HIV/AIDS
A Review of the Approaches and Interventions in Thailand

M.S. Shivakumar
V.P. Karunan

A report submitted to *CEBEMO*
The Netherlands

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Descriptions of the Levels of *HIV/AIDS* Care

Home level

The basic unit in any community i.e., the household. Family members are primarily responsible for activities at this level, whether they are seen as individuals, mothers of children or heads of the household. Neighbors, as well as home-visiting community workers of various kinds [including trained health workers] interact with the family and are directly involved in activities at this level.

Communal level

Activities at this level concern the health of a whole community [village/town or group of villages] and require common facilities and/or joint voluntary efforts of community members. Examples are campaigns, construction of facilities, information/education about HIV etc.

Community resource groups, or equivalent is the central coordinating mechanism for activities at this level. It also provides support to activities at the other levels, in particular the home level. The community development committee interacts with, and is supported by, the individual community members, various community groups, and provincial sectoral programmes including health programmes.

Community level *HIV/AIDS* health workers [*CWs*], as well as other community workers and volunteers, function at this level both in promotional/informational activities and in planning and implementation of communal health activities. Many communities provide space for clinicwor treatment centres.

First health facility level

This refers to the first level where a trained health professional is available and where facilities are available for running clinic sessions. The kind of facility and the type of staff available varies from place to place.

In addition to clinical activities, the staff interact both with the home level [during home visits] and the communal level. This level also plays a major supportive role in training and supervision of *CWs*.

First referral level

There are two types of referral systems: [a] clinical referral method which includes the supervision of performance at lower levels; [b] administrative referral, usually involving the district health office. This is the level involved in planning, management and support of activities related to disease control campaigns, health education/information, group support services or liaising with local NGOs.

Description of Terms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome, AIDS, is a predominantly sexually transmitted disease. The scientific community generally accepts that the human immunodeficiency virus [HIV] is the cause of AIDS. AIDS usually develops several years after infection with HIV and is the final manifestation of the destruction of the body's immune system brought about by the virus.
HIV	Human Immunodeficiency Virus *[HIV]*. This virus when fully blown turns into AIDS disease.
ARC	AIDS-related cases
NGO	Non-governmental, non-profit, private organisations.
PWA	Persons with AIDS i.e., those who are living with the HIV infection.
CCT	Church of Christ in Thailand
CCHP	Catholic Commission for Health Promotion in Thailand
CW	Community-level *HIV/AIDS* Worker
CSW	Commercial Sex Worker

This review documents areas of progress and difficulties encountered in the *HIV/AIDS* work being carried out, and is based on an analysis of the current *HIV/AIDS* interventions in Thailand. The field work was undertaken between mid-April and mid-August 1994; the synopsis was prepared between mid-July and end-August 1994, and the draft report was circulated for comments. The final report was consolidated in December 1994. This review attempts to summarise the objectives, strategies, and implementation attributes of *HIV/AIDS* interventions in Thailand. It is based on documents available and information obtained in interviews with persons familiar with the *HIV/AIDS* situation and are active in challenging it. The method of research based on field-conducted case studies and interviews allowed the writer to identify common patterns of experience and understanding of the issues.

Objectives of the Review

HIV/AIDS has been understood well with considerable commitment in Thailand, but implementation strategies are still being tested and assessed, both locally and nationally. Thus, a key purpose of this analysis was to examine the experience of *HIV/AIDS* interventions, and is primarily concerned with community-care support and efforts. The other *HIV/AIDS*-related interventions, such as surveillance of STDs and public health efforts - are discussed only as they relate to and are integrated with *HIV/AIDS* activities. Specifically, the objectives of this review are to:-

- Identify and discuss the major issues in *HIV/AIDS* situation in Thailand; and
- Record and catalogue various interventions to provide insights into their potentials, strengths, and problems.

Review Procedure

Although *HIV/AIDS* has occupied substantial space in public and development debate of Thailand, little comprehensive field-information is available. All the projects and interventions emerged in recent times and a quantitative study will have no relevance. Therefore, an analysis based on non-quantitative information was pursued. During the field work the writer participated in several meetings or interviewed knowledgeable persons. It covered areas of special relevance i.e., projects, agencies, government and individuals, who plan and implement *HIV/AIDS* interventions.

Throughout this analysis, an effort was made to examine the efforts from a number of viewpoints. Attention is given to the particular role and approach of NGOs, the stage of implementation, and project's scale. As much as possible, general *HIV/AIDS* issues, problems, and prospects are distinguished from those more closely tied to the operating procedures. Some commonness was observable in all interventions due to two broad reasons:- [a] the speed with which the pandemic struck the Thai population led to traumatic socio-economic and even political experiences; this trauma is still continuing; and [b] most of the strategies primarily emerged out of the efforts of the larger organisations like *Thai Red Cross Society* or *Ministry of Public Health* - therefore, it was rarely possible to differentiate between specific merits of the approach/strategy of any single agency.

Section 1

An Overview of the *HIV/AIDS* Situation in Thailand

In Thailand, the first case of *HIV/AIDS* was reported in September 1984. At that time, AIDS was believed to be confined only to homosexual men [and possibly restricted to urban areas]. It was not really perceived as a threat to the community and nation by most people. Four years later, early-1988, the first signs of the pandemic swept through the intravenous drug users *[IVDUs]* in Bangkok Metropolitan area. Even at that stage it was believed that the disease was limited to homosexuals and the drug user community.

Amongst the heterosexual community it was observed only in the late 1988 i.e., in the brief span of four years the human immunodeficiency *[HIV]* has spread from a handful of *IVDUs* to several hundred thousand Thai women and men. Since then consecutive "waves" have occurred and spread to commercial sex workers, their clients and pregnant women. Within the first decade of its presence in Thailand HIV has rapidly spread to all parts of the nation and all walks of life - particularly among the poorer sections. The main mode of transmission is heterosexual contact. The immediate causes are *IVDU* addiction among the lowest class of labourers, who in turn, give it to young commercial sex workers *[CSWs]*. They then spread it to their patrons i.e., Thai men of all ages and social classes. The distribution throughout the country is ensured by truck drivers, migrating labourers and a health policy that forces *CSWs* to leave the province once the infection is detected.

The origin of the pandemic, as is believed, is through contact with foreigners: the first *HIV/AIDS* cases since 1984 could be traced to such contacts, although not in all instances with complete certainty. It is conceivable that the virus was already introduced to Thailand before 1980: the sudden outburst of the pandemic in 1988, almost simultaneously in different populations, makes such a preposition probable.

1.1 Data on *HIV/AIDS* Incidence[1]

At present two major sources of information and statistics on HIV infection exist in Thailand i.e., AIDS/ARC Voluntary Reporting System and Biennial Sentinel Seroprevalence Surveillance. Each source covers a different epidemiological aspect of HIV infection. The Voluntary Reporting System provide information regarding individuals infected, and provides important information for planning community and hospital case. The Sentinel Seroprevalence Surveillance monitors the trend of the epidemic in specific groups reflecting the HIV situation among the general population.

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[1] For reasons of lucidity, this report assumes the availability of data and evidence on *HIV/AIDS*.

1.2 Future Trends and Repercussions

In a brief period of four to five years, AIDS has risen to pandemic levels in Thailand. Moreover, several demographic and epidemiological projections estimate that, if current trends do not change by 1995, two to four million Thais will be infected by the year 2000. While more males are initially infected, by the year 2000 more women will be infected than men. Available data predict rising rates of HIV-infected pregnant women, deaths of children under five due to *AIDS/ARC*, and AIDS/ARC-related orphan children as AIDS affects families.

Projected levels of illness and death will place significant financial burdens on families and the government. Health care costs for people with AIDS are estimated to be between US$ 660 and US$ 1,000 per year. These estimates are based on conservative assumptions about the type and level of care required. Treatment costs for AIDS represents between 40-50 per cent of annual household income for the average Thai family. The inability of families to bear this financial burden will require the government to fund the cost of care. With current health care expenditures of US$ 25 per capita, the costs of AIDS treatment will severely strain the governmental resources. A far greater future cost to the economy will result from deaths of individuals during their reproductive years. In addition, AIDS is likely to have an even greater impact on the Thai economy, particularly the most valued sectors of tourism, foreign investment and labour remittances from abroad[2].

HIV/AIDS in Thailand has no territory i.e., it is prevalent both in rural and urban areas. However, the rural population seems to be the most affected, especially adolescent single males and adolescent married females. The high prevalence found among army and police recruits is part of this pattern. There is no definite explanation for the concentration of HIV infection in the North of Thailand. About 50 per cent of all *AIDS/ARC* cases from the North suggest that apart from co-factors such as STDs, the spread in the North is also related to a specific pattern of sexual behaviour and culture which differs from other regions.

Some questions remain unanswered. For instance, the rapidity and effectiveness of the spread of HIV among certain sub-populations. For example, in case of *IV Drug Users [IVDUs]* not only well known factors of needle sharing and a specific subculture of common drug preparation and injecting within a closely interacting group were pointed out, but also the active mobility of *IVDU's* in search of treatment, their participation in travelling professions, the wide availability of drugs and characteristics of law enforcement apparatus - all these elements favour rapid transmission of HIV over long distances.

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[2] Based on various documents published the Ministry of Public Health *[MoPH]* and discussion with Dr. Wiwat, Chief, AIDS Section, *MoPH*.

Section 2

The Context and Nature of Risk Behaviour

Thai sociological texts and development experts contend that sex was considered as a necessary component of Thai life that was recently converted into a marketable commodity without causing moral conflict. Discussing sex is considere taboo in Thai society; however, available information suggests that sexual attitudes and the behaviour of both men and women is changing, from pre-marriage through to wedlock [The Nation, Yearend Review, 1994].

For example, in Thai society, extramarital sex is not only manifest in the patronage of minor wives, but also in the form of buying one's pleasure. City men now go to sex entertainment places for more than just enjoying themselves. The luxurious forms of sex entertainment, such as offered by cocktail lounges and member clubs, is widely used for the purpose of business advancement too. A recent research study[3] on "educated girls becoming commercial sex workers" indicates that several firms now allocate some "entertainment" budget for their executives to pay for their memberships in night-life clubs. This study concludes that: "generally, Thai men regard purchased sex as windfall profits in life. And when called upon to entertain their business guests, they often think of sexual services as the most satisfactory means". It is stated that young Thai females are encouraged to prefer to have sex with persons from higher socio-economic status or Western "strangers". This nuance is not available either in the Western or other Asian texts.

A look at the Buddhist forms of Thai sexual culture also reveals interesting elements. Buddhism preaches modesty, abstinence and chastity - one might deduce that there is a cultural regularity within Buddhism. However, this regulation does not repress or control sexuality. It provides positive motivation to give up the search for sexual pleasure or following erotic desire. If such assertions are true, we confront three major issues on *HIV/AIDS*:-

a. Is there a loosening of social control that resulted in increase of sexual behaviours that lead to *HIV/AIDS* infection?

b. In many ways sex has become a commodity in Thailand. Though Western media has commercialised sexuality for long, it did not allow commercial sex workers on a large scale to exist. If so, why and under what conditions commercialisation of sex took place in Thailand?

c. Why should newly acquired power and wealth be used to claim sexual services or command women for sexual needs?

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[3] *"Educated Girls Becoming Commercial Sex Workers"*, a thesis submiited to the Graduate School at Srinakhariunwiroj University, Bangkok by Chongchit Soponkanaporn in 1994 [unpublished].

The present state of the commercial sex industry in Thailand is that it is highly visible, economically successful, internally differentiated and illegal. Commercial sex industry no more depends on tourists alone, and has established a "local market" too. It is an irony that since the 1960s the main policy issue has been how to reduce the size of the industry while, in fact, this period saw the greatest growth of the industry, often under the indirect patronage of the government. Three major factors can be linked to the growth of the commercial sex industry in Thailand viz., gender roles, economic development and tourism. These factors are discussed below along with others to provide an overview of the present circumstances.

2.1 Context of Sexuality and Sexual Behaviour

The most discussions on *HIV/AIDS* is largely limited to the following: human sexuality and the social consequences viz., [a] those focusing on sexual behaviour itself, its analysis and change; [b] those focusing on the context that helps to clarify various forms of contemporary Thai sexual behaviour. The former group emphasise change in "knowledge, attitude and practice", whereas the latter group look forward to "socio-cultural-structural" changes.

Thailand is sometimes portrayed in the Western mass media as a sexually permissive society, but the reality is far more complicated. Social conventions governing sexual practices between unmarried Thais may be changing in response to numerous social, demographic, and epidemiological pressures; still, these conventions remain quite distinct for Thai men and women. Evidence is available to indicate that the occurrence of premarital sexual relationships was not unusual in the Thai society.

2.2 Attributes of Economic Development[4]

The pandemic of AIDS in Thailand is best understood by looking at the fundamental changes in rural Thailand that caused massive alterations in the physical and social environment which led to the substantial migration to the cities since the early 1960s.

Economic development in Thailand has had a strong international orientation. In the 1950s and 1960s, this was immensely related to investments made by the United States. These investments were mainly undertaken for strategic reasons by the US, but the result was large transfers of money and men into Thailand. Most of these men were military personnel who came to Thailand for short periods of time, either to serve at US military bases established in Thailand or in the neighbourhood. Their presence in Pattaya and other centres allowed the formation of "night entertainment" centres. After the Americans left, these centres survived and expanded on the basis of tourists. But the more important US investment has been to transform agricultural base of the Thai economy into a manufacturing and export-oriented economy. This change steadily began sometime in 1970s.

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[4] Refer to Santasombat, 1992; Sahasakul, 1992; and Krongkaew, 1993.

In the early 1960s, the first *National Development Plan* was formulated and implemented under which farmers were persuaded to plant cash crops and new varieties of rice that produced higher yields. The expected higher cash income was a very persuasive argument and the plan turned out to be successful. Thus, a subsistence rural economy was transformed into a market economy. Production of cash crops needed external inputs such as fertilisers, pesticides and chemicals for which farmers obtained loans from various sources. However, yield was not sufficient every year, and there were some difficult periods. To avoid destitution, farmers resorted to seasonal migration to urban areas, and returned to native towns in time for planting and harvesting. This seasonal movement steadily developed into a quasi-permanent or near-permanent migration to industrial or metropolitan areas seeking a livelihood.

The important military-related investments and impact of national development plan have been the domestic economic policies which have attempted to transform Thailand's agricultural economy into an economy with a high proportion of its nationalproduct derived from the export of industrial goods and provision of services was introduced in late 1960s through early 1970s. Economic growth during the 1970s was high, due in large part to high prices of farm products on the world market. a decline in prices of agricultural goods at the end of the 1970s coupled with a rapid escalation in the price of oil, depressed the Thai economy and prompted the government to apply for World Bank structural adjustment loans.

However, a shift in emphasis from agricultural to industrial exports, and from import-substitution to export-led growth, has also resulted a shift in the spatial concentration of development efforts and in labour force demands. The strategy of structural adjustment was pursued in conjunction with extracting surplus from the agricultural sector for industrial investment, subsidising urban dwellers in order to keep urban wages low, encouraging foreign investment and promoting tourism [TDRI Reports].

A few negative outcomes of this development strategy have been increasing inequality between areas and among social groups, marginalisation from economic development of some groups, and the increased commercialisation of Thai society. These processes are apparent in the contrasting patterns of urban and rural development. Poverty in Thailand is overwhelmingly rural-based, and its concentration is increasing. It also resulted in the inevitable commercialisation of the rural economy, and every feature of the villages is integrated with the urban economics and markets.

The growth of urban economic opportunities has led to increased level of migration, particularly among females. Migration to urban centres is dominated by women and this domination has increased over time. Unfortunately, female rural-urban migrants are confronted with low-paid jobs, which while adequate to meet the costs of urban living, provide them with little additional money to remit to their families.

2.3 Varying Sexual Behaviours in the Urban Context

Beginning in the 1960s, Thailand experienced two major developments viz., [a] effects of family planning; and [b] industrialisation, urbanisation and the resultant migration of rural

people to urban areas. Urban areas allowed young people to select a more permissive lifestyle. Women too gained mobility and access to contraception which altered their outlook. At the same time, remained as urban male-dominated, tourist-oriented economy feature of the city. As Thailand opted to promote tourism as one of its leading sources of revenue, it has also selected to sell all possible commodities, including its women. Most of the "tourist" places e.g., entertainment centres or service organisations - centred around women to bring in cash. Different forms of commercial sex was made available to accommodate various demands of male customers. As "casual" evening encounters occurred in the urban areas where there is less social control and probable anonymity, women were more free to make use of those meetings; the sexual behaviour is considered as an individual act or choice.

The rapid change in sexual behaviour and attitudes among urban youth adolescents, especially those who migrated recently from rural areas and lived in non-family settings, led to several other changes within the community. It is obvious that attitudes within this group reflect such changes from traditional norms of behaviour, but also a continuity with the traditional differentiation of gender roles. The traditional pattern requires unmarried girls to refrain from sex; for boys it leaves the option to visit commercial sex centres. This pattern continues to exist, but a new pattern arises where boys [mainly in university campuses] search actively for sex with girlfriends and where girls, while avoiding casual sex, accept it within steady relationships - change of the old active-passive gender differentiation.

It is no surprise that these relationships are not immediately stable or permanent. In practice, serial friendships with different partners take place. It is obvious that the threat of an overlap of two patterns i.e., sex with commercial sex workers and sex with girlfriends. The passive, non-initiative role of the girls suggest that they are almost powerless to address, discuss or demand safe sex techniques.

2.4 Gender Roles and Commercial Sex

Traditional views explain sexual relations as a passage to marriage and the starting of a family, as defined by family, kin and community. The sexual behaviour of an individual was a community concern as well, and the community members had various means of sanctioning sexual behaviour, such as ancestral spirit cults or gossiping. Hos has this process of social control altered in recent times?

In this context, the position of women in Thai society has been the subject of much debate, partly because of the complexity of defining women's status, and largely due to current role women have in the urban or household economy. A common assessment based on socio-economic indicators such as education and labour force participation, is that Thai women do not suffer major disadvantages compared to men [Limanonda, 1992; Wathinee, 1994]. Patterns of economic development have increased women's economic roles and reinforced their autonomy. However, there are a number of factors which run counter to these trends and have created an ideology in which a woman's physical beauty is considered as her major asset. Key among these factors has been the expansion of upper-class values associated with the roles of women.

In the rural areas, Thai women always had major economic roles and a high degree of autonomy. Much of Thai society, especially in the North is matrilineal, with the youngest daughter expected to inherit the family's agricultural properties. But in upper-class Thai society, women were totally separated from economic activities and were expected to pursue "feminine" interests [Santasombat, 1992]. Many of these interests were focused on pleasing their husbands. Additionally, polygamy was widely practised by Thai upper-class men and was viewed as a prerogative of psoition and economic success. This stress placed on feminine values found in the upper class has spread throughout Thai society, even though there has been concurrent improvements in female education and access to modern sector occupations. The stress placed on beauty and service to men was reinforced by the mass media.

Women had less mobility, less access to travel and less sexual freedom than men, though there was the possibility of pre-marital sex. Rural women married at a young age, and the marriages are not arranged. Thus, marriages are pragmatic unions and marriage partners are chosen first and foremost for their reputation as reliable. As such, some women saw marriage as an avenue for social mobility, or a vehicle to escape obligations to her family. The unbalanced societal expectations of boys and girls in relation to the family stipulated that, for example, in case of hill tribes, women take responsibility for virtually everything.

It is in this context that some researchers [for example, VanLandingham et al., 1993] and activists agree that many women view commercial sex as a tool to become upwardly mobile, and not in opposition to moral principles, if there are no alternatives to "fast-buck" employment [Chayan, 1993]. Many women also tend to internalise the external associations with commercial sex, such as male attention, entertainment or wealth. For example, commercial sex may be seen as a much more glamorous job than working at a construction site. Moreover, the tendency to relate commercial sex with tourism is discounted by many [e.g., Chayan, 1993].

Other factors associated with women's roles in Thai society also help explain the constant supply of women available to work in commercial sex industry. There is a deep-rooted cultural expectation that daughters contribute in every way to support their parents and families. This expectation, in conjunction with an economic structure which provides relatively high rewards for work in the commercial sex units, can represent a strong motivation for young women to enter into selling sex. The matrilineal basis of Northern Thai society provides an added incentive for daughters to support their parents as they would eventually inherit from their parents [Pramualratana, 1990].

The view that men are sexual predators and that their sexual appetites must be satisfied if the virtue of "good" women is to be protected is also common in Thai society. Many even argue that "sex-related crime rates would increase if commercial sex centres are banned". This view supports the continuance of commercial sex centres as outlets to protect the larger society!

Thai women, in contrast, report extremely low levels of premarital or extramarital sexual activity, do not make use of commercial sexual outlets [although some of them have experience in selling commercial sex], have had fewer STDs, and make little use of drugs or alcohol. Based on observations and documents one could conclude that for the majority of Thai women, their major HIV risk factor is sex with their husband or regular partner. In fact, the rate of infection

at antenatal clinics is increasingly rapidly as a consequence of this. A small number of women may also be at risk from non-commercial casual sex that is now common among never married women [living both in urban and rural areas][5].

Among women, *HIV/AIDS* risk perceptions are varied: married women attempt to assess the sexual behaviour of their husbands or partners; never married women maintain a lesser check list. This may be due to poor knowledge of HIV transmission modes or lack of knowledge of risk behaviours on the part of their partners. Commonly, risk perceptions did not influence their spouses or partners to reduce or eliminate risk behaviours.

Generally, Thais[6] tend to describe the political economy of sexuality and locate the issues of *HIV/AIDS* that has allowed within various forms of "less control" and "change of contents".

2.5 Power and Prestige

An attempt to understand the sexual relations and sexual behaviour of contemporary Thai society has to look at the phenomenon of rural-urban transformation and power relations. Generally, increased mobility plus urban lack of social control created a series of opportunities for sexual liaison of a casual, not necessarily commercial nature. Most interestingly, the pattern described varied clearly from a universal Western-style. These relations, for example, were not characterised by individually-expressed personal emotions, but showed a high degree of instrumentality; sex was used as an instrument to achieve something else e.g., access to power, wealth or prestige [Chayan, 1993].

Thai sociologists concede that the socio-cultural forces play a significant role and altered the sexual norms of adolescents. The changes were attributed to a general loosening of family control over young people's behaviour, increased inter-sex interaction of young people, and to liberal access to sexually stimulating materials. Part of this might be due to some global trends that induces people to seek material aspirations.

2.6 Levels of Risk Behaviour

The change in the risk perceptions of the sexual behaviour needs some attention i.e., [a] an individual choice or act in the urban area; [b] no longer part of the biological life cycle and aimed at reproduawion; and [c] sex is merely viewed as a pleasure act. This description somewhat fits into the middle class universal perception of "sex as an instrument for useful purposes". Thai situation may not support that notion, but what is slowly occurring is: increased permissiveness is felt and a process defined as sex becoming a commodity and as urban phenomenon. Thus, a new form of sexual expression has gained acceptability i.e., sex without commitment.

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[5] For example, Werasit et al., November 1992.

[6] For example, Chayan V., 1993 and discussions Khun Sunatree of CARE, Chiang Mai.

Descriptions of change in sexual behaviour and related risk behaviours within their meaningful context demonstrates that the observed changes amongst Thais are not identical with Western patterns of increased sexual freedom or looseness. It is only that there is greater tolerance among Thai youth for pre-marital sex, continued gender differentiation, extreme gender disparity which does not fit into any Western discourse. Thai women, historically, had more freedom to act and move autonomously, to make decisions on marriage or migration. One possible conclusion from this: different mode control over sexuality constitute variations in, for instance, form, organisation and openness of commercial sex.

Some analysts [e.g., Phongpaichit, 1991] even argue that women have become free from older forms of control, decline in population growth as less time was spent on child care or women who migrate and engage in sexuality for survival. However, they admit that even non-commercial sex is dominated by money and power.

2.7 Sexual Behaviour Patterns Among Youth

Boys were, and still are, socialised from a young age to value experience and knowledge gained from the concept of *"pai aoe sao"* [visiting and courting girls], and have more freedom and few responsibilities. Most young men learn about sex by visiting prostitutes, or being with girls who are sexually experienced. It is their peers and elder friends who help teach them to go through the process of sexual initialization.

2.8 Community Perceptions of Risk and Some Reflections[7]

If the self-reported information gathered by several surveillance centres [e.g., Thai Red Cross Society; San Sai Health Centre, Chiang Mai] is correct, then men and women exhibit radically different patterns of HIV risk behaviour. Many Thai men have large numbers of sexual partners, both pre-martially and extra-martially. They visit female commercial sex workers, and generally do not use condoms. Majority of them drink alcohol, reported sex after drinking, occasional use of drugs and have had experience with STD-infected persons.

There might be a "concealed reporting" of sexual behaviour by women e.g., many of the males reported that their first sexual associate did not become their spouse or regular partner. If men have a great deal of sex outside of relationships and women having little means, then there must exist a small portion of the female population which is very active and is servicing the majority of the male population. These individuals are commercial sex workers, who are readily visible and accessible throughout Thailand, in both urban and rural areas.

Because such a small female population is servicing a large male population, both the frequency of encounters and the risk of HIV infection for these women must be high, especially given the low levels of reported condom use in commercial sexual centres/transactions. This risk

[7] This section is based on discussions with Dr Chayan, Dr Praphan, Dr Wiwat, Dr Bennett and Dr Peacock.

is reflected in the phenomenal high rate of HIV infection in the commercial sex workers, especially in those working in low paying brothels who have many customers each day. At the same time, these women are also at risk of other STDs which may enhance the transmission of HIV, both from customer to sex worker and from sex worker to clients and/or children, placing both at greater risk. This is supported by the fact that so many males in every area have reported experience with STDs and also by the high rates of HIV infection in men attending STD clinics in the country.

Men living in rural areas prefer to maintain anonymity and do not openly accept visiting commercial sex centres. Moreover, for married men it might be difficult to spend evenings engaging in commercial sex, or lower economic ability of these to obtain the cash required to purchase it. One could conclude that in the rural areas it is mostly young, single men who might predominantly engage in commercial sex and condom use amongst them may be lower.

Almost every "normal" man one encounters view themselves at no risk of HIV infection. This indicates an immediate need to raise risk perceptions and make clear to the public the high levels of HIV infection in Thailand.

Several people present during field discussions believed that one of the high risk group is "military men". Ties between military men and rural communities is strong as most soldiers come from rural villages and a significant proportion are stationed in rural areas during part, if not all their time of service.

Besides the movement of these relatively high risk groups, other forms of internal migration are also taking place in Thailand at a significant rate. Particularly noteworthy is the movement of unskilled labourers, men and women, from rural communities into urban areas. Because of the workers' high level of replaceability, their jobs are among the least secure in the event that they come down with the disease. Thus, the cost of AIDS to them and their families is high. Also, important is the "reverse" migration of adults from urban areas to rural areas in the North and Northeast.

Finally, mention must be made of the substantial number of Thais travelling overseas in search of employment. It is estimated that about 100,000 Thais [most from rural areas] are working at low skilled jobs in the Middle East and East Asia. While many of these workers are tested for HIV antibodies before leaving the country, an unknown number re-enter Thailand carrying the virus. The risk is particularly high for women who are hired to work as bar girls and entertainers in Japan and/or other Asian nations.

The widespread movement of individuals, especially those already infected with HIV suggests the need to distinguish between the site of HIV transmission and the eventual distribution of people with *HIV/AIDS*. While the former information is important for the planning of AIDS prevention and education campaigns, the latter may prove more important in gauging the long-term impact of the pandemic.

Section 3

HIV/AIDS Knowledge and Attitudes

During field work, Phra Pong Thep informed that someone had died/suffering from *HIV/AIDS* in two villages i.e., Bang San and Ban Chan near Chiang Mai[8]. We visited these two villages and met village leaders, youth and school teachers. Recent *HIV/AIDS* deaths in this area enabled us to question people on on their attitudes towards [i] those living with HIV or, [ii] those dead [s/he] as her/his health slowly deteriorated as a result of suspected HIV infection. Progressively, we built a discussion on their knowledge and attitude of *HIV/AIDS*.

Most Thais are aware of *HIV/AIDS*, and the problem has passed the stage of "denial". They are aware of *HIV/AIDS*, but there are gaps in their knowledge. Some view it with trepidation, others with little hope or rationalise their risk behaviours. People believe that they can always detect an HIV carrier, which may allow them to rationalise risk behaviours. A large majority of Thais do not know specific transmission modes and discreet efforts are made to stigmatise those infected. There is widespread discrimination of those infected, and it is believed that only the poor will get easily infected. The speed with which HIV moved from the relative confinement of homosexual and *IVDU* communities to the wider heterosexual community has been been a point of discussion among the general Thais and their response to *HIV/AIDS*.

For many, an awareness of the significance of HIV and behaviourial modification took place only when they saw physical results of *HIV/AIDS*. The response was with a "disbelief" as AIDS-related case *[ARC]* deaths began to rock their own villages. In the initial stages it surprised many as one was generally confronted with "healthy Thai people" with sufficient income levels. They began to accept prevalence of *HIV/AIDS* in their villages once many persons were reported affected and it became "normal" to be a *PWA* in the area. It is not clear as to when this change process occurred. Some village leaders speculate that "acceptance" of *HIV/AIDS* began sometime in late 1992.

The general reaction of villagers to those with *HIV/AIDS* was clear: ostracism of the afflicted, and an environment of shame both for the afflicted and their families. Informants claimed that they feel sympathetic for those infected with the HIV and care for close kin, they would not do so for those who were not so close. Some women were rejected by their husbands or children if they contracted HIV; in some cases, women have also rejected their HIV-infected husbands.

Largely, individual members of the families, isolated persons living with *HIV/AIDS* provide only little care. Discussions regarding the care of people with *HIV/AIDS* suggest that there is little understanding of issues such as a lack of appetite and the need for emotional

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[8] With Phra Pong Thep, the members of the study team [Vitoon, a local anthropologist, Shivakumar and Som] visited two villages in the area on July 14th and 15th, and had discussions with the people on the local "development" issues in the area. This discussion slowly matured into a debate on *HIV/AIDS* situation and their personal views were elicited.

support. Villagers place some restrictions on the persons living with *HIV/AIDS* e.g., separation of food, communal facilities like water; methods to minimise physical contact with persons living with HIV.

As a result of this highly negative response to people with AIDS [or *PWAs]*, a prominent feature of the pandemic is a high suicide rate amongst those infected with HIV. There is little official data on this; village informants and NGOs suggest that many infected with HIV exhibit a suicide syndrome. Suicide may take place either on learning of infection, or when it becomes difficult to hide the condition from others due to opportunistic infections associated with AIDS.

As AIDS and ARC-deaths have become a prominent feature of many Northern Thai communities over a relatively short period of time, some of their reaction towards people living with AIDS and to ARC-deaths seem exaggerated and irrational, and suggest a lack of understanding about AIDS. It could be argued that these are couched in traditional cosmological classifications and patterns of reactions to any contagious disease and deaths.

3.1 Religion and *HIV/AIDS*

In Buddhist villages of Thailand, where the concepts of *sin* and *morality* are fundamentally different from those found in the West, the cultural basis of the stigmatisation of people with *HIV/AIDS* function differently from that found in disease epidemics in Christian Europe or Islamic nations. Moreover, given the absence of moral restraints on male sexual activity and the lack of moral opprobrium attached to sexually acquired diseases, people like Phra Chamaroon of Saraburi suggest that it is unlikely that *HIV/AIDS* in Thailand would be stigmatised only on moral grounds. Additionally, the stigmatisation of people with AIDS or AIDS-related illnesses in Thailand must be differentiated from contexts where *HIV/AIDS* is primarily associated with homosexuality or drug abuse, and where such persons are popularly categorised as deviant. Therefore, it is more useful to view Thai response to *HIV/AIDS* as part of values concerning illness, contagious diseases, and general beliefs regarding social pollution.

Some of the villagers even asserted that *HIV/AIDS* infection was a matter of *karma*, the rule of mere retribution. In such a context, the conditions of *karma* must be accepted "because there is nothing one can do about them." This is particularly the case with respect to issues concerning health and diseases, where the notion of *karma* has always served as an important explanatory tool. Sometimes this tendency attempts to personalise the causes of *HIV/AIDS* infection.

In the Thailand of the 1990s, explanations of illness are somewhat complex, and notions of *karma* are synthesised with medical model of health and disease. In this context, an understanding of more serious contagious diseases such as leprosy, cancer and tuberculosis may be important to understand the Thai reaction to *HIV/AIDS*. Phra Pong Thep, Rev. Sanan and Rev. Jerry of *CCT* summarised that the general response to leprosy, in the past, was a mixture of "horror" stories and avoidance, and the infected persons were either denied physical care by their families or, were rejected by their fellow villagers due to fear of contagion from the disease. Later the situation changed with more exposure and education on the disease and its

effects; for example, those who suffer from cancer may combine merit making and meditation with radiotherapy and traditional herbs. They anticipate a similar response of the Thais toward *HIV/AIDS* which is part of the cultural pattern of reactions to disease epidemics.

3.2 Death of *HIV/AIDS* Persons and Ceremonies

Death from ARC and related conditions may take place either at home or in hospital. In case of death at hospital, the corpse may be cremated but, more usually, it is placed in a plastic bag and taken home for the performance of the mortuary rite. Significantly, the funerals of those who have died of AIDS related conditions, and who are publicly known to have died of such conditions, are different from those who die from other causes.

Death from AIDS also characterise "bad death" i.e., it is untimely, it is painful and prolonged, it is expensive, and disfiguring, and critically, it is the death over which humans apparently have no control. The mortuary rites of those who have died, or who are suspected of having died from AIDS, are very similar to the mortuary rites given to those who have died a bad death i.e., short funerals, restrictions on common sense and fears of entering the house of the deceased due to contagion. This clearly shows that AIDS related deaths are considered bad deaths - deaths which are highly inauspicious, highly polluting, and highly dangerous for those in the neighbourhood. Thus, Thai people, especially in the rural areas, lack knowledge on AIDS and its attributes - yet prefer to honour the dead through cultural and religious methods which are carried out in a mechanistic way.

In the Chiang Rai area, several "cremation" associations have been established by local touts that seek to make quick profits from those who are infected with HIV. These associations offer "honourable" death ceremonies for those living with AIDS for a huge lump sum payment in advance.

Section 4

Vulnerable Groups

4.1 Commercial Sex Workers[9]

Most Commercial Sex Workers *[CSWs]* consider their occupation as temporary, and generally feel that *HIV/AIDS* is not their biggest health problem or concern. They realise that their occupation is filled with all types of social and health consequences, and AIDS is just one among them. *CSWs* have a tendency not to request a "clean" or "regular" client to use a condom. Their main objective is to serve as many clients a day as possible, and in their overall opinions, condom use hinders this process. Additionally, if a *CSW* requests a "regular" client to use a condom, possibly this might ruin their mutual relationship and trust.

As for the clients, they use price and appearance as screening devices to indicate *"AIDS Free"* to *CSWs* and one for which they will not have to use a condom. Many male members also appear not to use condoms with their wives, girl friends and casual sex partners. For clients who do not use condoms with *CSWs*, they may serve as a bridge for spreading the disease among low risk groups.

4.2 HIV-infected Women

If the HIV-infected person is a woman, the issue assumes a different perspective within the family and community. In reality, the number of *HIV/AIDS* infection cases among pregnant women, mothers and children are increasing every year. At least half of the pregnant women, who are HIV positive are housewives. This reflects the painful fact that *HIV/AIDS* is no longer outside the family domain, but it is becoming an even more devastating part of it.

Although women were initially mislead to a false sense of security as many of those who contracted AIDS were men - today there is greater awareness that women are the most affected. AIDS has become the leading cause of death among women in North and Northeastern parts of Thailand. Women are particularly vulnerable to HIV infection and the discrimination accompanying it. Their disadvantaged and subordinate role in Thai society hampers their ability to both protect themselves from infection and to defend themselves from prejudice and intolerance. They do not have sufficient opportunities to learn about the disease or how to prevent it because of the lack of equal access to education and health services.

Women face many difficulties in negotiating safe sex with husbands or partners or clients. If infected they face the decision of whether to have children, and whether to abort if they are already carrying a child. Abortion is illegal in Thailand, and young women seek medical

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[9] Based on literature review and discussions with ACCESS, Empower, Dr Chayan and Rev. Sanan.

assistance from make-shift "abortion clinics" which have no facility to perform such tasks. Recent news reports on "illegal abortion centres" confirm the probability that one of the transmission routes could be through such places. If they abandon their traditional roles and insist that their husbands or partners use condoms, the response may be at best mockery or rejection, at worst violence and abuse. Many married women fear beating or divorce if they refuse sex or press their husbands to use condoms. They have even less leverage in trying to promote reductions in their husbands extra-marital affairs.

Women living with HIV infection may be denied medical assistance, rejected by her family and friends, and forced to leave her job and home. She may be physically abused by her partner and thrown out onto the streets. Such stigmatisation has occurred even when the woman has been infected through a monogamous relationship or through rape.

In many districts of the North the rate of HIV infection among pregnant women is approximately 6 per cent. Women are vulnerable in the spread of *HIV/AIDS* and are inadvertently put in a very responsible position: to protect themselves, their husbands and their children - and care for family members.

The women at highest risk are those under 19 years of age, of low economic status, and especially those experiencing their first pregnancy. The risk factor associated with infected pregnant women is the STDs history of their husbands.

Some data is available on the pediatric AIDS that seek to explain clinical and epidemiological aspects of the pandemic. However, no substantial information is available on the psychosocial consequences affecting HIV positive women/mothers and children, how they cope with their lives, and how families and communities react or adjust [positively or negatively] to the particular issue.

4.3 Children

Yet another vulnerable group are the millions of marginalised children who live on the streets of the urban centres like Bangkok, Chiang Mai, Khon Kaen and Pattaya. Most of them are without health care or identity cards. Many of them turn to commercial sex for survival. A NGO working with the street children in Pattaya and Chiang Mai has regularly screened these children and estimates that about eleven per cent of them were HIV positive. Street children, by and large, view adults as enemies, so reaching them is difficult. Three NGOs have opened up exclusive "shelter centres" for children infected with HIV positive. Several NGOs and government agencies now focus on campaigns like "children and AIDS".

Some of the recent studies and available data [e.g., Wathinee Boonchalaksi and Philip Guest, Mahidol University, 1993; surveillance data at the San Sai Health Centre and Health Sciences Research Institute, Chiang Mai, 1993] indicate that if there is no change in sexual behaviour related to HIV infection and fertility, the number of child and infant deaths will increase from several hundred in 1990 to over twenty thousand by the year 2000, and the effects on mortality will be significant. Also, changes in behaviour can have large effects on the number

of children dying from AIDS. Lower levels of fertility for women infected with HIV virus would also have an obvious reducing effect on the number of children who would die from AIDS.

The projections predict that by the year 2000 there will be approximately 86,000,000 children aged 12 years and below, and 30,000 children aged under 5 years would have lost their mothers because of *HIV/AIDS*. Thus, the number of children exposed to the risk of being orphaned will grow rapidly over the decade of 1990s. By 2000 AD, there will be over 350,000 living children born to mothers who are infected with HIV, compared to only 5,000 in 1990; and these children will be less than 5 years.

By the year 2000 almost 7 per cent of children aged 5 will be directly affected by the AIDS pandemic. A portion of 0.6 percent will have already been orphaned through the death of their mother and additional 6 per cent will be orphaned or themselves die as a result of AIDS sometime soon around the turn of 2000 AD.

In any event, the number of AIDS orphans would continue to increase throughout the decade of 1990s and in the year 2000 a total over 53,000 children aged 12 years and under.

4.4 Street Youth[10]

Street youth as a group were plagued by family conflict, parental rejection, abuse and personal adjustment problems. A number of pathways led them to the dangers of city streets. Most were intermittently on the street for short periods when forced to leave each of a series of living arrangements provided by parents, friends, relatives, agencies and other social service organisations.

While on the street they become physically run down because they slept and ate irregularly, and were unable to keep themselves clean and adequately clothed. Most also compromised their health and values by using drugs, become sexually promiscuous and, once entrenched in street life, some resorted to criminal activities, and a few to violence. Many submitted themselves to the influence of a street subculture that endorsed these activities because friendships were crucial to their emotional and physical well-being.

It is not known as to what proportion of young people on the streets engage in commercial sex, unsafe sex, violent sex, and IV drug use with shared equipment. There is some evidence to suggest that this group has limited and possibly inaccurate information on *HIV/AIDS*, its transmission and its prevention. Comprehensive sources of information on the lifestyles of these young people are lacking. It seems realistic to speculate that street youth may be at particular risk for contracting this deadly illness. Much of the adolescent behaviour consists of experimenting with a variety of activities, many potentially perilous, including sex, substance use and violence.

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7 Based on discussions with Duang Prateep Foundation, Empower, Fr Maier and Fr John.

These young people, transient and distrustful of "straight" society, are a difficult group to reach with social and health services. The effectiveness of education depends on how the youth view service available.

Currently, a few NGOs have a programme component to particularly take care of "street children and youth who are infected with HIV" [e.g., Foundation for Better Life; Weing Ping for Children Group]. If the present indicators are correct, then it appears that this group is the most vulnerable and their numbers might increase in the coming years.

Section 5

Interventions on *HIV/AIDS*

It is believed that an effective vaccine for AIDS will not appear on the scene until the end-1990s. In the foreseeable future, communication and education are the only preventive tools to inform people that they need not "die of ignorance". What strategies have been pursued by various agencies? Do these strategies have an impact?

Three broad categories of groups participate in the intervention efforts on *HIV/AIDS* care and control in Thailand i.e., [a] Government; [b] Bilateral and multilateral agencies [either independently or through Government]; and [c] numerous non-profit, non-government organisations *[NGOs]*.

5.1 Target Groups for Intervention

Target groups for intervention are classified based on their current occupational or educational status. Each section contains a mixture of women and youth.

a. Young Persons

Because of prevailing social practices, many married and unmarried *young* persons [men and women] are exposed to HIV and other sexually transmitted diseases [STD]. Those who are married can, in turn, transmit infection to their wives. In some provinces [e.g., Khon Kaen, Songkla and Chiang Rai] and among some population groups this spread has already been documented as well as alarming.

As a result of changing life styles, considerable commercial sex in all urban centres, and general ignorance regarding AIDS and other sexual transmitted disease, urban youth are increasingly at risk of HIV infection. Youth with lower income are particularly vulnerable e.g., construction and factory workers, people working in tourism and other service industries.

Because of prohibitive medical costs and to maintain anonymity, many young persons approach pharmacies for self-treatment. Not only do they often get inadequate treatment, but they receive nothing in the way of advice on how to avoid STD and particularly HIV in the future.

b. Women

Women are the most vulnerable group and have become the largest group of HIV carriers. A rapid increase in HIV transmission has been noted for vertical transmissions from mothers to their infants. No other mode of transmission involved a higher rate of increase since the late 1990. Data of ANC clinics are not comprehensive, but indicate 4.5 per cent of pregnant

women tested who are HIV positive in some northern areas to less than 0.5 per cent in other provinces. The current national average is estimated at one per cent [*Refer* Ministry of Public Health documents]. About 70 per cent of pregnant women attend Ante-Natal Clinics and other Mother and Child Health and Care services and contact Family Planning Clinics - and this infrastructure to reach this "risk" group and has received strong support from the Government Departments and to extent some NGOs [e.g., Empower and Access].

c. University Students and Youth

Middle class young people, including university students, increasingly have access to information about AIDS and to health services through public and private clinics. The lower income working youth however, have less access if any to such information. In addition, they are usually disinclined to use the services of public and private clinics, even when there are symptoms of STD. There are also psychological barriers to visit public clinics for reasons of confidentiality and the private ones because of a feeling that they are for other classes.

Youth [Rural and Urban]	e.g., factory workers, construction workers, fishermen, boat drivers, co-residing workers such as those living in dormitories, teenagers [including teenage mothers], slum dwellers and the hill tribes.
Campus Groups	e.g., students, teachers and administrators of first, secondary and vocational schools.
Out-of-school Youth	e.g., unemployed and/or hard to reach persons including adolescents, slum dwellers, street children, the homeless, teenage gang members.
Women at Reproductive Age	e.g., the asymptomatic women attending family planning and ante-natal care clinics.
Occupational Groups	e.g., commercial sex workers, managers of sex establishments, matchmakers, co-workers.

5.2 Strategies : An Overview

The strategies pursued by the Government and others so far could be classified as: [a] clinical care; and [b] social care/concerns. The strategies at the local level generally is clinical i.e., efforts that aim to develop the capacity of district *[amphur]* level hospitals to deliver care, treatment and testing services. These service centres are close to most communities to be used, but far enough from the village community to provide confidentiality desired by the clients. These services are also offered on an anonymous basis and linked to existing ANC and family planning services. Some information and education activities will also reach out into village communities of the district under the general guidance of the physicians. Efforts are made to strengthen the laboratories, testing facilities and equipments.

The *social care* proposes to develop AIDS counselling network through activities, such as training of physicians on AIDS issues; curriculum development for counsellors; to provide counselling and psychological support to those already infected with HIV; to promote low-risk behaviour of young factory workers and commercial sex workers; focus group discussions, in depth interviews, and other social-behavioral efforts to determine appropriate interventions; development, field testing and use of educational materials.

The present education policy supports inclusion of *HIV/AIDS* knowledge in the content of primary and secondary school curricula on Life Experience and Character Development subjects as well as extra curricula activities such as sports, art, boy-girl scouts, red cross and girl guides. The main objectives are to develop healthy attitudes to sexuality in children and to improve their personality development. The Ministry of Education has prepared *HIV/AIDS*-related curriculum and instructional materials for the two educational levels, including teaching guides, lesson plans and reading materials. In collaboration with the Ministry of Health, posters, pamphlets, slides and videos on AIDS prevention have also been produced. The major concern of the NGOs at present is not to simply make it another educational module but to involve children, teachers and parents to make practical use of the knowledge gained.

As a complementary to the above, interventions are made among teachers to provide on-the-job training for primary and secondary schools teachers on how to effectively run an AIDS education programme; train student leaders to increase knowledge on *HIV/STDs* and to develop attitudes for behavioral change and the prevention of *HIV/STD*; and increase and improve the active role of trained student leaders in social activities concerning *HIV/AIDS* and STD prevention. This is expected to prepare them to assume leadership roles in *HIV/AIDS* prevention.

Some groups of concerned people have already commenced interventions among [i] orphan children; [ii] paediatric AIDS; and [iii] those engaged in fishing, farming and such other non-urban occupations. In summary, the present efforts are:-

Clinical Care

- o increased diagnostic facilities, treatment options and maintenance of progress reports
- o locally developed clinical training kits on *HIV/AIDS* for physicians [though still in the preliminary stages]
- o HIV Testing facilities [e.g., trained laboratory staff, test kits and monitoring to assure accuracy of test results]
- o motivate self-referral by blood donors; periodic versus routine screening of donors
- o sentinel surveillance to determine the prevalence of HIV [i.e., to rely more on anonymous testing]
- o sentinel surveillance to include private sector units, commercial sex workers and IV drug users

- o voluntary confidential HIV-testing at sites separate from blood banks where persons wanting to be screened can be screened with appropriate pre- and post-counselling - this is pursued by both physicians and NGOs

Social Care

- o monitor use of language in relation to the pandemic
- o regulate information circulated for accuracy, value-freeness and positive attitude
- o distribution of information e.g., brochures with cartoons and interesting stories; posters containing information about the transmission, prevention, diagnosis and treatment of STDs and AIDs; short video presentations which are interesting and designed to appeal to specific groups like commercial sex workers by depicting them in their everyday work context; reinforcement of STD and AIDS messages by counselling by the clinic staff.
- o Group meetings and peer counselling e.g., Wednesday Club; Penpals of persons living with AIDS; Women's Support Groups.

Interventions based on Human Rights Perspective

- o raise awareness to integrate law and ethics into HIV policies and programmes; to provide input into legal policy formulation and legal and ethical advocacy.
- o to appraise individuals affected by HIV of their legal rights by integrating legal advice into general HIV counselling
- o to file test cases or public interest litigation on select HIV-related issues
- o to provide a forum for discussion and debate about the role of the law in the pandemic, and for a comparative examination of legal strategies adopted by other countries within the region and internationally.

5.3 Role of the Thai Government

Since its establishment in 1942, the Ministry of Public Health *[MoPH]* has continually expanded its services in Thailand. *MoPH* is a complex organisation with responsibilities relating to the physical and mental health of the whole nation, and each department and each geographical area has multiple goals that are indicated in their yearly plans.

In January 1987, *MoPH* stated that the two major public health problems it then confronted were: [i] the nutritional deficiencies of the Thai diet, especially for poor urban and rural children; and [ii] some contagious diseases had to be eradicated from some locations of Thailand. Malaria eradication in rural areas was observed to be illusive. During that time there was a resurgence of interest in traditional medicine that received Royal sponsorship. Several NGOs also supported such a move. The 1987 document of *MoPH* also was concerned with continued neglect of health needs in Cambodia and Laos that border Thailand. Thus, we observe that *HIV/AIDS* was not considered as a "problem" by *MoPH* as recently as in 1987.

Though *HIV/AIDS* action was initiated around 1984, yet it was within the context of health care and attached to public health principles as an extension of STD. Government initiatives were largely care and support programmes, focussing on institutional care with large support from bilateral and multilateral agencies, like the World Health Organisation, UNICEF or USAID.

Some of the earliest attempts at operationalising community health concepts were made in the context of programmes that promoted the use of contraceptives for family planning. This pioneering work provides some of the practical demonstrations of the approach on a major scale, and helped to develop many state-of-art techniques.

Thailand's *National AIDS Programme* began in 1987 following a cabinet decision to develop a national response to the AIDS pandemic. Since then, the Royal Thai Government has focussed the country's attention on the *HIV/AIDS* situation, and has developed numerous national strategies to address the health, social and economic aspects of AIDS.

In 1987, the cabinet approved the launching of *"Thailand's AIDS Prevention and Control Programme [1988-1991]"*, as developed and proposed by the Ministry of Public Health. The following year, with technical assistance from the World Health Organisation, the *MoPH* formulated a "Short Term Programme" with an initial funding of US$. 500,000.

Thailand's "Medium Term Programme" for the *Prevention and Control of AIDS* began in 1989. The programme, implemented and directed by *MoPH*, was a three year plan with detailed workplans that were developed annually. It included activities in programme management, health education, counselling, training, surveillance, monitoring, medical and social care, laboratory and blood safety initiatives.

It was only in 1990, plans were announced to establish AIDS Rehabilitation Centres in the four regions of Thailand. Some provincial governors opposed this move on economic reasons as that might affect the tourist trade. While such protests were purely motivated by economic considerations, some of the government's attitudes to this programme was also criticised by social activists and public health educators.

It was during the brief tenure of Dr Mechai Viravaidya as Deputy Prime Minister in the military-nominated Government in 1991 that the Government publicly acknowledged the seriousness of *HIV/AIDS* situation, and announced *"Thailand National AIDS Prevention and Control Plan [1992-1996]"* on *HIV/AIDS* in September 1992. Quite interestingly, it was not a

simple rhetoric statement; but an amalgam of a wide range of political, legal and constitutional, and administrative instruments. Perhaps the most significant was the political commitment to accept the scene on *HIV/AIDS*, and welcome every NGO, community organisation and social group to work towards the containment and elimination of *HIV/AIDS*. This led to the expansion of NGO activities on *HIV/AIDS*. Chantiwipa of *Empower* summarised the effect of that Government initiative as: "an unique policy statement which provided us the legitimacy to work with the communities or intervene at the commercial sex establishment level. We could openly talk about HIV or AIDS."

It was only in September 1992 that the Thai Government publicly acknowledged spread of *HIV/AIDS* and noted that:-

> "In the past AIDS prevention and control activities have lacked a frame for coordination of implementation and continuity of effort. Therefore, the National Economic and Social Development Board [NESDB] has developed this National AIDS Prevention and Control Plan for the period 1992-1996 under the 7th Five Year National Economic and Social Development Plan to serve as a framework for coordinated AIDS prevention and control throughout the nation. ....
>
> This policy aims to prevent transmission with relation to behaviour [sexual and drug-use practices], and in the medical care setting, to improve the understanding and acceptance of HIV-infected persons so that they can remain integral members of society. This will be accomplished through the mobilisation of resources and manpower in the sectors of government, business, non-government non-profit agencies, and the international donor community to work together to prevent and control AIDS through support for implementation of the following four programmes:- public information and education; medical treatment and care; human rights and social support; and research and evaluation[11].

The Thai government allocated substantial funds to various hospitals and departments under "clinical care" to *HIV/AIDS* work. In reality, its major responses were:-

a. Political will and policy commitment

Public acknowledgement of the prevalence of *HIV/AIDS*; establishment of sero-surveillance centres, National AIDS Committee with the Prime Minister as the Chairperson; a central coordination body that runs to provincial levels.

b. Public education

Prior to 1990 the government was reluctant to discuss about AIDS in public as that might "hurt" tourism and the image of Thailand. Since then television and radio spots have

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[11] Thailand National AIDS Prevention and Control Plan [1992-1996] published by the Office of the Permanent Secretary, Thailand.

been aired on prime time that warn about the danger of AIDS and explain exactly how to prevent it. The messages are explicit and clear, and stress the idea that men who sleep with commercial sex workers should change their behaviour or else use condoms. Education on AIDS was also placed on the school curriculum.

c. Protection of blood supply

This was the first prevention strategy of the Government. With the collaboration of all hospitals, the government established measures to prevent HIV transmission through blood transfusion. Mandatory screening of blood donations was implemented.

d. STD control

The government has 215 specialised STD treatment and control units in all 73 provinces of the country. STD unit provides routine physical check-up and early treatment of STD for commercial sex workers and male clients with minimal charges. Available data indicates that with good coverage of STD services both by the government and private sectors, the rate of all STD has declined since 1988.

e. Promotion of condoms among *CSWs*

In the beginning of 1991 with the collaboration between the Ministry of Health, Ministry of Interior and the Governor of each province, the "condom only" policy in all sex establishments was launched. The condoms used by the clients of commercial sex workers is reported increasing and that might have led to reduced STD infections.

Government efforts were also disturbed by "fear" campaigns by vested interests within the provinces or communities. For example, a small centre in Chonburi Province was never regarded as "successful" and attempts to establish a centre in Lampang Province in the North on a plot of land allocated for a leper colony, away from water sources, populated communities and tourist spots, was thwarted.

5.4 Some Common Features and Concerns of Government Interventions

Any government development initiative has numerous complex components. *HIV/AIDS* interventions also face similar challenges that most government initiatives confront. The studied observations and views of those interviewed could be summarised to concisely locate the response of the Thai Government to the pandemic[12]. Acting primarily from a social planning approach that over time has included some aspects of the goals proposed by the Government and the following has been the development techniques used by the government [and *MoPH*] via.,:-

[12] These observations were received through personal communication from Dr. Praphan, Fr. Jean Barry both of Thai Red Cross, Dr. Voravut of San Sai Hospital and Phra Charmoon of Saraburi.

- Infrastructure development in health care
- Government facilities improvement
- Creation of new Departments or Bodies
- Allocate more resources
- Encourage self-help by individuals and community groups
- Expansion of knowledge and change in attitudes or values [through campaigns]
- Improvement of quality of services being provided
- Collaboration with NGOs

The weakness of the responses of the Thai Government to *HIV/AIDS* work can be summarised as follows:-

- Screening and treatment only to "Thai nationals" is discriminatory as those "illegal" migrants from Myanamar and Cambodia do not come forward for testing or clinical care; this is applicable even for those hill tribes in the Northeast, who have not yet "joined" the mainstream Thai society.

- Many of the initiatives lack commitment, and merely show a Government presence in the affected areas. Therefore, resources are not allocated in time for intervention.

- Government is merely keen to minimise the damage to Thailand's *image* and its tourism development plans through a comprehensive propaganda that informs "absence" of *HIV/AIDS* to public.

- Government has made elaborate tourism development plans that aim to increase more tourism-based development opportunities in the border areas offer economic hopes to rural poor through relocation and migration opportunities; this de-priortises the prevailing pandemic conditions.

- Neglect of formal education [general and specialised] that would stress on integrated social development rather than economic gains alone

- Inadequate expansion of basic facilities and services

- Refusal of the Government to legalise commercial sex establishments [and therefore possibility to regulate commercial sex establishments and *CSWs*]; in fact, Dr. Praphan argues that legalisation of commercial sex centres would allow medical personnel to intervene among women who sell sex. In his view this is necessary to curb spread of HIV infection.

It was also noted that the Government has not taken steps to strengthen additional supportive environment for primary prevention of HIV, such as expansion of education, reform social norms related to multiple partners, regulations on abortions, materialism and overcome poverty in rural areas. The preventive efforts remain weak as not much information is made available on specific underprivileged population subgroups, who are vulnerable to the pandemic.

5.5 Participation of Bilateral Agencies

Bilateral aid to challenge AIDS was quite significant since the 1980s. It now provides somewhere between US$ 100-120 million per year. This aid has enabled free flow of technical expertise or equipment, and opportunities for broader exposure and study that often accompany aid projects. These agencies considerably support *HIV/AIDS* education programmes for people who are not infected with HIV, to educate them to understand and accept that such infection is preventable by maintaining or altering one's sexual and/or drug use behaviour. Basically the efforts aim to reassure people that HIV infection can be controlled and that they themselves are able to manage it.

Agencies like AIDSCAP, have evolved multi-sectoral involvement as an essential component to develop an adequate local understanding of the determinants and consequences of the pandemic, and was therefore planned as an integral element of their activities. The experience of these agencies indicate that multi-sectoral involvement requires much more than just education/information activities provided through different sectors to address determinants and consequences of the pandemic, development of adequate infrastrastructure within communities and workplace policies, and implementation of effective strategies to deal with the complex interactions between HIV and development. They also work to integrate HIV into the normal work of various local level government departments.

Bilateral organisations have also independently launched AIDS programmes in Thailand:

- *The AIDS Control and Prevention Project [AIDSCAP]* of the Family Health International is designed to support the local capacity to prevent and control AIDS. It aims to reach individuals at risk of HIV infection through clinical care, education and increased access to and use of condoms. It takes an active role in ensuring that policy makers have complete information on HIV infection and prevention activities, have best available analysis of likely outcome of various policy choices, and become, when appropriate, personally vested in prevention and control efforts. It has policy support, grants and research activities.

- *Thai-Australia Northern AIDS Program [NAPAC], Thai-Australia Non-Northern AIDS Program [NONAP] or, Australian International Development Assistance Bureau [AIDAB]*'s AIDS Programme aims to reduce the rate of transmission of *HIV/AIDS* infection in Thailand. These efforts collectively assist government, non-government and private sector organisations to develop effective measures for the prevention and control of the disease, and to develop and implement strategies for the care of those infected with *HIV/AIDS*. It provides financial support to AIDS initiatives developed by local organisations to various regions in Thailand. Currently, about fifteen projects are supported and a larger number is linked through networks.

- Independent initiatives of agencies, like USAID or the Dutch Embassy, is generally through a local partner organisation. For example, USAID works closely with AIDSCAP and Duang Prateep Foundation; the Dutch Embassy supports the programmes of the Thai Red Cross Society [in collaboration with UNICEF].

5.6 Response of the Thai Business Community[13]

Continued economic boom will result in enhanced roles of the private sector at all levels of the Thai society. In Thailand, rapid economic development and urbanisation have resulted in greatly increased numbers of young people working in factories. The most important age group among young factory workers also shows the highest *HIV/AIDS* prevalence rates. The 15-24 years age group, both male and female, accounts for 66.3 per cent of all presently HIV infected people. Most factory workers have only primary education and in general have less access to health services and information/education services on *STD/HIV/AIDS,* due to their socio-economic status. Most of the workers live in dormitory-type of residential units without any normal family ties, and fall prey to the usual attractions within an urban setting. Many of the workers were observed to be sexually active with *CSWs*. This in turn affected the employee turnover and may affect productivity.

The business community began to consider *HIV/AIDS* as a problem sometime in early 1992 when casual medical tests of workers indicated the arrival of *HIV/AIDS* in the factory premises. The nature of business community's attitude has undergone a quick change over a period of two years, both through private and government stimulation. The current thrust of the business community is to press for more open propaganda and other forms of communication that are more informative and persuasive. Some industrial units in Khon Kaen, who have participated in the programmes of the Thai Red Cross Society, do have some guidelines and internal policy on such issues like maternity leave or abortion. Their strategies include:-

- Authorise increased "educational" campaigns and distribution of condoms within the factory premises [Thai Red Cross and UNICEF are currently carrying out some programmes at the factory premises e.g., UNICEF and Thai Red Cross initiatives in the industrial units located in Khon Kaen region; a day workshops on *HIV/AIDS* of Thai Red Cross organised at various industrial units in Thailand].

- Allow regular visit of Counsellors/Trainers to the factories.

- Financial contribution for *HIV/AIDS* activities within and outside factory premises e.g., workers' residential areas.

5.7 Community Outlook and Practices

It is a tradition in Thai society that relatives look after their own sick family members. At the village level, people do visit a sick person and provide support. In the same vein, many people would indeed take care of their family members when any of them were ill of HIV infection. This is despite the fear of stigma, and possibly the family itself supports the seemingly irrational fear of transmittablity. There were at least four instances, in Bang Chan village and neighbourhood, where the family members remained compassionate towards the ill person, and

[13] Based on discussions with Dr. Peacock, Dr. Kruse and Dr. Barry.

long discussions with them indicated that their personal support has encouraged the sick person to recover well.

Generally, the initial response was compassion and sympathy. They did express fears of infection - yet "duty" concept within the family made them to overcome ambivalent feelings and be sensitive to the HIV-infected person or *PWAs*. Overall, it is evinced that the family will take care of any members who might receive HIV infection, the family can and will attempt to provide good care and support, with some reservarions. Protection care at household level was taken, such as: separate dishes, offer clean and separate toilet facilities.

The difficulty appears to have arisen only where the family disregards the ill person. Such an attitude limits the integration of *PWAs* or HIV-infected person into the community. The discrimination and stigma associated with them outside the family raises the questions as to whether there will be individuals without families to support them. However, during the field visit, the researcher did notice a number of HIV-infected persons without family-support. One could conclude that the community at large responds positively if and when the family is supportive and helpful.

Section 6

Hospice Approach[14]

In Thailand, most of those infected with HIV are from poorer communities, and at times refugees from the neighbouring nations; half of all deaths are infants, children or women. In many poor communities HIV-infected women and children are scorned and neglected. In general, refugees and poor people's lives are characterised by almost continuous ill-health; a high proportion are also disabled. Therefore, the problem of HIV has to be viewed in terms of severity, scale and, in some cases, residential location among the poorer sections.

The poor in urban areas live in crowded tenements, cheap boarding houses or illegal housing and usually suffer comparable or even higher rates of disease and death than their rural counterparts. The close proximity of large numbers of HIV-infected persons in urban areas, in an environment which provides no protection, often results in disastrous epidemics and quick social isolation of *PWAs*.

On the other hand, in the rural areas the reality is different: population density is less; social and family fabric is strong; and, therefore, chances of a *PWA* gaining good health and confidence appears bright. However, in the countryside, people are fed with myths, rumours and soap opera stories on *HIV/AIDS,* and this results in *PWAs* constantly moving out of the villages to protect their identity and honour.

In such circumstances, it is imperative to increase the *PWAs* access to health care and emotional support, and enable reunion with their families and rehabilitation possibilities. Such an effort, even symbolic, could demystify some of the misinterpretations on *HIV/AIDS*, provide hope to *PWAs* and their families. As a response, a few NGOs have pursued "hospice" approach - a strategy that was effectively used among cancer patients, a century ago, when that disease was considered as dreadful. This approach was considered necessary as more and more HIV-infected people were found to have been rejected by their families and remain without appropriate support and social-psychological backing. The main purposes of hospice are:-

- o to offer immediate nursing care, counselling service to any HIV infected person;
- o to enable *PWAs* and their families gain proper understanding on *HIV/AIDS*, their physical conditions and enable them to live confidently as a normal member of the society; and
- o it is considered as a wholistic care in which members of the family are encouraged to accept *PWAs*.

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[14] Data for this section was gathered between April and August 1994; a second round of information collection was pursued between 20th and 24th October 1994. During the second round of interviews following persons were met: Fr. Jean Barry [20th]; Fr. Giovanni and Ms. Usanne [21st]; monks at Dhammarak Nives, Lop Buri [22nd]; and visit to the National Institute for Communicable Diseases, Bamrasnardoon Hospital [24th]. For purposes of easy reference and to maintain independence of this Section, discussions here are not explicitly quoted elsewhere in this report.

Hospice approach relies on three major components: [a] terminal and continuing care; [b] elicit family support and enable *PWAs* re-integrate with their families; and [c] train people on symptom control. Generally, when the members of the family get involved, they learn also on symptom control. Thus, the approach is much more than mere medical support; it has elements of personal and spiritual care too. Commonly, hospice projects require the following as the essential resources:-

- o proper understanding of the *HIV/AIDS* issues;
- o land and building;
- o trained personnel;
- o availability of medical care/hospital and life saving services;
- o participation of family members; and
- o finance/material support.

6.1 History of Hospice in Thailand

In Thailand, hospice concept was introduced and nurtured by Fr. Adriano, a catholic priest[15]; he was earlier affiliated to the National Institute of Communicable Diseases [Bamrasnardoon Hospital] in Bangkok which was the only centre where HIV-infected people could be accommodated for medical/nursing care till early 1992. However, the number of patients who sought care and support at this hospital rapidly increased, and the hospital authorities could not accept more persons though deserving, and needed immediate attention and care. In due course Fr. Adriano also observed that many *PWAs* were rejected by families and remain as "social orphans".

To cater to this category of *PWAs*, Fr Adriano established a small "hospice" centre, with a capacity to accommodate a maximum of five persons, at the *Our Lady of Mercy Church*, a few kilometers away from the Bamrasnardoon Hospital in the Nonthaburi Province. There were no specialist doctors on *HIV/AIDS* to take care of the patients or offer training to other paramedical workers who could take care of *PWAs*. The resident-*PWAs* of the Church could get general medical care from the Hospital, and the volunteers of the Church provide emotional and spiritual care at the hospice centre. After sometime the Parishoners raised objections to the continuation of the "hospice centre" within the Church premises.

Fr. Adirano explored several other locations [including some of the Buddhist temples] but could not establish the centre as people were not enthusiastic to welcome HIV-infected persons in their neighbourhood or in the temples. It was only in 1993 that the Carmillian Priests could rent a small place to accommodate fifteen *PWAs*. Even today, in the strict sense, this Centre cannot be classified as an hospice venue as it offers only some facilities and amenities. A few even argued that presence of *PWAs* within the religious premises would diminish the sanctity of that place.

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[15] Traditionally, Buddhist monks are considered as "healers" also. Temples and monks did respond to some of the earlier health issues, and their approach is somewhat similar to "hospice". However, in reality, those healing efforts were considered as part of emotional and spiritual support that a religious person provides to his/her followers.

However, in the meantime, the hospice approach was enthusiastically adopted by two Buddhist monks i.e., Phra Alongkot [Dhammarak Nives in 1992] and Phra Pongthep [The Friends for Life Project, 1994]. Doi Saked in Chiang Mai encouraged monks and citizens to understand the principles of hospice so that *PWAs* within the family or neighbourhood could be taken care of. The Buddhist Sangha has not explicitly recognised their work; nevertheless, several monks come over to these two centres to listen to some introductory lectures on *HIV/AIDS* and the role of Buddhism and Buddhist monks. In all these efforts, Fr. Adirano played a significant role: he inspired, animated, persuaded and offered necessary training to enable them adopt hospice principles and implement them.

6.2 Level of Activity

The hospice centres in Thailand always do not expect *PWAs* to visit them; in fact, staff of the hospice centres undertake regular "family visits" that serve as a survey of infected persons or possible infections, and maintain contact with the family members and community; some centres also pursue "AIDS Education" through public health education efforts. The care and support under hospice is both "sought" and "delivered", and is part of a larger initiative.

There are eight organisations in Thailand which presently pursue [or recommend] the hospice approach viz.,

- *St Camillus Foundation* [Relief Centre], Bangkok, has rented a place that could accommodate up to 15 persons, where *PWA* [either alone or with some of his/her family members] could stay for a period of four to five weeks. Currently, it maintains an "in-patient" strength of 15 persons, and has a waiting list of around 40 *PWAs*. Generally, every day the centre receives 3 to 4 fresh requests for admission into the centre. Over a period of time, a *PWA* is trained to serve as the Manger of the Centre i.e., Mr. Wiboonchai Yureun-ngam; he takes care of administrative and training aspects of the Centre.

- *Dhammarak Nives* [Lop Buri] established in mid-1992 by Phra Alongkot is an important hospice centre that has 75 beds with rehabilitation facilities, and the bed strength is expected to be increased to 100 by end-1995. In a limited way, it also serves as a training centre for those who are keen to work with *HIV/AIDS* persons. This centre is now completely occupied by *PWAs* and the monks could not even register new requests as the "waiting list" for admission is around 600 persons. *PWAs* generally stay for six weeks; in some cases, they even stay longer, and serve as "volunteers" in the activities of the temple.

- Urban Development Foundation *[Welcome House]*, Bangkok, is involved in AIDS education since 1992. It functions from a rented place and recently constructed its own building that they are yet to occupy. Currently eight to ten *PWAs* reside; when they move to the new premises, it is expected that the occupancy level may be increased to 15 persons. As the House is located in one of the huge urban poor settlements in Bangkok [i.e., Klong Toey], it receives ten fresh, personal requests

a day from the families who reside in the neighbourhood. Except in rare cases, *PWAs* do not stay for more than two weeks; but after their "discharge" from the House, they visit almost every day for two or three months; sometimes, they engage in other activities of the Foundation like card making or candle making.

- *Franciscans' AIDS Care Centre*, Pathumthani near Bangkok was established in early 1993. It has an occupancy level of 10 *PWAs*, and concentrates on family orientation. As the centre is located on the outskirts of the city, it has a large farm land in which *PWAs* and/or their family members could work. There is no time limit for the *PWAs* stay but decided on the basis of the progress made.

- *The Friends for Life Project* [Chiang Mai] was established only in early 1994 and is a small hospice centre. It can receive upto six *PWAs*, and relies on para-medical workers for nursing care. Being a new centre it remains informal and has little procedures for "stay-in" *PWAs*.

- *Meditation Centre* [Mae Hong Saon Province] has no regular "resident" system. It welcomes *PWAs* to undergo a training session on meditation to overcome emotional stress, provide counselling to members of the family. The training session is limited to a week.

- *Doi Saked Temple* [Chiang Mai] has a demonstration centre on hospice to train women and monks in *HIV/AIDS* work, and is expected to remain as a training centre on hospice and family-care nursing support to *PWAs*.

- *Phra Manat Nathipitak's Dhamma Training Centre* in Phayao province follows the perspectives and practices of the Doi Saked Temple in a micro format.

In aggregation, about 150 *PWAs* who are either rejected by their families or do not have a secure place to reside and live, are presently covered by the "hospice" approach. These centres also adopt varying components of the "hospice" approach, and no one organisation has adopted all principles/components of it in total. Currently, all hospice centres are fully occupied; non-cooperation by many general hospitals have forced many *PWAs*/families seek support of hospice centres, and about 2,000 persons have registered in the "waiting list" seeking admission into any one of the hospice centres. A *PWA* is taken care at the centre for a maximum period of four to six weeks under "hospice" treatment; later, if s/he continues to reside, then s/he generally engages in some employment activities. In few cases, the long-time residents serve as resource person for training programmes on *HIV/AIDS*.

6.3 Land and Building

High vulnerability of the *HIV/AIDS* persons living in low-income settlements is obvious. Their vulnerability is associated with three key factors: the character of the settlement, the physical environment, and the social environment. Whereas the *HIV/AIDS* persons need utmost nursing attention and care, the availability of land/building is severely limited for them. Many

in their readiness to participate; therefore, the time and effort require vary from family to family.

Therefore, overall, results have been mixed. Families have collaborated with the centre-initiated activities, and considered it as one-time effort. Many factors have been identified to explain the generally low level of family participation. Much of its principles, perspectives and contents remain unexplained to common people. Foremost among these is the vagueness of the intentions of the hospice centre to foster and monitor progress of the "family". Also, little time and money, and too few human resources are allocated to continuously organise families, sustain and support them. The other reason could be that most of the *PWAs* come from poorer households, and the economic pressures of the family determine their continued presence at the hospice centre and learn.

6.7 Financial Resources

The analysis of the hospice centres confirm what a knowledgeable student of community development would consider as "fair" i.e., hospice centres, though relevant, provide limited services to the infected persons and therefore, restricted in its scope. Hence it is not surprising that all the eight projects reviewed above face serious financial difficulties; limited resources significantly hamper their ability to sustain themselves and train others. Moreover, with inadequate resources, hospice centres could not attract trained personnel.

6.8 Cultural Constraints to the Hospice Approach

The perspectives of hospice approach in Thailand rely on one of the most fragile cultural components of the society. The two key cultural paradigms[16] of the Thai society are: [a] projection of social-political consensus on any issue [so that economic development is not disturbed]; and [b] efforts are made to "cover" up bad features. For example, AIDS in Thailand has received a good deal of political and media attention. In addition, there are numerous local and international agencies which write reports on it, and initiate projects to solve what is invariably seen as a "problem". The proposed solutions are generally directed towards women as *CSWs* while disregarding men. Those that focus on men typically stress on short-term strategy of invoking some health care. Many a times hospitals are constantly surveyed by a few over-jealous media persons [or even fake doctors looking for a prey] who might "exaggerate" fears of the pandemic which would ultimately affect the economy of Thailand - especially that of tourism sector - and "image" of the country.

To protect the national economy and Thai image [and national honour], at any cost, several steps are taken to "minimise" the destruction that emerge out of any socio-political problem. One such effort is to "cover up" the existence of *HIV/AIDS*. It is argued that a number of government agencies, NGOs and activists [supported by the mainstream media, populist

[16] Paradigms are quoted based on discussions with Professor Surichai Wangaeo and Professor Chayan.

middle class, business groups and elites] do not consider hospice as a necessary strategy to challenge *HIV/AIDS* - as that would "expose" the conditions in Thailand to the outside world, and adversely affect the national economic development efforts - and this refusal to accept hospice is considered as a "cover-up" paradigm of the Thai society! Thus, there is some resistance to establish, support or recognise hospice as relevant. Inspite of this denial, many view that hospice is an essential tool to meet the growing challenges of *HIV/AIDS* situation.

6.9 Some Viewpoints

Many non-hospice NGO projects, who concentrate on "AIDS Education", question the relevancy of "hospice" approach in the long-run. They consider that a large investment to offer services to few persons could be avoided. In general, all those engaged in hospice centres are missionaries [i.e., Buddhists or Christian], and remain committed despite adverse criticism/publicity to their work. They reason that:-

- it is necessary to demystify some of the interpretations or understanding on *HIV/AIDS*; until then some social groups will have to take care of the infected or rejected persons, especially from the poorer communities;
- human beings are discriminated on the basis of the disease which is a violation of human rights;
- a person merits a helping hand to "die in honour"; and
- for the households and society to understand the circumstances of *HIV/AIDS*, the re-integration of *PWAs* into the families is essential.

Those engaged in hospice strategy offer counter-critique to the "prevention" or "educational" approach. They consider prevention or educational strategy as:-

- "cover up" efforts of the mainstream activists;
- easy and painless to pursue;
- most tasks are desk-oriented, office-based and generally terminates in some meeting or a statement [i.e., conventional/institutional approach]; and
- remains as an attractive package to donor agencies.

In several instances, hospice centres have faced "resistance" from some of the mainstream sources. For example, Government refrains from establishing hospice centres on its own for fear of continued obligations that might prove to be a financial burden. The Thai business sector is worried as news of AIDS might affect investment/export markets. For many existence of a hospice centre confirms the "scope and magnitude" of the problem in Thailand, and that they would like to hide that fact at any cost! Some activists [both pro-hospice and anti-hospice proponents] consider that the forceful promotion of "condoms" as a panacea for the *HIV/AIDS* problem is part of an "institutional resistance", and possible "cover up" strategy of the government and a few pro-establishment agencies. Experienced AIDS workers believe that use of condoms will not merely serve as an insurance against infection, and, any way, many men are reluctant to use it.

settlements also develop bias against *PWAs* and do not allow them to live in the vicinity or neighbourhood. The possibility of social deviance is also high. Street violence is a major issue in these settlements. Thus, a poor *HIV/AIDS* person is exposed to serious risks to his/her life. Therefore, it is necessary that *PWAs* are provided a balanced environment during the period of treatment and intensive care.

Capital expenses for a hospice centre in Bangkok is calculated to be around USD 75,000 [excluding land costs]. Escalating land prices do not allow establishment of hospice centres in the urban areas. Many temples/churches do have vacant land in the city; however, internal bureaucracy and people's hesitation fail to help the situation even in rural areas. The running costs of the centre remains modest. For example, Dhammarak Nives spends about USD 60,000 per year on operational expenses; Relief Centre has a budget of USD 15,000 per year. Therefore, one could tentatively conclude that establishment of an hospice centre requires substantial capital whereas operating expenses will be marginal.

Some Buddhist monks express willingness to take care of *PWAs*, who need nursing and spiritual support; however, members of the religious community generally do not accept establishment of any centre for *HIV/AIDS* persons within the premises of the temple/church.

6.4 Hospice Workers

Training paramedical workers to provide services at the hospice centre is a common strategy of all organisations and aimed at providing culturally appropriate and affordable support. The approach is based on the fact that the most common care and support can be provided by someone with brief training and understanding of the situation. Projects do report difficulty in recruiting and training small number of "hospice cadre". This is also hampered by social discrimination of "AIDS Centres" where *PWAs* reside [e.g., objections raised by Church parishoners in Bangkok or Members of Buddhist Temples].

In Thailand, no qualified doctor in *HIV/AIDS* work was available till 1992; even today only eight medical personnel are specifically trained to focus on *HIV/AIDS* work. In addition, there is no institution which trains personnel on *HIV/AIDS* care. National Institute of Communicable Diseases in Bangkok has a short-term programme for "all" medical and non-medical men. The contents of this training vary from dealing with sophisticated epidemiological data to mere first aid and care.

The first part of a somewhat comprehensive training programme for grassroot level AIDS workers on the "Context of Sexuality and *HIV/AIDS*" was organised in November 1994 by the Relief Centre.

6.5 Medical Care/Support and Life Saving Services

Hospice centres exclusively rely on "outside" sources for nursing/medical care. Even Dhammarak Nives which has a clinic within its premises, transports *PWAs* from Lop Buri to Bangkok twice a week for some of the specific treatments and medication. Unquestionably, *PWAs* living in an hospice centre require nursing care, but each project has to realistically assess

what configuration of facilities it can offer. Thus, hospice programmes are inherently difficult to manage and support. Experienced persons like Fr. Giovanni or Phra Alongkot also find it difficult to determine as to whether certain packages or mixes of services were more required than others, and what combination and use of hospice will be most cost effective and improve conditions of *PWAs*.

In their normal living areas, only a small proportion of *HIV/AIDS* persons can obtain access to an ambulance in an emergency. Many hospitals reportedly turn away HIV-infected persons for fear of losing others. Most cannot obtain quick treatment from trained health personnel. Most of the low-income people, among whom incidence of *HIV/AIDS* is higher, live in settlements where serious accidents and emergencies are much common because of the lack of infrastructure and services, the poor quality and overcrowded housing, and poor quality sites. They also face the dual burden of housing and living environments which make them far more vulnerable to accidents and injuries, combined with little access to nursing care.

A reduction of vulnerability requires both environmental improvement and increased availability of nursing services. A key requirement in both cases is an intervention of what can be termed "regularisation" that involve [a] improvement in the confidence of the person and his/her family; and [b] provision of basic needs. In such a content, hospice centres tend to provide only minimum services, and their quality is debateable.

6.6 Participation of Family Members

An important component of hospice approach is to enable family members understand the nature/characteristics of the disease, accept the *PWA*-member within the household, and later serve as "home care givers". The role of family members varied considerably in the hospice centres, indicating that organisations receive *PWAs* who have different backgrounds and levels. Some families have stayed at the centre for sometime, volunteered to work for other *PWAs* and returned home with confidence and pride. In such circumstances, a *PWA* reciprocates well. Important strides have been made in some cases like family offering to finance purchase of drugs for *PWA*.

Insufficient Planning

The stimulation of family members to get involved in the hospice effort has received only few resources and support. Generally, an hospice centre is considered as "personal" experience and the members do not share their learning with others in the community. This may be because of unfavourable Government attitudes or lack of awareness of the level of effort and complexity of fostering family participation.

Inflexible

The education, motivation, organisation, and support of a large number of members are not activities conducive to have fixed schedules and to use of management planning techniques which programme activities for certain period of time. Individual members of the families differ

Section 7

Responses of the Thai NGO Sector

The recent list of NGOs, who challenge *HIV/AIDS* situation in Thailand, is found through their *"AIDS Action Networks" or "National AIDS Prevention Activities in Thailand"*, which is largely complete. A close scrutiny of the available data indicates that [entries are multiple]: there are about 42 NGOs/agencies who are actively involved in *HIV/AIDS* treatment, care, control and prevention, and educational activities. Of these, 23 groups are engaged in public health work, 14 relating to education, 10 provide vocational training, 12 relate to art and culture, 7 have formed women's support groups, 16 serve other NGOs, and 4 provide financial assistance for action.

The NGO[17] projects/initiatives reviewed were selected at random by the researcher with the help of social activists, policy-makers and NGOs. For purposes of the review/interview, following criteria was maintained:-

- an NGO or its project should express a goal to engage in *HIV/AIDS* work;
- currently be in operation; and
- pursue some form of intervention in *HIV/AIDS*.

The NGOs/projects reviewed were classified and examined [Refer to the list provided in the Appendix] according to a number of variables, including health care approach; operational level, or population covered in the project area; project history/implementation; and range of services provided at the most marginal level.

To explore the role of NGOs and understand their work it is necessary to examine and document responses to the following questions:-

- how NGOs specifically focused upon *HIV/AIDS* came into being;
- why existing NGOs have turned their attention to *HIV/AIDS* work, and what has been the outcome; and
- how and why NGOs operating outside the health sector have or have not become involved in HIV-related activites.
- what do NGOs share in common vis-a-vis challenges from *HIV/AIDS*? Is a categorisation of them possible on the basis of their activities and coverage?

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[17] In this section the terms "NGO" and "project" are interchangeably used to refer to similar organisational arrangements and convey the same meaning. Fr. J. Barry, Dr. Bennett and Dr. Praphan offered useful clues to organise this section.

7.1 Background

The Thai NGO sector, in fact, had responded to the *HIV/AIDS* pandemic much before the official acknowledgement of the situation. Some NGOs like *Empower, ACCESS* were established by the mid-1980s to challenge the emerging situation among the urban poor youth or commercial sex workers. *Population and Community Development Association* [with which Dr. Mechai is associated] launched its *"Say Yes to Condom"* campaign by 1988 itself. It is even argued that the NGOs forced the Thai government to accept the prevalence of *HIV/AIDS* in the country and that needed serious attention.[18].

In the kind of expansion of NGO activities, the reaction of the government, and the policies laid down by government with respect to NGOs, proved to be crucial. Until official recognition of the *HIV/AIDS* problem by the *MoPH* in 1991, Government was merely tolerating the "campaigns" of the NGOs on *HIV/AIDS* but did not allow appropriate mechanisms to be in place and work. But with the acceptance of the problem, public institutions were accelerated to work with the communities and funds made available.

7.2 Approaches to *HIV/AIDS* Work

All the NGOs/projects follow one of the two major approaches to extend support and solidarity in *HIV/AIDS* work: community-based or facility-based [that includes clinical care]. Most of the projects are community-based and focus on "prevention and education" activities through trained staffpersons or community volunteers. This approach can be subdivided into those who depend on volunteers, and those in which community workers are paid a salary. Some projects use a more conventional, facility-based delivery mechanism combined with peer group counselling [e.g., The Friends for Life Project, Chiang Mai; CARE; Thai Red Cross]. This division highlights difference in the programmes and emphasise the implications of the variations.

Community-based projects tend to rely on either volunteers from the community or paid community level workers, or even government personnel [e.g., Thai Red Cross]. In some projects [e.g., Northnet, Chiang Mai] health workers at the most minor levels are usually selected from the community [in some instances *PWAs* also serve as volunteers]. However, such efforts are merely experiments and sporadic. The community plays a planned and pivotal role in all the projects.

In some places [e.g., Chiang Rai and Phayao] NGOs have trained few members of the community and paid them "allowances" to support efforts in their respective villages. In this category of projects, the community's role is much smaller than that the preceding category [e.g., Duang Prateep and World Concern]. In the rural poor settlements, however, it would be unrealistic to look for communal financial support for the volunteers.

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[18] Based on available literature and discussions with Dr Chayan.

The Friends for Life Project, Saraburi Buddhist Monastery, Mercy Home, St Camillus Foundation of Thailand, few of the hospice centres, and to some extent Thai Red Cross, which rely on clinical care, attempt to introduce exclusively trained new categories of community *HIV/AIDS* workers to help bridge the perceptional gap between care givers and people.

7.3 Location

37 NGOs/agencies have units located in Bangkok, 15 in Chiang Mai, 6 in Phuket and 6 in Khon Kaen. Some groups have two or three "field centres". [Refer Table 01]

7.4 Coverage

To classify the projects according to coverage, the planned scope of operation of the project was used, rather than current/actual coverage, because the framework of operation was considered as important to review the implementation experience. Also, estimates of coverage [planned and actual] are not always given in project documents, and they are of limited value to understand the attributes of the projects - as projects regularly expand coverage and modify geographic boundaries. The difference between planned scope of operation and actual coverage does not appear to be great for the small and medium-scale projects, but it is great for some national-scale projects. In discussing the coverage of the *HIV/AIDS* projects, it is important to bear in mind that, for most groups, coverage is determined by availability of funds. National-scale projects almost always involve multi-donor financial support.

The projects examined in this report range from national efforts to small pilot, or demonstration, programmes. As Table 01 shows, 14 are national in scope, 12 are regional projects designed to reach from 500,000 to 2 million people; 27 are smaller, local level projects with populations ranging from 100,000 to 500,000; and 7 are small-scale experimental projects designed to cover fewer than 100,000 people. The remaining 3 projects/agencies provide general institutional support to various programmes and have no field component. This coverage scene provides a perspective on the role of project size in the type and severity of implementation problems encountered.

Of the 14 national projects, approximately one-half are currently operating nationwide, with activities in more than two regions. These are Empower, ACCESS, Duang Prateep, FARM, Thai Red Cross, CARE and World Vision. Some agencies [e.g., AIDSCAP] though national in character, tend to function more as "supporters" of the initiatives rather than "implementing" groups. Some projects are still expanding coverage, region by region.

In addition, two smaller projects located in Phayao and Saraburi are integral parts of national implementation efforts [i.e., World Vision and ACCESS]. Sometimes smaller projects are planned as an integral part of a larger regional or multi-regional programmes of a group. For example, *Northnet's* specific *HIV/AIDS* programme covers only 40 villages whereas it has activities in about 90 villages.

7.5 Level of Implementation

The NGOs/projects described in this review are in various levels/stages of implementation. Approximately 60 per cent were initiated before or during 1991. Because one or more years of start-up activities typically are required to establish the work, many of the projects have begun to intervene or deliver services or commence education programmes at the village level only within the last two or three years.

A number of projects have varied background and long histories. The most notable are: Empower, Phra Charmoon, ACCESS, Population and Community Development Association, Relief Centre and Thai Red Cross. All groups use volunteers, and the last employs government-salaried personnel too. Other projects, such as Duang Prateep or Welcome House, represent expansions of programmes that have been underway since the mid-1970s, under either community development or urban poor development initiatives. The projects that were more than five years old do offer a clear perspective and clarity of their "vision and mission" towards implementation; they do show effectiveness in implementation and intervention areas.

7.6 Range of Efforts at Micro Level

One of the objectives of *HIV/AIDS* work is to make essential care/support available to everyone. The components of the care and support-services were obtained from the discussions, and it could be categorised as follows:-

- *Clinical care* [i.e., appropriate testing facilities, treatment and provision of essential medicines]

- *Preventive efforts* [i.e., maternal and child health care; immunisations; stress on safe sex or condom use].

- *Educational support* [i.e., public education in the recognition, prevention, and control of prevailing circumstances/problems with a specific focus on *HIV/AIDS*; promotion of adequate food and nutrition standards, and facilitate access to it]

NGOs differed in the number of support-efforts they plan to undertake. Most cover a range of curative, promotive, preventive and educational aspects. Majority of the projects are planned to be preventive and educational. However, many do include simple curative care, offer some referral services, monitor nutritional status, provide immunisations, although less than one-third have plans to promote "safe sex" and implement "use condom" campaigns.

Many NGOs have recognised one serious impediment to their effort: *lack of beds in the hospitals to take care of fully blown HIV cases*, and provide confidence and support to *PWAs* and their families. The "waiting" period to get admission into a hospital for treatment is about six months, and reducing this, for concerned persons like Dr Praphan, is a major challenge to the government and other agencies.

In analysing planned interventions by NGOs, one has keep two facts in mind viz.,

- ☞ In some instances, *HIV/AIDS* work is only one of many programmes, and vertical programmes may well operate side by side with them [e.g., Duang Prateep or *Northnet*]. Many years may be required before existing categorical [vertical] programmes are integrated into their work, in the interim, similar or overlapping efforts may co-exist.

- ☞ Although a large number of support efforts are planned in most projects, close scrutiny reveals that many planned care or support-services are not being provided at this time.

7.7 Community Participation[19]

Community participation is the key word in NGO activities. Progress of community support was examined with reference to generally "inhibited" programmes like *HIV/AIDS* of NGOs. Information was gathered from NGOs, professionals and people themselves during the field visits.

The degree of community participation varies considerably. However, participation expected from the communities commonly takes on three forms: helping to organise a project, contribute financial support/resources, or actually carry out *HIV/AIDS* [prevention or curative] activities.

Mobilising Community Support

In many projects, community support vision/perspectives have not been translated into clearly defined activities on which project staff can focus and which can be reviewed well. Although certain expected forms of participation [e.g., the selection of AIDS cadre and the formation of health committees] are well-defined, neither the communities nor project personnel appear to have precise understanding about what they should do or what they should expect from general community participation goals, such as communities' actively seeking solutions to *HIV/AIDS* problems.

Most NGOs agreed that community support to specific and concrete functions and activities [e.g., training programmes or provision of labour for activities] has been successful, but other kinds of activities have not. Communities tend to support activities, but not initiate them. Some feedback received from the NGOs/*MoPH* officials on community participation and support to initiatives is summarised below:-

- o At least 80 per cent of the projects have proposed village level committees as the organisational framework for community participation at the local level, and to promote

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[19] This part is based on the information provided by Dr. Praphan, Dr. Seri and others.

interaction between the community and *HIV/AIDS* programme personnel. Some NGOs have used existing development organisational frameworks to elicit community participation [e.g., training school teachers on *HIV/AIDS* by the women's project of World Vision in Phayao]. In some of the villages in Northeast, Women's Clubs [mostly comprising of *PWAs* or AIDS-related destitute] are responsible for the village programmes and its members take an active role.

- In addition to work on HIV tasks, some committees have been given responsibility to stimulate community efforts to solve complex environmental, economic, and social problems that may contribute to spread of HIV in the community. Community "self-help health committees" with broad directives were found in *Duang Prateep, CCT and CCHP.*

- Generally, local committees undertake few of the responsibilities, and they are active during the "crisis" phases.

- Typically, some groups have sought local contributions for clinical care [e.g., medicines or testing facilities] and support of the village level worker. The problem has not been to get individuals to pay for medicines, but to obtain sufficient money or in-kind contributions at an acceptable and consistent level. None of the NGO could achieve self-sufficiency through "user fee" collection.

- Most projects pay minimum attention to finance village level worker to continue efforts on a long-term basis. The need for village level support is mentioned, but concrete plans, yet there is no clear strategy to generate income. Some of the projects initiated by *NAPAC* have paid more attention to the issue of community financing, wherein the experiences of the earlier projects are being considered. Some projects opt for collaboration with the community to work out suitable methods to mobilise resources before commencing interventions at the village level. Phra Pong Thep, for example, insists that the village committees work out a viable financial plan before they can begin work or training on *HIV/AIDS.*

- Direct community interest has been considerable in many areas, but little effort is made to stimulate/encourage communities to recognise *HIV/AIDS* problems, develop solutions, and mobilise resources to challenge the issues; hospice centres have been successful in stimulating family interest. There has been only limited and occasional community support to undertake even general health care activities. The strongest evidence of community-initiated activities was provided by least 10 projects, and the contributions occured in cases:-

  - Some projects commenced work with a Knowledge-Attitude-Practice Survey [KAP], and struck a good rapport with the local community. Using the contacts of that survey and its results, these projects/NGOs were easily able to form "AIDS Support Committees" at the village level, and implemented *HIV/AIDS* related programmes that include the construction of "care centres" and development of community gardens.

- Some communities have initiated activities such as the "voluntary medical check up", peer education programmes, Women *PWAs* Clubs or Mothers' Clubs.

These NGOs/projects share two important characteristics: all are small-scale and half have been implemented by local people. Three projects have populations of fewer than 60,000 persons; two are under 100,000. All the projects have long experience in the areas, and community participation is an integral part of their philosophies. It appears that - experience and orientation to community participation - provide the sensitivity to both the culture and the process of community development that is needed to undertake successfully the difficult task of *HIV/AIDS* work.

NGOs who have succeeded to elicit community support for *HIV/AIDS* work, and that involvement varies widely in their characteristics and implementation histories. They, however, share a number of common attributes:-

a. Financial support

In all the projects, the major capital-investment costs of HIV work are borne by either the Government sources or the donor agencies; community has seldom mobilised resources. May be it too early to look for community efforts to mobilise resources to support the initiatives.

b. One-time effort

Few NGOs have undertaken some discrete construction efforts. They also tend to involve one-time efforts that require little community involvement or attention [other than maintenance] once they are completed. Unlike communal gardens, the community mobilisation effort can be concentrated during a brief period, and follow-up can be sporadic.

c. Community organisation efforts

Many NGOs stand out as having given more than the usual attention to generate community support. Of the 18 projects closely reviewed, only 4 appeared to have expended considerable effort in this area [e.g., ACCESS, Empower, Thai Red Cross and Care].

Factors that inhibit community support/participation

Discussions with NGOs and people indicate that the generally low to moderate level of community participation in *HIV/AIDS* work was the result of both pre-existing community and government outlook, and of shortcomings in project design and implementation. These factors are summarised below:-

in *HIV/AIDS* work. Training these workers as "care givers" represents, for most projects, a major change in intervention strategies. Every project considers mid-level staff to be critical as it is they who handle identification of HIV infection within the community, refer for treatment, follow it up, take that opportunity as an entry point for community discussion and possible action. They provide varying orientation to *HIV/AIDS* care at the village level. This is possible because these are "new" categories of personnel whose responsibilities and training incorporate this dual orientation.

Community level workers generally perform a variety of tasks that include:-

- **Thai Red Cross**: Trained nurse-clinicians and care givers provide curative services for some of the common problems in *HIV/AIDS* and perform essential preventive, promotive and educational activities. They are trained to diagnose and treat common *HIV/AIDS* problems, organise preventive health care for children and mothers, institute public health measures, and stimulate community-development efforts.

- **Dhammarak Nives, Relief Centre, CCHP, CCT and World Vision**: Para-professionals are being trained to provide a wide variety of basic curative care to initiate public health measures; they also provide social care and counselling. These personnel are located within the communities.

- **Saraburi Buddhist Monastery** [and some of the hospice centres]: A new category of care givers were trained and introduced to provide support for common *HIV/AIDS* problems, to promote community level education programmes and to supervise community health cadre formation. This is being followed in a number of projects in North and Northeast of Thailand.

Training Community Level *HIV/AIDS* Workers/Educators

Training villagers [or co-industrial workers] to provide their communities with *HIV/AIDS* care/support is a common strategy amongst most of the projects. Large segments of rural populations do not live within easy reach of health facilities, and even though new facilities may be constructed, these cannot be expected to cover large, dispersed populations adequately. Community-level *HIV/AIDS* workers *[CWs],* therefore, could reach unserved populations. In addition the use of community workers is presumably more cost-effective than the use of facility-based paraprofessionals. Physical barriers - transport or travel time - could be reduced through such an intervention.

Among the NGOs reviewed, *CW's* responsibilities vary widely. Most of the programmes have trained one person to perform a number of promotive, curative, and preventive tasks - the full range of care provided at the village level. But a number of groups have assigned curative functions to one kind of worker and promotive and curative functions to another [or sometimes several types]. In these projects, the different categories of workers function as a team.

Those programmes that divide functions among different *CWs* usually depend, at least in part, on volunteers. The use of this strategy probably reflects an attempt to limit the amount of time any one person must volunteer. The worker with preventive and educative functions usually is given much briefer training, and is expected to contribute less time and effort, than his curative counterpart.

Although division of tasks may facilitate the *CWs* ability to provide the full range of *HIV/AIDS* care and support, because each worker is responsible for learning and performing fewer tasks, this strategy brings with it problems in generating financial support, if any of the workers are to be compensated. Generally, neither the Government nor communities can afford to finance two workers per village.

7.9 Performance : Preventive and Curative Functions

Discussion with the field Coordinators of the NGOs indicate that *CWs* actually perform only a limited number of the tasks for which they are trained. It is asserted by them that with the increasing incidence of HIV-infection *CWs* are forced to concentrate on curative or referral activities, to the neglect of preventive and promotive functions. The reasons for this are not clear. It may be that the *CWs* are assigned an impossibly large number of tasks, that their training or supervision is deficient, or that community support and incentives largely determine what work *CWs* carry out.

The average *HIV/AIDS* worker is generally trained to handle a number of tasks. For example, in Lampang [near Chiang Mai], the village health volunteer [*CW*] is responsible for providing basic curative care, including first aid; organising educational events; providing basic health education in schools; assist some of the control programmes; monitor children and mothers' health conditions; and promote community participation. Almost everywhere *CWs* are expected to conduct educational activities. Condom promotion campaigns by *CWs* is common. Most projects also include a number of maternal, child health and family planning activities too.

Without exception, NGO documents and action plans stress on preventive care and education, but on the whole programmes have experienced difficulty both at the village and family levels. For example:-

- **Daughters of PWAs** [Phayao] found that village level *HIV/AIDS* workers rarely spend time doing anything other than dispensing medicines as the pressure for clinical care was substantial.

- **Welcome Home** Project staff found that it was difficult to sustain the interest of the people in preventive care in Bangkok as the community was eager to obtain curative care; even family members begin to evince interest to participate in the training programmes only after adequate care was ensured to *PWAs*.

- **Relief Centre** could not train *PWAs*, who are destitutes or refugee-orphans, as they were keen to become economically independent by taking up a job.

7.14 Project Support

An analysis of *HIV/AIDS* projects/programmes confirms what one might consider as possible - that management problems are the most pervasive and serious cause of the implementation difficulties encountered by NGOs/Government. Although implementation is just beginning in many of the projects that were examined, a pattern is discernible; Government has little difficulty completing the start-up activities of an initiative [e.g., Wednesday Club of Thai Red Cross], but once health workers have been deployed and require support, serious problems arise in managing the project. Specifically, these are problems of administration, logistics, transportation, supervision, and collection and use of information.

It is noteworthy that staff from the NGOs with the longest operational experience are frequently the persons who stress most strongly the importance and the difficulty of establishing adequate support services. Despite the progress some NGOs have made in different areas of management, none of the longer-running projects has satisfactorily solved its management problems.

7.15 Problems and Causes

Nearly every NGO is burdened by serious problems in one or several areas of management, including:-

- *Organisation* [arrangements to support programme objectives, to reduce duplication of effort, and to avoid internal conflicts];
- *Finance* [i.e., NGO funding comes from a wide range of world wide sources. A few NGOs intentionally avoid foreign funding];
- *Personnel* [i.e., staff, job descriptions, assignments, training, permanency, salaries and benefits, commitment, and satisfaction]; and
- *Supervision and material support* [i.e., planning, implementation, management and monitoring; complex yet simple simple tasks like transportation and procurement and distribution of educational materials and others]

Causal factors vary, depending on the economic, cultural, and political conditions in the area, as well as on the size of the project, key personnel and donor agency. However, certain factors are common to nearly all NGOs/projects. These are the pace of *HIV/AIDS* spread; lack of funds; the shortage of trained human resources; and underdeveloped institutions and infrastructures.

7.16 Fresh Strategies

Many NGOs are experimenting with new appraoches and strategies. Of particular interest were the following components:-

- *Employment initiatives* [Some groups have began programmes to place PWA or their families in gainful employment - this includes training in self-employment];

- *Local resources* [In Phayao and Khon Kaen, communities are motivated to develop, as a precondition for continuity of the programme of *HIV/AIDS* education, a viable financing plan to pay local volunteers; this effort is still under discussion];

- *Condom distribution* [PDA, Empower and other groups experiment with the use of a commercial pharmaceutical supplier to provide condoms for distribution at the village level through *CWs*. However, Dr. Voravut of San Sai Hospital asserts that NGOs are trained neither for medicine distribution nor clinical care; he does not perceive a role for NGOs in long-term clinical care efforts];

- *Medication/treatment costs* [e.g., Folk Doctor, CCPN and CCT have introduced use of inexpensive traditional medicines into the health education system in an effort to reduce programme costs].

- *Use of local health care providers* [e.g., CCT, CCPH, ACCESS and World Vision are training pharmacists or other para-medical personnel in an effort to upgrade the diagnostic and prescriptive skills of these widely-used private sector health agents. Projects in Phayao and Khon Kaen are testing their effectiveness as distributors of condoms and leaflets].

- *Curative-preventive care* [Every project has been designed to establish clinical support at the community level before preventive/educational components are introduced].

- *Community participation* [The projects in Chiang Mai and Phayao - small scale - have achieved considerable extent of people's participation through active and vibrant health committees at the community level that are established through non-formal education efforts. These committees focus on peer education or use of *PWAs* as resource persons for the *HIV/AIDS* campaigns].

- *Mass media support* [news, views and concerns on *HIV/AIDS* have received plentiful cooperation and solidarity from the newspapers, radio and television programmes].

7.17 Overall Inferences

Through sustained campaigning NGOs have placed HIV/AIDS on the national debate and agenda, and also successfully carried out several preventive and curative programmes. One may consider that the initial phase to consolidate NGO activities is complete, and the most challenging test for them is ahead i.e., how to proceed from here and make it more purposeful? In general, the essential components of NGO interventions consist of education, campaigning and propagation of home-based care and counselling. Many NGOs consider home care is a useful entry point when it aims to develop the communities' own capacity to prevent and control *HIV/AIDS*. This appears appropriate for three reasons:-

- Firstly, it places organised response to the pandemic, slowly, at the level of the community, where NGOs function effectively, where communities' coping strategies can be built upon and beneficiaries are more likely to be involved in decision-making and management; this will also help to eliminate expensive centralised, national bureaucracies.

- Secondly, this community-level response tends to spread family's financial burden among community members, a kind of risk-sharing necessary for long-term financing of the pandemic, which is also a community-building strategy.

- Thirdly, it encourages solidarity support among NGOs and enable them respond to the specific needs of individuals, groups and communities.

In addition, traditionally non-health sector NGOs [e.g., women's groups, development groups, self-help groups and other empowerment initiatives] have evinced keen interest [or have already began] to work in some method to control the spread of *HIV/AIDS* and educate people. All these groups are expected to build multi-level solidarity and generate prevention and the impact-reduction activities working through their particular constituencies and interests.

Section 8

Responses of Religion

Apart from numerous NGOs, an important role is played by religious groups in Thailand, who publicly participate in *HIV/AIDS* clinical care and education. These institutions could be classified based on their faith denominations as: [a] Buddhists; [b] Christians [either Catholic or Protestant]; and [c] Muslims.

8.1 Buddhist Thought and Action on *HIV/AIDS*[21]

Traditionally, Buddhist monks themselves were healers and known for their knowledge on herbal treatments; the temples and monasteries have beds for in-patients. Their social and public health concerns were obviously to participate in the efforts that was not supported by the "traditional" schools within the monasteries. In some places, members of the local community disapproved the proposal [e.g., one abbot discussed a proposal to establish an *"AIDS Care Centre"* that was not accepted by the community as it might disrupt the sanctity of the temple and cause inconvenience during ceremonial occasions. However, this abbot has initiated a training programme on *HIV/AIDS* for monks and villagers].

Many villagers [who were met during the field visit] agreed that the monks need not have any physical or administrative involvement in such works, but hire trained nurses or lay people to care for the persons with AIDS, allowing monks to merely coordinate the function of operations which would be in a special building in the temple grounds, or, they may wish to only provide spiritual guidance and support. In this sense, it would be a care support primarily provided by the community.

The querry on the use of the temple for care and education of *HIV/AIDS* purposes has received a mixed response from the Buddhist clergy and common people alike. It is a rather radical concept as people have conservative views on the role of the temple and monk. Initially, people reacted with a negative view and found the premises to be "unsuitable" for *HIV/AIDS* work as:- [a] purity of the monks may be contaminated; [b] youth who may have to stay in the temple might tarnish the image; and [c] should at least be prohibited for infected women.

In many temples it appears that the villagers, perhaps more so than the monks, would not agree to a hospice centre, nor do they agree to general sermons on AIDS prevention and control. It may be the case that a *hospice* in a temple is only possible when the monk is fully supportive and knowledgeable, and can influence local villagers.

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[21] Based on discussions with Phra Pong Thep and views of several other monks who participated in a training programme on *HIV/AIDS* specially organised for them on July 12, 1994 at Chiang Mai.

Each Thai village usually has a temple and all may not be suitable to establish a hospice centre. Many may have one or two monks only with very little facilities. For example, meditation temples may not be appropriate and that temples where the main activity was teaching and conducting rituals would not be suitable or would not be open to such suggestions. Some temples could be classified as "development" temples, where monks are well-informed, interested and involved in community development, and it would be the most appropriate.

The proposal to establish a *hospice* programme in a temple has financial benefits too - as land does not have to be purchased and volunteers are the main care givers. Villagers normally supply all food and provisions for the monks and temple activities are supported by donations and voluntary labour, as is much of general maintenance. The temple, in this sense, is a community resource while at the same time being sacred in nature.

The reluctance of the people to establish *HIV/AIDS Centres* at the temples reveal some tension between the monks themselves to accept infected persons as normal members of the community and teaching villagers to accept them without any stigma. Phra Phong Thep argued that HIV persons will not defile the temple any more than youth attending violent movies and listening to loud contemporary music within the temple grounds. However, first of all, monks have to develop this level of understanding themselves through training, and able to face the issues associated with *HIV/AIDS*.

Monks may be an important adjunct in offering moral support through counselling. This would require that they are fully trained in order to have a comprehensive understanding of the *HIV/AIDS* pandemic. Thousands of monks have been trained throughout the country, and over 1,200 monks have been trained in the North, through temple and non-government initiatives.

Monk training emphasises on care and control of the spread of *HIV/AIDS*. The training sessions are similar in content to other training programmes meant for lay people. Strategies of care and control are, of course, essential to slow the rapid spread of *HIV/AIDS*; however, it is becoming increasingly important that the concept of living with AIDS be widely promoted also. It is here that the monks have a significant role to play as they could blend Buddhist teaching with "care, affection and love" to *HIV/AIDS* persons, thereby reduce tensions between people, groups, and with no offence to any person.

7.2 Christian Missionary Efforts

Protestant work in Thailand began some time in the 1830s covering public health and educational activities as an integral part of the Christian mission to Thailand. By the 1950s, agricultural support had been acknowledged as also needed and an important activity to be engaged by the churches at least by the Presbyterian, Disciples of Christ and American Baptists. Some missionaries moved from China to Thailand after World War II and that was mostly non-denominational work.

However, involvement by Protestant Christians in development activities has probably increased in recent years although types of programmes undertaken has changed. For example,

the *Church of Christ in Thailand [CCT]* maintains an extensively coordinated programme that include highland development, agricultural support, handicrafts promotion, public health and leadership training to rural people in about fifteen provinces in the North, Northeast and South of Thailand. *CCT* is actively engaged in provision of care services to persons living with *HIV/AIDS* and has an elaborate education programme in the rural areas. Issues pertaining to *HIV/AIDS* are discussed during Sunday assembly or posters/leaflets distributed everywhere. *CCT* considers *HIV/AIDS* work as a source of empowerment and a tool for securing public and social accountability of the society at large. YMCAs [e.g., Chiang Mai and Bangkok] have also taken some initiative to train school teachers on *HIV/AIDS* tasks; they also have small-scale outreach programmes.

Catholic missionary work in Thailand has been very diverse and until the late-1960s some development efforts without much coordination was pursued. The formation of *Catholic Council of Thailand for Development [CCTD]* provided a new perspective and framework for the Catholic institutions and personnel to act. Four broad areas of action include:- emphasis on self-help; conscientisation of religious and lay leaders as to the wholistic nature of development; work towards purposeful decentralisation of responsibility at all levels; and reciprocity between leaders and target group people to mutually share in planning and action.

The *Catholic Commission for Health Promotion [CCHP]* with its headquarters based at St Louis Hospital in Bangkok, plays a significant role to develop fresh thought and action among Catholic missionaries to encourage community health initiatives on *HIV/AIDS*. *CCHP* has given due importance to this programme since 1990 and included the following activities: motivation of missionaries to gather information, gain understanding, promote awareness and support to fight against AIDS, in aspects of both prevention and assistance; developed and supported personnel involved in the work on AIDS through: provision of temporary shelter [e.g., Mercy Home, Welcome Home, St Carmillus Foundation and others], groomed counselling skills, coordinated with NGOs and state agencies as well as other religious organisations involved in AIDS work. Under the auspices of the Catholic Church about fifteen initiatives are in progress in Thailand and a small training network is available amongst them.

Norwegian Church Aid has formulated a comprehensive strategy to intervene in *HIV/AIDS* conditions in the Northeast of Thailand. Despite this, they tend to remain as "projects" and limited to some select locations.

Christian missionaries established hospice approach in Thailand through numerous training, information sharing and persuading Buddhist monks to participate in such efforts. In general, many missionaries [along with some Buddhist monks] convincingly propose *hospice* care method as an effective response to the challenges as: [a] majority of those affected from the poorer communities, who lack access to medical care, and generally neglected by the government programmes; [b] it fits into the basic socio-cultural orientation; [c] stress on "dignity for those dying"; and [d] extension of their traditional pastoral care.

8.3 Islam

The Southern part of Thailand has a substantial Muslim population. It appears that most Thai Muslims, at best, have taken a passive attitude towards government-sponsored development. Few groups perceive an active resistance by the Muslim elite to many development activities, especially education because they bring closer Thai government involvement in and undeniable disruption of parts of traditional "Malay-Muslim" religious and cultural life, attempt to reduce separatist and pro-Malaysia feelings, and are part of a larger effort to reduce ethnic solidarity of the Muslims of southern Thailand. There is no group that subscribes to Islamic principles which is active in *HIV/AIDS* work.

Section 9

Popular Strategies

Risk avoidance in case of *HIV/AIDS* is very difficult to propagate. A virus and the immune system are not easy concepts to grasp. The situation is complicated with several hearsay proposition that circulate on AIDS. People often try to distance themselves and disbelieve things they do not understand. However, many groups have initiated popular strategies to educate "person in the street". This section elaborates a few such approaches.

9.1 Condom Distribution and *HIV/AIDS*[22]

One of the key strategies of Thailand's *National AIDS Prevention and Control Programme* has been condom promotion. Condoms are commercially available throughout the country at affordable prices. Government policy for years has been open and supportive of condom use, both for family planning and STD prevention. Subsidised and free condoms are made available through family planning, clinics, drug treatment centres, STD/AIDS clinics, entertainment places and through community volunteers.

In 1991, the *National AIDS Committee* approved a Government plan to implement a "100 Percent Condom Promotion" programme in all of the provinces. This nation-wide programme combines the unique skills and political networking of provincial governors, police and public health authorities to address the issues of commercial sex, condom use and empowerment of women. Some agencies like UNICEF consider it as a "success story".

Government funding has expanded to ensure an adequate supply of free condoms throughout the year to all targeted populations. In addition, condom logistics and distribution systems have been strengthened, as well as facilities for condom quality assurance testing. Efforts are on to assess the feasibility of female condoms, particularly among commercial sex workers.

Early days, the association of condom with sexually transmitted diseases and illicit sex inhibited their promotion in a public way. Currently, condom promotion campaigns seek to tackle the spread of *HIV/AIDS*, and condoms are generally distributed for a price or free of charge. However, the distribution was symbolic as the total condoms distributed were less than 5 per cent of total sales.

An active anti-AIDS campaigns that use some of the imaginative techniques to promote "safe sex" methods are undertaken e.g., condom inflation contests and raids on bars by people in condom costumes; graphic educational material on condom use were produced for homosexual

[22] Based on discussions with PDA, Empower and Thai Red Cross.

and bisexual person with some results of reported increase in adoption [e.g., activities of NGOs like PDA or Empower].

Some organisations like Thai Red Cross/PDA/Empower/*MoPH* have launched radio campaigns, and claim that mass media techniques and community-based distribution methods have increased condom usage. Their promotion methods also include point-of-purchase advertising such as posters, comic books, calendars, shopping bags, T-shirts, as well as exhibitions at local fairs and mass media such as songs and music videos, television and radio public service announcements, talk shows and dramas - all promote responsible sex and condom use. Condom distribution for prevention of AIDS has increased with political commitment in 1991 to open and aggressive techniques, opening the door for other contraceptives too.

9.2 Mass Media, Peer Counselling and Networks

Although the Thai Government and international agencies have geared up to a wide-scale publicity campaign to prevent spread of *HIV/AIDS*, results have so far been mixed. A major, multi-media campaign in 1992-93 increased awareness but little to change the behaviour of the average heterosexual, sexually active person or commercial sex workers. The average number of partners and use of condoms among heterosexuals remained the same throughout the country even after that high profile campaign. Campaigns which position AIDS as the "grim reaper", intending to send fear into the general population about sexual promiscuity, have not been very successful.

General messages prove to be ineffective because they are not meaningful and easily shrugged off as *"someone's else"* problem. But wide-scale public messages aimed at specific groups, such as homosexual and bisexual men, helped the Government and NGOs to reinforce the concept that AIDS is a "gay disease". In Phayao, an AIDS education programme aimed at sexually-active heterosexual public had little effect on attitudes/actions concerning the number of sexual partners permissible, in spite of a high level of knowledge about HIV heterosexual transmission [e.g., World Concern].

In Khon Kaen, the free distribution of condoms to a group of commercial sex workers, together with intensive counselling, was found to have increased the use of condoms from twelve per cent before the programme to about 45 per cent six months after the programme started[23]. This indicates that people would respond to such efforts but require constant encouragement and educational input to sustain it.

In Chiang Mai, peer education, formal and non-formal, has been proved as an effective strategy to reduce at-risk behaviour. This programme included planned peer education, taping into an already existing network of commercial sex workers who knew little about *HIV/AIDS*. Early discussions led to the formation of a group of six women leaders as peer educators who talked to several others. In the early stages of this experiment, only one in every three women

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[23] *"AIDS Education among Female Prostitutes: An Experimental Study"*, Department of Obstetrics and Gynecology, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla; March 1991.

understood the issue, whereas at the end, six out of ten understood it. In fact, word-of-mouth dissemination of the programme was found to be successful that many commercial sex workers enrolled in a supplementary programme, purchasing condoms at a wholesale price [Refer to the works of Chayan V.].

A similar approach has been successfully carried out in the suburbs of Bangkok and Pattaya [e.g., Duang Prateep Foundation] where AIDS transmission has been largely heterosexual. Leaders among commercial sex workers were trained to provide health education, support and condoms to their co-workers. Sex market places, such as one-night-stand hotels, were ordered to provide condoms free to their customers and commercial sex workers were taught to incorporate condoms into their foreplay with customers.

In the urban poor settlements of Bangkok, an extensive publicity campaign also involved an exchange programme for needles and syringes and distribution of condoms among addicted commercial sex workers. In addition, a local NGO [e.g., Empower] involved the target group to design the educational intervention, paying attention to the lifestyles of the average drug user and appealed to them to stabilise their social relationships, employment patterns, and illegal activities. These very liberal interventions and open communication about the problem had a positive impact in that the residents were more open to accept the problem as "prevalent" and decided to take effective action.

9.3 Cultural Activities

Many NGOs [e.g., Thai Red Cross's Cabaret Shows] have formed cultural troupes to spread the message on *HIV/AIDS*. Family planning education was traditionally pedantic, unimaginative and in most cases, failed to reach youth. The present band of artistes, on the other hand, try to meet youth at the discos, streets and clubs, and bring in essential messages which blend in with their culture and view of the world. Popular youth music stars use their talent to promote sexual responsibility. They give messages on literacy, family planning, sex education and women's welfare. To a large extent these initiatives have succeeded in raising awareness and creating demand, especially among the urban youth.

In Phuket area, a local artist, an AIDS victim himself, took up the cause and made *HIV/AIDS* an acceptable subject to talk about. He produced pictures and displayed them at prominent points in the city. His battle for life caused a public stir for weeks. This new openness facilitated awareness campaigns aimed at the general public as well as programmes aimed at specific risk-groups.

9.4 Use of Mass Media

Apart from the coverage in newspapers, television spots on *HIV/AIDS* have become a common feature and, in addition, many regular programmes and documentaries were created by NGOs [e.g., PDA] and agencies for wider dissemination. This partnership led to the formation of a group *"Partners in AIDS Education"*, who were prominent members of the society e.g.,

artistes, sports persons, writers or politicians. Its members posed for posters, addressed rallies, toured outlying areas, appeared for television spots and gave press interviews to support AIDS education. By publicly endorsing such an issue, they became high-visible advocates for the AIDS education. Amongst the NGO community, theatre and cultural groups were formed to support AIDS education, and the themes were commonly linked it with other social issues.

However, it is cautioned that in *HIV/AIDS* prevention programmes, mass media alone appears to have had a limited effect. Emphasis on mass media campaigns may leave out significant at-risk portions of the population who have little or no access to the media. Very general messages carried over mass media may have little effect on the average person who may shrug of the message.

In appears that the most successful approaches in condom distribution and AIDS education have been those aimed at specific at-risk groups where interpersonal communication and peer counselling were encouraged to play a significant role. There is a growing awareness to address the problems of groups, such as commercial sex workers, drug addicts and street children.

Section 10

Home and Community Care and Support

10.1 Home-based Care and Support

Increasingly, home-based care and support is recognised as being indispensable to reach the wider community. Successful mobilisation of community energy for AIDS care, prevention and control is considered as the real challenge. It is most likely to be sustained by building an understanding of counselling in the community, and of community development.

AIDS programmes that focus on family and community strength is in progress in the following places apart from the large Thai Red Cross Society's effort. For example: [a] Duang Prateep Foundation - ACT Power; [b] Dhammarak Foundation's efforts; [c] ACCESS; and [d] Christian Missionaries work in hospice centres, and in the North and Northeastern parts of Thailand. A few have formed an *AIDS Care Unit* that include a home care team. The decision to shift the emphasis from the hospital to the community was based on several assumptions:-

- o that other health programmes need to continue;
- o that the family is the greatest long-term strength;
- o that patients prefer to die at home;
- o people learn best by talking together; and
- o that behaviour change can be achieved through activating traditional leadership and facilitating responsibility transfer for care and prevention.

The objectives of the *AIDS Care Unit* also include identifying specific target groups for education, and coordinating medical policies for management within the hospital. The objectives of the home care team were primarily to care for patients by supporting families, to maintain a data base, and to promote *HIV/AIDS* control through contact tracing and the development of strategies for behaviour change by the community.

In some organisations [e.g., Thai Red Cross], the AIDS Team is a multi-disciplinary group - the precedent for this was already established through the leprosy, drug de-addiction and primary health care programmes. It was felt that people should be informed of the diagnosis and provide adequate follow-up. This was consistent with the hope that a realistic strategy for AIDS could eventually emerge.

In discussing programme development and the impact of the Saraburi Centre of AIDS and Dhammarak Nives, it was observed that a home support work, through which information can be obtained, could be established effectively.

Prevention and control strategies can then begin to develop strategies which are locally relevant, and which recognise the inability of established health system to deal with the problem except through a recognition and facilitation of community capacity. Defining locally applicable

management principles if the first step to consolidate the initiatives. This guards against loss of momentum, and promotes capacity for change. Through home based care, motivation for prevention within the community is positively emphasised. The "bottom up" approach is one that is preferred by those who suffer most, and it will therefore be sustained.

For the Government, Thai Red Cross and numerous NGOs, future success is likely to be found in those programmes which explore the principles of community development that respects local community initiative and are much more likely to implement the primary health principles determined in the late 1970s.

10.2 Community Counselling

The purpose of education and counselling and all other disciplines of AIDS management is behaviour change in a specific direction. This is mediated most effectively through counselling which will take the form of individual, family and community counselling. Some Buddhist monks and Christian missionaries have integrated it with education that functions as a tool, just as it is for pastoral care, and for community development.

Community counselling on *HIV/AIDS* is still in its experiment stage. Largely, it is an activity that focus on groups and communities to promote responsibility transfer for behaviour change to the whole community. Generally, the community has group structures, shared values and mutual concerns. This is relevant for crisis issues such as AIDS. Community counselling is also needed for measurement of behaviour change. There is evidence in the Bang Chan area [Chiang Mai district] of the powerful influence of family and community on individual behaviour e.g., decisions on means of ritual cleansing, established certain community structures such as temples, the re-introduction of the teaching of taboos, re-introduction of formal wedding ceremonies, and elders settling family disputes in an amicable way.

Since late-1989 several community counsellors were trained by various agencies [e.g., Thai Red Cross and Empower], and these are now active in their respective areas. By joining the existing village health work teams, these animators have become part of health service structure. They work with community health workers and, if felt appropriate by the community, can fill both roles, though it should be noted that this rarely happens.

The process requires a community counselling team. Training in *HIV/AIDS* counselling for non-formal counsellors has been incorporated into the AIDS education and prevention programme since 1991. For example, UNICEF and the Thai Red Cross have taken a pioneering lead to pursue this training effort among industrial workers.

The team at Northnet [Chiang Mai] has now worked with many communities at various stages of the process that include strategy formulation and implementation. This is the critical point for training community counsellor from within each community, to work as an "insider", rather than one who views the community from outside. Almost all efforts rely on *peer-group networking* approach. Peer-group approach is popular among industrial workers, in particular those living in provincial urban centres outside Bangkok.

10.3 Peer Group Training

Peer-group training in the industrial community is an eight-hour session [given in one day or two] that enable the participants to counsel other industrial workers at their workplace. Workers who have received training can serve as peer counsellors, provide counsel and advice to their peers. These workers, in turn, are likely to pass the information on to their families and friends in their hometowns. It helps to ensure that words on AIDS reach everyone in the provinces within short time.

Workers in the training programme are taught in sessions comprising thirty people, represent as many factories, as possible at the rate of about one trainee for every fifty workers. Trainees learn about the situation of *HIV/AIDS* in Thailand, the nature of the disease, its mode of transmission and prevention and the importance of relationship building among HIV-infected and non-infected workers. The workers are taught basic communication skills as well as teaching and counselling techniques. They are also provided with materials like flip charts and videos to present to fellow workers in their provinces. The training sessions are conducted by social workers and health educators. The training for non-formal AIDS Counselling programme for 1992 and 1993 targeted at seventeen northeastern provinces and fourteen central provinces.

The community counsellor/peer group educator is viewed as a key support component in AIDS care and prevention, because s/he is community selected and based, with specific training in *HIV/AIDS* work. The community counsellor is a significant and specific indication of community involvement and is likely to prove in the long term to be the chief factor in sustaining the commitment of all the people in the community to care for those who suffer, to prevent the disease in those who are still seronegative, and ultimately, to control the disease in the area, as counselling teams are formed within communities to reach other communities.

10.4 Women as Community Care Specialists

Women, and primarily housewives, are the main care-givers in the affected families. Women's groups do appear to have the potential to support each other. A school teacher [who works with a Catholic School] in the Northeast who is an AIDS educator among women, suggested that the housewives' group has been formed to collectively help families and individuals afflicted by *HIV/AIDS*. Women in the focus groups close to Chiang Mai collect food, money, laundering of clothes and other basic needs. Some women informed that the informal support of neighbours or people outside the family was limited. Family members also prefer not to seek help - for fear of "social oppression".

10.5 Therapeutic Communities

Apart from the Government's successful intervention through the Thai Red Cross Society, the Lampang Project, Southeast of Chiang Mai, has evolved more advanced programmes over the past four years despite adverse propaganda. A local monk has staked claims to manage this project but the government has kept the proposal "under consideration". At this place, the monk

has prepared for what is known as *"Therapeutic Community"*, where HIV people would be able to stay for extended periods accompanied by family or friends, if necessary. The efforts pursued include counselling, occupational training if appropriate, and medical and nursing care. The ultimate objective is to build "self-reliant" individuals and families of *PWAs* to enable them cope up with the situation.

Section 11

HIV/AIDS - Threat to Life and Human Rights[24]

Persons living with *HIV/AIDS* face double threat: they face death, and while they are fighting for their lives, they often face discrimination. This discrimination is manifested in all areas of life i.e., from health care to housing; from work to travel. It is generally based on ignorance and prejudice and is expressed in particularly harsh forms against the most vulnerable: homosexual men, women, children, prisoners, and refugees among them. Whereas most illnesses generate sympathy and support from family, friends and neighbours, persons with AIDS are frequently feared and shunned.

In 1989, *Empower, Phram Charmoon, Fr Giovanni* and other activists observed that some persons living with AIDS *[PWAs]* were confined against their will in a special prison-type shelters, where a strict surveillance system was in force. Since then many groups have documented discrimination patterns against persons with AIDS as well as measures to provide protection for them. A few even suggested that a legal examination to seek remedies available to those subjected to discrimination. Their search and efforts highlighted the dangers to public health of discrimination against AIDS-infected persons.

Punitive measures and discrimination against HIV-infected people have become widespread, interfering with their right to work, education, housing, travel and medical treatment. Homes, hospitals and the workplace have become hostile environments for many with AIDS. Discriminatory measures such as denial of medical treatment, quarantine, restrictions on movement, social ostracism are increasingly reported. This creates misery for those already suffering from a life threatening disease, and make public health efforts to control the pandemic more difficult. Those who might benefit from counselling and medical care are often reluctant to seek help because of well-founded fears that breaches of confidentiality might result in loss of jobs, housing, or insurance, and abandonment by friends, co-workers, and family. Such a situation make it more difficult to carry out studies needed to quantify the prevalence of HIV and to monitor its spread.

AIDS served as a convenient excuse to further malign people and stigmatise them, and was seen as a punishment for their sinful and aberrant behaviour. It was not the disease which was judged, but the acceptability of individuals affected by it. A serious consequence of prejudice has been medical neglect of those afflicted. Phra Pong Thep summarised the situation as follows: "The response of the government and medical community would have been different if the same disease had appeared among businessmen or showbiz people. Unfortunately, it started with the poor and sometimes commercial sex workers that it was stigmatised." At the beginning of the pandemic, many Thais had little sympathy for persons living with AIDS. The feeling was that somehow people from certain groups "deserved" their illness. Nitaya of Duang

[24] This section is based on discussions with Empower, Dr. Seri, and Dr. Chayan.

Prateep Foundation concluded: "We are fighting a disease and not people. An infection is used as an excuse to discriminate some groups and individuals."

Few Thais, in fact, refuse to work beside a person with AIDS, and such prejudices against them are common. In the initial stages of the pandemic, HIV-infection led to termination of employment in the industrial units or restaurants. In some instances, the status of the worker was changed - for example, from a permanent employee to a piece-work labour after testing HIV positive.

Children with AIDS [or born to HIV-infected persons] face deprivations of their human rights. Many are born into poverty-stricken families which cannot afford medical treatment. Because of lack of parental care, they do not receive proper education; those admitted in schools are shunned and excluded. The strains on the ability of extended families to care for HIV-infected children or orphaned children have become too burdensome.

After several years of discriminatory practices, Thais have been developing greater tolerance toward HIV-infected children [or children born to HIV-infected persons] at school. Some orphaned children are placed in institutions where they receive care. A few provincial schools have been successful in challenging exclusionary policies such that it is now fairly well settled that there is no medical justification to exclude HIV-positive children from schools.

There have also been cases of students and their parents trying to force out teachers infected with HIV from schools. Students were encouraged to boycott classes/schools taught by a HIV-infected person.

The following human rights violations against persons with AIDS were specified in discussions:-

- o attempt to kill commercial sex workers who are HIV-infected or suspected of infection;
- o the segregation of prisoners
- o forced confinement of *HIV/AIDS*-infected patients in institutions or colonies isolated from the rest of society;
- o compulsory testing of individuals and groups;
- o restricting movement of infected persons, and denial of entry to selected racial groups unless they submit to tests;
- o termination of employment or denial of employment because of HIV status;
- o denial of housing to AIDS-infected persons and eviction of infected persons from their homes;
- o exclusion of children who are infected or thought to be infected, from school; and
- o exclusion of persons with AIDS from access to social security, welfare and other services.

Section 12

Towards New Partnerships in *HIV/AIDS* Interventions

Notwithstanding Thailand's recent economic boom, AIDS pandemic represents added strain on its developmental fabric that is already hit by several factors. Growing incidence of AIDS in the neighbouring nations like Myanmar, Cambodia, Laos and Vietnam multiplies its burden. Moreover, obviously, a growing nation like Thailand does not have the requisite resources to deal with a problem of this magnitude.

In developing nations, health systems are institutionally weak, per capita health expenditures are less and health budgets have been declining in real terms. For the health system to cope with the *HIV/AIDS* pandemic on top of an already over-stretched personnel and financial situation is far out of reach. For example, the direct treatment cost of an *HIV/AIDS* person is estimated to be around 10,000 Bahts, and as a nation Thailand cannot afford to treat all *HIV/AIDS* persons adequately.

Additionally, it is not possible to "seal" all the transmission routes of the HIV virus immediately; probably, government cannot even bar "illegal" immigrant women from bordering nations to enter into commercial sex. Therefore, HIV-infected persons, especially those from the poorer families, will have to be taken care now to avoid rapid transmission, and build confidence among people that *HIV/AIDS* is a manageable disease. However, the response of the Government is generally cautious.

If government bankruptcy and family and community impoverishment are to be avoided, however, some mechanism to challenge the pandemic must be found. This third alternative is found in the NGOs. Traditional roles for health sector NGOs in Thailand tended to vary between conventional charity type activities, essentially meeting the gaps in government services, and innovative, trend-setting by small-scale activities, piloting models with a flexibility and care the public institutions cannot manage. Perhaps a major third role that is emerging which appears more appropriate for dealing with the HIV pandemic i.e., to provide on a large scale an extra-layer of social welfare service, establish primary responses, referral mechanisms and links between private and government institutions, and between the government institutions and communities.

12.1 Circumstances

The spread of *HIV/AIDS* was rather rapid in Thailand and the transmission route appears more or less clear now i.e., the infection spread from homosexuals to drug users who share needles, to commercial sex workers, to men to housewives, and now remains a "family" concern. As coping with the disease is getting more and more difficult for people in the affected communities, people are steadily approaching various agencies and sources for support. The initial fear that the agencies, religious heads may turn away from the *HIV/AIDS* as it is seen by some as a punishment from God [i.e., *karma*] has now receded.

Several groups and organisations now demonstrate solidarity with the affected and rejected. Bearing in mind the inadequacy of trained health care workers, services etc., one has to embark on a strategy based on three main areas of action, aiming to provide: emotional support, medical support and family services. The objectives can be achieved through training, increased medical support and counselling.

In the absence of an effective, affordable, and widely available vaccine, prevention programmes for the foreseeable future must concentrate on curbing the spread of *HIV/AIDS* by modifying high-risk behaviours and provide health care facilities. However, to date, regional or ethnic differences have received little consideration in setting policies, and interventions have not been tailored to these cultural differences. Critical issues to be addressed include:-

☞ What are our assumptions regarding risk groups and risk behaviour? How do these assumptions stigmatise groups? How are populations determined and boundaries defined in terms of coverage for care?

☞ What are the assumptions regarding specific interventions, and their impacts on policy?

- o population-based testing and counselling;
- o coordination with other health and education programmes;
- o control of HIV in the commercial sex industry;
- o socio-economic "predisposing" factors and impact on individual households;
- o HIV transmission by IV drug use;
- o vaccine trials and immunisation;
- o care for HIV infected patients and support for families; and
- o rights and obligations of HIV positive persons.

☞ How can knowledge and cultural diversity at best be integrated into planning and implementing HIV control and treatment policies and interventions? e.g., integration of minority ethnic group members; support of socio-behaviourial efforts.

☞ What are the limits to and potential hazards of national policies?

Some other questions that support the response to the above are: Can narcotics control policies that led to the suppression of poppy cultivation be modified to reduce the risk of HIV transmission? How far commercial sex industry will respond to legal measures to prevent recruitment of workers; is it possible to propose a care system for the "illegal" immigrant *CSWs*? Will legalisation of prostitution help or hinder *HIV/AIDS* control? Will more focus on *HIV/AIDS* imply neglect of other preventable, treatable or curable conditions? Will failure to stop transmission because of fear of offending rights of privacy?

12.2 Basic Assumptions of a Comprehensive Strategy

a. Evidence indicates that one type of risky behaviour, sex with multiple partners, is not confined to commercial sex workers or their clients, that there are many

gradations between monogamous individuals and commercial sex workers and their clients, and that gender-based double standard of sexual behaviour, is widespread. In sum, risky behaviour is not confined to isolable sub-populations.

Available information shows that stigmatisation increases the difficulty to control the spread of HIV and caring for HIV positive persons, ARC and AIDS patients by modifying behaviour.

At present there is no strategy that recognises the different levels of risk associated with identifiable groups and minimise the potential socially, psychologically and epidemiologically harmful effects of the stigma.

b. Present interventions appears to assume that the epidemiological boundaries are similar with national, social or ethnic boundaries. However, information and data from neighbouring countries, minorities and tourists indicate that there are no strict pattern of flow of the virus between the sub-populations. Therefore, tourists and transborder movement of people should be included in the intervention policies and programmes. This is more so if one considers the migration of people from the Shan province of Myanmar to North and Northeastern parts of Thailand.

c. Some of the present interventions are limited to "high risk" groups or "captive audience", such as military recruits, commercial sex workers and women delivering in hospital. Persons in such groups move many a times before they "settle" down; this makes surveillance and follow-up difficult.

12.3 Clinical Care/Support

The health community [i.e., medical personnel and public health officials] have responded well to the spread of *HIV/AIDS* by directing considerable resources and energy towards development of policies, programmes, and interventions that will help prevent and control the disease. Non-governmental organisations are giving increased attention to *HIV/AIDS*, and their expertise has become an important resource in the drive against the spread of the disease. Several international agencies have also launched programmes to prevent and control the spread of the pandemic in the region.

When speaking of *HIV/AIDS*, the terms "prevention and control" are frequently used to describe the necessary initiatives related to the pandemic. However, it is true to say that prevention of the pandemic has not been successful in Thailand, which has put care and alleviation of consequences on the priority action agenda.

A serious concern expressed by Dr. Praphan and others relate to availability of beds "in time" and "in adequate number" for the *PWAs*. Everyone agrees that "unless infected persons are taken care and health institutions illustrate that AIDS can be tackled and cured - no one is going to believe it as a normal disease that could be controlled" - till such time *HIV/AIDS* will remain as a "soap opera" illness!

Preventive Measures

As the situation is grim, it is not possible to differentiate between preventive and curative measures. *Making AIDS visible* through care, support and openness is considered important as a preventive measure. Personal contact with AIDS may, therefore, stimulate prevention as: it is primarily a coping process, usually carried out one-to-one or in small personalised groups, initiated by a distressed *PWA* and aims to reduce stress by means of dialogue.

Clinical care of a person infected with HIV or a patient with AIDS can considerably improve his or her quality of life. However, there is still an element of denial and complacency within the medical profession itself, mainly due to the fact that AIDS has no cure so far, and the meagre resources, it is felt, may be utilised for treating other diseases whose cure is known. Coupled with this are myths about HIV and AIDS which have made the clinical management of people with HIV or AIDS a very difficult task indeed. Therefore, there is an urgent need to educate health professionals and health care providers on the true nature of the issues involved in managing HIV infection and AIDS.

HIV-infected persons *[PWAs]* with recurrent illness require clinical management, including occasional hospitalisation. At the minimum, clinical care should include pain relief and treatment for common opportunistic infections; this requires adequately trained health-care providers and a reliable supply of essential drugs and medicines. It is more than mere medical management.

12.4 Living and Coping with *HIV/AIDS* : Counselling

In Thai culture, counselling is limited largely to religious sermons. There is no pre-marital or post-marital counselling sessions. Even in the urban areas, counselling is not popular for non-AIDS problems too. Thus, counselling has not yet penetrated into the society as an element of normal suggestion seeking and guidance.

A diagnosis of HIV infection or AIDS, or a suspicion or recognition of the possibility of infection, brings with it profound emotional, social, behaviourial and medical consequences. Subsequent individual and social adjustments required often have implications for family life, sexual and social relations, work, education, spiritual needs, legal status and civil rights. Adjustment to HIV infection demands constant stress management and adaptation. It is a dynamic evolutionary and a life-long process that makes new and changing demands on the infected individuals, their families and communities in which they live.

HIV/AIDS counselling is a continuous process that aims to prevent transmission of the infection and provide psychosocial support to those already infected. Thus, it is different from education, as it deals with a specific risk group member. Generally, counselling is extended to members of the family, peer-groups and neighbours.

12.5 Community-based Care and Support

Within the health sector, efforts need to be undertaken to ensure the involvement of families and others in HIV treatment centres and in drug de-addiction treatment centres. Many NGOs [e.g., Empower, Northnet, World Concern and NAPAC] have also indicated willingness to increase their involvement to promote and organise community-based care centres i.e., *hospice* centres within the community.

A large number of NGOs and activists believe that family and community-based care for people who are ill, is a deeply rooted aspect of Thai culture and that it is expected that such care will relatively easily be provided to people with HIV.

More comprehensive strategies will be required soon to determine feasibility of strategies to develop the capacity of communities to provide such care, especially in circumstances where water supply and sanitation are inadequate, where people with HIV care are estranged from their families due to distance or culture, or where hospitals simply become overwhelmed by large numbers of people with AIDS-related conditions.

12.6 Interventions among Drug Users

Interventions among *IVDUs* is a disheartening task due to the complex issues involved. The major objective is to prevent drug abuse. In such situations abstinence-oriented treatment approach, a series of subtle harm reducing strategies are to be promoted. Peer-to-peer programmes to convert drug injectors to drug inhalers, education for decontamination of needles and syringes with bleach are pursued by various agencies [e.g., Thai Red Cross or Duang Prateep Foundation].

The enormity of the task makes it difficult to pursue a single strategy in Thailand. Possible interventions will have to scrutinise access to opium areas with determination to evolve an action plan.

12.7 Role of Religious Groups and Individuals

The response of the religious organisations and personnel [i.e., Buddhist Wat or Church] has been generally ambivalent. Some of the efforts undertaken by them were out of personal conviction and commitment rather than institutional policies. As Buddhism plays a major role in rural life, one could explore the possibility of building "healing communities" that include pastoral care, to work against the discrimination and oppression, and to ensure protection of human rights of persons affected directly or indirectly by AIDS.

Moral, theological and ethical debates certainly delayed the Church's response to the AIDS problem. Beginning in 1985, several initiatives were taken to promote hospice centres, education, pastoral care and advocacy. The challenge for the religious communities was to deal with prejudices surrounding the issue of AIDS [e.g., Relief

Centre and Dhammarak Nives], to assist people in their dying and to offer them a sense of peace, a feeling of acceptance and love. Church institutions in Thailand continue to seek, listen to and learn from partners around the world confronting the realities of AIDS and to encourage the exchange of ideas through dialogue and exchange of experiences.

Within the Buddhist and Church communities discussions are now being pursued to sharply focus on the imperative to recognise and rediscover the role of the local monasteries and congregations in the context of the social ministries of religion. Pastoral care is seen as a challenge to enable building a caring community within the area and neighbourhood where religious personnel work. They are more concerned with provision of "terminal care" for the PWAs and performance of death-related ceremonies.

12.8 Mass Media

Mass media has significantly contributed to raise the awareness of people on *HIV/AIDS*. However, past experience indicates that reporting of HIV and AIDS issues is casual that led to inaccuracies, sensationalisation of information or failure to keep pace with rapidly changing information.

It is stressed that adoption of standard terminology while writing about *HIV/AIDS* is essential to overcome the problems. This will avoid misconceptions and mass hysteria about *HIV/AIDS*.

12.9 Human Rights

People with HIV or AIDS *[PWAs]* deserve the same dignity and human rights as any other person. Present public health principles tend to succumb to scapegoating, stigmatising or discrimination against HIV-infected persons in the vain hope of curtailing the pandemic. Non-discrimination is not only a human rights need but viewed as a sound strategy to ensure that infected persons are not driven underground or remain inaccessible to education programmes. There is a significant need to protect and promote confidentiality of the PWAs as the possibility of discrimination and ostracism is extremely high.

12.10 Some Key Problems

Orphans[25]

AIDS orphans represent the final stage in the social and financial destabilisation of the Thai family affected by AIDS. Orphans in Thailand are usually considered as children whose mothers have died, even if the father is still alive [or] those left alone by their

[25] Norwegian agencies have developed some framework on "how to deal with the AIDS-orphan children".

parents to search for a living. Women are primary caretakers in the Thai society, and public or private social service programmes to help people cope with child-rearing are virtually non-existent. AIDS orphans will undoubtedly pose one of the greatest challenges to the development of Thailand, because of the rapidly increasing numbers of adult and childhood AIDS cases, because the disease usually kills both parents, and destroys family networks, because of the stigma often associated with AIDS.

Some government departments and NGOs are beginning to discuss ways to meet the needs of AIDS orphans in the future. The concept of singling out AIDS orphans for special assistance, however, is rejected by some people [e.g., Northnet and Empower], because they feel it increases the potential for further discrimination against these orphans. It is considered that support to AIDS-orphans conversely discriminates against children orphaned from other causes who may be equally disadvantaged and in need.

In the past, most Thai orphans have been absorbed by the extended family. Confidence in the tradition of the Thai extended family has created complacency about the future of AIDS orphans. While the extended family has coped well with the burden of children orphaned by other causes in the past, it will not be able to cope with the large numbers of orphans which might be created by AIDS. Besides, its economic, coping, and caring capacity has become extremely fragile. This is increased by the pressures of AIDS. Currently, many AIDS orphans caretakers are grandparents - too old and too poor to raise the children well.

Phra Pong Thep asserted that non-biological children in an extended family may be discriminated and end up being servants. Therefore, the myth that the extended family can cope with the increasing AIDS-orphans' burden without external support is erroneous.

Many AIDS orphans will not have access to an extended family or to organised care, particularly as their numbers increase. Many urban women with AIDS were already marginalised and rejected by their own communities before infection, and AIDS has broken the final link. Their children may not be accepted in other families. Children with no satisfactory home will become "street children" and will be vulnerable in their turn to HIV-infection, as the need to exchange sex for food, shelter or comfort is more.

The major responsibility for assisting AIDS orphans in the rural areas of Thailand will certainly fall on NGOs or religious groups, as they have the most significant experience in implementing social service activities/programmes. The key will be to find methods to encourage extended families to accept the children, and enable them to care for the AIDS orphans. There are some difficulties viz., constraints in identifying children in need as they may dispersed; enormous logistical and distribution problems.

12.11 Towards New Partnerships and Initiatives

Providing essential support services [i.e., supervision, drugs, transportation, counselling etc] to numerous and scattered *PWAs* along with preventive and educational programmes for the

community is a challenge; and this is characteristic of any developmental intervention as it views elimination of HIV infection from the community as paramount - it remains as a major problem that prevents many agencies from adopting strategies such as hospice approach.

In summary, the programmes to date have promoted understanding of the nature of HIV and routes of transmission. The next step is to invoke strategies which enable individuals and communities to incorporate that knowledge into their own decision-making about behaviour pattern and the factors which influence their own and others' behaviours. Such strategies, everyone oncurs, should include peer education that provides access to community-wide discussions about changing economic and cultural circumstances in which behaviour take place, possible options for prevention of further HIV transmission, skills development, and the promotion of peer support for behavioural change.

☞ *Facilitate Change of Behaviour*

The primary emphases of the present strategies to promote behaviour changes have been:-

- o the use of mass communication techniques - leaflets, billboards, limited use of videos and radio;
- o use of training strategies; and
- o popularise statements of intent about the use of peer education strategies, and very limited introduction of peer involvement in other parts of the programme, often with little resourcing from the programme.

These fields in which knowledge has advanced internationally during the past five years, particularly as a result of new health promotion strategies adopted in response to the HIV pandemic, and more effective ways of using these methods could be introduced in Thailand.

Access to information about what works to promote behaviour change has been limited in the current efforts of the Government and NGOs, and the next phase should include strategies to improve skills in these areas.

☞ *Hospice Approach*

Hospice centres are complex projects and require substantial "implementing capacity" and resources than other forms of intervention. It is much more than mere institutional care; it views symptom control within the families as important; it seeks personal, spiritual and emotional support for the infected persons. Therefore, the complexity of its function has major implications for the leaders' capacity to build cadres, convince *PWAs* and their families.

Three themes in regard to hospice approach have recurred in our discussions and appear to be central to the promotion of that approach for *HIV/AIDS* care and awareness, especially for a resource constrained nation like Thailand.

a. The current rate of HIV infection and the approaches show that even if the efforts are scaled up severalfold, it would not have much positive impact. The scale of failure of the Government and other agencies to effectively predict the prevalence of HIV before it assumed alarming propositions recurred in the interviews was placed as evidence. This failure is considered as an illustration as to how the Government machinery is powerless and NGO efforts remain "predictable".

   The obvious weaknesses in "prevention and education" strategies were often cited as inadequate preparatory works carried out by both Government and NGOs. For those, engaged in hospice work, "prevention and education" will be effective only when it is shown that the present medical system and the society, in general, can take care of *HIV/AIDS* conditions. This strategy may not have developmental perspective, but has some moral and educational validity.

b. The factors responsible for the spread of HIV infection [e.g., IV drug use or unprotected sex] are the result of many factors as broad as the international context which affects each nation's economic performance and the possibility of the Government losing some investments or access to export markets. Such an impact will immediately affect the industrial workers, unorganised sector and urban poor, and as a mere survival strategy might force some of the *PWAs* to hide their infection.

c. Efforts should include promotion of more widespread consideration about which people are at high risk of infection, and what non-personal factors limit or enhance their choices and options for prevention of further transmission.

☞ At the hospice centres and counselling places, current efforts to involve those who are already HIV-infected *[PWAs]* is receiving a good response. However, what appears to be needed is a national strategy to promote development of peer education and other activities in thousands of localities that would result in establishment of "hospice centres" at the community level. Such a strategy should consider appropriate processes to increase the effectiveness of community-based care possibilities in the future. These will include the later development by communities of their own localised programmes to care and support those who are dependent on people, who are ill, or who have died, and the surviving children or elderly people.

☞ The challenge for a moderately developed nation like Thailand is to address *HIV/AIDS* problems in a more low profile manner[26], and make best use of its resources, knowledge and institutional capacity [e.g., cultural, religious and human] that would be culture-specific and minimise damage to the poorer communities, and to the nation.

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[26] Government efforts on *HIV/AIDS* would much depend on the popular pressure of Thais themselves, and which in turn would rely on popular awareness on this issue. Any high profile effort, generally, has received indifferent response amongst Thai public [e.g., campaigns to ban commercial sex centres]. As many of those affected come from poorer families and to be sensisitive to cultural precepts of the Thai society - low profile strategies could be pursued. Simultaneously, such efforts should help develop informal mechanisms among people's organisations, professionals and other interested parties to respond to issues relating to *HIV/AIDS*. This will facilitate to raise public awareness and slowly break culture of silence, which is essential to carry out large scale preventive efforts. It is also essential to evolve sub-regional mechanisms to share information and knowledge on *HIV/AIDS*.

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List of NGOs Engaged in HIV/AIDS Initiatives

Organisation	Activities	Data Source[1]	Activity Area[2]
1. Thai Red Cross	Clinical care, training, media development, counselling and research.	I + D	National
2. Hot Line Foundation	Counselling and networks.	I + D	BKK + CNX
3. World Concern	Counselling, training and networks.	I + D	BKK + Phy + CNX
4. The Association for Improvement of Home Services for Infected Prostitutes	Home services, vocational training and counselling.	I + D	BKK + CNX
5. Family Health International [AIDSCAP]	Research, grant-making and intervention.	I + D	National
6. Association for the Strengthening of Integrated National Population and Health Development Activities	Training.	D	BKK
7. Duang Prateep Foundation	Health education, surveillance, counselling and peer education.	I + D	BKK + others
8. The Planned Parenthood Association of Thailand	Training and educational curriculum development.	I + D	BKK
9. Foundation for Agricultural and Rural Management [FARM]	Training and clinical care.	I + D	BKK + North

Note

Data Source for the Review

1 **I** .. Interview; **D** .. Document Review.

Activity Area

2 BKK .. Bangkok; Phy .. Phayao; CNX .. Chaing Mai; C'Rai .. Chiang Rai.

Organisation	Activities	Data Source	Activity Area
10 World Vision	Clinical care, health education and pastoral support, where possible.	I + D	BKK + Phy and C'Rai
11 Chulabhorn Research Institute	Research, policy-support and training.	D	National
12 National Women's Council of Thailand	Health education and policy-support.	D	National
13 ACCESS	Counselling, hotline service and training.	I + D	BKK + CNX + ...
14 Population and Community Development Assocation *[PDA]*	Public relations, media development, training and interventions.	I + D	National
15 Programme for Appropriate Technology for Health *[PATH]*	AIDS education materials development, training and intervention programmes.	I + D	BKK and others
16 Empower Foundation	Health education, surveillance, counselling and peer education at the commercial sex areas.	I + D	BKK + CNX
17 FACT	Training and educational curriculum development on AIDS.	I + D	BKK
18 Media Link Group	Health education and media development.	I + D	BKK and others

Organisation	Activities	Data Source	Activity Area
19 CARE, Thailand.	Clinical care at the field level, health education and networks.	I + D	BKK + Phy + CNX + C'Rai
20 YMCA, Chiang Mai	Training and health education.	I + D	CNX + C'Rai
21 Daughters' Education Program, Chiang Mai.	Health education, training and formation of women's groups.	I + D	CNX and suburbs
22 Women and Youth Devt Project, Chiang Mai.	Counselling, hotline service and training.	I + D	CNX
23 NorthNET	Public relations, media development, training and community development activities.	I + D	CNX and suburbs
24 ACT Centre	AIDS education materials development, training and intervention programmes.	D	BKK + CNX .. ..
25 Mirror Group	Health education and training.	D	BKK
26 Nithat Show	Training and counselling.	I + D	BKK .. ..
27 Rural Doctor Club	Health education and counselling.	I + D	BKK and others

Organisation	Activities	Data Source	Activity Area
28 St Camillus Foundation	Clinical care at the field level, health education and networks.	I + D	BKK + suburbs
29 Urban Development Foundation [UDF]	Training and health education.	I + D	BKK
30 Catholic Reflief Services [CRS]	Health education, training and formation of *PWAs* groups.	I + D	BKK
31 Coordinating Committee for Primary Health Care of Thai NGOs	Training, counselling and health education.	D	BKK and others
32 Welcome House	Clinical care, terminal care, training and counselling.	I + D	BKK and suburbs
33 Health Development of Teenagers Organisation	AIDS education materials development, training and intervention programmes among young persons and in campuses.	D	BKK and suburbs
34 Church of Christ in Thailand *[CCT]*	Health education, training and family support programmes.	I + D	Mainly in the North but national
35 International Network of Engaged Buddhists	Training and counselling through propagation of Buddhist values and with monks.	I + D	National
36 The Friends for Life Project [Chiang Mai]	Clinical care, family support, training and health education through preaching of Buddhist values.	I + D	CNX
37 Catholic Commission for Health Promotion [CCHP]	Clinical care, pastoral support, enable formation of religious groups, training and networks.	I + D	National
38 Rebirth Centre	Clinical care and general support	D	BKK

Additional List

A Funding/Technical Assistance/Research

- Family Health International [FHI]
- AIDS Control and Prevention Project of FHI i.e., *AIDSCAP*

B Funding/Technical Assistance/Pilot Implementation

- Programme for Appropriate Technology in Health [PATH]
- Redd Barna Thailand
- World Vision Foundation of Thailand
- The Save the Children Fund [UK]
- Family Planning International Assistance [FPIA]
- Norwegian Church Aid [NCA]
- Thai-Australia Northern AIDS Prevention and Care Program [NAPAC]
- Thai-Australia Non-Northern AIDS Program [NONAP]
- Thai Red Cross Society

C Initiation/Implementation of Activities

- AIDS Crusade [Bangkok]
- Foster Parents Plan International
- Pearl S Buck Foundation, Inc. [Thailand]
- Thailand Fertility Research Association [TFRA]
- Catholic Commission for Health Promotion [CCHP]
- Church of Christ in Thailand [CCT]

D Government/International Agencies

- Ministry of Public Health
- UNICEF [through Thai Red Cross Society]
- World Health Organisation [through *MoPH*]

E Research and Training

- Thai Red Cross Society
- Chulabhorn Research Institute
- Chiang Mai University Social Research Institute
- Chulalongkorn University Social Research Institute
- Thailand Development Research Institute

Work Schedule

April

22	*AIDSCAP/FHI*
26	Hotline Foundation
29	Duang Prateep Foundation

May

02	Chulalongkorn University/Dr Abha
04	The Association for Improvement of Home Services for Infected Prostitutes
06	Empower
07	The Planned Parenthood Association of Thailand
09	Dr Wiwat, Ministry of Public Health.
10	Nithat Show
11	Rural Doctor Club and International Network of Engaged Buddhists
12	Thai Red Cross Society
20	UNICEF, Bangkok.
21	World Concern
23	FACT and Media Link Group

July

04	Thailand Development Research Institute
05	Chulabhorn Research Institute

12 to 16 *Chiang Mai*

- NPAC/NONAP/Australian Overseas Aid Bureau
- Chiang Mai University Social Research Institute
- The Friends for Life Project
- Northnet
- Church of Christ in Thailand
- DISAC, Chiang Mai.
- Dr Anchalee and Dr Ron of Phayap University.
- World Concern
- World Vision
- CARE
- San Sai Medical Centre/Dr. Voravut
- YMCA, Chiang Mai.
- Daughters' Education Programme
- Women and Youth Development Project
- ACCESS

- o Health Sciences Research Institute
- o Villages located in the suburbs
- o Dr. John Peacock, formerly of UNICEF
- o Church of Christ in Thailand

19 Population and Community Development Project
20 FARM
21 SCF, Bangkok.
24 Fr. Jean Barry s.j.
25 AIDSCAP
26 Catholic Commission for Health Promotion
27 Some of the Catholic Organisations [i.e., Welcome House; Catholic Relief Services; St Camillus Foundation]
28 Urban Development Foundation
29 Fr. Jean Barry s.j.

August

02 to 06 International Christian AIDS Network Conference *[I-CAN]*, YMCA, Bangkok.

10 to 16 Preparationn of blueprint for the draft report
20 to 28 Finalisation of the draft

September

07 to 12 Preparation and submission of *provisional report* to *CEBEMO* [including editing and formating]

October

20 Fr. Jean Barry
21 Reflief Centre [Fr. Giovanni] and Ms. Usanee.
22 Dhammarak Nives, Lop Buri.
24 National Institute of Communicable Diseases, Bangkok.
31 Submission of Section on "hospice" approach.

December

Receipt of comments

Consolidation of the final report