Aligning Macroeconomic Trends with HIV Sero-prevalence Amongst Direct Sex Workers in Thailand

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Spring 2008

General University Honors

Abstract

After health surveys during the 1980s found high HIV prevalence rates in Thailand, the Royal Thai Government began funding comprehensive HIV prevention and treatment efforts. Although these measures reduced prevalence rates and improved the quality of life for many Thais living with HIV/AIDS, 1 in 20 female direct sex workers remains infected with HIV. The HIV sero-prevalence rate for Thai female sex workers is falling, and UNAIDS projects further declines in that subpopulation. Examining the economic context of the Thai HIV epidemic can lend insight into improving policies that aim to address the HIV/AIDS epidemic and lower the nation's disease burden. For HIV policy to be most effective, the Thai government should engender macroeconomic policy and cooperate with civil society to create institutional and societal changes that enrich the capabilities of women and girls.

Introduction

Several years after the first diagnosis of HIV in Thailand, the Royal Thai Government began funding programs to address the HIV/AIDS epidemic in 1989. The booming economy and influx of government revenue enabled the government to commit large amounts of resources toward HIV programs. This approach came to be lauded as one of the best public responses to the HIV epidemic. The Asian financial crisis in 1997 resulted in an overhaul of the monetary system and sharp cuts to government spending, including HIV/AIDS programs. Although the Thai economy has been relatively healthy since recovering from the crisis, government expenditures on HIV/AIDS programs have not returned to pre-crisis levels of funding. This has significant ramifications for people living with HIV/AIDS and for subpopulations at increased risk for acquiring the virus, particularly women.

The government has made great strides in lowering the HIV prevalence rate for sex workers, but the subpopulation remains at greater risk for acquiring the virus. The prevalence rate for female direct sex workers was 5% in 2007, compared with 1.4% in the general population (Revenga 2006: 13, UNAIDS). Like many other countries, Thailand has a sizable sex industries and HIV continues to plague sex workers. HIV is an extremely complex problem that intersects with race, ethnicity, gender, class, and social norms. I reviewed the economic context of the HIV epidemic in Thailand to see if economic trends affected government policies that in turn increased sex workers' vulnerability to HIV.

From the start of the HIV/AIDS epidemic, Thai sex workers have remained at high risk for acquiring the virus. The 100% Condom Campaign was a largely successful, brothel-based structural intervention that became widely studied as nations and inter-governmental organization assessed the efficacy of HIV prevention options. Sex work and sex tourism in

Thailand has attracted extensive scholarship. Morris 2002 and Jackson write that Western academics risk perpetuating a transnational gaze of scholarship, effectively perpetuating Oriental stereotypes of Thais as a sexually available and exotic people. Scholarship and policy recommendations are of course important, but must be conducted with care in ways that are sensitive to social, cultural and political implications (Jackson and Cook 1999, Lim 1998).

Analyzing the economic patterns that generate Thai wealth, well-being, and consumer behavior can yield suggestions for creating longer-term social and economic solutions. I wanted to examine economic trends alongside HIV prevalence rates in Thailand. The conclusions here may be applicable to other Southeast Asian or middle-income countries, even if the circumstances of the HIV crisis vary for different countries. Several nations, including Vietnam and Cambodia, have already adapted the Thai approach in their countries, with varying degrees of success (Jackson 1999). The Thai model is good, but it must be expanded upon in order to continue lowering HIV prevalence rates.

Addressing the HIV crisis requires a multi-faceted effort backed by the private, public, and nonprofit sectors. Public health expenditures provide a critical short-term solution to the crisis, but a broader approach is necessary if societies want to eradicate the conditions that make its citizens vulnerable to acquiring HIV/AIDS. Civil society and governments must enact institutional and long-term economic policy shifts in order to create a healthier, more capabilities-rich populace. Gender-aware macroeconomic policy solutions offer governments and economies tools with which to ensure greater equity. They offer insights into current policy shortcomings, and suggest gender-aware ways to prevent transmission and improve the quality of life for people living with HIV/AIDS. A gender-aware approach provides a human-centric approach to development, which should be part of a holistic view of the disease.

Thailand steadily developed in the second half of the twentieth century, where it is now a middle-income country. Much of the economic growth can be attributed to the shift from the agricultural sector to the modern sector, such that manufacturing for export is a major source of revenue. The shift toward a market economy from a rural economy has necessitated increasing participation in labor markets for both men and women. Rural jobs do not offer a high standard of living or the trappings of modern life, and Thais are increasingly reliant on consumer goods produced outside of the home. This, in conjunction with inflation, creates incentive for workers to participate in well-paying jobs outside the home.

Gendered labor markets and extensive demand for paid sex in Thailand feed a booming sex industry, which draws hundreds of thousands if not millions of young women who hope to increase their earning power. Thailand has not yet successfully transitioned toward becoming a more highly-developed, high-income, information economy. The jobs available to young single women, especially those with little education, are generally agricultural, manufacturing or service sector jobs that are low-paying and low-skilled. They are often repetitive and tedious jobs with little potential for advancement. Sex work offers the prospect of meeting new people, living in an urban, 'modern' setting, and discretionary income that can support a worker's parents and family. For women with children, sex work offers a more flexible working schedule and is less time-intensive whilst remaining relatively well-paying (Lim 1998).

Both domestic and foreign demand for sex work is high, so the sex industry, including sex tourism, has become extremely lucrative over the past three decades: the sex industry is estimated to generate $4.3 billion annually. The earnings from sex work are significantly higher than in other sectors, which provide incentive for women to enter the labor market as direct or indirect sex workers. Although sex workers can attain a higher standard of living than women

who do not participate in the sex industry, their work places them at increased risk for acquiring HIV. Although most women are aware of the risks, the draw of higher wages tends to outweigh the potential risk of acquiring HIV.

The human immunodeficiency virus (HIV) has transformed the field of economic development around the globe, and governments have responded to the pandemic in a variety of ways. Scholars and health officials have praised Thailand for its strong and early response to the health crisis, but a number of policy evaluations have shown that infection rates amongst certain subsets of the population continue to rise. A gender-aware discussion of economic development and gender differences in utilization of HIV/AIDS resources can inform policy evaluation and adjustments, such that gender becomes a more integral part of government and private strategies for combating HIV/AIDS.

According to a 2006 UNAIDS and World Health Organization study, over four million new human immunodeficiency virus infections occur annually, despite efforts to promote education, awareness, and transmission prevention. HIV causes Acquired Immune Deficiency Syndrome, or AIDS, which is the fourth-highest cause of death worldwide. There are some 40 million people living with HIV or AIDS, with estimates as high as 47 million. Glynn estimates that over 1 million Americans are living with HIV/AIDS, and one-quarter of those people do not know they are infected. The virus can be dormant in a person for many years, and the patient would be symptom-free. HIV weakens the immune system and leaves patients susceptible to opportunistic infections, which are generally the cause of death in AIDS patients.

Antiretroviral therapy can improve the patient's quality of life for many years, but are expensive, can have a burdensome daily regimen, and can have a number of adverse side effects. These drugs suppress HIV replication, muting the effects of the virus, but cannot totally prevent

replication. Pharmaceutical companies have been slow to develop generic antiretroviral drugs, and countries have faced a number of patent barriers impeding the approval process for generic drugs. Efforts to develop an AIDS vaccine have not been successful, and debate continues on whether vaccine funding should continue at current levels, or if funding should be reallocated toward microbicide research or more conventional prevention efforts (Altman). HIV treatment costs over $500 a month for those with health insurance, and the working poor who are uninsured are particularly vulnerable if they cannot afford treatment (Nalls). Treatment and HIV-related health care in the U.S. can cost as much as $22,000 a year.

HIV is a complex problem that requires broad solutions engaging every member of society. Society as a whole has a moral imperative to try to stem the epidemic. HIV/AIDS stunts human development, or the capacity for people to lead decent lives, and compromises their ability to achieve their personal and professional goals. To remain indifferent to this crisis is to deny people basic opportunities for success. Failure to act will hurt families across socioeconomic levels, and will feed poverty and racial marginalization. Furthermore, HIV prevention spending is not a policy that can be put off. Prevention programs do the most good when they come early, before the virus spreads further (Revanga).

There is also an economic incentive for local and national governments to prevent HIV transmission, as prevention efforts are significantly cheaper than antiretroviral therapies, especially for advanced cases of AIDS. HIV/AIDS creates a disease burden that lowers productivity and hinders economic development, so it is in a nation's interest to keep workers healthy. Purely market-based approaches to HIV/AIDS will not remedy the crisis, as markets serve those who can pay, and this excludes a significant portion of people living with HIV. Government investments in HIV prevention strategies like mass media health communication

can lower costs for the private sector, as a healthier population is more productive and more conducive to economic development.

Engendering macroeconomics

Neoclassical macroeconomics uses aggregate measures and assesses aggregate effects to track growth and trends in economic production and consumption. Post-Keynesian models focus upon the role of political and financial institutions in creating market outcomes, and Keynesian economists advocate government policies designed to stimulate demand-side economic growth. The neoclassical models did not include women's economic contributions through household and care work. In the Harrod-Domar and Solow growth models, for instance, labor supply is exogenous and functions independently of growth.

Feminist macroeconomic approaches work to make visible and correct such inequities through engendering the traditional methodologies or proposing new, gender-aware methodologies. Feminist economists include both productive and reproductive labor when measuring economic production and labor, and endogenize the labor force. Labor supply is instead a produced 'good,' with household expenditures as inputs. They argue that gender inequality distorts markets, and removing those inequalities will increase the efficiency of the market. Grown et. al writes that heterodox models are easier to engender than neoclassical models, but both approaches would better fit the needs of a society by incorporating gender-aware components into the models. Darity (1995) creates a model for gender-segregated, low-income economies that can be applied in Thailand. Although the UN does not classify Thailand as a low-income country, the rural agricultural areas of the country contain 40% of the country's poor (World Bank), and the assumptions of the model fit with sociological assessments of Thai

rural society and gender roles. Darity's model predicts that gender imbalances in wages and malnutrition will diminish as male coercion (C) falls. This is a topic worth further exploration.

Gendered and gender-blind economic policies can result in growth while producing adverse outcomes for women. Because prostitution is illegal in Thailand, it is not included in assessments of economic activity. This is somewhat shortsighted, as large numbers of women participate in the sex industry and generate considerable amounts of income. Fear of legal sanctions stops many businesses and employees from participating in health interventions like the 100% Condom Campaign. This increases the vulnerability of women who are already at risk for acquiring HIV through direct or indirect sex work. Furthermore, government and societal refusal to acknowledge sex work perpetuates the stigma around the profession.

Gendered considerations in macroeconomics are critical to ensuring the well-being of women and children. Because women and children are more vulnerable to income and capabilities poverty than men are, economic policies that limit spending on social programs like education and health care will disproportionately fall along gendered lines. Women also face barriers to entry into the labor market, and they comprise a greater proportion of laborers in low-skilled, low-paying jobs with little opportunity for advancement (Catagay and Erturk). This compromises their earning power and, therefore, can impact health decisions and subsequent labor market decisions.

One concern with feminist economics is that the field remains outside of the mainstream of traditional economics, and therefore is somewhat limited in its reach. Feminist economic thought has a stronger presence within academia and the United Nations, but is less prevalent in international financial institutions like the International Monetary Fund and the World Bank. These institutions have billions of dollars with which to shape government policies and

infrastructure, and these policies directly impact women worldwide. The IMF favors neoclassical approaches to development, including liberalizing trade policy and curbing government expenditures, even though these policies tend to disproportionately affect women's income levels and access to government services. The IMF focuses on the goal of economic solvency, with less concern for the human consequences of creating a fiscal squeeze. However, the prospect of Asian nations pooling resources to form a regional reserve fund might have the potential to nudge IMF policy farther left. The pan-Asian fund was proposed by Asian finance ministers in late April 2008 as a less harsh alternative to IMF borrowing and debt assistance, which offers conditional aid that many criticize as exploitative. If the fund can incorporate gender-aware thought into its monetary policy, it has the potential to decrease the economic vulnerability and capabilities poverty of women in the region.

Exploring a link between economic health and the spread of HIV

A gender-aware review of past and present economic conditions in Thailand can inform policy suggestions for economic development and government expenditures. In particular, economic growth and government revenue streams have a significant impact on the extent to which government directs funds toward HIV prevention, treatment, and care. Therefore, a survey of the country's economic health is helpful for considering feasible funding levels for HIV/AIDS programs. Furthermore, levels of development impact consumption and labor participation decisions, creating settings that can be conducive to the spread of HIV.

Thailand is a middle-income country that has eliminated legal barriers to gender equality, but significant gender gaps in achievement and equity remain. The GDP per capita is PPP US$8677, and poverty rates have fallen as the country became wealthier (UNDP). As in other

nations, women have high levels of participation in the labor force, but are disproportionately represented in lower positions in firms and low socio-economic brackets. Women's labor force participation has remained constant since the 1980s, though female unemployment rates rose until about eight years ago, where they dropped in the years between 2000 and 2004 (World Bank). The unemployment rate in Thailand is 1.4%, and the female unemployment ratio is 80% of the male unemployment rate (UNDP). According to 1996 Thai government statistics, 24% of households are female-headed, and over half of those household-heads are widowed (NSO). Female primary school enrollment has risen from 75% in 1990 to 86% in 2004. The gender gap in enrollment rates has ranged from 2-4% during that time (World Bank). Sixty-six percent of women participate in the labor force. Of those, 41% work in agriculture, 41% work in the service sector, and 19% work in manufacturing. Fifty-four percent of professional and technical workers are women. Twenty-nine percent of legislators, senior officials, and managers are women (UNDP).

Thailand developed somewhat rapidly during the 1970s and 1980s due in large part to low price of labor, reductions in trade barriers, and relative economic stability. The country posted high growth rates[1], and Bangkok became a hub of financial and industrial activity, attracting millions of rural Thais and migrants from neighboring countries. During the Vietnam War, many American GIs spent their time off in Bangkok, which fed the expansion of the tourist sex industry there (Morris 2002: 50). The local economy benefited substantially, and after the war, the country began promoting tourism to continue attracting foreign visitors and the revenue they created. Thailand was a heavy exporter of agricultural products in the early 1980s, and continues to participate in global food production, but now exports mainly manufacturing products ("Thailand"). However, economic development was somewhat uneven, and the

[1] See Appendix A.

majority of Thais perform agricultural work in rural areas. Thailand has a number of natural resources and is the leading global exporter of rice and unprocessed rubber.

Throughout the 1990s, foreign investors poured money into Southeast Asian manufacturing industries, and many domestic investors borrowed heavily in US dollars to take advantage of the financial boom. Growth peaked at 12% between 1988 and 1990, and demand for labor outpaced the supply so wages rose and poverty rates fell (Coxhead and Plangpraphan 1999, World Bank). Financial institutions lent money to higher-risk debtors in order to capitalize on the demand for credit (Krueger). The surge of capital inflow from investors made the country more vulnerable to financial panic. The weakness of the financial sector and creditors' willingness to distribute high-risk loans were responsible in large part for the crisis. Flaws in the sector were masked by rapid growth and accentuated by large capital inflows, which were partly encouraged by pegged exchange rates. Additionally, government regulation of banks was weak.

The Asian financial crisis started in 1997 in the wake of high speculation on the Thai baht and the bankruptcy of the largest Thai finance company. The baht, which had been tied to the US dollar since 1945, depreciated rapidly, as did the values of numerous other Southeast Asian currencies. Because of fixed exchange rates, currency markets were unable to respond as quickly to the fluctuations in capital flows (Krueger). The crisis spread to other countries, including South Korea, which has the 11th largest economy in the world (IMF). In response, the IMF disbursed $14.1 billion in bilateral and multilateral aid to Thailand between 1997 and 1999, on the condition that Thailand agreed to a series of structural adjustments. To prevent the crisis from spreading further, the IMF worked with Thailand to introduce a floating exchange rate, reduce federal expenditures, close 56 bankrupted banks, increase the social safety net, establish credit bureaus, raise interest and tax rates, and create incentives for foreign and domestic private

investment. Between 1997 and 2000, Thailand and the IMF cooperated to shift monetary policy toward a monetary targeting approach that would slow depreciation of the baht and stabilize interest rates. Thailand aimed to decrease and stabilize the supply of money, and slow outflows of private capital (IMF, Bank of Thailand). After 2000, the baht had sufficiently recovered so Thailand again altered its monetary policy, this time to an inflation targeting approach (Bank of Thailand).

Thailand and other countries in the region did not recover as quickly as the IMF anticipated. Thirty-thousand Thais lost white-collar jobs, and deflation continued through 1998 before the economies resumed growth (PBS). The Thai economy bounced back to some degree, and real GDP growth has remained relatively constant over the last 5 years[2]. Still, private and public investment composed 29% of GDP in 2005 and has remained somewhat stagnant since, while it was over 40% of GDP prior to the financial crisis (Aiyar et al). Although significant amounts of poor-quality investment contributed to the 1997 crisis, Thailand has not seen similar levels of investment and growth since[3]. The country has a comparatively high savings rate and government surplus, consequently, but the low levels of investment are inhibiting growth and limiting job creation and innovation (IMF).

The World Bank forecasts 5% growth for Thailand in 2008, though rising food and energy prices threaten to undermine growth. Growth has been at a steady 4.5-6% rate since 2002. This is lower than many low-income and high-income countries[4] (World Bank), but the Thai economy does not risk overheating this way. Government revenue and expenditures in Thailand have risen steadily over the last ten years, and the deficit and debt are relatively low[5].

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[2] See Appendix B.
[3] See Appendix C.
[4] See Appendices D and E for Thailand's shifting growth rates compared against Southeast Asian countries over the past 5 years
[5] See Appendix F.

The deficit is 2% of GDP, government debt is 38.5% of GDP, and the country has $90 billion in foreign reserves, or more than enough to cover short term external debt (World Bank). Growth in consumption has fallen due to high interest rates and inflation. The prime interest rate steadily rose to 7.5-8.0% in 2006 before falling to 6.85-7.13% in 2008 (Bank of Thailand).

The inflation rate for April 2008 was 6.2%, and this rate will likely change as prices continue to rise (Pratruangkrai). The annual inflation forecast for 2008 is 5 - 5.5% (Nation). The price of food and beverages rose 9.8% in the same time period, which is of some concern since this means the urban poor will be more vulnerable to hunger (Bangkok Post). Rising food prices and appreciation of the baht could potentially result in a decreases in exports (World Bank), but due to rising global demand for food staples, Thailand could contribute up to 45% of global rice exports this year, up from 31% last year. This April, the country posted a 36% increase in rice exports over the last quarter, aided in part by Vietnam and India's limitations of rice exports in order to secure the domestic supply. Vietnam is the second-largest global rice exporter, and these countries are effectively driving world rice prices up by limiting the supply of rice for export.

If inflation leads to slowing domestic consumption, this could have critical human consequences leading to hunger and higher poverty rates, particularly for the urban poor, who do not participate in subsistence agriculture. The agricultural sector stands to gain from the global demand for rice, and the Thai prime minister recently announced plans for the development of a rice cartel composed of five Southeast Asian countries. Government price controls on over 200 items, including rice, should keep prices relatively affordable for Thai consumers. In late April, the Thai Ministry of Finance announced an increase in the minimum wage in order to help

consumers afford household and other goods and services. Still, women outside the formal labor sector, including sex workers, do not stand to benefit from this policy.

The economic makeup of Thailand is closely related to income levels and women's labor force participation. About 40% of the population and of the poor work in the agricultural sector, though it accounted for 9% of GDP in 2007. The rise in agricultural prices since 2004 has raised farm incomes by more than 15% annually. Farm incomes are estimated to have risen by another 26 percent in the first two months of 2008. From 2004 to 2006, Thailand's poverty headcount fell by almost 2 percentage points, with most of the reduction occurring in rural areas. This translates to over 1 million people who rose above the poverty line. This trend is expected to continue through early 2008. However, there is evidence that the urban poor, as well as the rural poor engaged in fishing and other non-farm activities, have been adversely impacted by the rise in food prices (World Bank).

Gendered differences in labor force participation, wages, and labor segmentation limit women's earning power[6] (National Statistics Office). Women make up a larger percentage of low-income wage earners, and earn about 62% of the amount men earn: In 2005, the estimated earned income for women is PPP $6,695, while the estimated earned income for Thai men is $10,732 (UNDP 2008). Traditional gender roles may contribute to this gap, especially in rural areas, as married men are viewed as the primary breadwinners while women are responsible for maintaining the home and the well-being of the family. Any work that women take on is more culturally sanctioned if it can be done from the home and it does not compromise her ability to perform household work. Many rural single women migrate to cities for work, and they tend to accept low-paying work in factories or the service sector. This contributes to the low rate of earned income. Female sex workers who may earn more than the average income level do not

[6] See Appendices G, H, I and J.

report their finances to the government, and this also affects the way aggregate statistics get reported.

IMF analysts argue that the Thai economy needs to keep developing and move toward production of higher value-added manufactured goods in order to avoid falling into a 'middle-income trap' of low growth rates and a plateauing economy. They use new growth models and advocate for policies aimed toward increasing investment in order to stimulate the economy. Although Thailand has adult literacy rates of 92%, with women lagging behind men slightly, education rates drop at the secondary and tertiary levels (Knodel) and this limits the amount of human capital available for companies to utilize when investing in research and development. Limited human capital and infrastructure means Thai companies have difficulty shifting production toward higher value-added goods or creating an information-based economy. Consequently, Thailand has not attracted high levels of private investment, which limits its capacity for growth (IMF).

In response to sluggish growth and infrastructural shortcomings, this year the government instituted a number of economic policies designed to stimulate investment and consumption. The government cut taxes for firms and lowered the reserve requirement for financial institutions. In late 2007, the government approved construction on three substantive mass-transit projects, which will cost over $3 billion US. The country also has plans to invest in development of the petrochemical sector (IMF 2007). In May 2008, Thailand entered into a plan with 12 other Asian countries to create an $80 billion foreign-exchange reserve fund. The fund would offer currency stabilization and loans to member countries, circumventing IMF interventions that require extensive restructuring and stringent conditions in exchange for aid (International Herald Tribune).

The economics of sex work in Thailand – push/pull factors

A high proportion of sex workers are young women who migrate to cities from rural areas. They often have lower education levels, so sex work is a higher-paying job than what they might otherwise earn in the service or agricultural sectors. Sex work is one of the most highly lucrative occupations available to women in Thailand, which places hundreds of thousands of young women at risk for violence, exploitation, and acquiring HIV.

Women who have fewer marketable skills or lower education levels may find that their most lucrative employment option is sex work, which is relatively well-paying in comparison to agricultural, industrial, or service sector work. International Labour Office surveys found a mean monthly income of US$800 for all sex workers, with a mean of US$1,400 for massage parlor workers and US$240 for women in brothels (Lim 1998). Although the Thai government devotes funding toward educating girls in particular, the scope of the program is limited and the majority of young women enter the labor force since tertiary education is unaffordable for most families (Knodel).

Women who do have some education still face somewhat limited career choices. Again, the sex industry provides a well-paying alternative to the largely repetitive, low-level jobs that are available to women there. Additionally, many rural men and women are attracted to urban areas as cultural, economic, and social hubs, which rural society cannot offer. The lure of higher urban wages convinces many young people to migrate. Although entering sex work can result in rise in income and standard of living, and the remittances sex workers send help support their families, women are vulnerable to violence, exploitation, and harassment from law enforcement agencies. Between 20,000 and 30,000 Thai sex workers are Burmese immigrants, and almost all

of them immigrated illegally. Additionally, a 1993 survey estimated between 30,000 and 50,000 Thai sex workers were minors, and many adult sex workers report entering the industry before they were 18. Some women were trafficked or deceived into working in the sex industry, but most Thai sex workers are in their early twenties and enter the industry voluntarily (Lim 1998). They do not generally stay in the industry for more than five years, but often get married or return home to work in a different sector (Seabrook).

Some scholars suggest that traditional gender and religious roles contribute to the entrance of women into the sex industry. Caring for their parents is one of the primary ways young women can attain religious merit in Theravada Buddhism, which is the predominant religion in Thailand. Because daughters are traditionally responsible for the economic well-being of their parents, societal and economic pressures make prostitution the most pragmatic choice for many women. Women working in the sex sector in urban areas transfer almost US$300 million annually to their families in rural areas, a sum that in many cases exceeds the budgets of government-funded development programs. Between 1993 and 1995, prostitution yielded an estimated annual income of between US$22.5 and 27 billion (Lim 1998).

Although traditional morality and the legal system sanction sex workers, government and legal officials, as well as families, tend to overlook the stigma around the profession. Families that benefit from a daughter's remittances may not question their daughter's work, though many women report lying to their families about their income source. Furthermore, Thais tend to be relatively permissive of men's premarital and extramarital sexual dalliances. Sex workers enable men to gain sexual experience and express virility and masculinity whilst allowing young unmarried women to remain chaste. Prostitution serves as an outlet that enables the majority of society to adhere to traditional gender roles and expectations.

There is a significant domestic and international demand for commercial sex, which feeds the booming sex industry. The Thai sex industry generates almost $5 billion annually, or about 3% of GDP (Associated Press 2003, Petras and Wongchaisuwan 1993 quoted in Kempadoo 242). The hospitality industry also benefits from consumption of sex, and firms in this industry generate considerable tax revenue (Lim 1998). Therefore, little economic incentive exists for the government to curb demand for paid sex in Thailand. It is instead more lucrative to simply promote safe sex between sex workers and their clients. Furthermore, the sex trade is notoriously difficult to control, and the government risks forcing the trade underground, decreasing government control, and increasing the vulnerability of sex workers if it attempts legal sanctions. Therefore, government policy generally does not penalize sex workers, but neither does it recognize sex work in the formal economy. This contributes to the continued stigmatization of sex work.

Young, single women may opt to participate in part-time sex work to supplement their incomes from full-time work in low-paying manufacturing or service sector jobs. Their economic vulnerability and lack of bargaining power places them at risk for violence, exploitation, and acquiring HIV/AIDS if they acquiesce to client refusal to wear a condom. Estimates for the number of sex workers in Thailand range from 200,000 to 300,000, out of a population of 65 million ("Thailand Debates Sex Trade," Lim 1998). Official estimates of the number of Thai sex workers are much lower. Government records counted about 61,000 direct and indirect sex workers for 1998, and indicate the sex industry is contracting[7] (National Statistical Office). Because of the mobility and transience of women in the sex industry, in addition to its illegality, it is difficult to obtain good estimates for the number of women and girls in the trade.

[7] See Appendix K for official estimates.

A 1998 International Labour Office study suggests the demand for paid sex in Southeast Asia is relatively inelastic, even during economic contractions. The sex industry flourishes worldwide, including in impoverished countries, since sex workers adjust prices to meet demand. Furthermore, consumption of sex and other luxury goods provided an attractive and relatively affordable distraction for Thais concerned about their jobs and the economy in tailspin. International sex tourists, particularly Western tourists, were largely unaffected by the economic crisis and had further incentive to take advantage of the lower price of sex work (Lim 1998).

During the financial crisis, tens of thousands of Thais lost their jobs, and empirical evidence indicates women, more than men, face decreasing job security during downturns in the business cycle. This would suggest that after the financial crisis, women's unemployment rates would rise more than the rate for men. However, employment statistics indicate men and women registered similar rises in unemployment rates during the 1997 financial crisis[8]. Women who lost jobs during the crisis may have opted not to re-enter the labor market, due to the scarcity of jobs and the depressed economy. It is possible that lower-income women moved into the sex sector to earn income, as Lim suggests, though white collar workers may be less likely to enter the sex industry due to their skill sets or education rates. Following the Asian financial crisis in 1997, the number of men patronizing sex workers dropped sharply, but as the economy recovered, the demand for paid sex rose as well.

Despite the 1997 economic contraction and budget cuts, HIV prevalence rates amongst sex workers continued to fall. HIV programs had been well-funded for several years prior to the crisis, so Thais had been well-exposed to HIV messages. This is an encouraging sign for other middle-income and high-income countries that face both economic downturn and similar HIV trends. Funding for the 100% Condom Campaign was cut during this time, and provincial

[8] See Appendices L and M.

governors ensured condom supplies had high turnover so few supplies remained, but the percolation of HIV messages and the economic mood may have been adequate to keep women safe and infection rates down. It may be harder to generalize for low-income countries.

Government successes targeting HIV in the general population and sex worker subpopulation

The high prevalence rate of HIV in Thailand during the 1980s spurred what came to considered one of the best approaches to treating the HIV epidemic. The first case of AIDS in Thailand was documented in 1984, three years after the U.S. Center for Disease Control identified the HIV virus. Subsequent testing of groups of sex workers and military conscripts showed alarming infection rates. Prevalence rates amongst direct sex workers peaked at 28.2% in 1996 before rates steadily declined. There was a 2% rise in prevalence between 1999 and 2000, but the gains in lowering prevalence rates resumed in 2001, falling to 5% in 2007 (Revanga 12). Still, this is high in comparison to the prevalence rate for Thai adults living with HIV, which is 1.4% (Global Fund).

According to public health officials, the virus spread through the population as men acquired the virus, often from sex workers, and transmitted it to their wives and partners, who in turn passed the virus to their children. Based on the early prevalence rates in Thailand, health officials predicted a huge surge in new infections. Due to government intervention, HIV rates have stabilized over the past few years, but rates of new infections are steady or rising in some populations. UNAIDS estimated that in late 2005, 39% of the 560,000 HIV-positive adults were women.

In response to the high prevalence rates, the Thai government unrolled a series of programs during the early 1990s to address prevention, treatment, and care for people living with

HIV/AIDS. Government spending reached US $82 million annually before falling to $65 million in the awake of the Asian financial crisis (Revenga 25). The government worked with businesses, religious groups, and other non-governmental organizations to introduce HIV awareness programs in schools and mass media. Public service announcements about HIV aired every two hours on television and radio in the early 1990s, and information was disseminated in a variety of public locations. This was made possible by making HIV/AIDS a central government policy priority. Thailand was fortunate that economic development during those decades made possible the direction of large amounts of government revenue towards prevention and treatment efforts. Although the country has faced political instability, the constitutional monarchy generally has a strong military junta that is able to concentrate funds toward large policy projects.

The 100% Condom Campaign was an effort starting in 1991 to promote condom use in bars, clubs, brothels, and other sites of sex work. The government distributed 60 million free condoms annually in order to prevent new infections. Government agencies encouraged brothel owners to refuse services to customers who refused to use condoms, and provided HIV testing, counseling, and treatment for sex workers (Breyer). Brothels that did not enforce the 100% condom use rule risked government closure, though studies have indicated that indirect sex workers have lower rates of condom use.

Surveys of HIV tests amongst military conscripts showed that young men had high prevalence rates, so the Planned Parenthood Association of Thailand and other public health groups worked with the military to incorporate HIV education into their training. Military instructors distributed condoms and directed conscripts to discuss HIV with other people, in order to foster straightforward conversations on HIV and sexuality (BBC). The Planned

Parenthood Association also reached out to educate fisherman, who have high HIV prevalence rates.

Furthermore, the Thai Red Cross Society provides free AZT to pregnant women, which has kept vertical transmission rates low. Thailand also began offering free antiretroviral medications as part of its universal health care plan, and encouraged the production of cost-effective generic ARVs. The country has received a significant amount of foreign assistance for fighting HIV/AIDS, but 40% of AIDS patients did not have access to treatment in 2005 (PBS). The Asian financial crisis decreased funding for HIV/AIDS programs to $65 million, but funding levels have since recovered.

Once a person tests positive for HIV, the next best way to contain the spread of the virus is to start him on antiretroviral therapy. By suppressing the virus and keeping his blood viral load, the individual is less likely to transmit the virus to other people (Revenga). In Thailand, the universal health care plan covers the entire cost of antiretroviral therapy, including the cost of early intervention and treatments for more advanced stages of the disease. The health care plan is better equipped to fund early antiretroviral treatment, since it becomes much more expensive to fund advanced treatment. However, the government decision to invest in antiretroviral therapy is made more feasible by the procurement of cheaper generic antiretroviral medications. The prevention efforts are therefore a key part of government policy, and are considered an investment that lowers government costs in the long term.

Several scholars and public health groups have criticized the government's reluctance to assist injecting drug users, who remain a high-prevalence population in Thailand. Additionally, most of the HIV outreach and media messages have been conducted solely in Thai, which is ineffective for ethnic minorities and hill tribes that speak Malay and other dialects.

In 2001, the Thai Ministry of Public Health began the Enhancing HIV-related Care and Treatment (ECAT) initiative, which provided treatment and care for HIV-positive mothers and their families in four provinces (Global Fund). The Thai government incorporated antiretroviral therapy into the universal health care plan in 2003. By May 2006, about 78,000 people had received antiretroviral therapy through the National Access to Antiretroviral Program for People Living with HIV/AIDS, and 8,000 people received ART through the Thai Social Security Scheme (Revenga 2006). In 2007, about 100,000 people living with HIV/AIDS received antiretroviral therapy (UNAIDS).

In 2007, HIV/AIDS expenditures from Thai agencies and foreign organizations totaled US $212 million. The total expenditure on HIV/AIDS accounts for 0.081% of GDP in 2007, or equivalent to 2.7% of Total Health Expenditure. Eighty-three percent of spending was conducted by the Thai government (UNAIDS). Of government spending, 72% of funding went toward care and treatment, of which antiretrovirals and opportunistic infection drugs accounted for 92%. Fourteen percent of total funding was directed toward prevention efforts, and the remaining 10% was spent on program administration (UNAIDS).

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has disbursed a total of $123 million to Thai government agencies and nonprofit organizations to assist with funding for treatment and prevention. In 2003, the Global Fund began funding a $14.7 million grant for the Ministry of Public Health's ECAT program, so the Ministry could scale up its pilot program to include every province of the nation. As of mid-April 2008, $10.4 million of the grant allocation has been spent. Although considerable resources went toward fighting HIV/AIDS, 20% of HIV/AIDS patients did not have access to treatment in 2006 (Revenga). Twenty-one percent of orphaned and vulnerable children received free basic child care, generally when one or both of

the parents were HIV-positive (UNAIDS). Forty percent of schools in 2007 had at least five hours of life skills-based HIV education curricula, though in some schools curricula could exceed 16 hours a year with an intensive lesson plan on sex education.

The nonprofit Thai Population and Community Development Association, run by former Minister of Public Health Mechai Viravaidya, established "Positive Partnership" microcredit programs for HIV-positive individuals. Because of the stigma and misinformation around HIV, especially in small communities, fearful citizens are sometimes reluctant to conduct business with people living with HIV/AIDS. The programs pair business partners, one of whom is HIV-positive and one of whom is HIV-negative. The program works to dispel myths about HIV and to provide a source of income for people who might otherwise face job discrimination based on their HIV status. Seventy percent of participants are women. The microcredit program disbursed US $100,000 to 388 people in 2004, or about US $258 each. Income earned per month ranges from US$ 50 to US$ 500 with an average of US$ 90. Given that HIV medications cost at least US $30/month if paid for out of pocket, these programs can have a strong impact on the quality of life for people who are HIV-positive[9] (Population and Community Development Association).

HIV policy evaluation

The government approach to the HIV epidemic in Thailand was relatively well-handled, especially for preventing heterosexual transmission, which is encouraging for other middle-income countries. Low-income countries in Africa have adopted brothel-based interventions similar to the 100% Condom Campaign, and this is promising because prevention efforts are

[9] For more on sex-disaggregated household income and expenditure, see Appendices N and O.

currently the most cost-effective manner to control the spread of HIV (Revenga). Still, the Thai government must continue to expand prevention efforts and access to HIV treatment.

Current scholarship has focused on how the epidemic has played out in Thailand, and how the government can continue working to eradicate the virus. The 100% Condom Campaign significantly raised rates of condom usage amongst sex workers, but government strategies still need refining. Although condom rates are relatively high for direct sex workers, averaging about 90%, indirect sex workers report lower rates of 86%. Infection rates amongst sex workers and the general population have declined over the past two decades. The decreases in prevalence rates can be attributed to increased testing and higher rates of condom usage. UNAIDS reported that in 2008, 52.6% of female sex workers surveyed had an HIV test in the last year and know their status. Additionally, sex workers who tested positive for HIV subsequently retired from their jobs, which would lower prevalence rates. HIV rates remain high amongst sex workers, so treatment and prevention efforts remain important policy goals. Men report consistent condom usage with sex workers, but report low rates of usage in the context of marital or romantic relationships (Revenga 11). This endangers women who do not engage in high-risk behavior.

The US $434 million spent on HIV prevention and treatment during the 1990s resulted in savings of an estimated US $18.6 billion had the government taken no action over the decade. Spending levels were substantially more than what most governments were spending, but the World Bank estimates that each dollar spent saved US $43 in treatment costs for people who would otherwise be infected (Revenga xxv). Over 80% of people who need antiretroviral therapy receive government-provided treatment (Revenga xxiii). Although antiretroviral therapy is free with the state health care plan, barriers to accessing treatment remain, especially in small communities where stigma around people living with HIV/AIDS is pervasive (Revenga 3-4).

Some HIV-positive people move from their original homes where health workers will not recognize them, or they access treatment in an area farther from their home.

Government expenditures on HIV programs are critical for improving the quality of life for people living with HIV. A World Bank assessment of Thai government HIV spending found that the cost of antiretroviral therapy is generally beyond the means of average Thais, especially those with advanced HIV who need second-line therapy (Revenga 148). Even those who are in higher income brackets would have seen a substantial decrease in their standard of living if they paid for antiretroviral therapy out of pocket, since they would remain on the medications for the rest of their lives (Revenga 149). About 18% of HIV patients receive care from private providers, and the remainder utilizes government resources (Revenga 37).

Increasing demand for condoms should be a key goal for governments dealing with HIV/AIDS. Supply-side condom use strategies focusing on sex workers can be somewhat limited, since sex workers cannot always exercise much bargaining power and there are high economic incentives to provide unprotected sex (Gertler 2005, Nishigaya 2002: 41). Furthermore, such programs place primary responsibility upon women to enforce condom usage, while many clients resist condom use and threaten violence if the woman continues to insist upon usage. Frequent alcohol and drug use amongst both sex workers and clients is common, which creates further barriers toward enforcing condom policies. Many women who enter sex work are particularly economically vulnerable, and face violence and exploitation from their bosses, creating economic incentives to meet client demands for unprotected sex despite risks to their health and safety (Nishigaya 2002).

Women provide a significant amount of unpaid care work for people living with HIV/AIDS. Young women who acquire the virus often return home and her parents care for

them there (Bates), and married women look after their husbands and relatives who are HIV positive. This saves the government and private sector a significant amount of money. However, it lessens the free time and earning power of women who provide such care work.

HIV prevalence rates amongst sex workers have decreased while economic growth has slowed. Economic concerns and political instability currently have greater political salience in the country, meaning less attention is paid to HIV/AIDS. Furthermore, Thais have been more complacent about condom usage and prevention efforts, since many Thais hold the perception that the HIV crisis has largely passed, or they underestimate their risk for acquiring the virus. Although prevalence rates have decrease in most subpopulations, women remain vulnerable for acquiring the virus, particularly sex workers.

HIV policy alternatives and recommendations

Thailand must continue to make prevention and treatment efforts a policy priority, and to publicize the continual salience of HIV/AIDS as a key health concern for Thais. The government should develop efforts to include the role of gender and HIV/AIDS into considerations of trade, growth, and monetary and fiscal policy. The government currently has several offices that focus on issues of gender equity, including the Thailand National Commission on Women's Affairs and the Office of Women's Affairs and Family Development. It is critical that these offices remain fully funded and that their input is incorporated into national policy formation and economic affairs.

Revenga et al. suggest that the Thai government's HIV expenditures have been extremely cost-effective, so continuing to fund HIV programs is a good use of government revenue. She suggests the government could potentially reward patients with cash transfers for adherence to

antiretroviral therapy, since the government has an interest in keeping the populace healthy and productive (Revenga 150). If the government HIV budget is stretched, the government could consider implementing low user fees, though this might discourage people living with HIV from utilizing the resources. Revenga suggests that frequent and consistent HIV testing would save money on treatment costs, so newly infected individuals could access antiretroviral therapy sooner. Knowledge of HIV status would help prevent new infections, and would also be cheaper than diagnosing HIV after it has already become symptomatic, in which case a more intensive therapy is necessary.

Government and economic reevaluations of the work that women perform has the potential improve the lives of women in Thailand. Government policies should offset care costs through subsidies or cash transfers to women who perform care work for people living with HIV/AIDS. This could improve the quality of life for both caregivers and care recipients, since AIDS diminishes a patient's ability to work, and care work cuts into a woman's ability to participate in the formal and informal labor markets. Programs that provide HIV education for caregivers would also be beneficial for improving the quality of care for people living with HIV/AIDS. This would have the additional benefit of enabling caregivers to inform other people about HIV if an acquaintance asked to learn more about the disease.

Lim advocates for government recognition of the economies of sex work, even if sex work remains illegal. By making this work part of the formal assessments of economic activity, governments can make visible a significant portion of work that is otherwise ignored or assigned little value. Governments could then collect better data and formulate better-informed policies. The challenge for feminists and labor advocates would be ensuring that government oversight was acting in the best interests of sex workers. An idea balance of government intervention

would include government enforcement and prosecution of trafficking laws, while ensuring that those who do choose sex work have access to a safe working environment free of harassment and exploitation (Lim 1998).

Legalization or decriminalization of prostitution can mean sex workers gain access to social security plans, retirement funds, regular vacation time, health benefits, and greater legal protection against employers or clients ("Thailand Debates Sex Trade" 2003). However, it is possible these approaches could result in continued incentives to traffic women, as has happened in the Netherlands. Several European countries have legalized or decriminalized sex work in attempts to reduce crime and prevent the spread of disease, and these attempts have had mixed success in doing so. Britain and France decriminalized prostitution, while Germany, Denmark, and the Netherlands legalized sex work. The Netherlands continues to struggle with organized crime and sex trafficking, prompting Amsterdam city officials to buy up property bordering the red-light district and resell it to private retailers and shop owners. Several countries, including Sweden and the U.S., criminalize paying for sex in an attempt to lower demand for sex work, but this measure has not had a significant impact on reining in the sex industry (Graff 2008).

Another way to engender Thai macroeconomics is to quantify the value of nonprofit organizations and include those figures in gross domestic product calculations. These organizations are a critical resource for helping sex workers remain healthy and obtain better working conditions. The groups are often reliant upon unpaid volunteer labor, particularly from women. Although they do not directly generate profits, their services are inputs into the labor force, such that their beneficiaries remain healthier and better able to work. Assigning monetary value to the work nonprofit organizations conduct would accomplish two things. Firstly, it would lend greater social value to nonprofit work, and secondly, it would reemphasize the

feminist economics argument that the labor force is produced and is an endogenous factor in growth.

Such organizations are reliant upon government grants as a primary funding source, and consistent government support is crucial for preventing new transmissions and improving the well-being of women. If the government and the private sector are reliant upon a healthy, productive population, it is in their interest to invest in the health and well-being of its citizens. Co-ops offer an empowering way for sex workers to assist themselves and others. Calcutta sex workers in the Usha Multipurpose Cooperative Society created a bank specifically for sex workers to use, after Usha's founder faced barriers to setting up accounts and accessing the financial system. Sex workers have organized co-ops in Vancouver and Bangkok, and advocacy organizations for sex workers exist in over forty countries (nswp.org). The co-ops, funded through private organizations and contributions from sex workers, have provided women with a safer indoor space for women to sell sex.

Nishigaya 2002 and Gertler, et al 2005 suggest that government and health sector efforts should work to increase client demand for condoms within commercial sex settings. Knodel suggests that health officials can encourage client condom usage by appealing to clients' sense of masculinity. By emphasizing their roles as breadwinners for their families, condom campaigns can promote safety and responsibility in a culturally-sensitive manner.

Research suggests that raising women's earned income and education levels increases their bargaining power within relationships. When women experience a rise in earned income, they have a higher propensity than men do to spend income on household expenditures that benefit their families. Sex workers who are illiterate, have little education, or do not speak fluent Thai tend to have higher rates of unprotected sex (Ford). Increasing women's knowledge about

HIV helps women better protect themselves, and more education can have positive effects on self-esteem and positive health decisions. Moreover, further government investment in primary, secondary, and vocational education can provide women with skills for more lucrative career options outside of sex work. Expanding the educational system would increase the nation's human capital, enabling companies to better utilize their employees' talents and develop more competitive products. Additional government spending that appropriates funding for girls and women in particular will better ensure their needs are being met.

Numerous behavioral interventions have been tested to suggest ways to improve on HIV policy and expenditures. For example, the World Health Organization tested an intervention for sex workers that attempted to boost worker self-esteem as a strategy for promoting condom usage. The intervention contained nonjudgmental information about HIV and encouraged workers to consider their long-term plans and goals (Ford). The study effectively tried to provide women with tools with which to increase their bargaining power. The intervention was somewhat successful for high-income indirect sex workers, but was less successful for low-income brothel workers.

Although the women were able to learn more about HIV and methods of transmission, this study seemed based on the premise that women enter sex work because they undervalue themselves and their earning power. The researchers did not discuss economic motives, drug or alcohol use, threats of violence, and pressure from madams and pimps to generate income as considerations that might affect condom usage. They did receive feedback from sex workers while developing the intervention, and incorporated those suggestions into the study. This emphasizes the importance of including sex workers as active participants in health programs, especially marginalized workers with less access to education and information. Some programs

have focused too extensively on the effects of AIDS and not enough on presenting information in a way that is approachable and conducive to further discussion.

Women in the Can Do bar in Bangkok work eight hour shifts six days a week, whereas most sex workers are only allowed two day off each month. They receive the Thai minimum wage, access to the government social security program, and paid holidays, sick leave, and overtime. Condoms and lubricant are readily available, and workers have on-site access to resources on safe sex as well as Thai and English language materials. Additionally, sex workers in the bar are not pressured to consume alcohol, unlike in many other establishments (Empower Foundation). Grassroots efforts have led to improved working conditions for sex workers in various locales, but their scope is often extremely limited. Government and private sector support can help these organizations scale up their efforts.

The World Health Organization, with extensive support from private groups like Rotary International and teams of grassroots volunteers, has successfully contained the spread of the polio virus, even in highly unstable countries like Somalia. This intervention was effective in spite of severe poverty and other social problems that countries face, but it would be mistaken to think the current HIV epidemic can be solved in a similar manner. Although the polio program was one of the great accomplishments of the WHO, the persistence of HIV and the behavioral component requires a larger-scale effort to stop the spread of the virus. Until scientists create a vaccine for HIV, more involved behavioral and structural interventions are necessary for curbing the spread of HIV. These interventions must treat people living with HIV as agents in their labor, treatment and care decisions, not simply as passive recipients of government aid.

Conclusion

Monitoring HIV in Thailand requires reviewing the past and current policies in place, but should also involve a broader approach that takes into account institutional weaknesses and strengths of a society. If women in Thailand have little bargaining power within relationships or are limited in their capacity to obtain well-paying jobs outside prostitution, they will continue to remain vulnerable to acquiring HIV. Engendering macro policy can correct some of the imbalances in valuing women and the work they perform. Removing gender inequality from the markets would result in greater efficiency, and would also be an end in itself. This implies the need for greater investment in human capital, health care, and creating more income-generating opportunities for women so they can attain a decent living and a decent life.

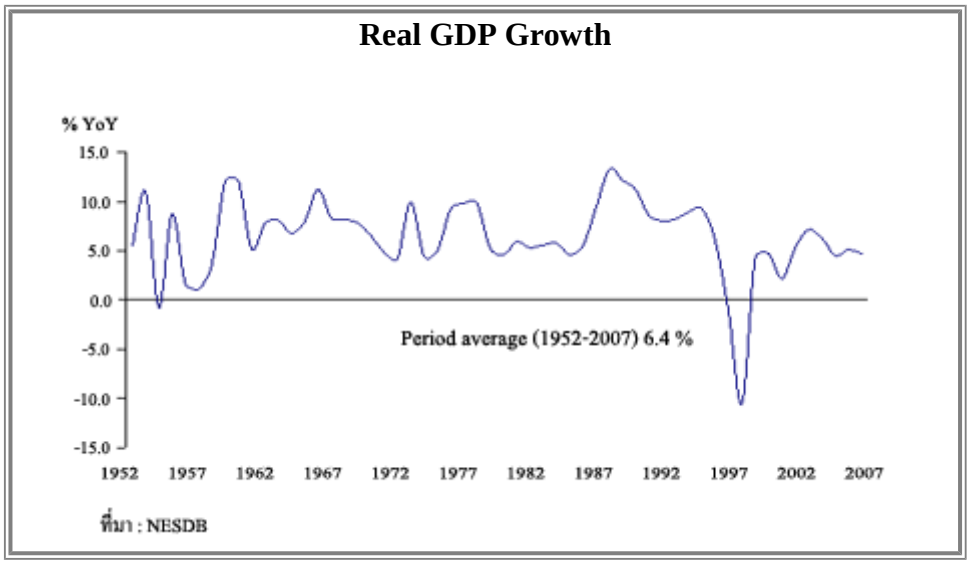
Given the somewhat stagnant growth of the Thai economy, feminist economists should take the opportunity to analyze economic patterns and suggest further ways for the government, nonprofit sector, and private sector to expand. For instance, feminist economists could engender the Todaro rural-urban migration model in order to better characterize the "feminization of migration" in Thailand (Lim 1998). More traditional economists could include gendered variables that represent discrepancies in educational attainment and accumulation of human capital into neoclassical growth models. Since post-Keynesian growth models focus on how income distribution affects demand, a gender aware model can integrate gendered wage gaps into assessments of growth and barriers to growth.

It would be fitting then to recommend that the Thai government should continue to fully fund investments in HIV/AIDS programs, as these are critical for maintaining the labor supply, sustaining growth, and achieving both economic and human development within Thai borders. Inflation due to rising energy and food prices may affect the price of providing affordable health

care, but the global demand for Thai exported rice may help alleviate the pressure on rural families. If women share in the profits of rice sales, this may provide greater incentive for women to remain in the rural economy, and higher gas prices may decrease the propensity to migrate. The Thai government should incorporate these and other gender-aware considerations into health and economic policy formulation. Doing so can create more equitable and efficient market outcomes and improve living and working standards for women in Thailand.

Appendices

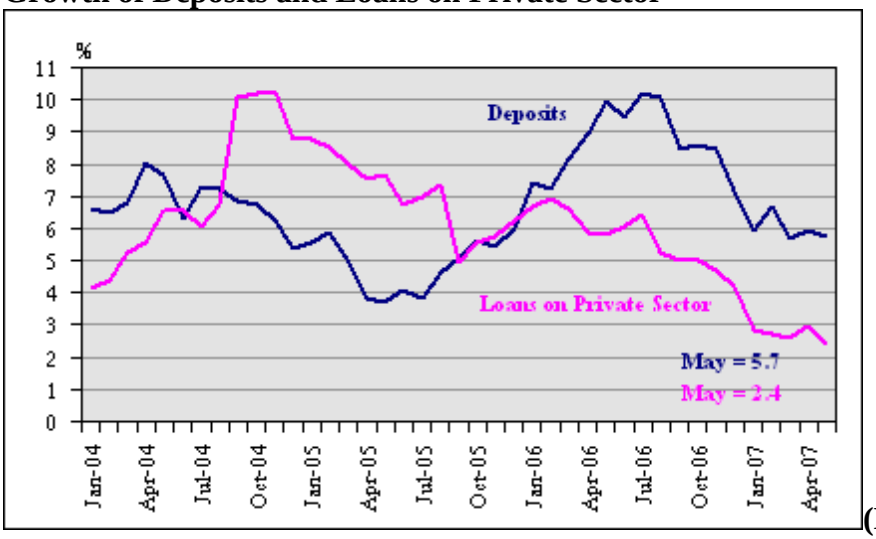
Appendix A



(Bank of Thailand)

Appendix B

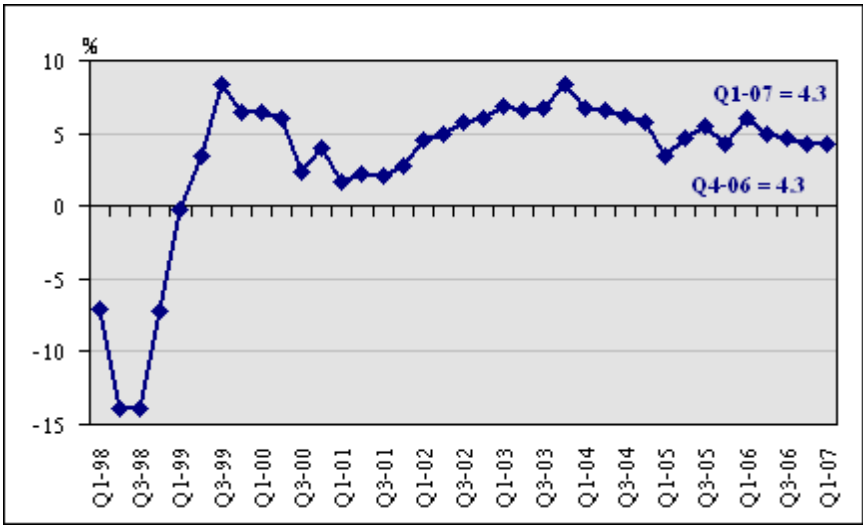
Growth of Deposits and Loans on Private Sector



(Bank of Thailand)

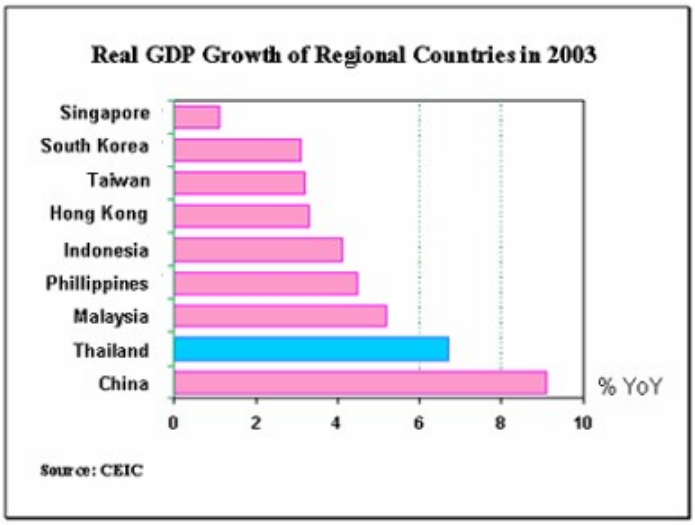
Appendix C

Real GDP Growth



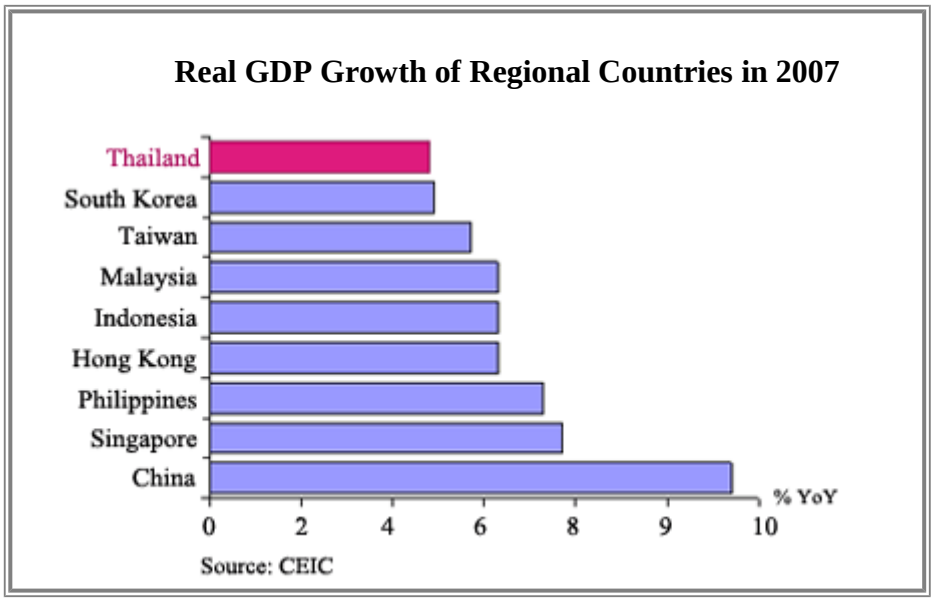
(Bank of Thailand)

Appendix D



(Bank of Thailand)

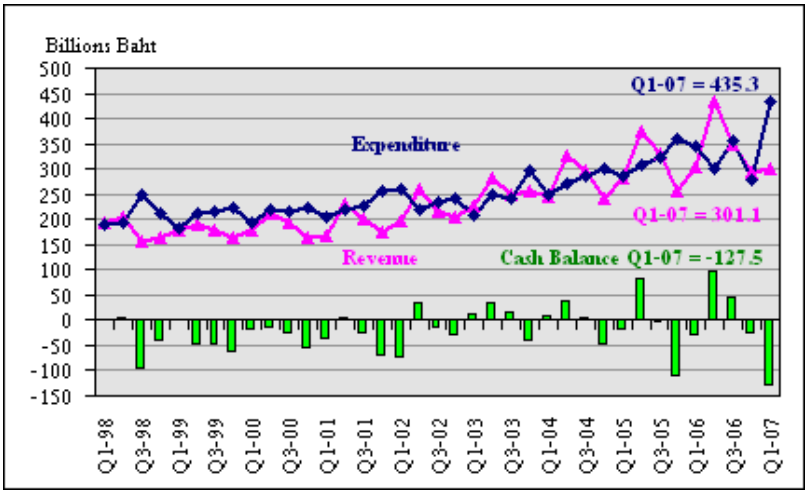
Appendix E



(Bank of Thailand)

Appendix F

Fiscal Position



(Bank of Thailand)

Appendix G

Table 51 : Average monthly income of worker by size of establishment, level of position and sex, 1998 (baht)

Size of establishment	Total		Level of position							
			Director		Department manager		Supervisor		Officer	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Total	**15,074**	**23,742**	**51,206**	**63,848**	**29,666**	**35,998**	**15,545**	**18,355**	**9,388**	**10,971**
100 - 299 persons	12,964	19,791	41,396	53,847	24,666	30,143	13,335	15,750	8,473	9,112
300 - 499 persons	15,139	22,727	53,851	63,229	28,063	36,174	15,815	18,092	9,368	10,162
500 - 999 persons	16,266	27,108	59,751	68,678	35,032	41,570	16,720	20,730	9,702	11,485
1,000 persons & Over	19,079	32,372	66,176	85,365	37,305	43,812	19,207	23,481	11,502	17,215

Source: NSO. and Office of the Civil Service Commission; Pay Survey 1998.

Appendix J

Table 55 : Average monthly income of household by source of income and sex of household head, 1996 (baht/month)

Source of income	Whole kingdom		Urban		Rural	
	Women	Men	Women	Men	Women	Men
Total	**11,119**	**10,670**	**22,485**	**19,607**	**7,561**	**8,545**
Wages salaries	4,016	4,388	9,101	10,640	2,424	2,902
Profits non-farm	2,320	2,091	6,492	5,014	1,014	1,396
Profits from farming	826	1,436	170	157	1,032	1,740
Property income	341	115	1,086	243	108	85
Current transfers	1,343	594	1,765	675	1,211	574
Non-money income	2,126	1,886	3,765	2,766	1,613	1,677
Other money receipts	147	160	106	112	160	172

Source: NSO; Household Socio-Economic Survey 1996

. Appendix K

Table 70 : Number of prostitutes by place of services, 1989 - 1998

Year	Total	Brothels	Hotels	Bar/ Night-club	Turkish bath	Others
1989	85,126	27,842	6,967	6,330	14,044	29,943
1990	85,078	29,148	7,034	5,848	13,627	29,421
1991	74,048	21,712	3,845	6,020	12,317	30,514
1992	75,376	20,786	4,370	6,536	10,431	33,253
1993	68,512	14,039	2,968	11,722	13,312	26,471
1994	67,067	11,825	2,549	12,173	12,776	27,744
1995	81,384	9,057	2,237	12,418	18,226	39,446
1996	66,190	6,413	1,670	12,057	14,115	31,935
1997	64,886	5,847	1,638	12,221	14,426	30,754
1998	61,135	5,457	1,680	9,068	15,383	29,550

Source : Ministry of Public Health ; Department of Communicable Disease Control.
Note: Others include barber-shop, beauty-saloon, escort, pub, discotech[sic], cafe, coffee-shop and guesthouse

Appendix L

Table 41 : Percentage distribution of unemployed persons by duration of unemployment and sex, August 1996-1998

Duration of unemployment (weeks)	1996		1997		1998	
	Women	Men	Women	Men	Women	Men
Total	**39.9**	**60.1**	**41.0**	**59.0**	**34.2**	**65.8**
< 5	35.0	65.0	41.0	59.0	33.4	66.6
5-9	36.9	63.1	38.5	61.5	33.0	67.0
10-14	42.3	57.7	46.1	53.9	34.1	65.9
15-26	61.0	39.0	41.9	58.1	36.2	63.8
> 27	17.5	82.5	37.0	63.0	36.2	63.8

Source: NSO; Labor Force Survey , August 1996- 1998.

Appendix M

Table 42 : Percentage distribution of unemployed women and men by duration of unemployment , August 1996-1998

Duration of unemployment (weeks)	1996		1997		1998	
	Women	Men	Women	Men	Women	Men
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
< 5	35.8	44.2	47.4	47.4	33.1	34.3
5 - 9	21.0	23.8	18.4	20.4	23.9	25.2
10 - 14	19.4	17.6	12.0	9.7	14.1	14.1
15 - 26	22.2	9.4	17.1	16.5	20.5	18.7
> 27	1.6	5.0	5.1	6.0	8.4	7.7

Source: NSO; Labor Force Survey , August 1996- 1998.

Appendix N

Table 53 : Employed persons by income and sex, August 1998

Income month (baht)	**Percentage distribution**		**Percentage share among**	
	Women	**Men**	**Women**	**Men**
Total	**45.1**	**54.9**	**100.0**	**100.0**
< 3,000	47.9	52.1	61.7	55.2
3,001-6,000	43.8	56.2	24.2	25.5
6,001-9,000	35.4	64.6	5.6	8.4
9,001-20,000	40.0	60.0	6.5	8.0
20,001 & over	35.1	65.9	2.0	2.9

Source: NSO; Labor Force Survey 1998
Note: Excluded unknown income.

Appendix O

Table 57 : Average monthly expenditures of households by type of expenditure, residence and sex of household head,1996

(baht/month)

Type of Expenditure	Whole Kingdom		Urban		Rural	
	Women	Men	Women	Men	Women	Men
Total	**7,951**	**8,111**	**14,776**	**13,773**	**5,814**	**6,765**
Food and Beverages	2,864	2,986	4,692	4,658	2,291	2,589
Tobacco and Alcoholic Beverages	235	413	381	761	189	331
Clothing and Apparel	432	441	845	642	303	393
Housing (Include Rental Value of Home)	1,984	1,827	3,979	3,413	1,360	1,450
Medical Care Personal Services	583	557	861	906	496	744
Transport and Communication	1,333	1,440	2,943	2,530	830	1,182
Recreation, Reading and Education	395	359	955	821	220	250
Miscellaneous	124	88	220	46	126	98

Source: NSO; Household Socio-Economic Survey 1996.

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