (his current extra-marital liaison).

I: Would you like a mia noi?
M33: No, it's not easy to make money to pay the mia noi.

He continues to explain that rich men can afford mia noi's but they also want younger, inexperienced women,

...so they (older women) have the experience, they (rich men) want to try the girl with no experience. Maybe more fun.

In numerous countries, including Thailand, men want sexually inexperienced girls or ideally virgins as they will be disease-free. Young Thai girls sold into prostitution extract a huge sum of money from their 'first' client.

M39: ...so this is the reason they have the minor wife, because of AIDS, it makes the men not want to go [to CSWs].

**Sex Outside Marriage with CSWs**

The reasons women feel men go to CSWs is multifactorial. It is perceived as a combination of men's sexual needs and boredom within a long term marriage. Wives will try to ensure that their husbands do not get bored but accept them going to CSWs as unremarkable. Several women said it is common for men to go 2-3 times per month, oftentimes on payday on a Friday night accompanied by other friends and preceded by drinking. Many of the female respondents felt it was their responsibility to do all that they could to ensure that their husbands not go to CSWs. However, the
inevitability of that outcome was recognized, tolerated, and at times justified.

The level of acceptability by the women is exemplified by F26's situation in which she actually had to pay her husband's debt to the CSW. F31 believes if her husband loved her and their family, he would not go to brothels. It may be her hope and desire that he not go but her reality is that he might and she therefore has to go to the next level of reasoning, perhaps promulgated by her fear of the 'new disease', and assumes he will protect himself.

In all of the responses, women's sexual needs were not recognized and how they were expected to manage keeping their husbands sexually satisfied when many of them worked and had children was not questioned.

F19 was asked to envision what her married life would be like. She stated that she would not accept her husband going to a CSW and would ensure his not going by taking...

....good care of him and make him love me more and more and don't let him get bored of me.

F25g feels that it is drinking that makes men go to CSWs. She states,

...I saw men after they drink, so they go to the prostitutes.

F26 justifies her husband's ventures several ways by viewing it as less serious than having a minor wife and making the analogy that sex, like food, is a necessity. She also says that her husband drinks a lot and becomes very irresponsible which is why she ended up paying for the CSW and motel room. These are perhaps her conditions under which she accepts something she cannot change. She explains her feelings by saying,

I didn't feel anything because he went to the prostitute. He didn't go with ordinary women. If he went to the an ordinary woman, he would do it again and again and
then she would become his minor wife. It's like, I bought noodles for food. It's the same that he went to the prostitute.

I: How can you prevent your husband from going to a CSW?
F27: Hmmmm, there's only one way. If he ask for sex, by not refusing him.

I: Does he [your husband] go to prostitutes?
F29: Yes, it's very ordinary....but I'm not paying attention because I read that I should understand him because he has needs about that, about sexual relations....also I think that we have a long marriage so its okay.

She continues by talking about a women who nagged her husband so much he acquired a minor wife.

F31: I told him if you love me or the family, please don't go to the prostitutes.... I think it's common to go, it's nothing special but now there is this scary disease so I'm scared. But if he goes, that's okay but he has to protect himself ... he has to be careful... if he wants to go it shouldn't be too often. Maybe 2-3 times a month but he has to protect himself.

When she was later asked if she allowed her husband to go, she stated,

Because we have been married for a long time, so I think it's very boring, everything is the same, so I think most men need to find someone new...

This respondent has gone from an idealistic scenario in which her husband does not go to CSWs because of his love for his family to realizing he must go anyway, and therefore, must meet certain conditions in terms of frequency and protection.

F32 does not find it acceptable that her husband goes to CSWs but knows it is inevitable if he goes out with his friends. When asked how she could stop him, she said,

It's very difficult to stop him, except if he doesn't go out with friends in the big group and drink.

The peer group is obviously very strong and exerts more pressure than any
disdain or admonishment from a wife could. Men spoke about their visitation to CSWs mostly as it occurs within the context of the peer group when drinking alcohol was involved. Women tended to regard commercial sex work as part of their reality, their married life whereas men tended to view it as something quite apart from their wives or family. It literally is something they do for fun and to relieve themselves.

Essentially, the wives cannot do anything. The use of CSWs is so prevalent and ingrained that M28 could not believe that any man would not avail himself of sexual services especially within the context of drinking with a group of friends. His response is very illustrative.

I don't believe it .... they are not telling the truth. Like I am a man and all the men's habits, by nature. Maybe if the girl is very ugly maybe you do not but why pay money? Mostly they have sex.

I: Why do men go to prostitutes?
M40: The business men, most are married, but when they finish working, they love to relax and then they go drinking. After drinking they go to prostitutes or go somewhere and have fun... most business, they choose what kind of prostitute they should go. Mostly they love to go to flirt with singers in cafés or sometimes in cocktail lounges, they will flirt with receptionists. But if they like each other, then the girl will become a minor wife.

There appears to be a higher cultural regard for what it is to be 'masculine', such as patronizing CSWs, than for what it is to be 'feminine', to remain virginal. This creates a paradox as the two cannot exist side by side which has resulted in a special class of women whose virginity is disregarded for a time.

The gender discrepancies that exist allowing men far greater sexual privileges and freedom of expression than women, cannot be disregarded. This is particularly the case in Thailand, as in other Asian countries, where a heavy emphasis is placed on the woman being a virgin at marriage while her male counterpart is expected to indulge almost indiscriminately in sexual trysts. This is slowly beginning to change as young people are living together before marriage.

This study revealed that some young women do not expect their future husbands to have sex outside the marriage and would strive to ensure that it did not occur. How
this will impact on commercial sex patronage remains to be seen. With increasing education women are perhaps becoming more outspoken and looking for equity in their relationships. Not to be minimized is the men's fear of contracting HIV from CSWs which is beginning to affect their patronage. In fact, Sittirak (1996) refers to the National Commission on Women's Affairs (NCWA) from the Prime Minister's Office in Bangkok stating that prostitution in the form of rented wives may once again become popular among wealthier men in order to avoid the risk of HIV/AIDS. Similar reasons are motivating men in this study to seek waitresses and other casual acquaintances for sexual encounters and for women to find a once humiliating tradition to appear as the safer option in terms of risk for HIV.

4.1.5 Commercial Sex Work and the Male Peer Group: Interactions and Inextricability

The women respondents were very aware of circumstances under which men went to brothels – with friends after drinking whiskey and rum as part of payday and weekend fun. Visiting commercial sex workers is part of the social context and does not frequently happen in isolation. In fact, F32 felt she would have to stop her husband from going out drinking just to stop him from going to brothels.

F32: It's very difficult to stop him unless he didn't go out with friends .... if men love to drink, we cannot stop them at all [from going to CSWs].

F34 works with her husband driving a songtaew and sees much of the activity. She states,

Mostly they go with friends ....they go with a group, four or five together....because when they get paid every two weeks, they go to the brothel every time they get paid... mostly they love to go on Friday and Saturday nights.

F36: They go with friends because mostly they have whiskey before they go to prostitutes because after they have whiskey they have more fun and go to
prostitutes together.

The following represents the functioning of the peer group and the role of the leader from the male perspective. M23 in particular talks about the decision-making process. Most men talk about friends being very persuasive in reference to commercial sex visitation. As previously stated, some men such as M28o and M37 accompany their friends and watch rather than participate thereby fulfilling a friendship bond and not losing face. If a man is married there is less of an expectation for him to participate thereby legitimizing his abstinence without fear of reprisal or judgement from the friendship group. Similarly to VanLandingham, Knodel et al.’s (1995) findings, the men described the drinking group as typically consisting of 4-6 men. The group sometimes expands throughout the course of the evening after an initially smaller start. In university, it is the senior who takes a large group of freshies. According to M40, the senior will ensure that he gets a ‘good’ CSW to teach the freshies about sexual relations.

M37 is more conservative in general and is the only one who talks about outcome or consequences of commercial sex work visitations in terms of costs paid directly to the CSW and indirectly for the treatment of STDs.

M19: Mostly with friends [we go to prostitutes]... we drink there... the place we go and drink is close to the prostitutes so we can look, and observe there... in one soi (road) there's an alcohol shop and inside there is a prostitute house. My friends do the same, just look.

M23 describes an evening’s excursion which starts with drinking whisky or rum but ...

... after conversation, there is a guy who is the leader ... he is the first to suggest we should go to the prostitute house, like that. He says ‘Okay, together, good, let’s go!’. He decides to go and then everybody follows... while they’re drinking they persuade each other.

He further explains group size and dynamics,
Yes, the group gets bigger. Sometimes two people meet. Sometimes you meet the same people. Mostly on a weekend, like Friday, Saturday, and Sunday but from Monday to Thursday, they don't go quite as often.

Although he is now married and does not go to brothels, his friends still try to persuade him but he does not feel it is problem saying 'no'...

...because my friends know the situation now that I am a married man so I have a reason to say 'no'.

M37 wants his friends to consider the consequences of a commercial sex work visitation.

I explain to my friends the consequence if you go there [to the brothel]. You have to pay for the prostitute. If you get VD, gonorrhea, syphilis, whatever, you have to pay more for treatment.

This respondent is using peer pressure in the opposing direction. When asked how his friends respond to his exhortations, he states,

They say 'oh, you are an old man, you are my parents, my dad.'

He still feels it is his responsibility to give his friends guidance and feels that they are respecting his opinion more now than in the past and perhaps over time he will be able to change their behaviour. Although a generational difference in attitude vis-à-vis commercial sex work is evident here, it is unclear why he would be 'like his parents' since commercial sex work has traditionally been accepted. Is their an emerging voice of caution because of the advent of AIDS? Or is the older generation regarded as being more cautious in general and it does not necessarily indicate a change in opinion regarding commercial sex work i.e. is it HIV/AIDS one should be aware of or is commercial sex work becoming less acceptable. The two issues are so intertwined it is perhaps impossible to approach them separately or conjecture about a present that is without AIDS.
M37b: Sometimes it's very scary to go but friends take us....like myself, sometimes I didn't plan to go but my friend persuade me to go so we went in a group to the brothels... I didn't prepare myself before we go ... my friend forced me to go and pushed me in the room and closed the door so I cannot do anything. I have to (laughing).

M40: ....friends take us to prostitutes, the friends who are used to having sexual relations with prostitutes before. Then later they take us to prostitutes but we will drink first ... if there is a boy who doesn't have experience, we will let him go first.

He also confirms that it is usually the same friend who is the leader or decision-maker. Now he goes with the same group of 3 to 4 men once a month on payday. He works near the university of Chiang Mai and says that often it is in the faculty of engineering because it is mostly men in that faculty, that a senior may take up to ten freshies to a brothel,

the senior will see the prostitute that they know before and try to find the prostitute who has more experience and is very good about sexual relations, and then the prostitute will teach how to have sexual relations.

Although the majority of commercial sex work visitation does occur in the context of the peer group, one of the brothels observed in CM did cater to clients who went in singularly during their lunch hour. They were tuk-tuk drivers and men coming from the stock market. The peer group is an extremely influential factor in commercial sex work visitations but obviously there are other driving forces at work which need to considered.

There is no doubt that peer pressure is a pervasive and powerful force among men to see CSWs but what of those men who do not avail themselves of commercial sex work? How are they regarded and what are their strategies? Both M19 and M280 indicated that they went to the brothels even though each confided that they no longer were interested but nonetheless bowed under peer pressure. In order to maintain the social bonding, not destroy the cementation among the men, and to save face, they went into the rooms without having sex but preserved the belief among their comrades that they had indulge. The importance of this 'shared' experience among men is
unwavering.

M19: I just go and look but don’t use the service there.

M28o: If you go to massage parlours, it’s about 200 baht per hour. I like to go to massage parlours just to watch and not to have sex.

He states that he will go to brothels with friends but will not go with a CSW. When asked what he does in response to his friends teasing, he says,

Sometimes I don’t want to lose face by not going so I just go in the room with prostitute but don’t do anything.

He says his friends only go to brothels once a month which, in his opinion, is not very often. Most of the time the brothel visits are unplanned and is an extension of a night’s drinking among a group of friends. He also says that sometimes they may pick up a waitress if they like her. What remains ambiguous is how declining commercial sex work visitations is affecting the male peer group and the cementation it provided.

Noi is a graduate student in his thirties who has long had experience with CSWs. He states many of the CSWs insist on using condoms and the younger generation of men are more prone to using them than the older generation. Obtaining sex for hire in Chiang Mai does not present a challenge for any man either based on economics or availability. Noi describes the various ranges beginning with ‘cheap’ sex workers at 50-60 baht ($1.50 - $2.00), medium range women for 100-200 baht ($3.00 - $6.50), and the very expensive call girls or escort services which can be as expensive as 2000 baht ($50). The latter are usually regarded as being the most beautiful and are chosen for a whole night from a photo album. Some of the women operating out of escort services are university students who like to choose their clients from outside the area to avoid seeing them in school.

Like many people, Noi feels the more expensive CSWs are at less risk for HIV as they see fewer customers, perhaps as little as one per week or even one per month in contrast to the street or brothel CSWs who see as many as ten men per day. There
is a class distinction formulated in this opinion since the only men who can afford these more expensive CSWs tend to be white-collar or professional men. Overall, there is a strong consensus that less educated blue-collar men know less about the virus. Therefore, this upper echelon of clients and CSWs are regarded as forming a safer 'pool', a belief based on several erroneous assumptions. As seen in other cases, knowledge and education do not, unfortunately, translate into behavioural change. In fact, frequent partner change with the use of condoms may be safer than infrequent partner change without condoms. As well, it is unknown who these 'white collar professionals' or upper class prostitutes have had unsafe sex with before or outside the commercial sex encounter. For example, CSWs often do not use condoms with their regular non-commercial sex partners.

In the latter stages of his life, Noi has become a social activist and has spent research time in the rural villages and hill tribes where he has seen the context within which women become CSWs. Since that time, he has not been able to make love to a CSW because he has realized that they do it without feeling and it is their circumstances which drive them to it. He invokes the five precepts of Buddhism to further explain why he can no longer use sex services. The third precept does not allow for improper sexual activity. He uses his notions of Buddhism to be the best possible person he can be which means having empathy for these women’s lives. In the Buddhist world view, commercial sex work _per se_ is not stigmatized but exploitation of others is not favourable. Noi does not condemn commercial sex work but no longer wants to personally partake in what he now views as exploitation. Because of his extensive previous experience with commercial sex, telling his friends he does not care to go to the brothels with them after an evening of drinking whisky is not problematical. He also comments on the change in younger people who have more freedom and are having sex before marriage.

**4.1.6 Thai Women’s Voices and Sexuality**

In an attempt to assess women’s comfort level and potential decision-making powers within a sexual relationship, they were asked a variety of questions regarding
their ability to discuss sex with their partner, initiate a sexual encounter, and how they felt about sex in general. Having the ability to communicate, to have a voice, about sex and the confidence and comfort to do so is implicit in so many AIDS prevention messages but is not always an accurate reflection of reality. Do Thai women have a voice which they can use and be heard? It is imperative to understand the communication dynamics between the genders for AIDS education to be effective, especially when negotiating condom use or discussing past sexual histories.

Women respondents varied in their comfort level with regards to asking boyfriends and/or husbands about past sexual experience. Comfort level does increase within the marriage as presumably sex becomes an appropriate topic to discuss. Conversely, discussing past sexual experience in a relationship that is not solidified by marriage may jeopardize it, a risk a young man or woman may not want to take. Overall, it is not expected that men will fully disclose their past experience. Women tend to assume that it is through commercial sex work that men learn lovemaking and sexual techniques. F17’s boyfriend did tell her he had sex with someone who later found out she was HIV positive.

In any case, if past sexual experience is not generally discussed until marriage, the wife has already been put at risk if they were previously sexually active. This is not to imply that discussion equals prevention, but having a discussion initiates a process that addresses safer sex and perhaps facilitates the introduction of condom use. F31 has openly discussed her fears about AIDS with her husband. Both of them agree on protecting themselves but how they will do so remains uncertain.

Unfortunately, discussion followed by action is a huge barrier to cross especially if young women do not discuss sex with each other in a very intimate fashion. To assume they can surmount personal and cultural inhibitions is naive and simplistic. The women talk vaguely about what it means to have a boyfriend but are generally more concerned about their future. Young men, on the other hand, tend to discuss sex with their friends more than with their partners.

F17:.... the last time he [boyfriend] had sexual relations was with a commercial
student and he heard she had an accident and she has blood test and she has
AIDS and he’s afraid that maybe he gets AIDS as well but he had blood test. It’s
negative but he is positive for Hepatitis B.

F19, with a bit of nervous laughter, says

Suppose they love and marry each other, it’s hard for him to discuss [past sexual
relationships], it’s better to have a good relationship [and not discuss].

When F25 was asked whether she would ask her boyfriend about his past sexual
experience she said,

No, I don’t think so. I don’t want to ask him....because I’m afraid that if the past
experience was bad, it will make him unhappy.

Similar to F19, she is primarily concerned with keeping the relationship a happy and
stable one. Once she gets married she will ask her husband about the techniques he
used when he had sex and feels most women ask about this sort of thing. She expects
the man will tell her the partial truth.

F31 knows her husband had a previous girlfriend but never discussed his past
experience before they were married, only after.

I: Did you ask about his past experience?
F31: I used to ask him about going to prostitutes because my husband, he’s very
scared to go to the prostitutes. He said he used to go when he was a teenager.

With regards to risk from HIV, she states,

I think it depends on my husband and myself so we have to talk to each other so I
can protect by not letting my husband go to the prostitute. Say my husband get
HIV then I myself can get it so I think it’s better to protect ourselves from HIV and
not have sex with other people.

She believes her husband will be truthful about having sex with other women since they
are married.

M21: I used to talk to friends, discuss with friends about sexual relations.... sometimes we discuss how that woman is after we have sex with her.

M28: I only talk to my close friend about that, I used to have sex with these people or this girl. That's all.

Women were asked how they felt about initiating a sexual encounter and the appropriateness of such an action within the marriage. The prevalent tendency is for men to ask first but women can initiate. There is a feeling that women must be 'good' about sex (F26) and understanding when their husbands want it. F(36)'s husband became angry when she refused. There seems to be an implicit understanding within a marriage that sex is a large part of it and an expectation from both partners. It may perhaps be safely assumed that men will initiate more often since they are perceived as having an elevated need and desire for sex.

I: Is it okay for women to ask for sex from their husbands?
F26: Mostly I don't ask. I take off my clothes and after I take a bath and I take everything out, he knows... I read that if husband and wife stay together forever, it means that a woman must be very good about sexual relations... sometimes if my husband goes to a prostitute, sometimes he says that ‘oh, you are not as good as my wife’.

F36: I refuse him for two weeks and he was very very angry.

Sexual egalitarianism comes not primarily from women feeling empowered enough to initiate sex but more importantly from believing she has a voice. In this context, women feel they can refuse their husbands sex under certain conditions of tiredness or menstruation. There is the recognition that women work very hard at jobs outside the home as well as taking care of the home and children, issues facing women worldwide. There is the sense that as much as possible, women should not refuse to have sex but one respondent (F37) said if they must refuse, it should be done as gently as possible. For a few women sex, or the withholding of sex, becomes a weapon in
quarrels. Clearly, women feel they have the right to refuse their husbands but for some women, the consequences of such a refusal will be him either going to a brothel (F26) or forcing her to have sex (F36). Acquiescing to sex may be a woman's primary preventive strategy to dissuade her husband from going to CSWs.

F31: Mostly they [women who refuse to have sex with husbands] are tired or they are not ready to have sex. Or they have many serious things to think about.

F34: Sometimes they are sick (women who refuse to have sex with husbands). If they are menstruating, they don't sleep with their husbands.

F36: We can get along but you know sometimes I refuse him. I don't want to have sex with him. I say that I have a headache or something like this so he didn't say anything but when we sleep, he force me, he make me have sex with him.

F37: If a woman is not too tired, it's not necessary to refuse husband

but if she does refuse him the

...woman should know how to say it in a gentle way.

In response to a woman refusing to have sex M19 states,

because sometimes woman is tired from working and maybe both of them are tired from working.

I: Do you think that a wife should always say yes to her husband if the husband wants to have sex?
M37: It depends, not all the time. If you work very hard, things like that, okay, you can say no. Or if you have problems, you have to let him know, okay why, what is the reason...

F32: If he makes me angry, I refuse.

F26: Sometimes I feel bored, sometimes very irritated because I want to sleep. Sometimes we have a quarrel, then it makes me think that if I refuse him, then he will go out and go to a prostitute because if he needs sex he cannot control himself. For women, mostly we can control ourselves.
I: In which way can you prevent your husband from going out?
F27: Hmmm, there's only way. If he asks for sex, not refuse him.

F40: Because if a woman is not ready to have sex with her husband, she can refuse. If men bought a woman, that was another case, but if they are the same they have like been married or something so they have rights to say no.

F40's response is very interesting as she regards CSWs as something other than 'woman' because she is under a contractual agreement based on payment of money to have sex. She does not have the same rights as a woman married to a man who may also be receiving money from her husband in some form.

Klausner (1997:5), a reputed Thai scholar, states "A core element of Thai culture is the avoidance of confrontation." Anger, displeasure, tension, and conflict are emotions to be avoided. This is not to imply that Thais, people from the 'Land of the Many Smiles', are always happy, but they have other methods of dealing with such emotions that are more subtle. This avoidance of tension and confrontation may make women's ability to confront, communicate, or negotiate safer sex with their partners an extremely difficult one. The globalization of the AIDS education model entails the empowerment of both genders through adaptation and modification of the model, but implementing that philosophy in Thailand will mean overcoming some basic cultural and historical barriers.

Klausner (1997:61) reminds us that the traditional symbol of Thailand, the elephant, is in actuality a representation of the patriarchy as the men are said to be the front limbs, the leaders and thinkers, and the hind legs are the women, the passive followers. Women activists like to feel that the elephant is now rearing up on its hind legs. He sees Thai women are challenging the existing patriarchy. Many Thai women have a university education and gainfully employed outside of the home. The expectation that these women will adhere to the subservient behaviour of the past is perhaps unrealistic. Klausner (1997:62) states "Wives of today can only shake their heads when told of the subservient behavior of Thai wives in former times when they

7The following section on commercial sex work and condom use discusses the role of alcohol as a means of negotiating encounters in a hierarchical setting.
went to bed after their husbands and rose before them; slept on the left side of their spouse; and waited patiently while their husbands ate the first mouthfuls of a meal.”

4.1.7 On the Compatibility of Men, Condoms, Commercial Sex Work, and Alcohol

Politically, as well as from a public health standpoint, Thailand has been extremely aggressive in promoting condom use particularly in the commercial sex environment. How that translates into individual behaviour in different contexts was investigated in terms of accessibility of condoms and its usage within a married and unmarried relationship, within a casual relationship, and within a commercial sex work encounter. By and large, due to a massive public health intervention, condoms are easily available at either drug stores found throughout Chiang Mai or obtained for free at various clinics and NGOs. The majority of respondents knew where to obtain condoms and there was a general consensus regarding their use within commercial sex.

M21: Men, even if they’re scared or embarrassed to buy [condoms], they have to be brave and buy. Because it’s quite risky if they have sex with other woman, so it’s necessary for them to buy and to use. Right now in Thailand, 99 percent there are condoms for men ...

He explains that condoms in drugstores are quite expensive, approximately 30-50 baht ($1.50) for packages of 3 to 5 condoms, but if they are from Mechai, they are free via public health services*. He continues,

.... in the sexual services, mostly they ask every client to use condoms and they include it in the services.

Having said this, when asked if he uses condoms, he says “No, not often”, even

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*Mechai is a government official who has been innovative, progressive and influential in orchestrating the AIDS prevention program including the 100% Condom Campaign. Because of his public support of condoms, they have been nicknamed ‘mechai’. He is also the owner for the Condoms and Cabbages restaurants found in Bangkok and Chiang Rai.
though there is heavy promotion by commentators on T.V. and public health employees who visit the schools.

Condom promotion as a method of birth control has not been strongly supported and it is therefore not surprising to find a weak association between condom use and sex with a girlfriend/boyfriend or wife/husband. The contraceptive pill is the main method of birth control however many women complained of the side effects.

M21: Because she took birth control pills so it's not necessary for me to use condoms.

M21 does not believe condoms are necessary if married,

Because it's not necessary to use [condoms], it wastes time.... as well, if they have children already, so they have tubes tied, but if they're unmarried, it's very necessary for them to use.

A few couples did use condoms for birth control. For example, M33 has been using condoms with his wife for birth control as an alternative to her getting injections. F40 used condoms with her husband after the birth of their child but later thought it was better if she used the birth control pills. It was at his suggestion that they use condoms.

M25, whose current extra-marital partner is a fruit and vegetable vendor, says he uses condoms with her. When asked if his wife knows he uses condoms, he responds while pointing to an area near the entrance way to his house,

Yes, I put them there. When I stay home I put [the condoms] there and when I go out I take them with me. If I don't use the condoms, I put them back in place.

Excerpted from the focus group discussion:

M: In general, I don't like to use.
F: But suppose the girl wants you to use?
M: Oh, it's not natural. But the girl will feel it if I don't use condoms so I must use ... but if I use condoms it means that it's the curtain the closes happiness like a wall ... like the Great Wall of China.
F: If the man uses condoms it's good because I don't take birth control pills.
There is little mention of the risk for AIDS when discussing sex with non-commercial sex partners which may instill a greater sense of safety or security in not using condoms although this was not fully addressed.

**Condom Use and Commercial Sex Work**

In the past, condoms were not such an issue and more of an individual decision primarily for protection against STDs. Now, because of AIDS, men know they have to use condoms. The “100% Condom Campaign” has made condoms readily available. It is not something men have to prepare for or plan ahead as the majority of CSWs will usually have condoms and insist on them. The extensive promotion and acceptance of condoms within commercial sex has been very beneficial in reducing HIV transmission in a context when brothel visits are often spontaneous and accompanied by drinking. M40 discusses various reasons why some CSWs may or may not use condoms based on HIV status. However, some respondents said they did not always use condoms.

M23: Brothers and father tell me about this, that if I go out to the prostitutes I should use a condom....it depends on the family, the father will teach sons to use condoms. Presently, it is the prostitute who suggests men use condoms. At this time, the prostitute house only has guests wear condoms, but in the past, it's up to the man, if he wants to protect himself then he brings it [the condom] himself.

M25: Before I marry, I didn't use condoms. At that time there is no AIDS.

I: Sometimes when men are drunk, do they forget to use condoms when they go to see prostitutes?
M28o: In the past, I think yes, a lot, but right now because of AIDS I don't think that they don't use condoms. Because right now, AIDS is the most scary disease.

M40 has several opinions regarding condoms use and commercial sex work. He states,

Normally prostitutes have condoms and prepare for men because prostitutes are also afraid. Some prostitutes, if men don't wear condoms, sometimes she doesn't
allow the man to sleep with her.

When asked what happens if the man offers the CSW more money to have sex without a condom, he says that

Oh, it's up to the prostitute because sometimes the prostitute herself knows that she has got HIV, so maybe it's easier to say okay. But if the prostitute doesn't have HIV, they always refuse. But sometimes if the prostitute has HIV, sometimes they don't want to transmit to someone else so sometimes they won't allow it.

With further probing on this issue, he states

Mostly they [men] drink and later they cannot control themselves. They're drunk and sometimes they forget to use condoms. Later they get HIV/AIDS because when they are drunk, mostly they are not worried about HIV or AIDS.

CSWs who have regular customers may be more inclined to forego condom use based on a sense of familiarity which may increase their sense of security (Sacks 1996). Unlike street walkers in cities such as Toronto where sex is of a manual or oral nature since much of it occurs in cars and alleyways, Thai CSWs tend to have vaginal intercourse as their standard and it is what Thai men expect.

Brothel managers have been instrumental in providing the support CSWs need to enforce condom use. The solidarity between the managers (mamasans) and the CSWs has made the condom-only policy a success. This was found to be due to the high level of knowledge of HIV transmission coupled with a concern for the welfare of the employees at the brothel (Sakondhavat et al. 1997). Although a high compliance rate of condom use was found among brothel-based CSWs, there was low condom use with their private partners. Their sexual partners did not consider themselves to be at risk for HIV as they believed their wives and girlfriends consistently used condoms with their clients (Sakondhavat et al. 1997). Condom use became inconsistent with clients when free supplies from Ministry of Public Health was interrupted.

Other studies have also documented condom-use in the commercial sex work setting. For example, Renzullo (1996) notes that by the mid-1990s, there was a decline
among the Royal Thai Army conscripts of commercial sex work visitations as well as an increase in condom use among those who continue to visit CSWs. Public health efforts promoting condom use and the training of mamasans regarding HIV has lead to a direct impact in the workplace (Sakondhavat et al. 1997). This has led to the researchers commenting that a structured approach to behaviour change is more effective than simply trying to educate individuals. This structured approach also implicitly involves a hierarchical approach which may also be a benefit and used in other venues of education. An environment of collective support needs to be created and supported by upper level personnel regardless of the type of work involved.

The assumption that condom-use is quite high in northern Thailand is evidenced by the decreasing rates of HIV and STDs. However, Wawer et al.'s (1996) work among CSWs has shown a less than 100% compliance which illustrates the potential for HIV to travel through various networks. Their work in the North and Northeast among CSWs indicated that condom-use was inconsistent and AIDS knowledge was low given the intensity of public health campaigns. Through focus group discussions, they found discrepancies in knowledge of HIV transmission through sexual activity. They also found that a number of CSWs did not think that a man who looked healthy could transmit HIV leading to unsafe sex. The reasons given included pain and irritation due to lack of lubrication, the perception that the client was healthy, and client refusal further motivated by need for money. As well, men take longer to climax with a condom which can also result in increased irritation and a decreased number of clients due to either time taken up or soreness.

Additional reasons given by Wawer et al.'s (1996) commercial sex participants for non-use include the regularity, and thus familiarity, with the client. "If he is a regular client, a client that we are sure that he does not have fun elsewhere. That we know he only comes to us for fun, we don't have to use a condom." Other comments made in

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9 The lack of lubrication and ensuing irritation was also mentioned by one of the key informants. Public health supplies condoms but not lubricants, therefore, after many clients irritation and sometimes sores develop which can be counterproductive in terms of HIV transmission. Not only do the sores or site of irritation provide an entry route to the body for HIV, but the immunological response consists of T-cells appearing at the site thereby facilitating transmission of the virus as they are the primary cells directly infected by HIV.
that study regarding non-use of condoms were based on whether the client is “handsome... dress well ... skin temperature is cool ... colour of the penis is normal ... has certain look in the eyes” (Wawer et al. 1996:459). It was also found in that context that not using a condom was a symbol of trust in the client/CSW relationship. Additionally, a commercial sex worker’s fear of poverty may be much stronger and more real than her fear of AIDS.

Havonon, Bennett, and Knodel’s (1993) study on men have found that condom use is generally high but decreases with increasing frequency of patronage. Men feel if they are a frequent customer, the woman probably would not have other frequent customers, or she would not ‘deceive’ him in this way. In other words, there is the sense that she would be more loyal to him and not put him at risk for HIV. Some men feel that if she is using condoms with everyone else, he should be safe if not using one. At the root of the problem are gender issues of privilege. Men, on an individual basis, continue to feel privileged and omnipotent regarding their sexuality even in the face of an epidemic; a sentiment not unique to Thais.

Alcohol and Condom Use

Drinking often impairs decision-making and has been found to be a critical factor in condom use. Some of the men and several of the women respondents alluded to impaired decision-making when drinking, whether it was to go to a CSW or to use a condom once there. A study (MacQueen et al. 1996) investigating the relationship between alcohol consumption and consistency of condom use by Thai military conscripts in a brothel setting found that alcohol consumption

1) was used by men to decrease their inhibitions when dealing with women and each other;
2) made them less inhibited to sexual risk taking;
3) provided a socially acceptable excuse to not using condoms;
4) is associated with brothel attendance by military conscripts; and
5) enhanced sexual pleasure; the opposite of condom use.
Previous studies have shown the critical role alcohol plays in Thai male behaviour with CSWs and with each other (VanLandingham et al. 1993, Havanon et al. 1992). Alcohol consumption is a socially constructed and supported phenomena that alleviates social tension, which is particularly high in Thai society, where behaviour is very structured. Thai behaviour is bounded by kreengcaj, the ability to anticipate other's feelings before acting upon them. It is the quality of kreengcaj that is believed to foster kindness, avoidance of confrontation, and self-restraint, highly valued behaviours in Thai society (Klausner 1997, Mulder 1992). In unequal social settings, this may be perceived as deferent and solicitous behaviour from those with lower social status and restraint from those with higher social status. In either case, behaviour is bounded by cultural expectations.

In the MacQueen et al. (1996) study, alcohol use among military conscripts was found to facilitate social interactions. There is tremendous pressure for the conscripts to drink with their peers otherwise they are considered outsiders. With regards to brothel outings and drinking, one of the focus group participants in the MacQueen et al. (1996) study stated:

Group 1 S7: Sometimes, we won't plan anything but when we get drunk, where to go? The brothels! Go to the prostitutes.

In concurrence with MacQueen et al.'s (1996) study, this research found that male social interaction and brothel attendance reinforce each other. Similarly, their respondents stated they will go to brothels just to socialize with friends and not always engage in sexual intercourse. Brothel going may be a social event that has been underestimated or too singularly focused upon as simply being a sexual access point. Sex is not the end point but part of the socializing ritual. This legitimizes statements from several of the male respondents who indicated they did not always 'go' with the girls but sometimes either waited outside or simply talked with the girls.

Alcohol reduced social shyness among men, reduced sexual shyness with women, and abated their fears of HIV and STDs. MacQueen et al. (1996) also found that alcohol consumption was the primary reason given for inconsistent condom use in
the commercial sex setting and may in fact justify or excuse their sexual risk-taking. Alcohol has long been known to give exemption to those who indulge for their socially unacceptable behaviour whether it is being discourteous or a more harmful activity. Alcohol is also used to enhance and prolong sexual pleasure.

That drinking with friends was a reciprocal activity was also indicated in this dissertation and the MacQueen et al. (1996) study. The male respondents in my sample also said that paying for a CSW as part of a group outing entailed reciprocity further cementing male social bonds. The expectation of reciprocity, whether it is simply taking one’s turn in paying for the drinks or the CSW, forms an obligatory social cementing between friends. It is used to alleviate the social distance inherent among Thais (MacQueen et al. 1996). Interestingly, the participants in their study insisted that there was not a leader in the group and that actions were consensual and spontaneous among the group. This is in contrast to this research where there was definitely a designated leader.

The men in MacQueen et al.’s (1996) study did find condoms to be a barrier to pleasurable sexual relations. CSWs exerted considerable influence over men’s behaviour and their condom use. The women are forceful in their negotiating and men may take on a passive role while the CSW puts the condom on. MacQueen et al. (1996:421) conclude by stating,

... drinking is embedded in a series of positive feedback loops with behaviours that are positively valued by the men, such as male social interaction, sexual pleasure, and brothel attendance. To say the alcohol is the ‘cause’ of inconsistent condom use in this context is an oversimplification with limited utility for the design of appropriate HIV interventions.
4.2 THE REALITY OF HIV/AIDS

There are two critical issues in understanding the AIDS epidemic. The first is sexual behaviour and the context within which it occurs and the second is perception of risk for HIV/AIDS. The construction of both is multifaceted. Thus far, the stage for sexual behaviour has been set. In determining perception of risk, general knowledge of HIV transmission must first be assessed. Knowing the source of the information is useful to legitimize the level and reliability of that information. Overall attitudes towards the disease and an impression of who is at risk also plays a role in constructing individual perception of risk. For example, the greatest barrier to safer sex is a lack on an individual's part to identify with who they perceive to be at risk for HIV (refer to 'Methods' section for an overview of Scrimshaw et al.'s (1997) outline pertaining to knowledge, attitudes, and beliefs). Therefore, if a young female university student only perceives CSWs to be at risk, she will not identify with this risk category and is less likely to protect herself. Public health campaigns and the popular media are key players in the construction of a disease.

Specifics about behavioural transmission is ambiguous. For example, many respondents thought that oral sex on a man or woman was high risk and that deep kissing and mutual masturbation was low risk. Using condoms was the most frequently cited means of protection. Among the respondents, F25b seemed to rely on the boyfriend to use protection which is a common theme throughout this dissertation. F36 said having one husband would be protection from HIV. Some respondents thought that perhaps good-looking men would have a greater likelihood of having HIV. On the other hand, all the respondents were aware that it is impossible to know who has HIV until the terminal stages of infection. Although abstinence and condoms are cited as the means to protection, several respondents realized that condoms are not 100% effective. Responses from both genders were very similar except the males more often associated HIV with CSWs. The increasing number of people infected with HIV/AIDS also translates into an increasing number of affected people whether it is directly or indirectly. In view of the stigma associated with HIV almost universally, this is not the case among these respondents in Chiang Mai. The majority of respondents said they
would not be afraid to be close to someone with HIV but intimated that at the community level, people with AIDS may be discriminated against.

Knowledge of HIV/AIDS

Knowledge regarding the seriousness of HIV/AIDS is ubiquitous due to the Thailand Ministry of Public Health’s prolific and aggressive AIDS campaign. Numerous respondents referred to it as a ‘scary disease’ that could not be transmitted through casual interactions. Basic modes of transmission through sexual intercourse, sharing needles, or the exchange of blood was known by all respondents. The nuances of transmission in terms of fluids or behaviours, however, was unknown. For example, many were uncertain whether some of the bodily fluids such as tears, urine, sweat, and menstrual blood could transmit HIV. Two women mentioned breastmilk was like blood, perhaps as a life-giving force, but the viral concentration in blood is much higher than in breastmilk.

F19: ...AIDS is very scary and I think that it takes a long time to see the symptoms or if someone gets HIV it takes a long time to know if that person gets HIV or AIDS but if I have friends that have HIV or AIDS, I think that I will still take good care of them because this kind of disease is hard to transmit. But I think that there is one kind of disease that is more scary than AIDS. I think it is Ebola, but right now it’s far away from Thailand.  

F20: It’s the most scary disease. There is no medicine to heal. I think if we know how to protect ourselves, there is no problem. If we are very careless, it can happen, AIDS can happen anytime.

Similarly to many respondents, she knew that blood, semen, and vaginal secretions could transmit HIV but was unclear with regards to any other bodily fluids.

F23: Because this disease can be transmitted by having sexual relations so we know how to protect ourselves by using condoms. But condoms are not 100%. I

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10 At the time of interviews Ebola was a public-health crisis in Africa with news reports appearing frequently in Thailand.
can solve the problem by not having sexual relations.

I: Do you know how he protects himself?
F25b: Yes, he used condoms but I'm not sure. Most men have to know how to use condoms so they know how to protect themselves.

F27: ...if they [men her age] have to go out, they have to use condoms. Mostly, they know, but sometimes the people who have not had good education, sometimes they don't want to use condoms. Also they know it's a serious disease but it's hard to transmit which is why they're not scared.

M28o: Mostly transmitted by blood, sexual relations, and a little bit from saliva. [Protection?] Using condoms is the best.

M19: I know that it's the most serious disease that cannot heal. Mostly it comes from sexual relations and from addicts.

F40: ...if they have something from menstruation, they have to destroy it into pieces before and then throw it away and flush it.

M23: First, it [HIV] can be transmitted by prostitutes. Second, by blood. Third, from drugs when they use the same needles.

Several other respondents mentioned a 'group' rather than a 'behaviour'; undoubtedly a reflection of the public health campaigns.

**HIV/AIDS - Source of Knowledge**

There is a high accessibility of HIV/AIDS information through various venues including T.V., radio, newspapers, announcements, exhibits, brochures, and signs within hospitals and clinics as well as those put out by public health throughout Chiang Mai. The information is basic but accurate and focuses on HIV transmission primarily through unsafe sex or contaminated blood. People found the method of dissemination reliable and many felt more information was necessary.

I: Do the signs of the hospital give you the same information that you got by looking
Perception of Disease

Public health campaigns have been very diligent in enforcing the notion that one cannot tell by looking at someone if they are HIV positive or not although earlier in the decade, scare tactics were used. Pictures of horrendous aspects of the disease depicting sores and cancers in the mouth, skin, and genitals were distributed throughout Thailand in the first few years of the epidemic which resulted in the stigmatization of people living with HIV/AIDS (PLWHAs). The current approach to AIDS education is more subtle, using humour and straight-forward common-sense (see Figure 3 for contrast in AIDS education campaigns).

Two respondents (F25 and F26) mentioned that even a good-looking man or a beautiful women could have HIV. All the respondents knew that symptoms were more likely to be manifested in the latter stages of the infection. Rashes and spots as being perhaps indicative of HIV/AIDS was mentioned by most respondents. Nonetheless, it was recognized that such standard symptoms such as weight loss and dermal spots could be suggestive of numerous other diseases.

Again, the adjectives ‘scary’ and ‘serious’ were reiterated. One respondent thought AIDS was the result of immoral or unnatural acts with monkeys. Several of the women knew someone with AIDS which seemed conducive to a more sympathetic attitude. M23 mentioned one instance of the traditional funeral rite of opening the coffin was not followed due to fear of contagion. Similarly to F25b in the previous section, M280 also said that women live longer because their menstrual blood rids the

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11The ‘flash cards’ are pictorial depictions of sexual acts designed and used by the researcher to assess people’s level of knowledge for HIV transmission. According to this respondent, the flash cards are far more explicit than any AIDS education and prevention information received. The information may be widely available but perhaps is not detailed enough.

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Figure 3. Contrasting approaches to AIDS education and prevention from scare tactics to using common-sense and humour.
body of disease. F20r/b thought AIDS was a phenomena to balance nature. People's perception of disease will affect their perception of risk when electing to have sex with someone. Several men and women respondents said only a blood test could ascertain whether a person had HIV.

I: Do you think you can tell by looking at someone if they have HIV?
F19: In the beginning it's hard to tell. Maybe they have a rash or spots but they may have some other disease and not HIV.

I: Suppose someone in your community has AIDS. Can you tell if that person has AIDS?
F25g: No, I don't think so because it's very difficult and maybe we think that he has the disease of the skin more than AIDS because it takes a long, long time, many years, to know that people get AIDS.

F25b: There is an exhibition at Thapae Gate so I learned from that. ... sometimes the men who are good looking get HIV, but we don't know until the last stages. The person gets worse so there is something to show, like some spots. I think that it's most difficult to see it in women because we don't see anything when women get HIV. They can live longer than men because we have menstruation... if men have HIV, mostly they cannot live longer than one year.

Interestingly, M28o also felt that menstruation imparted a beneficial effect if women were to be infected with HIV. Menstrual blood is perhaps viewed as a purifier in which the disease or virus flows out.

F26: I think that both men and women, we cannot tell but men get weak more easily. Only 2-3 months because he will become pale and then he will get something else, he will get a rash or something like that. But for women, I cannot tell because sometimes they are very beautiful so I cannot tell if she has HIV. There are many beautiful women that get HIV.

F40: I know because that person begins to get pale and thinner. Mostly Asian people, when they get AIDS, they can know by their skins. And after that they cannot eat. In my community, I know someone who got AIDS. They are not hungry or don't want to eat. They have sore throat and also their tongues are affected.

M21: ... and also they are quite dark, the skin is not bright.
This respondent (M21) put forth his theory that all the STDs of the past have become one entity now known as HIV. He explains that before AIDS, they used to hear a lot about other STDs like gonorrhea and syphilis but since AIDS, they are now all gone. This is why he feels they perhaps have gathered into one STD, HIV.

M28o: ... but mostly men....because men don’t have periods. But girls have periods, so when they have a period, so all the disease goes out with the period. So that makes men die more quickly than women. (See F25b above for a similar comment on menstruation).

M33: No, I cannot tell [if person has AIDS]. Only by checking with blood test... after that person gets worse I can tell they have AIDS.

M23: Before burning the body, they have to open the coffin to see the dead...they say the last farewell to the dead. But if the dead had HIV, they will cover with plastic.... A public health person went with the body as they didn’t want anybody to open the package or bag that packed the body.... Everybody’s afraid of the disease.

There have been similar reactions in numerous other countries in Asia and Africa regarding the possibility of post-mortem transmission especially in situations where ritual cleaning is fairly invasive.

F20 r/b: It’s a balance of nature because right now we have the expansion of the population so this disease makes a balance.... also maybe man or woman do something wrong with monkeys.

**Attitudes Towards HIV/AIDS**

Socio-economic class was not a factor in the respondents’ perception of how others behaved sexually or their risk for HIV/AIDS. Only a few comments alluded to less educated or poor people being at higher risk for AIDS either because they went to CSWs more often or were less likely to use condoms.

The sense of inevitability and inexplicability as to who gets HIV and why, may be factors in the lack of stigma currently associated with the virus. Lack of stigma was
not always the case in Thailand, where the first few years of the epidemic were rife with it. In North America, the stigma attached to people with AIDS includes a moral judgement that somehow they represent the ‘other’ which deserved to get AIDS. This seems to be absent among this particular group of respondents in Chiang Mai and may or may not reflect a more general attitude towards PLWHAs. Several respondents empathized and said there is no blame associated with being HIV+. Public health has alleviated the fear of HIV/AIDS through casual transmission and countered any stigma attached to people with HIV.

Although everyone fears the disease because of its severity, knowledge of its basic transmission has made the majority of respondents unafraid for their own personal safety and hence, feel compassion towards a community member, close friend, or family member with HIV. The respondents did not hesitate to state they would not change their behaviour when it came to being in close proximity or sharing food/drinks with someone who was HIV+. In fact, many of the respondents exclaimed they would try their best to be gregarious and encourage the person by talking and eating together. M28 felt that encouragement would help them live longer. They indicated they would behave the same if someone close to them had HIV. Because most people understand the general mechanism of transmission, there is no fear in touching, hugging, or sharing food or drink with an HIV+ positive person. Similarly, Brown and Sittitrai (1996) found in their focus groups that when status was revealed to family or significant others, strong support and love was expressed. In fact, an alarming number of respondents from this study knew someone who had AIDS which, when personalized, perhaps generated greater acceptance and sympathy.

Few respondents said they would not eat or share a water bottle with someone who was HIV+. They explained their reluctance would be subtle enough not to hurt the person. On an individual basis, each respondent emphasized they would not treat a positive person any differently. They did, however, feel that the community at large would. F25g said seeing doctors on T.V. being close to people with AIDS helped her realize there was nothing to fear. Somewhat philosophically, she also expressed her opinion that there was no point in being afraid since everyone dies of something.
Two female respondents felt an obligation to take care of their husbands should they become HIV+. This was said without rancor or resentment. Their primary concern was for their own safety and each said their husbands would have to fulfill their own sexual needs. This is perhaps a mixture of obligatory fulfillment towards the husband coupled with the inevitability of being afflicted with HIV. Because anyone can become HIV+, there is no judgement or stigma attached to it and the risk of abandonment is perhaps not as high as seen in other countries like central Africa.

M28: I will encourage them because I think that this encouragement will make them live longer. And tell them to be happy all the time and exercise.

M21: Mostly the one who got AIDS, they need to stay in the family. They need the warmth from the family. No one should refuse them.

F31: Mostly if a person in the community gets HIV the people in the community will refuse him and not go visit... I would do the ordinary way, the same as before because HIV or AIDS does not mean it will be transmitted by talking or eating together.

F26: I can talk to them [someone with HIV/AIDS] but I don't want to drink water from the same glass. Sometimes my friends, other taxi drivers, they ask water from me because I have a bottle of water in the car. When they ask for water, if they drink from the same glass, after that I throw it away. I'm not sure if they have HIV or not, it's hard to tell, we will know only at the end of their lives.

F25g: The first thing, I should encourage them and cheer them up because I think that it would help. But about eating food together, I think that maybe I would eat my own. I have to explain this to them so they don't worry about it.... I saw a lot on T.V., that many doctors or people that are close to patients with AIDS are not scared so why should I be scared? Because everybody dies one day.

F32: Oh, I will take care of him [her husband if he had HIV]. I will never feel badly towards him. But I have to be careful because we have heard that it's from sexual relations so I have to avoid this but I have to take care of him.

F40: Sure, this [coming into contact with blood] is forbidden to my husband [who is a police officer]. I forbid him, don't help or don't touch the person who gets into an accident if they are bleeding.

This respondent has a greater fear of AIDS perhaps due to her husband's profession.
When asked how she would treat her husband if he were positive, she stated,

Everything as usual except sexual relationships. If my husband needs sex, he can help himself....first of all, I would have to check myself to make sure I am negative.

She states that it would be necessary for her and her husband to discuss the care of their child should one of them die.

**Who is at risk?**

There is a general consensus among the respondents' statements that anyone who is sexually active is at risk for HIV. There does not seem to be the 'us vs. them' dichotomy that exists in the West which subsumes moral judgement and blame. Nonetheless, certain groups of people are thought to be at greater risk including CSWs, injection drug users (IDU) who share needles as well as medical personnel such as doctors, nurses, and surgeons due to their exposure to blood and needles. A much stronger association was made by the male respondents who predominantly identified risk for HIV with CSWs. Some respondents categorically stated that those who drink are at risk because when drinking, people are less likely to use condoms. M40 stated that teenagers are at risk for the same reasons. The link between CSWs, their clients, and their wives is just beginning to germinate in some of the responses. In recognition of the changing sexual behaviour among young people, university-aged respondents definitely thought their peers were at risk for AIDS because they like to drink and have sex. F19 blamed the high prevalence rate of HIV on tourism in Chiang Mai and its association with commercial sex work.

M28o: If we don't go to see prostitutes, its hard to get AIDS. I can say that every person is at risk if they go to the prostitute....or the one who works at massage parlours, something like this, or karioke.

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12 The link between drinking and condom use is a crucial one which has already been addressed in the previous section on "On the Compatibility of Men, Condoms, Commercial Sex Work, and Alcohol".

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I: Who is at risk for HIV?
M19: Mostly the construction workers. Because all of them, after work, they drink and after that they go to prostitutes.

M21: The first is prostitutes, the second is those who use needles. Also doctors and nurses. It's [AIDS] very popular in Chiang Mai because in Chiang Mai there are a lot of prostitutes and addicts.

F27: Nurses are more at risk than doctors. Also nurse assistants are very much at risk because they will collect medical equipment like needles or clothes for patients.

She also says that men who go to sexual services are at risk for HIV.

I: Do you think some people are at greater risk for HIV than others?
F18: Housewives. Because her husband may have sexual relations with prostitutes and come back home.

Ffocus group: Housewives, sometimes the man go to prostitute and she doesn't know. Thai woman, she doesn't ask ... she has to believe everything.

F21a: If prostitutes know how to protect themselves it's okay. Students as well are at risk because students love to try, they have no previous experience so they need to try.

F19: Right now Thailand is very popular because of the prostitutes, even the tourist places, but we still have good points. Not just sex and prostitutes......mostly university students, they are quite mad too. They have a high risk and have to know how to protect themselves......many of the Chiang Mai University students love to go out and love to have sexual relations.

F36: Like the one who works here ( she is the mamasan at a corner bar on Moonmuang Rd.) and go out with the clients and sometimes they drink, they get drunk, and they go out together. Sometimes I don't know if they use condoms or not because they are drunk.

She later adds,

I am concerned about students more than anything else if they go to school, they have sex together.

M40: Teenagers, because after drinking they don't want to use condoms, they are very brave after drinking. After drinking they always feel that, oh it's not scary. Then they don't use condoms. We have the expression that we are not afraid of AIDS but we are afraid to stop having sex. Right now, I don't know which girl is safe or which girl doesn't have any diseases in her, because sometimes the most
beautiful woman is the one who has AIDS. The ugly woman, maybe they don't have HIV or AIDS...if the man go to see the prostitute with high class, sometimes the men think that the high class prostitute know how to protect themselves already. They become careless, or sometimes men go to see prostitutes and they see the beautiful prostitute and it's a little bit expensive, so they think that it's safe. Then he becomes careless, so he is at risk for HIV. It's scary the man who is married and go to see prostitutes and then gets HIV and transmits to the wife, because right now in the north, the housewife gets HIV from the husband and AIDS can be transmitted through the whole family.

Key Informant NLFC: I think that students are at high risk for HIV...because the group of students, many of them are from the countryside...they are far away from home so they have the free time to go out and have fun. And also there friends tell them to go out... and also the group of labourers [are at risk for HIV]... there is one member [of NLFC] who is a student. He told us that he went to the prostitute without knowing anything but he always use condoms. And he ask me why did he still get HIV. I don't know the reason why.

Although health centers and public health campaigns always advise using condoms when having sex particularly with CSWs, they do not advertise that it is not 100% safe nor are they suggesting that condoms should be used in any sexual encounter.

**Individual Perception of Risk**

Several women felt their only risk for HIV was through the men in their lives. Many assumed the husband would use condoms with CSWs even though it was not discussed with their husbands. Of the married respondents, condoms were not used within the marriage for either protection from STDs, including HIV, or birth control. Most trusted in their husband's good character to protect himself since the sign of a good man is one who would not put his wife or family at risk. One respondent suggested sexually satisfying the husband would alleviate his need for a CSW and hence obviated the risk for HIV. Some women presumed if their husbands were scared of AIDS, it implied they protected themselves.

There is an increasing reliance on blood tests for HIV before marriage and becoming pregnant. Unfortunately, the respondents did not seem to be aware of the short term implications of a blood test and that it did not imbue men with a sense of fidelity or safeguard them from future risks. A few of the male respondents indicated
donating blood as a means of getting tested which can have disastrous results in terms of infecting the blood supply.

Several of the men have changed their behaviours and now only have sex with their girlfriends (M19) with a few saying it was necessary to use condoms. For those no longer having sex with CSWs, the time period since their last encounter varied from 4 years to 2-3 months. M21 stated non-CSWs, or women in general were safe especially if they are virgins. A few respondents were quite resigned to their fate in life regarding illness and death.

F26: I have no protection because I’m sure about my husband because he stopped drinking about 5 or 6 years ago.

Drinking is a large part of going to brothels so it would seem rational for a woman to feel at low risk for HIV if her husband does not go out with friends. This, unfortunately, is not always the case and some men do go on their own outside of the peer group and drinking context. She later unconsciously contradicts herself slightly by saying,

I think everybody is at risk for AIDS. Most men don’t say the truth. A group of men that I saw sometimes they persuade themselves to go to prostitutes but when their wives are asked about this, they say 'no, they didn’t go'.

Not uncommonly, the risk is always more perceivable in other people.

F34’s own perception of risk for HIV is illustrated in the following quote,

The reason I had a blood test was my husband was sick and became thinner so I asked him to go to get check, but he refused all the time, so I went to the hospital by myself and had a blood test.  

F29: I think that it (AIDS) is the most serious disease but if a man transmits it to me,

\[13\] The HIV status of people was never asked. This was made clear at the beginning and during the interview.
it's okay if I die because I have no children. Sometimes I think that it's not fair if I die. My mother says I should warn him. I say no. It's up to him. I have no right to tell him...because I believe in my husband and I'm also sure that my husband knows how to protect himself.

F20, while discussing her perception of risk for HIV from a potential husband, says

I have to ask my husband to sometimes use condoms, like at the beginning when we live together, because we are not sure about this. But if we are infected with HIV, I think that is our bad luck. I don't know that after we marry he went to prostitutes and then he get HIV and infect us. But I cannot forbid him.

In this woman's world view, commercial sex work is such an ingrained part of everyday life that even with the threat of HIV, she would not consider forbidding her husband to go assuming she had the means and influence to do so. Her 'bad luck' may stem from her Buddhist beliefs in karma; that HIV is an unavoidable fate due to past actions in this life or previous lives. Therefore, to take any action would be futile.

I: Do you worry about AIDS?
M19: Yes. In the past I had many girlfriends, but right now after I had blood test I'm not worried.

He donates blood fairly regularly. He did have a virus, possibly Hepatitis, but not HIV and feels quite secure. He also does not have sex with anyone other than his girlfriend because he is afraid of AIDS.

F17's boyfriend found out that one of his sexual partners tested positive for HIV. When asked whether she thinks she is at risk for HIV, she says,

I suppose if he has HIV, I'm at risk because it can be transmitted by saliva but I'm not sure. If he's got hepatitis B, it's easier for me to get....hmmmm, maybe I've got it already so right now I don't know how to protect myself and maybe one day I will donate my blood because doctors will check my blood and see what is wrong with my blood.

F31: I used to have blood tests when I prepare to have children. My husband and I both have blood tests...I'm very afraid of this disease (AIDS)... I told him 'If you love
me or the family, please don’t go to the prostitutes’... if my husband goes to
prostitutes, he has to use condoms but I don’t want my husband to go after he’s
drunk. He should be conscious.

She is one of the few respondents who has verbalized her fears to her husband.

M33 went to get tested,

Because I have a few girlfriends I don’t really trust.

He went with friends to get tested. He feels that only women in the general population,
or non-commercial sex workers, are safe to have sex with.

In discussing past sexual experiences, M21 states

Mostly girls like to ask about past experience but they never talk about past
experience.

He says women who are virgins are safe but there are only a few ways to prove that. If
she bleeds then a man knows for sure she does not have any past experience. He also
says,

...there is a secret that you can check if it’s true or not. We have to notice her legs.
If her legs still have muscles, it means they have no experience.

In addition to visually assessing women he may potentially have sex with, he also
donates blood as a means of assuring his continued good health.

Affected by HIV/AIDS

A number of respondents personally knew someone either through family,
friends, or community members who had AIDS or died of it. There is a poignancy to the
more personal interactions. Interestingly, in this context the women made an
association between commercial sex work and HIV but the men did not. There are
several instances of men becoming infected through CSWs and then transmitting it to their wives.

Focus group: My friend, she had sex with someone and he died of AIDS and now I don't know if she has HIV. But she doesn't tell anybody. And I don't know if she knows what he died of because she told everyone he died of malaria. But another friend, her sister works at the hospital. So she knows that he had AIDS. She told me.

M23 had a friend with HIV. His parents took care of him at home when he developed AIDS. He describes his friend's parents as being,

... a little shy to let anybody know their son got HIV so they didn't take him to the hospital. They keep him in the house.

M25: I only know that it's dangerous and a couple of people in the village died because of AIDS.

F25g: My cousin didn't have sex with his wife because his wife is pregnant. He's scared to transmit AIDS to his wife. At last, he died without telling anybody or telling his wife that he has AIDS.

F20: His wife was infected from him because he went to prostitutes... I saw only the man, you know. When he was sick, his wife took care of him. I'm not sure at that time if his wife knew that she had HIV as well. I saw the husband when he was quite a bit thinner and had a wound on the skin.

F32: I used to talk to villagers because there's a lot of people that died because of AIDS... I heard that this person was sick because of AIDS and they say 'Why don't we go visit him?' and someone say that 'yeah, he got AIDS, he loves to have sex, yeah,' we discuss something like this but sometimes we think that if the husband got AIDS, so we think that the wife should have AIDS as well...since I know that people who loves to drink and go to prostitutes, so I know 2 men, they loves to go to the prostitutes and both of them right now they die.

F34: If someone died from AIDS, everybody helps each other. A lot of men in my village have died because of AIDS. Mostly they are young...there is one woman in my village that died from AIDS. She is only 30 years old. She died 3 months ago... she loves to have sex with other men, and she used to be a minor wife of a teacher in Sarapi...[another couple] died because they took pesticide, they committed suicide. I don't know how they know they got AIDS. They committed suicide but
they left a child, two years old alone. Someone said that the husband got AIDS when she was pregnant for nine months already. He got AIDS from the brothel. After the wife gave birth, then they slept together and both of them got AIDS. The baby is fine. ...mostly the hospitals don’t say the people have AIDS. Mostly they say they die because of cancer or something else.

Regarding a woman in her village who died of AIDS, F34 states,

The mother said that her daughter didn’t die because of AIDS, she died of cancer. But everybody knows that she died from AIDS because she became thinner and there were spots on her skin. During the funeral, they opened the coffin because they used ice to keep the body from rotting. Someone said that the ice after it melted was dark.
4.3 HIV/AIDS LOCAL SOCIAL SUPPORT SERVICES

"I fight because I would like people to think that it's the same as all diseases."

Executive director, New Life Friends Center, 1995

Key informants in AIDS service organizations were included in the study design because of their in-depth knowledge of various aspects of the AIDS epidemic with regards to 1) how the epidemic is moving throughout the population and whether they have detected any changes in the demographic profile of people becoming infected, and 2) whether the services available in Chiang Mai are adequate to meet the needs of people affected and infected with HIV.

With the rates of HIV increasing among the adult population, the provision of caretaking facilities and education for the increasing number of children orphaned due to AIDS has already become a critical issue in some countries of Africa, parts of the United States, and is increasingly a concern in Thailand (Foster 1998, Michaels 1992, Ankrah 1991, Valleroy et al. 1990). Fear of AIDS has lead some orphanages in Thailand to refuse admittance to HIV+ children (Brown and Sittitrai 1996). In Chiang Mai, both the New Life Friends Center (NLFC) and the House of Tomorrow offer care and counseling services for families with HIV. House of Tomorrow is specifically designated for women and children and acts as a temporary hospice for up to three months. Unfortunately, there is room for less than a dozen individuals, many of whom are illegal immigrants, largely from Burma, or CSWs escaping from brothels. The House of Tomorrow has had problems from both the police and mamasans and must sometimes resort to hiding their occupants. Many of the young women want to go back home and stay at the House until they have made enough money to return home. The hospice is for women only since men have other places to go, such as temples, or have their wives to care for them. As the epidemic continues to escalate especially among women, and in consequence for children, hospice care is a critical issue that needs to be addressed as soon as possible.
The Hotline Counselling Center and HIV/AIDS Clinic Chiang Mai (Hotline)\(^{14}\), which works in conjunction with the House of Tomorrow, also does home visits for families with HIV. Food is a component of the visits, usually rice, which provides the Hotline workers with a valid and non-judgmental or non-discriminating reason for the home visit. As a key informant of that NGO states:

> Because if we have something like this (rice), it is the medium to take us to the house... so mostly when we visit the house, rice is the most important. Milk or fruit they cannot eat. Later we look around their landscape and we think about their cleanliness or the way they spend their time. Another important thing is about the heart, about the soul. We think that nothing is more important than the soul. There are many other organizations that give things already but mostly we do counselling. If they get counselling already and later they get sick so we have to organize how to cooperate with other organizations such as the hospital.

Neither the NLFC nor the Hotline have standard medicines for the treatment of opportunistic infections, but the NLFC dispenses a wide variety of herbal remedies. In both situations, there is a referral system to clinics and specific doctors who are understanding and sympathetic health care providers. Discrimination against people with HIV or AIDS has been documented in medical settings (Brown and Sittitrai 1996). According to the NLFC respondent, this was and continues to be, a major problem.

> ...we have a problem about the doctors because some doctors don't understand us. Right now we have the cooperation of the doctors that understand us...they also give good information and counselling. Dr. Vararoot and Dr. Gringhai, they are very good. So our doctors don't refuse or feel bad about the patients.

New Life Friends Center receives up to 300 people per week from Chiang Mai, Chiang Rai, and other areas of northern Thailand who go there to receive food, participate in activities, and obtain more information on HIV/AIDS. Centres often receive newly diagnosed people and will advise them on the most appropriate course

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\(^{14}\)The Hotline receives support from AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, World Health Organization, NOVIB and Misereor.
of action for the maintenance of their physical and mental health. In the earlier years of the epidemic, the centre served primarily men with some families, but the last couple of years has seen a shift towards an equal representation of men and women and entire families. Clients are typically between 19 and 30 years old with the majority in the 25-29 age group. The NLFC was started by the current executive director and a small group of HIV+ people who felt they were not receiving adequate care. The main objectives are improving the quality of life for PLWHAs within their communities and families, as well as offering health care information, support and encouragement. The beginning of the epidemic in Thailand was marked with stigma and fear, some of which remains today, and must be countered by individuals and AIDS service organizations. Talking about his own experiences, the director states:

At the beginning, it was very bad... I was sick in Bangkok and I went to the hospital where the doctor said I got AIDS and there is no medicine to heal. Then I quit the hospital and tried to heal myself. I went to the wat at Ratburi where they have a healing center. I had no idea about AIDS before. I used to have friends who got HIV but I myself didn’t believe I was at risk. After I got HIV I got AIDS.

Talking about the stigma surrounding HIV/AIDS, he says mostly they hid themselves from other people and I myself hid myself from other people as well. You know, since the beginning when I got this AIDS I didn’t tell anybody in my family.

He spends much of his time fighting for the acceptance of PLWHAs in Thai society. He poignantly states "I fight because I would like people to think that it's the same as all diseases." He also actively lobbies for access to treatment, including herbal remedies. Some of the committee members, all of whom are HIV+, are trained speakers who do outreach to educate and inform the public about HIV/AIDS and those affected by it. Many of the NGOs dealing with HIV/AIDS have their offices in

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15 As many of the respondents indicated in previous sections, stigma towards HIV has decreased dramatically in the last several years as people are becoming more educated. It is not unusual, as more people are affected by HIV through family members, close friends, or colleagues, that understanding and compassion take precedence over fear and stigma.
houses in small neighbourhoods in Chiang Mai. Several of them, including NLFC and the Hotline, were discriminated against quite aggressively and had to move several times until they were finally accepted in their present locations.

"This place at present, we don’t have any problems but before we come to this part we had to move to many many places before. So now there is no problem with the neighbourhood because we broadcast about who we are and we fight for the situation, to live in the society with happiness."

Although the Hotline does some outreach, its main focus is providing anonymous telephone service. The Hotline started in 1986 as a general hotline phone service covering a number of issues including abuse, violence, and mental, physical, and emotional health but added HIV/AIDS was added to their services in 1990. The Hotline also operates as an advocacy group for human rights and public policy. The hotline staff generally have backgrounds in social work or psychology, and receive several months of training in Bangkok before working the phones. Their main objectives include the provisioning of pre- and post-test counselling as well as counselling and health education to PLWHAs and the public. Their target groups include:

1. PLWHAs of both genders and all ages and level of social status, their family members and friends.
2. Men who often visit CSWs.
3. Both male and female CSWs.
4. Teenagers both in and outside school systems.
5. Northern, local, and mountain Thai people in remote areas.
6. Employees and people in Northern Thailand industry.
7. PLWHAs in some neighbouring countries.

The majority of calls to the hotline are regarding HIV/AIDS, with many repeat callers, a possible indication of a high perception of risk. There are 3 general
categories of callers: those who are afraid of becoming infected; those who have just received a positive diagnosis and need to talk about it; and entire families who have become infected and are requesting information about how to care for each other, which hospitals to go to, and whether they should tell their neighbours. On average, they receive over 400 calls per month. Interestingly, more men call inquiring about risk for HIV but more women actually walk in. In describing the women, the Hotline respondent said:

Mostly they are married. Sometimes they come with the whole family with the husband. If they give a call we make an appointment for them to come to the center and after that we have home visiting.

The majority of men who call are between 18 and 36 years old. Some of them are male students worried because they have had sex with their girlfriend after having had sex with a CSW and are afraid of transmitting HIV to them. When the Hotline respondent was asked who she felt was at high risk for HIV, her response was

Mostly the group of housewives because the husbands of the housewives still believe they can go out and have sexual relations with other people. And also the group of teenagers because they have girlfriends/boyfriends and then they change.

Counsellors at the Hotline are periodically asked to talk to students within a classroom setting. This informant also stated that HIV among young men becoming monks is increasingly a problem because, as their surveys indicated, some monks continue to have sex with men and/or women once they have entered the wat. Unfortunately, they have been refused access to facilitate safer sex workshops in wats.

Due to the downward spiraling economic situation in all of Asia since mid-1997, many NGOs have lost their funding, including the AIDS Hotline which now only operates phone lines and is no longer able to conduct home visits. Similarly, the Ford Foundation, which is responsible for baseline research on many issues affecting women's health, including HIV/AIDS, may be relocated to Vietnam where the incidence of HIV is currently rising.
The Thai Youth AIDS Prevention Project (TYAP) currently has 3 full-time staff but will be cut back to two very shortly due to funding cutbacks. The project's goal is to reduce HIV infections among youth, to counter discrimination towards PLWHAs, and to change sexual behaviour. The target audience is youth in middle vocational schools, and street youth in Northern Thailand. TYAP has 25 volunteers recruited from high schools, colleges, and universities who receive comprehensive training to facilitate workshops among their peers. Thom, the volunteer co-ordinator at TYAP, feels women are at most risk for HIV because they do not receive as much information as men. Although there is a willingness by men and women to use condoms, the attitude that it indicates a lack of trust still exists. Women must also contend with being made to feel very uncomfortable when purchasing condoms.

TYAP's outreach also involves setting up displays in shopping centers and the Night Bazaar. A prime attraction, the Bazaar is a nightly market on one of the main streets of Chiang Mai. I observed 4 workshops conducted in middle schools in Chiang Mai where Thom and her peer educators were very well-received by staff and students, who energetically participated in the workshop activities. Similar to AIDS education in Toronto, information was explicit, and imparted through a series of participatory activities; in contrast to teachers or public health nurses giving the information lecture-style. In other potential areas for outreach, such as pubs, discos, and karaoke, the response has not been as favourable with owners fearing the attention would reflect poorly on their establishments. TYAP must also contend with parents' attitudes, which are not always supportive, as some fear TYAP is actually promoting sex in general.

Abortion is a popular topic of discussion among women especially now that they are more sexually active. Still illegal, abortions can nonetheless still be had for 2000-6500 baht ($50-$197). Women without financial resources resort to beating their stomachs with their fists or drinking alcohol with pills. There have been rumours of escalating numbers of rapes, perhaps to forego using condoms as men force themselves onto women. In Thom's opinion, the apparent increase in rape may actually be due to more informed awareness and reporting of rape.
Many small local groups in Chiang Mai yield social power and are important disseminators and resources of information. They tend to focus on health, support, and survival issues among the general population and for specific groups. One such group is the EMPOWER (Education Means Protection Of Women Engaged in Re-creation) Foundation, initially founded in Bangkok in 1985 as a centre for the protection of women's rights in the entertainment sector. It was organized by local feminists, foreign women, and former CSWs (Erni 1998) and served as a drop-in centre for CSWs. There, they could find support and take English lessons in an effort to empower them in their business negotiations. Women were also taught others skills such as sewing, batik-making, video, photography, and drama workshops. The women use their skills to put on performances in local bars to teach CSWs and their clients about safer sex. In 1991, a center was opened in Chiang Mai and by 1993, with the expansion of their educational and vocational training, they were recognized as an informal educational institution where women could study for state qualifications. Erni (1998) refers positively to these groups as a 'guerilla activist movement' which addresses women's multiple identities. He describes them as “... wives, sex workers, sisters, experts of street life, appropriators of resources, mutual educators, strategists when dealing with men, and informal leaders in the fight against AIDS and the structural problems connected to the epidemic” (Erni 1998).

The main objective of the foundation is for women to have control over their lives, whether it be in their occupation, education, health, love, or marriage. To achieve this goal, workshops are given weekly not only on occupation-related issues such as HIV/AIDS and safer sex, but also for the development of a broader base of knowledge and improvement of self-confidence. Their success is based on several factors: 1) they are not trying to dissuade women from participating in the sex industry, but offering them marketable skills so they have options should they want to get out; 2) the women are welcomed in a comfortable, non-judgmental setting; and 3) the classes are scheduled according to their work hours, which tend to be in contrast to regular college classes. The EMPOWER Shop in Chiang Mai was opened in 1995 near Tapae Gate, and addressed women's involvement in community concerns, such as the
environment, labour issues such as ethical trade practices, and HIV/AIDS. The women in the organization produced a variety of environmentally friendly, quality items such as soaps, shampoos, and clothing. The shop also provided safer sex information in a non-intimidating atmosphere, and was operated by volunteers who could render more information or referrals. Unfortunately, by 1997 the shop had closed but the organization remains very active in Chiang Mai.

Jackie Polloock, one of the executive members of EMPOWER in Chiang Mai, highlighted some of the dilemmas and barriers they had to contend with in their work. In 1995, there had been an unprecedented number of brothel raids throughout Chiang Mai. This action was unexpected because the police were, by and large, bribed by the brothel owners but commercial sex was becoming so out of control in Chiang Mai that Bangkok was forced to send their own task force to initiate official activity. With this loss of face, the Chiang Mai police was compelled to continue the raids which meant the dispersal of CSWs and the inaccessibility of the brothels to EMPOWER staff. Until that time and after the crisis passed, EMPOWER was able to access the brothels to distribute information and condoms. Additionally, public health put up 'condoms-only' signs around the brothels. Other commercial sex work locations including discos, karaoke, and some computer shops were accessed with safer sex information.

Computer shops and cafes are quite prevalent throughout Chiang Mai, particularly near Chiang Mai University, attracting many young people. In response to a new venue for clients, CSWs have begun targeting these computer places.

Notwithstanding the success of the condoms-only policy, there are other considerations that need to be noted. Jackie states that some women sleep with approximately 10 customers per day and if they use condoms with each of them, the consequence is vaginal drying, resulting in pain and irritation. As was previously mentioned in the 'Women, Buddhism, and Commercial Sex Work' section, condoms are widely available but lubricants are not. In this situation, a woman has several options: 1) she can limit the number of customers to avoid the pain, but that leads to a loss of money; 2) she can continue having sex in the presence of pain but if there is semen spillage, the irritated skin may actually facilitate HIV transmission; or 3) she can
occasionally not use condoms which will lessen the pain and may actually make the client finish more quickly. More time may lead to more clients.

Certainly, women in brothels are more confident and feel empowered to insist on condoms if that is their choice. Women who are least empowered are those working the streets or new immigrants, particularly from Burma, who do not speak Thai. They are at the bottom of the commercial sex hierarchy and at greatest risk for HIV. EMPOWER attempts to have CSWs tested for HIV every 2 weeks at a local STD clinic or out of mobile clinics. In the event they are HIV+, they are counselled on how best to manage their lives and have safer sex. Several years ago the government tried to implement compulsory HIV testing of CSWs every 3 months, which would certify a clean bill of health on the pink cards women were to carry with them. The program failed due to the lack of infrastructure once women began testing positive. They did not receive any pre- or post-test counselling. Oftentimes, the brothel owners were contacted with the results of the tests. If a woman was found to be HIV+, the brothel owners still forced the women to continue working to pay off their debt. Most of the women Jackie encountered were concerned for their health more for the sake of their families should they die and revenue supplementation cease. Even with the options and support EMPOWER provides, these women are under tremendous pressure to continue working regardless of their circumstances.

In addition to a newsletter, EMPOWER also produces special issues and short stories on people living with HIV/AIDS, highlighting their struggles and courage. The following passage was excerpted from Living with HIV which underscores both the stigma and compassion PWHAs must contend with16:

When I was called in again [after the blood test], there were two doctors sitting at the table. I was very weak, cold and shaking all over. They did not even ask me to sit down, they said you have HIV. I was so shocked that I collapsed right in front of them. I woke up in a hospital bed, there was a card with my name on it but on the cards four corners were red marks. I knew right away that it was an

16Living with HIV is a special issue published by Naam-Chewit Project of the EMPOWER Foundation in 1994 and was co-edited by Chumpon Apsuk and Noi Apsuk.
HIV+ marker on my card. I left the hospital that night, wanting to find a place to hang myself.

I took a taxi to a small park near the expressway exit. As I got out of the taxi, I collapsed again. The taxi driver came down and asked me what was the matter. I broke out in tears and told him I wanted to die because I have AIDS. He hugged me, and sat down with me on the sidewalk, and said it was alright, there must be some way out...nothing is absolutely bad.

The above illustrates that, while there is a fear of AIDS, as many respondents indicated, their reaction and action would also be that of compassion. Ran, the author of the above excerpt, was fortunate in receiving that compassion and understanding from a total stranger. Not everyone has such a favourable experience in similar circumstances. After attending a pre-natal check-up, Pung, the subject of the following excerpt, has just been informed that she and her husband are both HIV+.

I remember crying when both of us sat in front of the nurse. She asked us what we wanted to do with our unborn child. She suggested aborting the child, and added that it would be free of charge. If I agreed to do so, I was also required to have a hysterectomy... I had my child aborted, with a special deal ‘Abortion with hysterectomy... Free of charge’. But, I still don't know what kind of hysterectomy I got. I am not sure if it is a reversible or permanent sterilization. I have no way of knowing what has been done to my own body...

For many people, their first encounter with the knowledge of their HIV status is within the medical community, and frequently has negative outcomes. To counter the negativity, NGO's such as New Life Friends Center, the Hotline, and EMPOWER work indefatigably to offer people hope, encouragement, and support.

The inception of the Thailand Business Coalition on AIDS (TBCA) was formed in recognition of the enormous impact HIV could have on the economy of Thailand due to the rising number of employees unable to work in conjunction with increasing health care costs. The majority of people affected by HIV/AIDS are in the prime of their lives and the loss of productivity is almost incalculable. The epidemic has the potential to adversely affect tourism and labour exports. It is estimated that the direct and indirect...
costs of HIV/AIDS will amount to $9 billion by the year 2000. TBCA, directed by business leaders, educators, and government officials, is very active in Bangkok conducting on-site workshops to help employees and employers deal with HIV. TBCA has also been instrumental in implementing policies and workplace education in business settings. In fact, TBCA has been very well received by the tourist industry particularly hotels and restaurants, where training is provided for human resource personnel and staff. Their target is Bangkok industries, where they are located, but industry in Chiang Mai could benefit enormously from their work.

Praween Payapvipapong of the Population and Community Development Association in Bangkok describes several of their projects in the North and among the Hill tribes and the issues that have arisen there. The association is a privately funded NGO whose primary concern is family health and AIDS. In the earlier years of the epidemic in Thailand, Khun Praween states that CSWs in the north found to be HIV+, were often sent home to their villages where health or social support services were unavailable. Khun Praween comments that there are a variety of differing opinions regarding HIV surveillance including the lack of support and counselling either before or after the HIV test. In some instances, treatment for STDs is less than optimal. He also points out that indirect CSWs, especially students or secretaries, who occasionally sell sex for money are very difficult to track for either testing or AIDS prevention. Unfortunately, men will often go to these indirect CSWs with the belief that they are safer.

The focus of AIDS education from the Population and Community Development Association is on men through their peers. How successful they have been in the North is as yet unknown. Praween feels that men's knowledge has increased, which is apparent in the data collected for this dissertation, but how that translates into behavioural change is difficult to assess. Their approach does not consist of telling men not to go to CSWs, but rather to have safer sex when they do. This is a more realistic and culturally appropriate approach rather than trying extreme measures of

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17Source: Pamphlet on Thailand Business Coalition on AIDS quoting from the Thailand Ministry of Public Health and the Office of the Prime Minister.
changing their whole behaviour. More importantly, neither the men nor the women are demanding such stringent changes.
4.4 WOMEN, CHILDREN, HIV AND THE FUTURE

On an international scale, AIDS is having a profound effect on infant and child health. Gains made in the last several decades with the eradication of smallpox, global immunization programmes, and the development of maternal/child health initiatives are being challenged by HIV/AIDS. UNAIDS estimated that by mid-1996, there were 3 million children infected with HIV and 9 million children orphaned by AIDS (Foster 1998). Approximately 500,000 babies are perinatally infected with HIV worldwide each year (MMWR 1998). Most of these infants are in developing countries. Most infants infected with HIV die before 4 years of age thus affecting the child mortality rate (CMR). For example, the U.S. Bureau of Census projects that by the year 2010, the CMR in West Africa will be nearly 70% higher than it would be without AIDS, 33% higher in Brazil, and 18% higher in Thailand (Foster 1998). The figures are perhaps not as dramatic for Thailand, where fertility rates have already decreased significantly and women are not having as many children as in some African countries such as Uganda or Zaire. Thailand also had the advantage of learning from the experiences of other countries. Nonetheless, the figure of 18% is significant and the potential exists to affect life expectancy if rates continue to escalate. Once the rates of HIV transmission stabilize in Thailand, the number of children acquiring HIV and orphaned due to AIDS is likely to increase for a period of time since the average number of years from infection to AIDS and death in adults is 8 to 10 years.

Accounts from the 1950s indicate that children of both sexes are highly valued by friends and relatives and readily accepted for short and long-term stays (Blanchard 1958). This is still the case but unfortunately, the advent of AIDS has changed that reality. Recent declines in infant and child mortality rates in Thailand and in numerous other countries are being reversed due to AIDS. HIV is affecting children directly through transmission and indirectly through orphanhood and poverty. There are an increasing number of orphaned children throughout Thailand, including Chiang Mai, for whom, in many cases, practical and economic consideration obviates the ability of family members to care for them (see Figure 4).
I have AIDS
Please help me....

Figure 4. Pamphlet produced by Wednesday Friends Club, Thai Red Cross Society

Increasing seroprevalence rates for young women attending antenatal clinics clearly reflects the cycle of transmission from CSWs to their male clients to the girlfriends and wives they go home to. As of 1994, 2.06 percent of women attending an
antenatal clinic were HIV+ 18. Brown and Sittitrai (1996) remark that the age
distribution will significantly affect the number of children becoming infected and/or
orphaned. Currently, AIDS cases are peaking in the reproductive age range; the 25-29
feel that the distribution will shift to higher ages, resulting in couples having more
children by the time one or both partners die of AIDS. Currently, women who are
infected by their husbands tend to die sometime after their husbands (Brown and
Sittitrai 1996).

Projections made within Thailand estimate that by the year 2000, 63,000
children will be infected with HIV and 47,000 more will have died of AIDS. The same
study estimates that 109,000 children under the age of 15 will have lost their mothers to
AIDS by the year 2000 (Brown and Sittitrai 1996). Overall, child health is likely to
deteriorate since mothers are the main caretakers of children. As grandparents, older
siblings, and relatives assume the responsibility of caring for orphaned children, the
burden may be too great to give adequate care. In the case of older siblings assuming
the responsibility, the knowledge and resources of caretaking may not have been
learned (Foster 1998).

The Viengping Home for Children, on the outskirts of Chiang Mai, is home to
160 children under the age of six, 59 of whom are HIV+ with numerous others having
lost one or both parents to AIDS. The home is located beside a hospital where HIV+
children can receive treatment such as AZT. A volunteer at the home stated that, on a
recent visit to a nearby village, they found it to be almost devoid of men due to AIDS
mortality. They were expecting that many of the women would probably become ill or
die of AIDS within the next five years which meant that the home would now have to
plan on receiving more children in the near future. If children have disabilities, it may
be more likely that they be placed in the Home rather than with relatives. For example,
the parents of both Pepsi, a 4 ½ year old boy, and Gaow, a 3 ½ year old girl, have
died of AIDS. Pepsi and Gaow both have polio and are given physical therapy in the

18This represents a fairly accurate depiction of the situation of women of reproductive age as most
women in Thailand seek antenatal care (Brown and Sittitrai 1996).
As the epidemic continues and more women are infected, the number of children who will invariably be affected either directly or indirectly will also increase proportionately. Health care and social service providers will need augmented training in the areas of HIV counselling, reproductive health, and psychosocial support. As it is, in many clinical settings women are counseled to abort or agree to sterilization (Brown and Sittitrail 1996). Pre-natal HIV screening is available giving women the opportunity to make a decision regarding the continuation of the pregnancy. If the pregnancy is carried to term, the mother and child can be monitored and receive treatment to reduce the chance of vertical transmission (Koetsawang and Auamkul 1997). This said, medical practitioners often ‘encourage proper reproductive decision-making’ which, in one hospital in Bangkok, meant permanent sterilization via tubal ligation or vasectomy, recommendations not widely embraced by young couples (Koetsawang and Auamkul 1997)\textsuperscript{19}. Although abortions are illegal in Thailand, they will be performed for HIV+ women. Counseling HIV+ women to abort is not a situation unique to Thailand and has been at the heart of many debates regarding women’s rights and social control in North America (Hunter 1995).

In formulating recommendations to prevent parental infection, Brown and Sittitrail (1996) suggest developing safer sex practices and establishing them as norms among young Thais as well as promoting discussion of HIV between couples. They also suggest voluntary premarital screening for HIV. International controversy surrounds the issue of mandatory versus voluntary premarital HIV testing. Logistical problems regarding voluntary premarital screening would have to be addressed. For example, would the couples go together to get tested and to receive their test results? Will their be effective counselling? What if one of the partners refuses to go? What if one partner is positive? What if that partner is the woman, the traditional caretaker? Will that mean the dissolution of the marriage? Will the couples be made aware that the

\textsuperscript{19}The poignancy of this situation is revealed anecdotally in the “HIV/AIDS Social Support Services” chapter. Directive counseling to abort occurred throughout Canada including Ontario in the early years of the epidemic. See Positive Women: Voices of Women Living with AIDS, eds. Andrea Rudd and Darien Taylor (Toronto: Second Story Press, 1992).
testing, if done accurately with regards to the window period of antibody formation, reflects only a moment in time? For instance, if one of the partners subsequently had unsafe sex with another partner, they could be putting both of them at risk and, consequently, any children they may have.

Once born, the infant is still at risk for HIV through breast-feeding. The majority of Thai women breast-feed although a few women in the sample used formula. Because of the risk for HIV transmission versus affordable access to formula and sanitary water coupled with a low risk of mortality from infectious diseases, the Thai Red Cross Society advises HIV+ women not to breast-feed (Brown and Sittitrai 1996). This could be a dilemma for an HIV+ mother who may inadvertently identify herself as having HIV if she does not breast-feed. The individual respondents in this study overall felt compassion for HIV+ individuals, but many remarked that the community would not react so positively. Fostering an environment of caring and comfort is a very lengthy process that needs individual activism and continual support from government and non-government organizations.

As previously stated, treatment is available but questionable in terms of equitable access throughout the country. Treatment is already a critical issue in Chiang Mai and will be exacerbated as more men and women infected in the last decade become symptomatic. As rates of HIV are increasing among women they are in consequence increasing in the pediatric population. Until recently, the AIDS Clinical Trial Group protocol 076 (ACTG 076), which is a zidovudine (ZDV, also known as AZT) treatment protocol, was the standard used to reduce vertical transmission from mother to child from 25.5% to 8.3% (MMWR 1998). This finding was confirmed with research conducted at several test sites around the world including Thailand. Benefits in terms of reduction of transmission have been proven but there remains the challenge of the complexity of the treatment regimen, which is lengthy and complex in terms of rigorous scheduling and numerous dosages, and more importantly, prohibitively expensive. This also addresses certain ethical issues when testing is conducted in less developed countries where treatment is drastically needed, found to be beneficial, but in the end, prohibitive due to costs.
In 1995, a study using short-course zidovudine treatment resulted in very dramatic declines in vertical transmission and may prove to be more feasible in terms of time and money in a country like Thailand where pilot studies have already been conducted (Taneepanichskul et al. 1997). ZDV is given towards the end of pregnancy at greater time intervals and does not involve infant treatment meaning a less cumbersome regimen at lowered costs. A study conducted in Bangkok among pregnant women using short-course ZDV resulted in a 9.2% HIV transmission versus 18.6% in the placebo group (MMWR 1998). Because the studies are currently underway, a longer follow-up is evidently necessary.

There are two unrelated points of interest in this study. The first being the lower value of the placebo group of 18.6%. The average vertical transmission rate is approximately 25%. The reasons for these disparate figures is unknown and is perhaps due to the changing natural history of the virus although far more research would be required to substantiate such a statement. The second point involves ethical issues of conducting placebo-controlled studies. Researchers may counter this by stating that there are possibly risks associated with being placed in the treatment group. Additionally, by having a placebo group does not disturb the status quo. Essentially, those women would not have been receiving treatment unless they were enrolled in a study. This does not justify case-control experiments involving drugs that have shown their efficacy. It would have perhaps been more humanitarian to disburse slightly more dollars comparing short-course versus long-course treatment regimens.

If treatment is not expected to be widely available, the absorption of orphaned children will become a serious social and economic issue. Numerous scenarios may evolve which may bear similarities to some Central African countries in terms of the demographic impact of HIV/AIDS. Because the father is generally the first to die of AIDS, the loss of the primary breadwinner poses serious financial difficulties for the family. To compensate, children may be taken out of school early to either contribute financially to the household with a menial job or to help with chores and agriculture. Inadequate education will affect job prospects for the rest of their lives. Additionally, if there are no older siblings to care for younger ones once the mother dies,
grandparents or relatives are left to care for the children. This becomes a difficult situation as many grandparents are being supported by at least one of their children (often the daughter). Relatives may already be overburdened by the current economic situation and not be able to afford taking in children who are possibly infected. Countries in Africa are already top and bottom heavy due to such a high mortality rate in the reproductive age range which is also the most productive age range (Hunter 1990). Thailand is already in a precarious economic situation. Families in the North have been particularly affected to the extent that many have had to rely on the daughters. What will happen if too many daughters become ill? And what of their children?

In addition to direct mother-to-infant transmission, children are at risk for HIV through child prostitution. The number of children under the age of 18 in the sex trade is estimated to be about 30,000 (Brown and Sittitrai 1996). The impetus for children, especially young girls, to enter prostitution is a combination of poverty and growing consumerism (Brown and Sittitrai 1996). Brown and Sittitrai (1996), in conducting focus group discussions, state that the number of men who had direct experience with child CSWs was alarming.

Street children are also at risk for HIV because of occasional commercial sex work, as well as casual sex amongst each other, which is often accompanied by alcohol and glue sniffing (Brown and Sittitrai 1996). One of the more outspoken church-based NGOs, The Campaign to End Child Prostitution in Asian Tourism (ECPAT), was formed in 1991 and concentrated in Thailand (Emi 1998). They have lobbied countries in North America and Europe to take legal action on men and women clients indulging in the underage sex trade in Asia 20. ECPAT was also instrumental in pushing the Thai government to take a serious look at its own sex tourism.

20In response, the Canadian government enacted Bill C-27 which mandates the prosecution of Canadians who engage in commercial sex with children abroad as if the crime had taken place in Canada. Unfortunately, the mechanisms to bring someone to the court’s attention are not in place and no one has been prosecuted. In the interim, the beaches and cities of Thailand are replete with (mostly) men walking hand in hand with the young boys and girls they just purchased.
5.0 SUMMARY OF FINDINGS AND IMPLICATIONS

The data, collected primarily through respondents, key informants, and archival material complemented with a focus group discussion and participant observation, provides evidence that women are indeed, potentially at risk for HIV. The following findings contributing to women's risk are summarized and discussed briefly.

1) A generation in transition.

Both young men and women are in a social and sexual transition. In contrast to the behaviour found in their parents generation, young women are going out more and having boyfriends, a situation they recognize as not being part of traditional Thai culture. Additionally, young women are experimenting with pre-marital sex. Perhaps in response to women's emerging sexuality, young men are visiting CSWs less frequently and having sex with their girlfriends more than they did in the past. Men are aware of women's increasing freedom. Coupled with increasing rates of sex before marriage are increasing rates of abortion indicating that safer sex is not being practiced.

2) University as a place for freedom for women.

There has always been a high university attendance by women in Thailand, but currently there is an increasing number of them moving away from home to do so. Away from parental influence and community scrutiny, young women have more freedom and autonomy. A conflict is felt by young women who are still strongly influenced by their tradition but experiencing greater independence and freedom from parental scrutiny. How this will affect filial obligation remains to be seen. Some of the young women are struggling to fulfill their parents expectations while seizing the opportunities available to them including having a career, going out to pubs with friends, and having pre-marital sex.

3) Gender, Sex and Accountability

The social and sexual transition is much more difficult for women than for men as the women are experiencing more of the changes, particularly with regards to
changing sexual behaviour. Women still feel accountable to their parents and strive to maintain traditional Thai values. They want to honour their parents and ensure that their actions will not bring shame upon them. For young women in university, this entails studying hard and making their schoolwork a priority. For women in general, there is the prevailing sense that pre-marital sex is still unacceptable in Thai culture. The fact that Thai culture is changing and peers are having pre-marital sex, poses a dilemma for young women.

Men, conversely, have a more self-oriented view of sex as they have never been held accountable for their sexual behaviour since sex, whether it be pre-marital or extra-marital, has been socially supported. Thai men have always had the freedom to indulge indiscriminately in sexual trysts within the commercial sex arena. Men are now merely making a transition from sex with CSWs to sex with non-commercial sex partners.

4) **Sex Defines Men**

The women respondents felt that having strong sexual needs and satisfying those needs was an inevitable part of being a man, and that the inevitable part of being a woman was to accept men’s sexual behaviour. Women felt that the need for sex was part of a man’s nature and therefore, unchangeable and uncontestable. Hence, women are left with few options but to accept the men’s need, especially since all of society accepts it. Curiously, neither the men nor women respondents regarded sex as part of women’s nature. The discourse on women’s sexuality has been given very little attention and is not fully developed. Indeed, women’s sexuality is not as highly regarded as men’s sexuality and is subservient to men’s needs. Without a doubt, the data attests to men having far greater sexual privileges and freedom than women.

Women expect, or at least assume, their boyfriends or husbands-to-be to have had previous sexual experience. This does not warrant discussion. The acceptance of liaisons with CSWs as a long and historical practice by men has not changed, but AIDS has added a new dimension, and, has forced men and women to re-evaluate the basis on which they will accept this tradition.
5) The Decreasing Acceptability of Commercial Sex Work

Men are currently accessing CSWs less frequently due to a number of factors including 1) the increasing availability of sexual activity with girlfriends; 2) the prevalent fear of contracting HIV from a CSW; and 3) an increasing awareness of commercial sex work as a social issue involving misfortune, economics, gender rights, and exploitation. Some men can no longer partake in the objectification of women. Not only are some of these men able to place women in the sex trade in a greater context of poverty and filial obligation, but in doing so, are developing compassion and humanity towards them.

6) Women's Voice within a Sexual Relationship

Ironically, it is CSWs who are empowered to insist on condom use within sexual encounters. Although many CSWs enter the sex trade because of poverty and are thus disempowered on one level, they receive tremendous social support to maintain a safer sex policy. Additionally, their profession has perhaps allowed them to discuss sex whereas their non-commercial counterparts do not discuss sex with either their friends or sexual partners. Some of the women respondents replied that it was better to maintain a good relationship than to discuss sex. There is a fear of AIDS through the male partner’s actions, but the personal and cultural barriers that need to be surmounted by women to communicate and negotiate safer sex is too great at this time.

7) Fear of AIDS.

The AIDS epidemic has had a tremendous impact on changing sexual behaviour for both men and women. Men are seeking CSWs less often partially due to the men’s fear of AIDS. This fear has been promulgated by extensive AIDS education campaigns linking HIV with CSWs and encouraging men to use condoms when with them. Men do not consider non-commercial sex partners to be at risk for HIV. In fact, they are less likely to use condoms when having sex with their girlfriends or wives. The possibility also exists that men will tire of using condoms with CSWs, or that, if the epidemic declines, men and women will perceive HIV as less of a threat.
8) **Knowledge and Source of HIV/AIDS Prevention.**

Basic knowledge of transmission through fluids and behaviours was high but the nuances of behaviour, especially with respect to oral sex, were unclear. There was strong consensus among the respondents that the source of the information, largely from public health, was appropriate and reliable but that more information was needed.

9) **Perception of risk for HIV**

The general opinion among the respondents indicated that anyone sexually active could be at risk for HIV but IDUs, CSWs, and medical personnel were felt to be at particular risk. Male respondents more closely associated HIV with commercial sex work, especially when drinking alcohol. Both genders indicated that teenagers and university students were at risk for HIV because of the increasing acceptance of pre-marital sex among themselves coupled with alcohol consumption.

The link between CSWs, their male clients, and the girlfriends and wives they go home to was beginning to emerge among respondents of both genders. The key informants re-enforced the idea that more women are becoming infected by their boyfriends and husbands. The AIDS service organizations in Chiang Mai attested to the increasing number of women, and entire families, seeking services. Women relied on their husbands and boyfriends to use protection in other sexual encounters. Some of the women felt their male partners were currently too scared of AIDS to continue commercial sex visitations. They are relying on the men in their lives to honour them and anticipate their thoughts and feelings to protect them from HIV. In either case, whether the assumption was that men used condoms or did not engage in commercial sex work, the role women take is passive and non-confrontational.

Many respondents mentioned relying on blood donations as a means of testing for HIV which, if positive, can endanger the blood supply. This is also a passive approach to confronting the situation.

The findings, although listed separately, are not discrete entities but inter-related. Western influence and the Thai response to the AIDS epidemic have been the
driving forces behind changing sexual behaviour in Thailand. Westernization, with respect to materialism, consumerism, and sexual liberation, has had an enormous impact in the changing values and traditions in Thailand. Among the many changes being experienced by Thais are the number of young women engaging in pre-marital sex. Additionally, AIDS education and prevention campaigns have made Thais re-evaluate previously held axioms regarding the traditional acceptance of sex with CSWs. Men are now seeking sexual outlets with their girlfriends.

In the introduction to this thesis, a very simple model of transmission was presented (see Figure 1 in Appendix 1); that HIV was transmitted between CSWs and their clients, in a bi-directional flow, but the men were also transmitting HIV to their girlfriends and wives. The latter flow of transmission tended to be more of a unidirectional flow as traditionally non-commercial sex partners did not have pre-marital or extra-marital sex. This thesis proposes that, as the sexual network has expanded, the model of HIV transmission is far more complex (see Figure 5 in Appendix 11).

In both models, the complexity of the contributing factors of commercial sex work is recognized and does not change from one model to the next. It is the flow of transmission that is the focus in the model presented in Appendix 11. To begin, commercial sex work continues to exist but pervasive AIDS prevention programmes which targeted CSWs as the locus of transmission, has been a prime motivator behind changing sexual behaviour among men. The prevention messages so strongly associated HIV with CSWs, that men are not visiting CSWs as frequently as in the past, and when they do, there is a high rate of condom compliance. Men are also now having sex with non-commercial sex partners as a safer option and because of the overall change in sexual patterns. Women's greater sexual freedom and liberalization also translates into the women having more than one sexual partner in their lifetime. Once married, it is still completely unacceptable for a woman to have another sexual partner but before marriage, women are indulging in pre-marital sex, perhaps with several boyfriends in succession. In these cases, condom use is not high due to a variety of reasons, predominant amongst which is the assumption that the men in their lives use condoms with other sexual partners. In such cases, the flow of HIV
transmission is bi-directional.

Young people, in particular, are being profoundly affected by their changing world. Young men who are well educated with regards to AIDS prevention are also developing a social consciousness which means they are not as ready to exploit CSWs. Additionally, young men and women are finding sexual outlets amongst each other. Therefore, it is feasible that HIV is finding its way into a larger sexual network in Chiang Mai, Thailand. As it does so, the fourth wave of the epidemic will inevitably result in the fifth wave as increasing numbers of women with HIV give birth to infants.

The economic and political revolution that is occurring in Thailand is linked to the social and sexual revolution. This research has found a change in gender roles with a noticeable shift in generational differences leading to internal conflicts. Women, in challenging a patriarchal way of life, are becoming better educated, more independent, often living away from their parents and earning their own wages.

Nuclear families are now quite prevalent whereas, traditionally, extended families were the norm. As this research attests to, traditional patterns of behaviour are modified in reaction to a changing environment. Educated Thai women are choosing not to marry, or not registering their marriage, because of the male biases in the law which they find unacceptable (Klausner 1997:71). Two-income families, especially in the cities, are becoming more prevalent. As they gain independence, women are becoming more self-assured and confident (Klausner 1997). Easy access to contraceptives, made possible in the last two decades, may facilitate a woman's autonomy and control over her destiny. Male and female respondents stated that within the home, there is the expectation of shared responsibilities concerning child-rearing and household chores.

Married women in this study who accepted their husband's extra-marital excursions often had conditions for their acceptance. For instance, for some women, the only stipulation was the maintenance of the family budget accomplished by avoiding situations which could result in monetary depletions. The female respondents felt that a married man who drinks, smokes, or goes to CSWs excessively is thought to have a poor character - a similar finding to Lyttleton's (1994) research in
Northeast Thailand, an area where some villages are severely depleted of young women who have gone to Chiang Mai and Bangkok for commercial sex work. Conversely, a non-commercial sexual liaison with a woman by a married man is considered a threat to the well-being of the family as the man may be obligated to support that woman and any children she may have with him (VanLandingharn et al. 1995).

To date, the Thai National AIDS Programme has been very successful in targeting young men involved in commercial sex encounters. The public health campaigns have highlighted risk behaviours, the role of STDs, and condom promotion. The success in the campaign has been marked by a notable decrease in the number of men visiting CSWs, the rapid acceptance and use of condoms in commercial sex, and decreasing rates of STDs (Brown and Sittitrai 1996). HIV prevention may not be the only factor responsible for a decrease in commercial sex patronage. In fact, this research has found that young men have a greater understanding of commercial sex work and have a more empathetic attitude.

The commercial sex situation is complex. It may have initially been motivated by poverty, which continues to be a primary factor, but is now coupled with young women’s need for the acquisition of material goods for themselves and their families. Having a greater comprehension of commercial sex work in Thailand clarifies their role in HIV transmission; that they are part of the flow and not the locus of transmission (see Appendix 11). What is also neglected is that the ‘men’ CSWs have sex with include not only their clients but their non-paying partners. In fact, a study of sexual behaviour trends among 8 population groups in Bangkok found that condom use was low among CSWs and their non-paying sex partners (Mills et al. 1997).

Mills et al.‘s (1997) recent study also found that commercial sex patronage declined among male factory workers, vocational students, and STD clinic attenders. STD clinic attenders and vocational students also showed a decline in their sexual activity with non-regular sex partners other than CSWs. In contrast, the university-aged respondents of this dissertation indicated sex was occurring with girlfriends and casual friends which was one of the reasons given for decreasing commercial sex
Mills et al. (1997) feel that according to their results, which are based in Bangkok, casual sexual partnerships are not replacing commercial sex visitations as a sexual outlet and that in fact, there is an overall decline in non-regular sexual partnerships (Mills et al. 1997). The possibility of under-reporting of sexual activity due to the bias against pre-marital sex is acknowledged. The Mills et al. (1997) study did not, however, take into account sexual intercourse occurring in relationships, which is beginning to characterize young Thais of the university age in Chiang Mai. As well, the contrast in findings may also be due to differences in research setting; that the large city of Bangkok and the much smaller city of Chiang Mai with numerous universities and colleges attracting many young people, may be conducive to different behaviours. For example, the overall freedom and autonomy of young women was more apparent in Chiang Mai than in Bangkok. Mills et al. (1997) feel that it is perhaps more important to put public health efforts into maintaining high condom use within the commercial sex arena rather than promote condom use in other sexual relationships which, they suggest, may be unrealistic. The fact that non-commercial sex partners (female factory workers, vocational students) have not increased their condom use in light of the heavily publicized condom campaign in a country experiencing a severe epidemic is still a concern.

I propose that the current campaigns focusing on CSWs should be maintained while adding another component targeting on young people having sex with non-commercial sex partners. Women in the Mills et al. study and this dissertation were obviously not identifying themselves to be at risk for HIV. Sexual behaviour is changing and action should not be taken only when young people start becoming infected. MacQueen et al. (1996:420) state “As the AIDS epidemic evolves in Thailand, sexual norms may prove variable across groups and unstable within groups.” This may impact on the generalizability of program implementation. HIV/AIDS prevention campaigns must 1) address women by recognizing their sexuality, and 2) re-address men by recognizing their changing sexual behaviour.

A common theme throughout this dissertation is young women's reliance on
men's use of protection. This assumption is their only means of protection. Young men are targeted with respect to commercial sex work but young women are not targeted at all. Young men need to transfer their safer sex behaviour from one context (commercial sex work) to another (non-commercial sex partner). Young women do not have a similar sexual health infrastructure. Women's sexuality has not been addressed and they have not been receiving safer sex messages. Since women are regarded as asexual until they marry, this is not surprising. Additionally, women themselves may either not perceive themselves to be at risk or if they do, they lack the necessary negotiation skills to protect themselves. Men have support, women have barriers.

In fact, women have several barriers to overcome. The first is acknowledging that they are sexual beings in a society not yet ready to support that decision. The second barrier is their ability to communicate their fears, anxieties, and insistence on condom use with their partners in a society where males are regarded as being more sexually dominant in terms of responsibility and experience. The third potential barrier is the association of condoms with commercial sex work which young women may feel would stigmatize them. This did not arise as an issue among respondents but the possibility exists. Such a situation could be countered with promoting condom use as a means of birth control which would be very timely considering the increasing rate of abortion and the number of women mentioning side effects of the pill. Brown and Sittitrai (1996) similarly found that the most common reason for not using the pill was due to complaints about side effects.

Although Thailand has been characterized as having a strong national identity, western influence is becoming particularly evident with each passing year. This has had a significant impact on young people's social and sexual behaviour. These changes in sexual attitude appear to be quite recent as respondents remarked on the differences between themselves and their parents generation. Generational differences are not uncommon but I would characterize the current generation as transitional. Western influence, as a term, has been referred to throughout this

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1The Ford Foundation in Bangkok and the Thai Youth AIDS Prevention Project both expressed their concern regarding the escalating rate of abortion.
dissertation. It is a value-laden term which can be at the same time vague because of the enormity of its potential meaning and interpretation. The world is undergoing a process of globalization, with customs and traditions moving across international lines. Influences from the West, which includes North America, Europe, and Australia, involves a liberalization of sexual attitudes and behaviour. This liberalization travels the globe in myriad forms, through television, print media, and direct contact. These modes of communication have all been facilitated through technology; the technology that allows us to plug-in the television set, surf the web, and fly a jet. Even the poorest of people will be affected and exposed in some manner. In fact, in Thailand, television sets are ubiquitously found in households, businesses, banks, and public transit. Exposure to western influence in terms of the influx of material goods, values, behaviours, and lifestyles is probably the greatest in the younger generation of Thais.

**Safer Sex and the Decision-Making Process: The Health Belief Model and the AIDS Risk Reduction Model**

Two theoretical models were proposed in the 'Introduction' to elucidate and contextualize Thais' sexual behaviour in the face of an epidemic. It was previously mentioned that both models were limited in specifically addressing the Thai situation but are useful in broadly understanding behaviour confronting a health threat. The first model, the Health Belief Model (HBM), is a socio-psychological theory relating to decision-making and preventive health behaviour. It was initially developed in the 1950s, revised by Maiman and Becker (1974) in the 1970s, and has since been modified and applied to research in HIV/AIDS (Mahoney et al. 1995, VanLandingham 1993). The second theory based on the AIDS Risk Reduction Model (ARRM), is the more appropriate of the two theories and most closely corresponds to the cultural context and stage of the epidemic in Thailand (Catania et al. 1990). Aspects of the HBM are, nonetheless, particularly relevant and complement the ARRM.

The Health Belief Model is based on the following conditions (Mahoney et al. 1995, Maiman and Becker 1974):

1) perceived susceptibility: readiness to take action based on perceived
susceptibility to a particular condition as a health threat;
2) perceived severity: evaluating the seriousness and consequences of the condition as a health threat;
3) personal benefits: personal assessment of the feasibility and effectiveness of action taken to deal with health threat.
4) perceived barriers: personal assessment of the negative aspects of a particular health action.

Maiman and Becker (1974) state "This expectancy-theory approach to health behaviour thus views the action that an individual will take as related to the subjective desire to 'lower' susceptibility and severity, and to an estimation of benefits minus costs." In other words, if an individual perceives a threat, and takes action, it is done on the presumption that the health action will outweigh the barriers. This theory is more suited to the attitude and behaviour of Thai men within a CS encounter who clearly perceive themselves to be at risk. This is largely due to the mass media campaigns which have focused on HIV transmission occurring because of an infected CSW. Because the most probable outcome of HIV infection is eventual death, it is perceived as very serious and life-threatening. Perception of severity is further confirmed through knowledge of someone who has AIDS or has died of it. Due to the escalating numbers of people with HIV in Chiang Mai, many respondents were affected through personal knowledge of someone with AIDS.

The 100% Condom Campaign promoted within the general population coupled with pro-active condom policies within the brothels has facilitated a change in behaviour, or the action that should be taken to deal with the health threat. The men know HIV is a health risk. Condoms are easily accessible in pharmacies or supplied free within the brothels. In addition, their partners - the CSWs - are insisting on condom use and the social structure within which the sex is occurring - the brothel - supports that decision. The predominant barriers to this health action are 1) the condom being an actual physical barrier to the full enjoyment of sex; and 2) alcohol intake which affects judgment to the extent that short-term gratification becomes a
stronger motivator than the perceived health threat. In this case, the perceived health threat does not manifest until years after infection. As well, some CSWs may choose to forego condom use in lieu of monetary compensation.

The theory is useful for men within the commercial sex arena but is not so well founded when applied to casual sexual encounters. The perception of the severity of disease outcome remains high but perceived susceptibility decreases when men consider sexual intercourse with their girlfriends, wives, or acquaintances. Condoms may not be as easily accessible in terms of being on site where the sex is occurring, the women are not likely to insist on condom use, and they are not within a social structure that will encourage that decision. In short, many of factors that are present within a commercial sex encounter are non-existent in non-commercial encounters.

The Health Belief Model theory is attractive and useful but does not take into account the power dynamics involved when having to negotiate the 'action' to decrease susceptibility to a condition when another person is involved. It subsumes autonomous and independent decision-making negating the dyadic nature of sexual relationships. This becomes most poignant when considering Thai women who perceive themselves to be at risk for HIV through their boyfriends and husbands’ activities but their ability to take action is limited. As several women stated, they would rather make sure the relationship remains a happy one rather than discuss the past or current sexual alliances of their partners. Rather than taking action, women have developed strategies to cope with the health threat which are more amenable to the AIDS Risk Reduction Model.

The two theoretical models are similar but the AIDS Risk Reduction Model (Catania et al. 1990) allows for greater freedom in recognizing the changeability of human behaviour. There are 3 basic stages to the ARRM which allows for fluidity between the stages. Indeed, the stages are neither unidirectional nor are they nonreversible. These are,

1) Labeling - recognition and labeling of one’s sexual behaviours as high risk for contracting HIV;
2) Commitment - making a commitment to reduce high risk sexual contacts and increase low risk activities; and

3) Enactment - seeking and enacting strategies to obtain these goals.

Because the model was specifically developed for HIV/AIDS, the perceived severity to the health threat is implicit. Similarly to the HBM’s stage of perceived susceptibility, is the labeling of one’s sexual behaviour. Of key importance with this model is the focus on ‘behaviour’ i.e. having unsafe sex, as opposed to the HBM which implies susceptibility through a risk group i.e. CSWs. This is, of course, due to the public health campaigns which have been very successful in the short-term, but their success may become a hindrance as sexual behaviour changes. It will be more difficult to move from perceived susceptibility to HIV from CSWs to the overall susceptibility through unsafe sex. In this context, the HBM more closely approximates the situation in Thailand but what would have been more advantageous would have been a greater effort in the labeling of the behaviours as being at risk. This is not a criticism of the work of public health, which is completely unprecedented in its success, but a recognition of the limitations its successes have imposed.

ARRM also recognizes that the decision-making process involves evaluating whether the benefits of the behaviour change outweigh the costs. Additionally, the degree of commitment towards a particular behaviour change may be hampered by the lack of commitment or belief on the partner’s part. The labeling process can be influenced by a sexual partner or friends. Thai men evidently have a stronger peer network in terms of sexuality and this could actually be used as an advantage in promoting and encouraging safer sex. Further, it is hypothesized that a person’s ability to accurately determine their personal risk for HIV depends on the level of knowledge he/she has (Catania et al. 1990). In Thailand, the level of knowledge is very high, but again, is restricted to a specific sexual context; commercial sex work. To reiterate, knowledge does not necessarily imply behaviour change. As well, as has been discovered in the United States, further strategies eventually need to be developed to maintain behaviour change (National Institute of Mental Health 1998). Messages reach
a saturation point and thus must be continuously changed to capture the attention of the audience.

Stage 2 of the ARRM involves the commitment to change behaviour. Other outcomes include remaining undecided, waiting for a resolution of the problem, or resignation to the problem. Thai men have made a strong commitment to changing their behaviour by using condoms with CSWs but there are some who seem resigned to their fate of possibly contracting HIV. This was observed in both male and female responses as their 'bad luck' or 'fate' in life.

Enactment to prevent HIV transmission, without a doubt, is occurring within commercial sex encounters. It remains to be seen as the sexual networks are changing whether the commitment to change sexual behaviour will cross all sociosexual contexts e.g. girlfriends, wives, casual encounters, and CSWs with non-paying clients. The costs of giving up something pleasurable - sex without condoms- for something perhaps less pleasurable - sex with condoms with its attendant side effects of lack of spontaneity, interrupted sexual play, and delayed ejaculation, must be weighed vis-à-vis the long-term effects of contracting HIV. Thai men, by not using condoms with their girlfriends and wives, must believe them to be at less risk for HIV. Although this may be so at present, the younger generation is in a state of transition with more young women having pre-marital sex which will result in expanding the sexual network. Belief in the ability to accomplish a certain change can be reinforced by seeing peers accomplishing the same change (Catania et al. 1990). Numerous male respondents knew their peers used condoms and many were under the impression that all men now must use condoms with CSWs reinforcing the public health campaigns. Expanding the use of condoms within all sexual encounters needs to be incorporated and promoted through individual peer networks.

That public health campaigns detailing risk behaviours and prevention through condom use, solidify commitment to behaviour change and provide the necessary cues, as has been proposed by Catania et al. (1990), is certainly the case in Thailand. Again, the overwhelming limitation to this approach has been the focus on CSWs and their clients, annulling the sexuality of 'other' women, the non-commercial sex partners.
They too are receiving the information but not identifying with the messages. Some identify themselves at risk not due to their actions but those of their male partners. They are not given cues or support, in the face of the monumental support men receive, to commit or enact safer sex behaviour. Therefore, their only strategy is to 'improve' themselves by keeping their partners sexually satisfied in the hopes this will alleviate their need for commercial sex work. This is not the best strategy and unfortunately buys into the double standard of sexuality where a woman is held responsible for a man's sexuality and is thus supposed to control it. Because CSWs in Thailand have the support of brothel owners, they are able to control men's sexuality in many circumstances. Unfortunately, the 'indirect' sex workers and non-commercial sex partners are not in such a supportive environment. The issue of women's sexual control and sexual autonomy transcends cultural, geographic, and temporal boundaries but HIV/AIDS has brought the issue to the forefront of public discourse.

**Women's Sexuality**

Thai women's sexuality has been neglected, although, that women's sexuality has been neglected in any setting, is not a unique circumstance. The urgency of the AIDS epidemic as a sexual disease with a high mortality rate, has legitimized and brought to the forefront many aspects of women's sexuality. AIDS education, no matter the cultural or national setting, has had a tendency, at some point in its history, to address risk groups (gay men, IDUs, CSWs) rather than risk behaviours. Thailand has followed suit in targeting CSWs obviating 'other' women. It could be argued that CSWs in Thailand have been identified more for the protection of men, their clients, than for their own protection. Under some circumstances, identifying a group may benefit that particular group to get the attention and education needed, but this is often at the expense of everybody excluded from the group who may nonetheless be at risk for HIV. Many AIDS-related initiatives may not be easily transferred to 'normal' women i.e. non-commercial sex partners (Emi 1998).

Thailand has dichotomized AIDS education between the general population and risk groups with little fluidity between the groups. Waldby (1996:9) poignantly states,
"The organization of risk hierarchies thus involves the privileging of certain bodies and sexualities at the expense of others, the protection of some through the disciplining of others." Sacks (1996) refers to the categorizing of women as risk groups which means a labeling of certain women to differentiate them from other i.e. 'normal' women. This has certainly been the case in Thailand, which for initial purposes of surveillance and containment of the epidemic, risk groups were established and included women attending pre-natal and STD clinics and CSWs. The labeling of some women for being at risk, often carrying some aspect of their transmitting or polluting capacities, deflects attention from women in the general population who can also be at risk for HIV.

Waldby (1996:10) further comments that "... women must act as the guardians of socially responsible sex while the wearers of condoms are not addressed." AIDS discourse is one of discipline and self-control (Sacks 1996) and thus the Thai CSW is supposed to control herself and her client to use a condom. Additionally, the wife or girlfriend back home is relying on the CSW's ability to control the sexual desires of her husband/boyfriend and use a condom to remain infection-free. It is the CSWs in particular who are the enforcers with the hoped-for support and acquiescence of their clients. The 'other' women, the non-commercial sex partners, are not addressed.

Ironically, women are stigmatized for their sexuality, or lack of it depending on which label women wear, while simultaneously held responsible for men's sexuality in order to protect themselves. Waldby (1996) regards many approaches to AIDS education and prevention as the pursuit of phallocentric interests. In some areas of the world, the heterosexual male privilege is very evident but in Thailand, men are not completely obviated from taking responsibility from their sexual actions. Unfortunately, men are held responsible mainly within a commercial sex context and not outside of it. Responsibility is part of the Thai value system. Acting responsible is an expectation and many female respondents valued that quality in a man and, in fact, some are staking their lives on it.

How people conduct their sexual lives becomes a matter of public health surveillance especially with regard to infecting more valuable bodies as opposed to the expendable bodies of the marginalized (e.g. CSWs, IDUs, homosexuals, people from
less developed countries). As Sacks (1996) eloquently points out, AIDS discourse is not simply about disease but equally about sexuality and power. AIDS discourses have brought to light pre-existing social norms, controls, and mechanisms of power relations between the genders. Unlike other countries where CSWs have been represented as socially and sexually deviant, Thai CSWs are mainly categorized as transmitters of HIV. There has been tremendous historical and international discourse of CSWs as vectors of STDs or HIV (Morrison and Guruge 1997, Gorna 1996, Carovano 1991).

Conversely, in Thailand, the men’s penchant for brothel visitations has been the main engine of transmission. The role of men as transmitters has received little attention. Sacks (1996:63) states, “…clients often are willing to pay more for unprotected sex, often assume they ‘can tell’ if a woman is ‘clean’ or not, and often underestimate the danger of their becoming infected, being infected, or infecting others.” Certainly, the male respondents of this study and findings from previous studies (VanLandingham et al. 1995) validate the above statement with slight amendments. Thai men do not underestimate the danger of becoming infected but do feel they can tell if a CSW has HIV. Curiously, they also never perceive themselves as possibly infecting others.

For public health messages to focus primarily on the CSWs as transmitters neglects how, by neglecting the grander social context of sex work, and from whom, the client, the CSWs contracted the virus. That same client who may go home and pass the virus on to his girlfriend or wife. It stigmatizes one group while leaving the rest with a false sense of security if they fall outside the named category.

More importantly, Thai women’s sexuality does not seem to be a large component of their lives except to fulfill their husband’s sexual needs. Women’s own needs are never referred to. Van Esterik (pers. comm. 1998) hypothesizes that Thais perhaps have a less developed erotic tradition than other Southeast Asian sex-gender systems. AIDS has perhaps allowed men and women to re-evaluate their sexuality in a safe context in the sense that women in particular would not be judged for questioning

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2For a more in-depth discussion of the historical antecedents which predispose women to being blamed and stigmatized as the transmitters of STDs and HIV, please see Morrison and Guruge (1997). The discussion ends with an overview of present-day efforts by NGOs to counter the blame.
the men in their lives having had and continuing to have sex with a CSW. They can place this type of discourse under the auspices of risk for HIV thereby achieving two goals 1) acknowledging that the risk for HIV is very real and should be discussed, and 2) curtailing unsafe sex with CSWs as a risk reduction strategy.

In a Thai woman's world view, commercial sex is such an ingrained part of everyday life that even with the advent of HIV, a wife would not consider forbidding her husband from using sexual services, assuming she had the means and influence to do so. Commercial sex work is far too socially supported to expect women on an individual basis to try to negotiate the de-construction of a traditional lifeway. These women are caught between two worlds, that of the past with its traditions and the present with its changing values and behaviours.
The focus of this thesis has been on women’s risk for HIV, which has received a thorough and comprehensive examination. The following recommendations are based on the findings of this research and the concerns of the service providers. They are offered to guide AIDS educators, policy-makers, and other researchers in further developing AIDS education and prevention programmes in Thailand.

1) Changing Sexual Patterns and Peer Education

Increasing sexual freedom juxtaposed with HIV/AIDS and decreasing parental influence has resulted in dilemmas for young people’s decision-making process. Male and female respondents felt sex education combined with AIDS education should begin between 12 and 15 years old. This may become a critical issue as teenagers are becoming sexually active, and have greater opportunities to become so once in university.

Peer education has been extremely successful in Canada and the United States. TYAP, the NGO working specifically with youth in and out of school in Chiang Mai, have modeled their outreach on peer education. HIV/AIDS prevention is a cultural communication process that takes into account similar experiences by people of the same gender, age, culture, and social environment (Yep 1997). This is the basic tenet of peer education: that messages are far more believable when given by someone who has shared, or is likely to encounter, a similar experience.

Peer education is certainly an approach to pursue in the high school and university setting. Peers know the language to use, are familiar with the those cultural factors that influence beliefs and norms and define gender roles as well as how young people interact sexually and interpersonally (Yep 1997). Open communication is necessary between the person delivering the message and the person receiving the message. This is particularly the case with safer sex issues that, once trained, peer educators feel comfortable talking explicitly which in turn engenders open communication between partners. TYAP, with less than 3 full time staff, have recruited
and trained close to two dozen peer educators. TYAP can be used as a model for other NGOs interested in peer education and outreach. Endeavoring to improve relationships with pubs, discos, and karaoke owners may prove fruitful to AIDS service organizations if it allows access to groups such as TYAP to do their outreach.

Many university-aged women and men spend their time in these places where drinking occurs which is often a strong predisposing factor for unsafe sex. Young women spend time together going shopping, to the movies, and out to restaurants. The peer group is extremely important among young people and could be accessed for HIV/AIDS education either on campus or in nearby eateries, cafés, and through outreach in shopping malls.

Students are fairly easy to access once entrance by an AIDS service organization into the school is gained. If classroom time has been donated, they are essentially a captive audience. Creativity is required to access people in the general population. With regards to men, an ideal scenario would be training the leaders of the drinking and brothel visit outings. Bangkok’s TBCA could be adopted as a model for Chiang Mai and include conducting workshops in factories and construction sites. The objective would be to promote condom-use within and outside of commercial sex encounters.

Additionally, research conducted by Sakondhavat et al. (1997) within the brothel setting concluded that training the mamasans regarding HIV led to a direct impact in the workplace. The researchers commented that a structured approach to behaviour change is more effective than simply trying to educate individuals. A structured approach also implicitly involves a recognition of the hierarchy within the workplace. This may also be a benefit and used in other venues of education. An environment of collective support needs to be created and supported by upper level personnel regardless of the type of work involved. A hierarchical approach coupled with peer education may result in an adherence to safer sex policies.

Many women in this study commented on the side effects of the birth control pill. The opportunity, therefore, exists to promote condoms for family planning and STDs, including HIV, protection. In fact, peer led workshops on birth control and STDs would
give a more integrated approach to sexual health and lessen the anxiety and associated stigma of receiving HIV information on its own. With the availability of the vaginal contraceptive film and the female condom, women now have more options. The introduction of the female condom has increased women's negotiating power on a global scale. Thai CSWs, who have been using the female condom as part of a study, can now ask "Would you like to use the male condom or the female condom." The choice is not longer "Can we use a condom'. The fact that a condom will be used is implicit requiring little negotiation. The public's general acquiescence to government directives has empowered CSWs, at least in business transactions, to negotiate condom use as if it were a given (Sokal and Ankrah 1997). Expanding this strategy by targeting women in the general population and high school and university students may have similar results.

Brown and Sittitrai (1996) suggest "...the promotion of Buddhist values such as concern about parents' feelings, respect for oneself, concern for others' well-being, and purification of one's mind may prove effective in reducing premarital sex.". Although their suggestion is to be strongly advocated particularly because of its insightfulness and its support to those not sexually active, it may prove impossible to convince young people who already are sexually active to take a step back in reducing premarital sex. It may be more realistic to focus on reducing unsafe sex while still promoting abstinence and other forms of low risk sexual behaviour. Many women relied on the 'character' of their boyfriend to protect them from HIV, the presumption being that they would not choose a man who would be so irresponsible and disrespectful as to put them at risk for HIV. Perhaps AIDS campaigns should target the conceptualization of male responsibility and use peer pressure to encourage and enforce it.

Currently, there is a struggle occurring between an emerging individualism out of the roots of a long historical collectivism. Within a collectivist oriented culture, AIDS prevention can be geared towards the family or larger social group. For instance, perhaps messages can emphasize that extra-marital sex with anyone without protection

1 The author is currently working with members of Toronto's Women's Outreach Network consisting of over 20 NGO's to lobby for the decreased cost and greater accessibility of the female condom in Canada.
can endanger the whole family. HIV/AIDS has inadvertently given people throughout the world permission, in a sense, to talk openly about sex because of the very real necessity of doing so becomes a life and death issue. Discussion of sex between partners should be promoted. Public health campaigns should stress the men's responsibility in keeping their family safe which includes protecting them from HIV.

When addressing gender, children and HIV, Brown and Sittitrai (1996:52) recommend that “Programme components would include: .... projects supporting behaviour norms change among single and married Thai males; expanded life skills training programmes reaching women both in and out of school; programmes to reduce the number of women and children entering commercial sex work; and mass media campaigns to promote the status of and respect for women.” The latter component regarding the promotion of women’s status would not only improve women’s ability to negotiate her sexual life but would contribute positively to other aspects of her social life. Addressing women’s issues through a mass media campaign can be achieved in conjunction with the implementation of women’s studies and human rights issues in the school curriculum within the high school, vocational school, and university setting.

2) Services

As more people in Chiang Mai become symptomatic with HIV-related illnesses, provisions for their care should be in place. The impact HIV will have on the health care system and NGOs will be formidable. In considering the complexities involved in the AIDS epidemic in Thailand, Erni (1998) explains “The inability of mainstream researchers to hear the complexity of women’s stories may therefore contribute to a cycle of delegitimation at the level of knowledge as well as the level of funding and resource coordination.” As more women become infected in Thailand, either singularly or as part of a family, services will need to address the increasing numbers. To date, services have been more available to men than women. The New Life Friends Center has remarked on the changing demography of people presenting at their hospice, once dominated by males, but now having equal representation of females often with their entire families.
As the epidemic continues to evolve and women and children, who are already infected, move from an asymptomatic to symptomatic stage, the increased need to access resources and support services will emerge. These already exist in Chiang Mai but are in need of greater recognition and financial support. Those services existing specifically for women are already suffering from financial cutbacks. Staff at the Viengping Home for Children also expressed a concern for the increasing number of orphaned children and the lack of hospice care that will eventually result. Further, as more children become HIV+, primary and secondary schools should receive appropriate information to avoid the hysteria that has occurred in Canada and the United States.

The NGOs currently operating in Chiang Mai have had to face many challenges. Having one umbrella organization through which information can be disseminated and resources coordinated may benefit the smaller NGOs. Staff could be trained together during periodic training sessions. The components of the training session would include basic aspects of HIV transmission, treatment updates, as well as an overview of the services offered by each NGO. Thus, everyone is equipped with the same baseline information regarding HIV/AIDS and staff are in a better position to refer to the appropriate agency should the need arise.

Volunteers are a tremendous source of labour, dedication, and commitment that has characterized AIDS service organizations in Toronto. Although several of the NGOs in Chiang Mai had volunteers, volunteerism needs to be exploited more fully as perhaps a means of merit-making. The respondents in this study did not indicate any fear or stigma regarding people with HIV/AIDS although several stated they did not think people in their community would accept a positive person. An increasing number of people working with PLWHAs can help dissuade any remnant stigma.

3) Diversity And Sexual Expression

Transvestism, transgenderism, and homosexuality are fairly common in Thailand but again they are not addressed in AIDS prevention messages. Some of the university-aged respondents mentioned transvestites in their university, indicating a
growing awareness and acceptance, of the diversity of sexual expression. Additionally, women-to-women sex is seldom referred to and must be incorporated into mainstream AIDS education. TYAP is currently holding regular support meetings in a relatively undisclosed and safe place in Chiang Mai for women who have sex with women.

4) Male CSWs

The issue of male CSWs is tangential to this dissertation but should be an area of concern for future research as well as for AIDS service organizations. Undoubtedly, male CSWs are fewer in number but are nonetheless visible in Chiang Mai and part of the sexual networking. Beyrer et al. (1997) conducted an epidemiological study among 103 male CSWs in Chiang Mai and found 58% were of heterosexual orientation and 16.5% were HIV+. The average number of clients per week was 2.5, significantly lower than their female counterparts who average 2-10 partners per day, but 72.1% reported inconsistent or no condom use (Beyrer et al. 1997).

A larger study consisting of 1172 male CSWs in Chiang Mai found an incidence rate of 11.9% per 100 person years from 1989 to 1994 (Kunawararak et al. 1995). This is purportedly the highest rate reported for any male group in Thailand. Clearly, these men are at high risk which in turn has risk implications for their partners be they men or women. The network enlarges when one considers that many of their partners are from abroad including other Asian nationals, Australians, Europeans, and north Americans. Beyrer et al. (1997) suggest this male population could be an important transmission bridge between their male clients and women in Northern Thailand (Beyrer et al. 1997). If the economic situation continues to deteriorate in Southeast Asia, it is foreseeable that more young men would seek commercial sex as a viable money-making option. Demand alone has perhaps had its effect on the market as an increasing number of male sex workers, transsexuals and transvestites were seen in Chiang Mai between the years of 1995 and 1998.
7.0 CONCLUSION

The macro-context of vulnerability to HIV can be viewed at the regional, national, and global level (Kammerer et al. 1995). The predisposing factors that determine the velocity and impact of the epidemic, particularly in Thailand, include the history, the culture, the economics, and the epidemiology of that country. These factors are not mutually exclusive nor are they static. In fact, they interact with each other in determining collective and individual perception of risk and social response. The issue of risk for HIV for women in Chiang Mai could not be examined in isolation.

Thailand does indeed have all the prerequisites for an explosive epidemic; a long and deeply ingrained history of commodifying women for sex; familial obligations placed upon the daughters; a culture that demands virginity from women but allows sexual freedom to men; and an economy that is rapidly industrializing which is, in effect, creating a greater disparity between the rich and the poor, the urban and the rural. These factors are within the context of a virus that has already swept through the drug injecting population, commercial sex workers, and the clients of these women.

AIDS prevention has been dominated by a focus on commercial sex work. This approach neglects the fact that most CSWs are in the business for only several years to then return home and become 'part' of society. It also neglects that many of the male clients may have been the original source of the infection, that transmission efficiency is greater from males to females, and that these men have sex with other commercial sex workers as well as their wives or girlfriends. The objective is not to shift the blame to men but to render a greater awareness of the implications of the sexual network. Commercial sex work needs to be regarded as a spoke in the wheel of HIV transmission. For women with few options, it is a part of Thai history driven by a changing economy while trying to fulfill a cultural obligation.

The focus of the Thai National AIDS Programmes on commercial sex work has been very successful in decreasing HIV transmission in the commercial sex context by increasing condom use but it has inadvertently made people not involved in commercial sex work, but sexually active, to perceive themselves to be safe from HIV. The
epidemic in Thailand is at a crucial transitional stage where HIV is being documented in all parts of society. AIDS education and prevention campaigns need to reflect that change by becoming more comprehensive.

This study has found that western influence and the response to HIV/AIDS have both impacted on changing sexual behaviour in Chiang Mai, Thailand. The change in sexual behaviour involves both men and women. For young men, the swing of the pendulum from high to low commercial sex patronage indicates that they are 1) becoming socially aware and responsible, and 2) finding sexual outlets through girlfriends and casual friends. These factors are thus alleviating the need and desire for CSWs. This is due to two simultaneously occurring forces in Thailand; 1) the AIDS education campaigns have focused on commercial sex as being the main vehicle of transmission while 2) there is a sexual revolution occurring among young people in Thailand. The advent of HIV/AIDS has begun to change the traditional male sexual pattern of accessing commercial sex. Because of the intense public health campaigns alerting men of the dangers of going to CSWs, they are now turning to salesgirls in shopping malls, waitresses, and classmates assuming these women are 'safe' from HIV and other STDs. As young people are invariably and inevitably turning to each other for sex, a conflict arises among those who are becoming sexually active but are faced with the threat of HIV. Very few programmes emphasizing the adherence to safer sex guidelines target those non-commercial sexual encounters.

Understanding the HIV epidemic in Thailand must be placed in a broader value system in Thai society which is currently undergoing tremendous change. Historical, cultural, economic, and epidemiological antecedents found in Thailand that have provided the framework which put women at risk for HIV have been examined. Although presented separately, these aspects of Thai life are inextricably intertwined in their impact and influence over each other.
Figure 1. Basic model of HIV transmission in Chiang Mai, Thailand. The existence of commercial sex work (CSW) is multifactorial. Dotted box represents focus of previous research.
APPENDIX 2. EXPLANATION TO POTENTIAL RESPONDENTS

I am a University of Toronto researcher interested in finding out about that people's attitudes and behaviour with regard to health issues and HIV/Aids. This study will involve only one personal interview that can take place whenever is convenient for you. It will take about sixty minutes to complete the interview. Is this length of time okay with you? You don't have to take part in this study if you don't want to. If you do decide to take part, you can leave the interview at any time as well. If you take part in this interview, you can decide which questions you want to answer and which questions you don't want to answer. This interview is completely anonymous and your name will never be recorded anywhere. Your responses to the questions cannot be traced back to you in any way.

Do you have any questions about what I have told you? Do you have any other questions? (If yes, answer) If you have no more questions, would you like to start the interview now?

No? Thanks for your time!
Yes? Thank you very much.

APPENDIX 3. ETHICAL PROTECTION OF RESPONDENTS

The data will be kept by the principle investigator and will not be shared with anyone. Because the respondents are never asked for their names, strict confidentiality is ensured. In the event that the researcher and the respondent run into each other at a later date, the researcher will not acknowledge the respondent unless the respondent first acknowledges the researcher. This will be made clear at the beginning of the interview and at the end to also ensure any presumption of discourtesy at a chance meeting. More importantly, the respondent is in control of who has knowledge of their participation in the study.
APPENDIX 4 KEY INFORMANTS

Khun Anothai
Hotline Center and HIV/AIDS Clinic
10/3 Samlan 6 Road
Phrasingha Muang
Chiangmai 50000
Telephone: 66 02 274151

House of Tomorrow
10/3 Samlan 6 Road
Phrasingha Muang
Chiangmai 50000

EMPOWER (Education as a Means of Protection of Women Engaged in Recreation)
2/1 Chaityaphum road
Changmoi
Chiangmai 50000
Telephone: 232321 Fax: 282504
(Executive member and volunteer)

Mr. Sumrung Tagun
New Life Friend Center
9/57 Moo 3 Suthep Rd.
Tumbon Suthep
Amper Muang, Chiangmai 50200
Telephone: (053) 808233

Thailand Business Coalition on AIDS
270 Raintree Office Garden
2nd/F D2 Building
Soi Japanese School
Rama 9 Road
Bangkok 10310
Telephone: (662)719-6450-52
Fax: (662) 719-6453
e-mail: tbc@ksc.net.th
(two individuals)

AIDS Bureau
Population and Community Development Association
8 Sukhumvit 12
Bangkok 10110

Thai Youth AIDS Prevention Project (TYAP)
Thom - Outreach Coordinator
Near Suthep Road
Telephone: (6653) 274-157
email: tyap@loxinfo.co.th

Dr. ChongChit TiamTong - Chiang Mai University, Chiang Mai

Dr. Suwatchara - Tammasat University, Bangkok

Noi - graduate student in social science division of Chiang Mai University

Chuck - frequent brothel attender
APPENDIX 5

Taken from Turner (1981) but originally extracted from Glaser and Strauss (1968).

**STEPS FOR ANALYSIS: GROUNDED THEORY**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Main Activity</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Develop Categories</strong></td>
<td>Use the data available to develop labeled categories which fit the data closely.</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Saturate Categories</strong></td>
<td>Accumulate <em>examples of a given category</em> until it is clear what future instances would be located in this category.</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Abstract Definitions</strong></td>
<td>Abstract a definition of a category by stating in a general form the criteria for putting further instances into this category.</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Use the Definitions</strong></td>
<td>Use the definitions as a guide to emerging features of importance in further fieldwork, and as a stimulus to theoretical reflection.</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Exploit Categories Fully</strong></td>
<td>Be aware of additional categories suggested by those you have produced, their inverse, their opposite, more specific and more general instances.</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Note, Develop, and Follow-up Links between Categories</strong></td>
<td>Begin to note relationships and develop hypotheses about the links between the categories.</td>
</tr>
</tbody>
</table>
7. **Consider the Conditions under which the Links Hold**
   Examine any apparent or hypothesized relationships and try to specify the conditions.

8. **Make Connections, where relevant, to Existing Theory**
   Build bridges to existing work at this stage, rather than at the outset of the research.

9. **Use Extreme comparisons to the Maximum to Test Emerging Relationships**
   Identify the key variables and dimensions and see whether the relationship holds at the extremes of these variables.
NOTE: Appendices 6-10 illustrate the various levels of broad categories used in the coding procedure. For example, under 'Sex Before Marriage' emerged 'Young People's' activities (p.185) which was further sub-coded.
APPENDIX 7 - SCHEMA FOR HIV/AIDS

- Perception of Disease
  - Education
  - Affected
  - Discuss

- Perception of Risk
  - Personal
  - Groups
  - Fear, stigma, compassion, etc.

- Attitude
  - Who is at risk
  - Services

- Knowledge
  - Source of
  - Degree of
APPENDIX 8 - Schemata for Marriage, Children, and Family

Marriage
  - Wife/Husband: Characteristics
  - Type
  - Divorce
  - Relationship Understanding

Children
  - Importance of Timing
    - Number
    - Gender
    - Breastfeeding

Family
  - Importance of Gender Differences
  - Support
  - Obligation
  - Responsibility

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APPENDIX 9 - Schemata for Young People and Condom Use
APPENDIX 10 - Schemata for Birth Control, Sex Education, Decision-making, and Life and Death

- Birth Control
  - Type
  - PILS/Side Effects
  - Information
  - Access
  - Discuss

- Sex Education
  - Personal
  - Children
  - STDs

- Decision Making
  - Composition
  - Household
  - Employment
  - Money

- Life/Death
  - Karma
  - HER-making
Dotted lines represent decreasing commercial sex visitations. Figure 5. Current model as proposed by those disseminating, of HIV transmission in Chiang Mai, Thailand. The sexual behavior of young people, in particular, was found to be affected by Western influence and the response to the AIDS epidemic. Westernization, i.e., girls' friends and wives and partners.

Appendix 11: SUMMARY OF RESULTS
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Ault, S. K.

Bacon, Jean

Bae, Hans A.

Baker, Paul T.

Batson, Benjamin A.


Berer, Marge with Sunanda Ray

Bernard, H. Russell

Beyrer, Chris, Andrew Artenstein, Piyada Kunawararak, Thomas VanCott, Carl Mason, Kittipong Rungreungthanakit, Patricia Hegerich, Kenrad E. Nelson, Chirasak Khamboonruang, and Chawalit Natpratan.

Black, Francis L.

Blanchard, Wendall
Bogue, Donald

Bolton Ralph

Boonchalaksi, Wathinee and Philip Guest

Brettle, Ray P. and Clifford L.S. Leen

Brody, Stuart

Brown, Tim and Werasit Sittitrai

de Bruyn, Maria

Caldwell, John C., I.O. Orubuloye, and Pat Caldwell

Carballo, M. and M. Carael

Carovano, Kathryn

Carswell, J.W.
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Celentano, David D., Pasakorn Akarasewi, Linda Sussman, Somboon Suprasert, Anuchart Matanasarawoot, Nicholas H. Wright, Choti Theetranont, and Kenrad E. Nelson

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