COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS: THAILAND

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1. Introduction

Following the International Conference on Population and Development (ICPD) in 1994, Thailand put forward a Reproductive Health Policy in 1997, stating that "all Thai citizens, at all ages, must have [a] good reproductive life" (Ministry of Public Health, 1998). Nevertheless, the 1997 Thai Constitution and the subsequent 2007 Constitution, drafted under a military government, made no specific mention of sexual and reproductive health or rights. Both constitutions reaffirmed that all persons are equal and shall enjoy equal protection under the law. This was to include all human rights. However, while equal rights in accessing public health services were identified, there was no specific mention of sexual and/or reproductive rights. Moreover, the equal rights of those who are not Thai nationals were in no way ensured.

According to Thailand's ICPD+15 Report, published in 2010, Thailand has achieved most of the ICPD goals and objectives. Nevertheless, the report also noted that certain populations in Thailand still "require special attention and care such as youth, people in remote areas on highlands, and in the deep South, and marginalized populations such as migrants, ethnic minorities, sex workers, transgender populations, drug addicts, and prison inmates" (Ministry of Public Health of Thailand & UNFPA, 2010). Of these marginalized groups, migrants—notably, migrant women—are the focus of this report.

Thailand has acceded to the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and the Convention on the Rights of the Child (CRC). However, Thailand has not signed on to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW).

Thailand currently has over three million migrant workers—including both documented and undocumented individuals—and approximately half are women. These women are doubly marginalized as a result of being both migrant workers and female. Migrant women face discrimination and abuse both in their home countries and in Thailand. These injustices are propagated by local authorities, employers, other members of their communities, and sometimes by other members of their own families. The types of abuse are varied and commonly include labor exploitation—underpayment of wages, deductions

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from wages, confiscation of documents, and unsafe conditions. Some migrant women also face severe forms of labor exploitation, including confinement, no pay, no rest time, verbal and physical abuse, and/or trafficking. However, migrant women face multiple levels of resistance when trying to expose abuses, especially sexual abuse. The migrant community itself may attempt to placate the women, fearful that any action will bring unwanted attention to the community and thus threaten their security. The police are not proactive in following up on cases of abuse against women, particularly migrant women; when the abuse has been committed by a family member in the migrant community, the police claim it is a migrant affair and therefore not of concern to them. Even agencies mandated with the protection of refugees or migrants have sometimes been reluctant to encourage women to pursue justice.

Access to information of all kinds and access to healthcare are great challenges for most migrant women. Migrant workers' sites are often far from city centers, and migrants are kept segregated from the general population as a result. They generally live on-site or very close to where they are working; the extent of their freedom of movement is the transportation provided by their employer to their workplace and back each day. Organizing a trip to a medical center involves discussions with the foreman, organizing transport, losing wages, and the possibility of losing their jobs.

Sexual and reproductive health and rights should not be a luxury or a privilege. They are a set of veritable rights that all migrant women are entitled to enjoy. However, few have fully explored the obstacles standing in the way of migrant women attaining their sexual and reproductive health and rights and, moreover, what needs to change in order for "SRHR For All" to become a reality. Such is the purpose of this report.

Migrant workers inherently live trans-national and cross-border lives. As such, one cannot merely look at the home or host country's laws and policies. In order to better understand the life of a migrant worker, it is important to take into account both

the home and destination countries' contexts. MAP Foundation primarily works with migrant workers from Myanmar, who comprise over 80 percent of the migrant population in Thailand. Therefore, while this report primarily assesses Thai law and policy vis-à-vis SRHR and how migrants are or are not incorporated into these, Myanmar SRHR-related law and policy will also be noted in some sections.

2. The Status of Sexual and Reproductive Rights in Thailand

Policies on Sexual and Reproductive Health in Thailand

At present, Thailand lacks an integrated sexual and reproductive health plan, with various components carried out by different ministries and departments (Center for Reproductive Rights, 2011). The Thai government established its first population policy in 1970, seeking to reduce population growth by promoting family planning through a National Family Planning Program, implemented by the Family Planning and Population Division of the Ministry of Public Health [Table 1]. At that time, the fertility rate was 6.3 children per woman (DKT International, 2014). Fertility declined to 1.9 by the year 2000, and this demographic trend has continued, such that the fertility rate dropped to 1.5 in 2012 (WHO, 2013). Due to this drastic shift, the Government has altered its focus to maintaining fertility at replacement level (Executive Board of the United Nations Development Programme, the United Nations Population Fund & the United Nations Office for Project Services, 2012).

In the middle of the country's implementation of its Seventh National Economic and Social Development Plan, the 1994 International Conference on Population and Development (ICPD) was held in Cairo. Thereafter, the Thai Government changed its emphasis from family planning to reproductive health. On July 10, 1997, the country adopted a National Reproductive Health Policy which declared that "All Thai citizens, at all ages, must have [a] good reproductive life" (Ministry of Public Health, 1998).

Thailand's first Millennium Development Goals (MDG) Report was prepared in 2004, and the ICPD+10 Report came out that same year. Both reports suggested that Thailand had achieved most of the ICPD goals and MDGs. However, disparities persisted among vulnerable groups and in some remote areas. Some key strategies addressed in the ICPD+10 included the following: enhancing the provision of information, counseling and reproductive services for adolescents and youth; and involving men in promoting the reproductive health of women (Ministry of Public Health of Thailand and UNFPA, 2004).

Reproductive health continued to be included in subsequent health policies. In the National Health Act of 2007, Article 6 included the promotion and protection of women's health, notably reproductive health. In that same year, the five-year Women's Development Plan (2007-2011) was included in the Tenth National Economic and Social Development Plan, particularly citing reproductive health as a priority. The Women's Development Plan advised the following strategies for women's advancement and gender equality: i) promote gender equality attitudes; ii) increase women's participation in political and public decision-making; iii) improve women's health, including reproductive rights; iv) strengthen women's personal security (with particular reference to violence against women); and v) promote women's economic empowerment (Ministry of Public Health of Thailand & UNFPA, 2010).

While Thailand has demonstrated an ongoing commitment to sexual and reproductive health in its policies, these policies have had an uneven effect across the population. Thailand must still improve its outreach and inclusion of the groups highlighted in the ICPD+15 Report, namely youth, people in remote areas, people in the deep South (predominantly Muslim communities), migrants, ethnic minorities, sex workers, transgender populations, drug addicts, and prison inmates.

A health insurance program for migrant workers was first introduced in 1997, following a Cabinet resolution permitting the Ministry of Public Health to provide health insurance to registered workers at 500 THB per person per year (Srithamrongsawat, Wisessang & Ratjaroenkhajorn, 2009, p. 25). The annual fee has successively increased, such that it now stands at 2,200 THB (67.45 USD). This is paired with a health examination cost (600 THB, or 18.40 USD) and a co-payment of 30 THB (0.92 USD) per visit when receiving care from health facilities. However, this health insurance program was previously only accessible to registered migrants. It was not until 2013 that the Ministry of Public Health announced that any migrant, regardless of documentation status, could register

for healthcare. This policy includes such benefits as family planning; health examinations and provision of care for pregnant women, along with after-birth delivery services; care of neonate from birth to 28 days of age; prevention of mother-to-child transmission of HIV (PMTCT); and, for the first time, antiretroviral (ARV) medicines (IOM, 2013).

However, in practice, migrants face several barriers to accessing healthcare services, such as language barriers and the location and time that the services are available, which may be inconvenient for those who are working long hours each day. Unregistered migrants are in an even more precarious situation, because they are vulnerable to arrest or harassment by local authorities when they go to public hospitals or seek transportation to local clinics (UNICEF, 2011). In order to travel to the medical facility, undocumented workers must pay excessive fees; otherwise, drivers will refuse to transport them due to the risks involved. As a result of these constraints, women often wait until their health situation worsens and will only seek out medical assistance as a last resort.

Employers continue to be one of the main reasons why migrant women are unable to attain full sexual and reproductive health and rights. This is particularly evident when a woman worker becomes pregnant. Employers will deny women the opportunity to visit a hospital or clinic for pre-natal care, threatening termination from work. Women in such sectors as construction, factory work, and agriculture are commonly subjected to long hours of backbreaking work; if they are unable to perform these duties, the employer will dismiss them. Dismissal on the grounds of being pregnant specifically violates Section 43 of Thailand's Labour Protection Act of 1998, yet it is almost never enforced for migrant workers. To make matters worse, employers commonly make up other reasons for dismissing the women in order to circumvent the law. Moreover, while all women workers in Thailand are entitled to 45 days of paid maternity leave under Section 57 of the Labour Protection Act, migrant women almost never receive this benefit.[1] Not only is their maternity leave unpaid, they also often return to their jobs to find that their employer has given their position to someone else, and they are thus left without any form of income. These clear violations of Thai labour law have been brought up in individual labour cases. However, these egregious violations of reproductive health and rights are not being concertedly addressed. Moreover, the Thai Government has repeatedly threatened to deport pregnant migrant women, a threat constantly looming over the heads of migrant women. This serves as just one example of how the Government is complicit in the denial of migrant women's SRHR.

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[1] Women can take maternity leave for up to 90 days. The employer is to pay the first 45 days, commensurate to the wages of a normal workday (Labour Protection Act, Section 59). Those women who are contributing to the Social Security system receive payment from the Social Security system for the latter 45 days as well, although migrants rarely receive Social Security benefits, even if they are contributing to the system.

Table 1. Overview of Thailand's Sexual and Reproductive Health Policies*

POLICY	YEAR	NOTE
National Family Planning Program	1970	Thailand's first population policy
National Reproductive Health Policy	1997	Shift from family planning to overall reproductive health
National Health Act	2007	Article 6: Promotion and protection of women's health, particular reproductive health
Women's Development Plan	2007-2011	Embedded in Tenth National Economic and Social Development Plan; cited reproductive health as a priority
National Reproductive Health Plan	2010-2014	Thailand's first national reproductive health plan

*Not exhaustive

Voices from the Ground
Ma Ma, Garment Factory Worker

Ma Ma, 28, has been living in Mae Sot, Thailand, for 5 years. Originally born in Kyaukkyi Township, Bago Region, Myanmar, she came to Mae Sot due to financial problems in her family. She started working in Mae Sot as a seamstress but for the past four years has been working in garment factories. Two years ago, she left the garment factory she was working at due to the very low wages she was receiving. She moved to another garment factory that had 500 workers, where she was tasked with sewing trousers and shirts. Her workday started at 8:30AM. She worked until noon and then resumed work from 13:00-17:00. She received a one-hour dinner break and then worked again from 18:00-22:00 for overtime. On a typical day, she would make 140 Thai Baht (4.32 USD), plus 15 Baht per hour for overtime, still grossly below the 300 Baht (9.26 USD) per day minimum wage that all workers in Thailand, regardless of nationality or documentation status, are entitled to make. Ma Ma has no documents. When she was living at the factory, police would sometimes come to inspect the factory for undocumented workers and the employer would make the workers flee the site. Technically it is the employer's responsibility to register migrant workers and secure their documents. Ma Ma's employer had not taken the initiative to do so.

Nine months ago, Ma Ma got pregnant with her first child. Ma Ma has been married for four years and was excited for her first pregnancy. However, when she was seven months pregnant, her employer forced her to stop working and required her to move outside of the factory compound. She was told to return after she gave birth, but until then she would have to live without any additional pay. Ma Ma tried to convince her employer that she did not need to stop working; even while pregnant, she was able to work as usual, as her job involved sitting and sewing at a table, which did not cause great physical strain. Now Ma Ma and her husband, who works at the same factory, must pay for their own place outside of the factory compound, costing them 1,500 Baht (46.32 USD) per month, plus other living expenses. While this should be a happy time in their lives, instead they are concerned about money, as their savings are quickly drying up, since Ma Ma's husband is now the only breadwinner. Ma Ma's employer told her that she would have a job at the factory after she gives birth, but she is not certain that such will be the case. Ma Ma is not the only woman who was forced to leave the factory. She has a friend who was only five months pregnant and was told that she would have to stop working. Ma Ma was lucky in comparison, because her body did not start showing until later on in her pregnancy and so she was able to continue working undetected. Ma Ma has visited the local clinic three times for free prenatal care. The next time she goes will be to give birth. Each time Ma Ma has to go to the clinic, which is about a 30 minute car ride away, she has to spend a great deal of money to pay off the taxi driver because she is undocumented.

Ma Ma is worried that she will give birth to her first child and not have the money to properly care for the baby. She was trying so hard to plan a good life for her child.

Policies on Sexual and Reproductive Health in Myanmar

If one were to compare Thailand's sexual and reproductive health policies with Myanmar's, it comes as little surprise that Myanmar has some room for improvement. Myanmar is a signatory to the International Conference on Population and Development's Programme of Action and the Millennium Declaration. The country has also pledged to work toward the fulfillment of the United Nations Secretary General's Global Strategy for Women's and Children's Health. In 2002 the Myanmar Ministry of Health formulated a National Reproductive Health policy, followed by its first Five Year Strategic Plan for Reproductive Health (2004-2008) and a second Five Year Strategic Plan for Reproductive Health (2009-2013) (OHCHR, 2013). Since the country has opened up, the Ministry of Health has increasingly worked in collaboration with WHO, UNFPA, UNICEF and international non- governmental organizations on such areas as ante-natal, delivery, post natal and newborn care services; birth spacing services; prevention and care for sexually transmitted infections and diseases, including HIV and AIDS and cervical cancer; adolescent reproductive health services; and male involvement in reproductive health (OHCHR, 2013).

Myanmar participated in the ICPD Beyond 2014 Global Survey led by a review committee consisting of experts from relevant government ministries and UNFPA. According to the survey, in the area of SRHR, progress was made for maternal and newborn health and birth spacing with a reduction in maternal mortality from 380 per 100,000 live-births in 1995 to 200 in 2010 (Country Statement by Head of the Myanmar Delegation to the Sixth Asian and Pacific Population Conference, 2013). The survey also indicated an increase in contraceptive prevalence from 37 percent in 2001 to 41 percent in 2007 (Country Statement..., 2013). However, data remains tenuous and further information gathering must be done to properly analyze the SRHR situation in Myanmar. The Myanmar Health Sector Coordination Committee Mechanism (M-HSCCM) was formed to improve coordination and cooperation among those entities and partners working on health, including maternal

and reproductive health. In addition, the National Strategic Plan for the Advancement of Women (NSPAW) (2013-2022) was initiated to build upon CEDAW principles and the 1995 Beijing Platform for Action's international declaration of women's rights (Country Statement..., 2013).

However, the reality is that the country has a long way to go. The healthcare system remains significantly lacking in infrastructure. Out-of-pocket health expenditure soars above all other countries in Southeast Asia—at nearly 80 percent of total health expenditure—due to lack of proper medical coverage. As mentioned previously, the maternal mortality rate hovered around 200 as of 2010. The percentage of skilled health attendants (doctors, nurses, midwives) present at birth was 63.9 percent as of 2007 (WHO, UNICEF, UNFPA, & The World Bank, 2012).

In essence, Burmese migrants are often left without viable healthcare options on both sides of the Thai-Myanmar border.

Grounds Under Which Abortion is Legal

Sections 301-305 of the Thai Penal Code (1956) state that abortion is illegal, except in cases when a pregnancy endangers the physical health of the mother or when the pregnancy is due to sexual offenses such as rape or incest (Center for Reproductive Rights, 2013). The abortion procedure must be performed by a medical practitioner. On 10 November 2006, the Thai Medical Council's Regulation on Criteria for Performing Therapeutic Termination of Pregnancy expanded the criteria for legal abortion to include cases where the mother is suffering from mental health problems, but in this situation it has to be certified by at least one other doctor, in addition to the one performing the termination.

A woman who causes her own abortion, or allows any other person to perform her abortion, is subject to up to three years' imprisonment and/or payment of a fine up to 6,000 THB (200 USD). The person who performs an abortion for a woman with her consent is subject to up to five years' imprisonment and/or payment of a fine up to 10,000 THB (320 USD). If this act causes grievous bodily harm to the woman, the penalty is increased to up to seven years' imprisonment and/or payment of a fine up to 14,000 THB (430 USD), and if the act causes the woman's death, the penalty is increased to up to ten years' imprisonment and payment of a fine up to 20,000 THB (640 USD) (Whittaker, 2002).

In practice, the law is not rigorously enforced. The prevalence of illegal abortions has been widely documented, particularly in more rural areas of the country. Most illegal abortions are performed by non-medical personnel, such as self-trained practitioners, within the first trimester of pregnancy. Whereas abortions can be obtained in urban hospitals using "vacuum aspiration" and Dilatation and Curettage, the most commonly used procedure in rural areas is traditional massage abortion and uterine injections. Moreover, the mental health reason for abortion is rarely honored by doctors. While more progressive abortion policies have been considered by the government, the Buddhist religious order, which is greatly revered in Thailand, commonly interjects and stops the passage of more progressive legislation, such as the legalization of the "abortion pills" Mifepristone and Misoprostol. Although Mifepristone and Misoprostol have been approved by the WHO for terminations, in Thailand it is illegal to use these pills for such purposes. However, doctors and academics in Thailand have called for the drugs to be legalized (Bangkok Post, 2013).

In terms of the migrant population, very few migrant women—even those with documents—go to a hospital or clinic to get an abortion. Most seek out non-medical personnel, such as self-trained practitioners, to receive an abortion, or they drink a traditional powder with alcohol. Some migrant women have been told that they are not permitted to go alone to get an abortion at clinic, endangering their right to privacy.

Abortion is illegal in Myanmar—other than to save a woman's life, although in practice it is categorically illegal (UN Department of Economic and Social Affairs, 2013). Nevertheless, it is also known that Burmese migrant women seeking abortions will commonly cross the border back into Myanmar in order to have abortions there, where the language barrier is less of an issue.

Even though emergency contraceptives are available at drugstores throughout Thailand and can be taken within 72 hours, women in more rural areas or migrant workers confined to their workplaces are often unable or are not permitted to leave their worksites to get contraceptive pills. Many migrant women are also not aware that these pills are available.

Policies on HIV and AIDS

An estimated 9,470 new cases of HIV infection are reported in Thailand each year, and approximately

440,000 people are living with HIV and AIDS throughout the country (National AIDS Committee, 2012). The majority of AIDS patients (89.41%) fall between 15-59 years old (UNICEF, 2012). Most cases are a result of unprotected sex (84.17%), followed by drug use (4.34%), mother-to-child transmission (3.61%), and blood transfusion (0.02%) (The Thai Network of People Living with HIV/AIDS, Thai NGO Coalition on AIDS, Raks Thai Foundation, & Foundation for AIDS Rights, 2011).

There is no law in Thailand that explicitly outlaws discrimination against People Living with HIV and AIDS (PLWHA) based on their status. However, it is arguable that the 2007 Thai Constitution and a number of health policies offer some general protection against discrimination for PLWHA.

Article 51 of the 2007 Constitution states:

> [All persons] shall enjoy an equal right to receive proper and standard public health service, and the indigent shall have the right to receive free medical treatment from public health centers of the State...A person shall have the right to receive proper prevention and eradication of harmful contagious diseases without charge in a timely manner (Constitution of the Kingdom of Thailand, 2007).

The right to non-discrimination in accessing health services is emphasized in Article 2 of the Declaration of Patients' Rights of 1998:

> The patient is entitled to receive full medical services regardless of their status, race, nationality, religion, social standing, political affiliation sex, age, and the nature of their illness from their medical practitioner (Chiang Mai University Department of Medicine, 2000).

Refusal to treat on the grounds of HIV and AIDS is clearly prohibited by the National AIDS Plan (1997–2001), which states: "Health facilities cannot refuse to provide services to patients on grounds of actual or suspected HIV/AIDS status" (Office of the Prime Minster, 1997).

Testing without knowledge is also specifically addressed in the National AIDS Plan (1997–2001):

> HIV tests must always be accompanied by proper pre-test counselling and, for those whose test results turn out positive, appropriate post-test counselling must follow. Both forms of counselling remain the responsibility of the health facilities which administered the test.

There have been subsequent National Plans for the Prevention and Alleviation of HIV/AIDS plans (2002-2006) and (2007-2011).

Voices from the Ground

Pregnant Without Support, Without Hope

Thi Thi Khaing, 37, is an undocumented garment factory worker who has been living in Mae Sot, Thailand, for two years. She has no children and was married for the first time at the age of 36. Three months ago her husband told her that he was moving to Bangkok to work at a factory, explaining that the pay would be better there. She decided to continue working in Mae Sot, but her husband left contact details in the event that she needed to reach him. Shortly after Thi Thi Khaing's husband left for Bangkok, she started feeling very sick every day. She suspected that she might be pregnant and called her husband to express her concerns. Thi Thi Khaing's husband said he did not believe her; she was probably just feeling sick for some other reason. Thi Thi Khaing was not so sure. As the symptoms persisted, she reached out to an NGO in order to get a pregnany test. Sure enough, the test came back positive. She tried contacting her husband again to tell him the news. However, her husband failed to answer her many calls. She found out that he was no longer working at the factory he had originally said he would be working at and he had changed his phone number. Thi Thi Khaing has tried and tried but has been unable to contact her husband. She is now three months pregnant but has been offered no support from her husband. She has no family in Mae Sot; all of her family lives in Myanmar, and they are not aware that she got married. She is afraid that her family back in Myanmar will not accept the baby once it is born, because her husband is unaccounted for. Thi Thi Khaing has been very sick, stressed, and weak as a result of both the pregnancy and her precarious situation. She has already taken two days off due to illness, and her employer told her that if she takes another day off, she will be fired. Thi Thi Khaing cannot tell the employer the real reason for her health issues, as her employer often fires women once he learns that they are pregnant. There is nothing she can do to challenge her employer's actions; she is undocumted and therefore seeking justice would also divulge her "illegal" status. Nevertheless, she knows that soon she will not be able to hide her pregnancy and will be forced out of her job, left without any means of income.

Thi Thi Khaing is not financially or mentally prepared to have a baby. She is concerned that the baby will not have the support and care that a child deserves. Moreover, Thi Thi Khaing earnestly wants to continue working but the symptoms of pregnancy are making the long hours of factory work very difficult. Ideally, Thi Thi Khaing would like to seek out a safe abortion, but her reasons for doing so do not fall under the legal qualifications for an abortion. Thi Thi Khaing has no idea how she is going to be able to properly provide for her child at this point, and she has no one around to help her get through this difficult time.

The National Health Insurance Act of 2002 supported the policy of universal healthcare coverage. Equal entitlement to health was introduced for vulnerable populations, such as the elderly, the disabled and abandoned children, as well as people with HIV and AIDS (Phoolcharoen, 1998). However, migrants and other non-citizens were not included in this coverage at the time, and Thailand continues to implement several health service systems with different standards and benefit packages (The Thai Network of People Living with HIV/AIDS et al., 2011). In Thailand, health-related policies are often established by the relevant councils and government bodies on a national level and then implemented at local health facilities through a decentralized process. Therefore, local health systems commonly provide inequitable services and/or unevenly implement policies.

Thailand's response to the HIV epidemic has been widely cited as a successful prevention and treatment initiative. The decision to make AIDS a national priority in the early 1990s paved the way for the implementation of many programs. However, according to the World Bank in 2011, infection rates remain high amongst vulnerable groups, most notably injecting drug users (IDUs) (20-60%, depending on the region of Thailand), men having sex with men (11.3%) and sex workers (2.5%) (The World Bank, 2011). The stigma and discrimination associated with many high-risk groups continue to hinder efforts in implementing greater preventative measures. Moreover, marginalized groups, including ethnic minorities and migrants, often have less access to information and services for HIV and AIDS prevention and care, greatly reducing their chances of survival if they are found to be infected (UNICEF, 2013).

As Thailand's ICPD+15 report reinforced, HIV infection is comparatively high in provinces where there are large populations of migrant workers (Ministry of Public Health of Thailand & UNFPA, 2010, p. 13). However, there is no comprehensive data on the prevalence of HIV among the migrant population in Thailand as a whole. A large-scale project, entitled the Prevention of HIV/AIDS Among Migrant Workers Project (PHAMIT), funded by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Global Fund), aims to increase migrant workers' awareness of HIV and AIDS. The Ministry of Public Health's Bureau of Health Administration provides support to the PHAMIT project, which is implemented by seven organizations, MAP among them. From 2003-2009, HIV prevention activities reached over 480,000 migrants in 22 provinces (PHAMIT, 2011). Partners improved migrants' awareness and knowledge of HIV, increased condom use, and supported the uptake of proper reproductive and sexual health services, as well as voluntary confidential counseling and testing (VCCT). The project is ongoing but not a cure-all. For example, when migrant workers go back to Myanmar, they must seek out a way to continue their ARV treatment, which can be difficult, especially as different organizations and health facilities may provide different ARV medicines.

As of 2012, UNAIDS reported that the HIV/AIDS prevalence rate in Myanmar among 15-49 year olds was 0.6 percent. However, that percentage is dubious due to the lack of comprehensive data and health information throughout the country (UNAIDS, 2012). In June 2013, the Global Fund pledged more than 160 million USD over four years to Myanmar to improve access to ARV medicines for patients, including those in neglected border regions and some areas controlled by ethnic armed groups. From 2011 to June 2013, ARV treatment coverage climbed from 32 percent of diagnosed patients to nearly 50 percent, and the government has established a target of 85 percent coverage by the end of 2016 (IRIN, 2013). Nevertheless, more than 70 percent of those treated were in the nation's two largest cities, Yangon and Mandalay, along with Kachin State. Coverage remains inadequate, and many Burmese people living with HIV and AIDS continue to cross the Thai-Myanmar border with the hope of receiving treatment in Thailand (IRIN, 2013). There are some cross-border treatment programs, such as in the Thai border town of Mae Sai, but these programs are not prolific.

Policies on Adolescent Sexual and Reproductive Health Services

As Thailand's ICPD+15 report explains, many studies have shown low condom use among adolescents, partly due to the perceived low risk of contracting an STI or becoming pregnant. It is estimated that only 20-30 percent of sexually-active young people are using condoms regularly (Ministry of Public Health of Thailand & UNFPA, 2010, p. 29). While there were 42.2 births per 1,000 women between 15-19 years of age in 1990, that figure had risen to 50.1 as of 2008 (Ministry of Public Health of Thailand and UNFPA, 2010, p. 30).

The Thai Government has promoted a "Positive Youth Development" approach, outlining a strategy

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that encompasses 1) increasing knowledge of sexual and reproductive health; 2) promoting a safe and supportive environment; 3) offering youth-friendly health services; and 4) enhancing youth participation and empowerment (Saejeng, 2009). A 2012 UN report, presented at the Economic and Social Council, estimated that 92 percent of young people between the ages of 15-19 had received information on sexual and reproductive health in Thai schools. However, a rising number of adolescent pregnancies, increased usage of emergency contraception, and high rates of unsafe abortions suggested that more needs to be done (Executive Board of the United Nations Development Programme..., 2012, p. 2).

To address adolescent pregnancy, the Ministry of Public Health revised the national reproductive health policy and introduced its first national reproductive health plan, spanning 2010-2014. The Ministry of Social Development and Human Security also developed a national plan to address the social issues associated with adolescent pregnancy, and the Ministry of Education has played a primary role in providing sex education for children and young people in formal and informal education (Executive Board of the United Nations Development Programme..., 2012). However, there needs to be better coordination among the relevant ministries and agencies to ensure that all young people have access to sexual and reproductive health information and services. Sexuality and HIV/AIDS education has been integrated into the school curriculum, and counselling services are reportedly available in every secondary school, with the school-based support system linked to the health service system (Executive Board of the United Nations Development Programme..., 2012). Nevertheless, the instructors providing sex education in the schools are often unqualified or poorly trained. The curriculum can be considered far from comprehensive, as it tends to largely focus on biological aspects and fails to delve deeper into other issues associated with sexuality. In addition, children below the age of 18 years are not allowed to access VCCT services without parental consent due to the rules and regulations of the Medical Council of Thailand. This deters younger people from seeking HIV and AIDS services and results in late diagnosis (The Thai Network of People Living with HIV/AIDS et al., 2011).

Meanwhile, the migrant population is essentially untouched by reproductive health policies pertaining to adolescents. Since the services are embedded in the Thai school system, migrant youth who attend migrant schools or no school at all are not included in these programs. While Thailand, since 2005, has permitted migrants, regardless of documentation status, to attend Thai schools, many migrant youth do not attend Thai schools for a number of reasons, including language barriers, lack of acceptance from the local school administration, or the need to work to support their families. Migrant schools do not have a uniform standard for sexuality education and many do not teach it at all. NGOs are generally the ones responsible for visiting schools and teaching about SRHR issues, but many students and young people outside the school system are not reached. Migrant parents have also expressed concern over sexuality education in schools due to the socially taboo nature of the material. As a result, migrant youth often have very little understanding even of the biology and emotional changes that come with childhood development. For example, girls commonly do not even know what menstruation is until it starts, because parents do not want to talk to their children about it.

In order to address this reproductive health oversight, in 2003 nine community-based organizations (CBOs) in Mae Sot, Tak Province, collaborated to form the Adolescent Reproductive Health Network (ARHN) to promote the sexual and reproductive health and rights of young people between the ages of 12-25 (Adolescent Reproductive Health Network, 2010, p. 4). In 2007, a parallel network, called the Adolescent Reproductive Health Zone (ARHZ) was developed in Chiang Mai through the participation of seven additional CBOs, MAP among them. Both initiatives share the same educational curriculum for peer education trainings for young people. These topics include reproductive anatomy and physiology; sexually transmitted infections and HIV and AIDS; decision-making and sexual health; drug and alcohol awareness; counseling; unsafe abortion; family planning; gender issues; youth friendly-health services; emergency contraception; and reproductive rights. Since 2003, over 3,500 peer educators have been trained. The peer educators

visit migrant schools and other spaces frequented by migrant youth. In 2009, the ARHN also opened a Youth Center in the border town of Mae Sot to provide counseling, health information, and referral services (Adolescent Reproductive Health Network, p. 4). Lastly, a partnership was launched in 2012 between UNESCO and Plan International, targeting Tak Province in order to further improve the sexual and reproductive health of migrant youth. The program will run until November 2014, targeting 20,000 migrants between the ages of 15-25 throughout Tak Province (Plan Thailand, 2012).

Nevertheless, sexual and reproductive health remains a taboo topic within many migrant communities. Parents are reluctant or unwilling to speak with their children about such issues, and young people are afraid to seek out contraceptives or services, concerned that others in their community will find out and they will be ostracized. Free HIV testing is offered at local clinics, but these clinics can be difficult for young people to access, and youth-friendly services are not always provided. NGOs are the ones that are, by default, responsible for the provision of these services, making for an unequal provision of services among the migrant population. Once again, while all migrants can now purchase health insurance, the scheme remains prohibitively expensive for many. Typically one's employer first pays and then a migrant must pay the employer back, meaning that young people who do not work cannot afford or access this healthcare plan.

Difference between Median Age at Marriage and Legal Minimum Age at Marriage

The legal minimum age at marriage without requiring parental consent is 17 for both men and women in Thailand (United Nations Statistics Division, 2012a). The singulate mean age of marriage is 24.10 for women and 27.4 for men (United Nations Statistics Division, 2012b).

In Thailand the legal age of consent for sexual activity is 15, according to Article 279 of the Thai Penal Code. However, the Penal Code Amendment Act of 1997 outlines a number of revisions such that ostensibly the age of consent is 18 years of age (Penal Code Amendment Act, 1997).

In Myanmar the legal age of marriage without parental consent is 20 for both men and women, although it is 14 years of age with parental consent (United Nations Statistics Division, 2012a). The singulate mean age of marriage is 26.1 for women and 27.6 for men (United Nations Statistics Division, 2012b). For a sense of comparison, twenty-five years ago, the singulate mean age for women in Myanmar was 22.40 (Quandl, 2014).

Gender-Based Violence

Extent of Gender-Based Violence

According to the Violence against Women Prevalence Data composed by UN Women in 2011, the percentage of women living in the provinces (rural areas) of Thailand who had experienced physical and/or sexual violence from their intimate partner in their lifetime was 47.4 percent. In the provinces, 33.8 percent reported experiencing intimate partner violence of a physical nature, and 28.9 percent reported experiencing intimate partner violence of a sexual nature [Table 2]. For women residing in the cities, 41.1 percent reported experiencing physical and/or sexual violence from their intimate partner (22.9 percent reported physical and 29.9 reported sexual) (UN Women, 2011). When extended to intimate partner and/or non-partner violence, 43.8 percent of women in the provinces reported experiencing physical and/or

Table 2. Extent of Gender-based Violence in Thailand

	Provinces (%, 2002)	Cities (%, 2005)
Physical and/or Sexual Intimate Partner Violence	**47.4**	**41.1**
Physical Intimate Partner Partner Violence	33.8	22.9
Sexual Intimate Partner Partner Violence	28.9	29.9
Physical and/or Sexual Intimate Partner and/or Non-Partner Violence	**43.8**	**35**
Forced First Sex	**5.3**	**3.5**
Abuse During Pregnancy	**3.8**	**4.2**

Source: (UN Women, 2011)

sexual violence in their lifetime. Thirty-five percent in the cities reported experiencing physical and/or sexual violence from either an intimate partner or a non-partner. The percentage experiencing forced sex was 5.3 percent in the provinces and 3.6 percent in the cities. Abuse during pregnancy was reported by 3.8 percent in the provinces and 4.2 percent in the cities (UN Women, 2011).

Among migrant communities, the extent of gender-based violence is more difficult to assess. Migrant women face multiple levels of resistance when trying to expose abuses, particularly sexual abuse. The community itself attempts to placate the women, fearful that any action will bring unwanted attention to the community and thus threaten their security. The police are not proactive in following up on cases of abuse against women, especially migrant women; when the abuse has been committed by a family member in the migrant community, the police may claim it is a migrant affair and therefore not of concern to them. Even agencies mandated with the protection of refugees or migrants have sometimes been reluctant to encourage women to pursue justice. Nevertheless, there are migrant organizations that specifically focus on offering assistance, safe spaces, and even legal assistance for women who have experienced gender-based violence.

In an extensive report published by the PHAMIT program, a survey of over 1,500 female migrant workers was conducted in Ranong, Tak, and Samut Sakhon Provinces, three provinces where migrants commonly live and work. The survey found that 8 out of 10 women had been subjected to some form of violence (verbal, physical, and/or sexual violence) (Dendoung & Dendoung, 2013, p. 71). The family sphere was the main source of violence against female migrant workers, with 68.4 percent reporting violence from a partner or family member. 61.4 percent reported that they had experienced violence and/or abuse at the workplace, and 15.9 percent reported abuse from government authorities (Dendoung & Dendoung, 2013, p. 73). The prevalence of abuse in these multiple spheres makes it difficult for migrant women to seek safety, let alone justice.

Migrant women face multiple levels of resistance when trying to expose abuses, particularly sexual abuse.

Legislation Related to Gender Based Violence

The 2007 Constitution is viewed as addressing violence against women in a number of its sections, including the following:

> **Section 30:** All persons are equal before the law and shall enjoy equal protection under the law. Men and women shall enjoy equal rights.

Voices from the Ground
Seeking Justice for Sexual Assault

Ma Toe, 38, worked on a construction site in Mae Sot, Thailand, where she lived with her husband and daughter, 13, the latter of whom also performed small jobs on the site. All of them are undocumented. One day, the foreman at the site raped Ma Toe. She did not dare tell anyone since the foreman had such authority at the workplace and she was afraid of losing her job. The foreman raped Ma Toe a second time, which made her feel both angry and introverted, as she shrunk from telling others about her ordeal.

On another occasion, the foreman tried to rape Ma Toe's daughter when the daughter was alone at Ma Toe's house. The foreman came by and asked the daughter to follow him. She did so because she knew him and trusted him. He took Ma Toe's daughter outside and tied up her hands and legs. He then stuffed the daughter's mouth with plastic and tried to rape her. Fortunately, the foreman's wife happened to come upon the scene and saw everything that was happening. She shouted and yelled for help from the neighbors. At first, the wife thought that Ma Toe's daughter was her husband's mistress. Ma Toe rushed over after hearing the commotion and argued on behalf of her child, explaining that such was far from the truth and, rather, the foreman was trying to rape her daughter.

At that point, Ma Toe could not be silent any longer. She decided to explain everything that had happened to her husband. She contacted an NGO, which then referred her to MAP Foundation. MAP explained to Ma Toe what action could be taken, and Ma Toe agreed to take the case to the police. The police arrested the foreman, and he was held for a couple of days. Rather than pursuing the case any further, as Ma Toe was concerned that doing so would be too difficult given her undocumented status, she agreed to negotiate with the foreman, who offered compensation instead of justice.

Since then, Ma Toe and her family have moved to a different workplace in another part of Mae Sot. She did not dare stay at the construction site, for the sake of her safety and her daughter's. She continues to live in fear after that traumatic experience.

Section 40: Every child, youth, woman or aging or disabled person shall have the right to appropriate protection in judicial process and shall have the right to appropriate treatment in case relating to sexual offences...

Section 52: Children, youth, women and family members shall have the right to be protected by the State against violence and unfair treatment and shall have the right to medical treatment or rehabilitation upon the occurrence thereof.

Section 81: The State shall act in compliance with the law and justice policies in providing support for the operation of private organizations rendering legal assistance to the public, especially the people who suffer from domestic violence (Ministry of Foreign Affairs, 2011).

Domestic violence has long been a concern in Thailand, but survivors of domestic violence were reluctant or unable to seek legal protection and redress due to the societal perception that domestic violence was an internal family affair. In 2007, after nearly two decades of advocacy and ten years of deliberation, the Protection of Domestic Violence Victims Act was enacted (UNICEF, 2011). The Act defines domestic violence as "any action intended to inflict harm on a family member's physical, mental or health condition and any use of coercion or unethical domination to compel a family member to commit, omit or accept any unlawful act, except for that committed through negligence"[2] (UN Women, 2007). A complaint can be made not only by the victim, but also by anyone who has seen or has information regarding a domestic violence situation. When a complaint is filed, the police have to investigate the complaint immediately, and the public prosecutor has to file the case before the court within 48 hours. The police are also permitted to make a complaint and/or file a case in the event that the victim(s) is not in the position to do so (UN Women, 2007). The Act has been criticized for not being implemented strongly enough and for placing too strong an emphasis on reconciliation rather than prosecution of the perpetrators (Immigration and Refugee Board of Canada, 2011).

[2] The Act aims to protect family members, including a spouse, a former spouse, a person cohabiting or having cohabited with another without civil marriage, a child, an adopted child, a member of a household, as well as any other dependents.

However, another legal channel was opened to women in 2007, when Articles 276 and 277 of the Criminal Code were amended, making marital rape a criminal act (UNICEF, 2011, p. 6). The definition of rape was also expanded to cover victims of all sexes and all types of sexual penetration. The law allows victims and offenders to try reconciliation in the event that they want to resume a family relationship, but the law also recognizes the need for victims of domestic violence to be protected by the police. When reconciliation cannot be achieved, women can seek divorce on the basis of violence and abuse (UNICEF, 2011, p. 7). This law technically pertains to all individuals residing in Thailand, regardless of their citizenship status (i.e. migrants).

The Ministry of Public Health has some 300 hospital-based One Stop Crisis Centre (OSCC) units to provide physical and mental health services, legal assistance, and recovery and rehabilitation to women survivors of all forms of violence (Ministry of Foreign Affairs, 2011). In 2003, the Ministry of Public Health's Office of the Permanent Secretary and the Ministry of Social Development and Human Security's Office of Women's Affairs and Family Development created guidelines for health professionals working at the OSCCs across the country (Ministry of Foreign Affairs, 2011). Within the Royal Thai Police, the Department of Prevention and Suppression of Crimes Concerning with Women and Children was established to handle cases of violence against women. The Royal Thai Police also established the Centre for the Protection of Children, Youth and Women to provide assistance to individuals who are assaulted or sexually abused. Within the Ministry of Justice, the Rights and Liberties Protection Department was formed in 2002 to protect victims of human rights violations, including victims of domestic violence (Ministry of Foreign Affairs, 2011).

However, some personnel responsible for the provision of services and assistance, particularly police and other law enforcement officials, often fail to take reports of violence against women seriously (Immigration and Refugee Board of Canada, 2011). Some women activists have observed that law enforcement officers lack sensitivity toward survivors of domestic violence; they promote reconciliation without considering the interests of the women or fail to file domestic violence cases. When a case is taken to court, evidence of the victim's background, sexual history or sexual relationship with the perpetrator—inadmissible in many countries—are often used in Thai courts to undermine a victim's credibility. A culture of silence and blaming makes women

reluctant to come forward (Thin Lei Win, 2013). In addition, many women are still not aware of their rights under Thai law, and even interviews with police have shown a lack of understanding of the law (Immigration and Refugee Board of Canada, 2011).

For migrant women, the individual inflicting the violence may also be Burmese. When such is the case, police will turn the victim away saying the issue is among their "own people," and they should deal with it on their own. Women who are abused by their employers are either so confined to their workplaces that they have no opportunity to report the abuses or they are too afraid that reporting these abuses will result in termination, backlash from the community, or indifference from the police. When women do choose to bring their experiences forward, it is common for Burmese migrant women to seek out the assistance of local women's NGOs in seeking redress.

Legislation and Policies on Sexual Orientation

Thailand's laws and policies do not expressly deal with discrimination on the basis of sexual orientation or gender identity (Foundation for Human Rights on Sexual Orientation and Gender Identity et al., 2011). The 2007 Constitution states in Section 5: "The Thai people, irrespective of their origins, sexes or religions, shall enjoy equal protection under this Constitution."

Section 30 of the Constitution also states:

> Unjust discrimination against a person on the grounds of the difference in origin, race, language, sex, age, disability, physical or health condition, personal status, economic or social standing, religious belief, education or constitutionally political view, shall not be permitted (Queen's University Belfast, 2011).

Although not specifically stated, these sections of the Constitution have been interpreted as prohibiting discrimination on the basis of sexual orientation and gender identity (Foundation for Human Rights...et al., 2011).

In 2002, under pressure from the gay community, the Thai Department of Mental Health removed homosexuality from its list of mental disorders. The Criminal Code was also amended in 2007, expanding the definition of rape to cover victims of all sexes and all types of sexual penetration. Offenders now face the prospect of four to twenty years in jail (Armbrecht, 2008).

There are no laws prohibiting homosexual behavior between two consenting adults, and lesbian, gay, bisexual, and transgender (LGBT) individuals can live together. Nevertheless, Thai law does not currently recognize same-sex marriages, civil unions or domestic partnerships. This results in discrimination against homosexual couples on issues such as inheritance, immigration, hospital visitation, child custody, social security benefits, and government health and pension schemes (International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), 2011). It is unclear if a same-sex couple or an LGBT Thai individual would be permitted to adopt or have custody of children. In September 2011, the National Human Rights Commission of Thailand and the Sexual Diversity Network, an NGO, proposed draft legislation on same-sex marriage and were seeking the Thai government's support for the law, but no progress of note has been made (ILGA, 2011).

Legislation and Policies on Gender Identities

Thailand's legal system fails to afford transgenders and transsexuals many of the rights and protections enjoyed by the rest of the population. Thai citizens cannot legally change their gender on their ID cards. This can endanger their job prospects, as many employers do not want to deal with the possible complications involved in hiring a transgender or transsexual (Armbrecht, 2008). Nevertheless, some strides have been made. Perhaps the most momentous stride to date was when the Administrative Court of Thailand ruled in 2010 that Section 30 of the Thai Constitution prohibits discrimination against transgender individuals (Foundation for Human Rights...et al., 2011).

Grievance Redress Mechanisms for Sexual and Reproductive Health Services

The grievance redress mechanisms for sexual and reproductive health services are somewhat ill-defined. The Medical Treatment Profession Act (1982) provides that a person wronged by the conduct of a medical worker who violates professional codes of conduct has the right to lodge a complaint in writing with the Medical Council.

The council then appoints a subcommittee to investigate the complaints before recommending that the Executive Committee of the Council take certain action. The Council's decision is considered to be final (Center for Reproductive Rights, 2011). Persons harmed by a practitioner may also initiate legal action for medical malpractice under provisions of the Thai Penal Code, such as criminal liability for negligent or unintentional acts, false certification, or disclosure of private information. The Medical Council, the Nursing Council, the Pharmaceutical Council, the Dental Council, and the Medical Registration Committee jointly issued a Declaration on Patients' Rights in 1998, outlining ten fundamental patient rights, as explained under the previous section on policies regarding HIV and AIDS. The Department of the Rights and Liberties Protection under the Ministry of Justice, established in 2002, is charged with promoting awareness about human rights, and a specific division is authorized to address complaints related to the violation of individual rights and liberties. The National Human Rights Commission, an independent agency established following the 1997 Constitution, examines and reports on actions that violate human rights and the government's obligations under international treaties. However, none of the Commission's subcommittees specifically focuses on gender equality or women's rights (Center for Reproductive Rights, 2011). Beyond these avenues, formal channels for expressing grievances in Thailand could not be identified.

For migrants, complaint mechanisms are next to none. Due to a number of barriers mentioned throughout this report—among them, confinement to the workplace, language barriers, concern over losing one's job, lack of documentation—migrant workers are reluctant or unable to raise grievances. Moreover, despite the efforts of migrant organizations, many migrants remain unfamiliar with the concept of sexual and reproductive health and rights as integral and inviolable human rights.

3. Recommendations

As MAP Foundation's primary focus and experience is with the Burmese migrant community, the following SRHR recommendations are with regards to migrant workers in Thailand.

1. Working together, the Thai health authorities and NGOs should develop a comprehensive Sexual and Reproductive Health and General Well-Being program for migrant women that, among other things, would include:
    - Mobile clinics that visit work sites and living quarters of migrant women
    - Illustrated information provided in migrant languages about a range of contraceptives
    - Counseling and unfettered access to a range of contraceptives
    - Provision of antenatal and postnatal care for migrant women
    - Information about and access to reproductive health services and screenings, with associated treatment available

2. The Ministry of Labour should start a campaign to inform migrant women of their right to maternity leave and should actively pursue and punish employers who dismiss workers on grounds of pregnancy or who do not provide paid maternity leave.

3. The Medical Council should review recommendations on the abortion pills, Mifepristone and Misoprostol, to legalize their use in medical settings.

4. All agencies—government, multi-lateral and NGOs—should work together to address prevention and redress issues of violence against migrant women. Migrant women who have been victims of violence should be issued with temporary stay permits to avoid any immigration problems during pursuit of their legal cases.

5. There should be greater coordination among migrant schools in each town and across towns to provide comprehensive sexuality education (CSE). Through the support of the Thai Government, NGOs should work together to create and provide the CSE materials and trainings for migrant schools and their staff throughout migrant communities in Thailand. Equal effort should be dedicated to establishing programs for out-of-school migrant youth.

6. The aforementioned CSE program should encompass a cross-generational approach as well. While youth must be educated on SRHR issues, so must adults, particularly in breaking down the taboos and traditional beliefs that stand in the way of embracing CSE.

7. Thailand should accede to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW).

8. Migrant women should be informed of grievance redress mechanisms for sexual and reproductive health services. The information and mechanisms

should be made accessible in migrant languages and should not compromise or endanger a migrant's physical security in Thailand.

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About MAP Foundation

MAP Foundation is a grassroots non-governmental organization (NGO) that seeks to empower migrant communities from Burma living and working in Thailand. In 1996, a group of local organizations joined together to try to respond to the needs of Burmese migrant workers in Chiang Mai, Thailand. It became apparent that migrants were having to work and live in unsafe and unsanitary conditions and that the needs were much greater than could be addressed by a network. In 2003, MAP officially registered as a foundation, and in August 2004 the organization won the first labor case for migrant workers in Thailand.

Today MAP has four programs: Labor Rights for All, which focuses on labor issues and has lawyers on staff to take on legal cases; Community Health and Empowerment, which largely focuses on HIV/AIDS awareness; Rights for All, which runs programs for women's empowerment, children's rights, and human rights education; and Multimedia, which operates two community radio stations, among other activities. MAP also operates Promoting Occupational Safety and Health (POSH) Corners on worksites and multiple drop-in centers where migrant workers can get information on labor rights, migration policies, and reproductive health.

MAP works toward a vision of the future where people from Burma will have the right to stay in their homeland and the right to migrate safely and where all migrants are treated with respect and have their human rights and freedoms observed.

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