HIV and health-care reform in Phayao

From crisis to opportunity

Joint United Nations Programme on HIV/AIDS

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Foreword

How do we cope when we find that we cannot solve some of the health problems that we are facing although we have the most advanced science technology and very modern institutions to provide answers to those health problems in our hands? Or when we suddenly find that some difficult health problems could be improved without any solutions from the presently available advanced science technology or very modern institutions. In this rapidly changing world, none of these circumstances is unusual.

The world is currently possibly facing another health revolution. Many health problems are teaching us to rethink the ways of health management that have been implemented for so long. There are no more magic answers which come only from advanced science technology or modern institutions, but the importance of the role of people and the community, is now more and more recognized as the essential factor to the solutions. The battle with HIV/AIDS is a good example for this phenomenon. The realization of the role of people and community in health development, is not a new idea, it was advocated before in the Alma Ata Declaration. Neglecting the involvement of people in the past might only result in the slowing down of progress in solving health problems, but with HIV/AIDS epidemics, failing to take proper action to ensure the involvement of people will rapidly expand the problems. The situation will be difficult to tackle later. This present health revolution cannot happen only through advocacy as in the past, but it will be forced to happen from the rapid expansion of the problem, and it will make us realize more and more that rethinking and reforming the management of health-care is inevitable.

Experiences of HIV/AIDS prevention and control in Phayao province are good examples of the rethinking of health-care management. Progress in battling with HIV/AIDS in Phayao had provided a good lesson: people, not institutions, are the ultimate contributing factor to the progress attained. Government and non-governmental organizations will be important, when they can facilitate and not constrain people in responding to HIV and AIDS.

When we had the idea to start the project on “HIV and Health-Care Reform in Phayao”, we wanted to explore some merits of HIV/AIDS prevention and control on health care reform. We finally realized, however, that effective health-care reform is a must if we really want to efficiently fight HIV/AIDS. This study has documented how our conclusions came about.

I would like to thank people in Phayao, from the Phayao AIDS Action Centre, especially Dr Petchsri Sirinirund and Dr Aree Tanbanjong with their teams, and more importantly people from the community, who all are vigorously playing their important role for the progress of HIV/AIDS prevention and control in Phayao. I would like to thank also UNAIDS, especially, Dr Jean-Louis Lamboray and Dr Agnes Soucat, who have untiringly contributed their efforts to search and document things that had happened. All of these people have provided us all the knowledge that we can learn, and this is a valuable learning process for us not only with the reform of health-care for the HIV/AIDS problem but also for the more proper health-care reform in the whole system. We learnt that we need to always involve the existing potential of people in every step of the reform, to guarantee the sustainable development of the reform. And these lessons are very important lessons, which most reforms recognize, but often do not consider when the process of reforms starts.

Dr Sanguan Nitayarumphong
Director, Health Care Reform Project.

Acknowledgements

Is your health-care system passing the HIV test?

While exploring this question, I met a lot of people who came to my help. I owe them great thanks. First of all there is Peter Piot, Executive Director of UNAIDS, who gave me carte blanche. Awa Marie Coll-Seck, Director Department of Policy, Strategy and Research (UNAIDS), gave me her unstinting support. Dr Sanguan Nitayarumphong, director of the Health Care Reform Project, welcomed the challenge and was always there to discuss possibilities to turn our undertaking into a success.

Thanks also to the Directors of the AIDS Division from the Ministry of Health, Dr Wiput Phoolcharoen and to Dr Chaiyos Kunanusont. They were always supportive and always there to discuss on strategic questions related to HIV/AIDS and health reform. Thanks to Drs Daveloose and Soucat for their comments and advice.

My deepest gratitude to Dr Petchsri Sirinirund. She welcomed us in Phayao Provincial Health Office for a whole year. We were challenging past, present and future, raising more questions than providing answers. Yet she was always there when the team needed her.

Dr Aree Tanbanjong was the moving spirit of this report. She headed the Study Team, composed of Phayao Provincial Health Office staff. Despite a very heavy workload, she took upon herself the correction of the study report. A national panel of experts came to Phayao for one day to discuss study findings and recommendations, to review the report.

Dr Toru Chosa and his team from Japan International Cooperation Agency (JICA), Dr Masami Fujita and Ms Yuko Kondo, were discussing their agency's support to Phayao while the report was being developed. In a remarkable show of flexibility and understanding, they adapted JICA support to the report's findings and are now assisting Phayao in implementing its recommendations.

Dr Brian Doberstyn, WHO Representative and Head of the UN Theme Group, was always there to share ideas. Three teams of Thai experts came in support of the Phayao Study Team. Dr Narumol Silarug led the epidemiological team, composed of Mr Chatchawan Boonreong, Mrs Chamchun Leongwitchajareon, Ms Pattiya Jeerajariyakul and Mr Reunrom Kochang; Dr Aree Tanbanjong led the social

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Dr Heidi Larson interviewed key actors and gave us very insightful help in structuring our approach. The study was no small logistical task. Mrs Piyanat J. Kimnual in Phayao, Mrs Lawan Sarovat in Bangkok and Marthe Mpendubundi at UNAIDS made it all possible.

Final thanks to Robert Walgate, David FitzSimons and Krittayawan Boonto for editing the report, Andrea Verwohlt for coordinating all production aspects, and Marlou de Rouw for administrative support.

Jean-Louis Lamboray,
Senior Advisor to Director, Department of Policy, Strategy and Research,
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Executive summary

What is the secret behind the observed progress on HIV/AIDS in Northern Thailand? While at first, HIV/AIDS hit people in Phayao Province (population 500,000) very severely, they have responded in remarkable fashion. HIV seroprevalence among pregnant women decreased from 11 per cent in 1992, to 4.9 per cent in 1997. Among military conscripts, HIV seroprevalence decreased from 20 per cent in 1992 to around five to seven per cent in 1997. In 1997, 66 per cent of male workers declared consistent condom use with commercial sex workers. Use of commercial sex services seems to have decreased, as shown by the decrease of the number of direct and indirect commercial sex establishments, and by parallel decreases in the total number of commercial sex workers. Communities are adapting their culture to the presence of HIV/AIDS. People with HIV/AIDS recognize that the quality of their lives has improved. Governmental and nongovernmental agencies have been very active: in 1996, Phayao Province allocated two US$ per capita to 75 projects in response to HIV/AIDS. In 1994, it set up the Phayao AIDS Action Centre (PAAC) to help implement a multisectoral response.

Recently, the PAAC reviewed existing data and reflected on its experience to identify lessons learned and to articulate “factors of progress”, or key ingredients in managing support to the HIV/AIDS response. The Centre could then foster further progress on HIV/AIDS and influence the design of health-care reform in that Province.

What main lesson did Phayao Province learn over the past ten years?

The outcome of the battle against AIDS is decided within the community. People, not institutions, ultimately decide whether to adapt their sexual, economic and social behaviour to the advent of AIDS. Governmental and nongovernmental organizations can only influence, either constraining or facilitating, people’s responses to HIV and AIDS. Hence, their single most important role is to strengthen the capacity of people to assess how AIDS affects their lives, to act if needed, and to learn from their actions. Supporting communities in such a process represents a major challenge to institutions involved. The PAAC considers that the following institutional factors may have contributed to progress over the past ten years:

- the combination of short-term action to reduce risk and longer-term action to reduce vulnerability,
- the establishment of partnerships across sectors whereby planning, decision making and resources are shared,

- the continuous adaptation of strategy as the province was learning how to deal with AIDS, and
- a human development strategy emphasising not only technical skills but client-oriented attitudes as well.

While progress in responding to HIV/AIDS in Phayao is evident, the time is not ripe for celebrating victory. Indeed, progress has been stalling over the past few years. After a rapid decrease in the early 1990s, HIV prevalence levels among pregnant women and among conscripts are levelling off, at seven per cent and five per cent respectively since early 1995. More progress is needed on the social front as well. People living with HIV/AIDS (PWHA) observe that unaffected families still look down on them. Fundamental causes of vulnerability persist. Very few people are informed about their own HIV status. Communication within families about sexual matters remains difficult. Alcohol abuse, while poorly documented, appears widespread. The lack of opportunity still drives many men and women outside the province. Some social norms, both old and new, are ill adapted to HIV/AIDS. Support from institutions to individuals, families and communities is still fragmented. Specific risk situations, such as anal sex and injecting drug use, are not addressed. In only two out of seven districts does youth have access to life-skills training. About five per cent of couples use premarital counselling services.

Now comes the hard part. To move from progress to success on HIV/AIDS, the province will organize the combined support to key participants to the response to HIV/AIDS. Among them, people with HIV and AIDS could make the greatest contribution to further progress in the short term. Such contribution hinges on the generalization of access to early testing and counselling, and on the combined, effective support from various sectors to their response. The long-term challenge consists in supporting the youth in adopting sustained behavioural change in response to HIV and AIDS.

To enable further progress on HIV/AIDS, profound health-care reforms are needed. The advent of AIDS is challenging the health sector at the level of purpose and roles. AIDS reminds us that the purpose of the health sector is not just to achieve better health outcomes through the delivery of health-care packages. Society does not only expect the health sector to provide care. The health sector has to counsel individuals and communities, and catalyse other sectors towards action for health. These latter roles have been advocated since Alma Ata. Now, however, it is a matter of life and death that “health” effectively plays those roles: no other sector will jump in. It will not be an easy task.

First, the counselling of individuals and communities throughout the province requires major changes in structure and process of a system used to control disease rather than influence other people's behaviour.

Secondly, reaching out to authorities and colleagues from other sectors constitutes a hard task for health workers who are used to vertical chains of command.

Thirdly, the incorporation of HIV/AIDS-related procedures into "the core health service", the standards for health-care system output in Phayao, remains a challenge. The key for this triple adaptation of the health sector has to be the health centre. At the interface with communities and close to the tambon (sub-district), the health centre is ideally placed to effectively implement the required changes. To develop AIDS-competent health centres, Phayao will restructure its district health systems, and further develop its human resource strategy.

The "HIV and Reforms for Health Agenda"

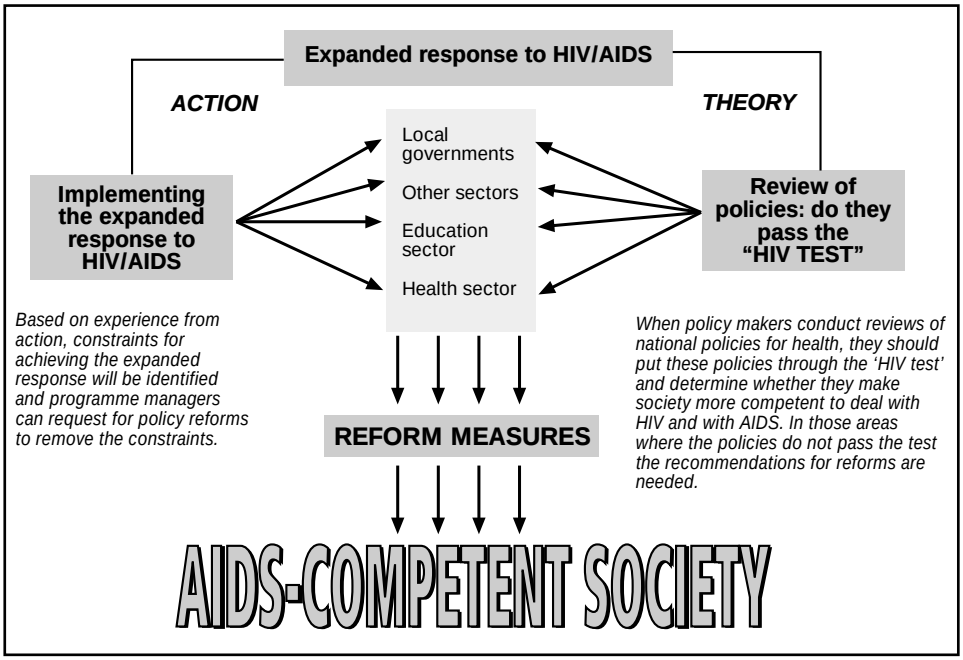
The UNAIDS *HIV and Reforms for Health Agenda*, which has been developed from the experience of Phayao, together with that of the Bamako Initiative for community-based pharmaceuticals management, purchase and delivery, is based on two complementary approaches (see Figure 1):

- local implementation of an effective and sustained expanded response to HIV/AIDS, and
- review of ongoing reforms for health with respect to the '*HIV test*'

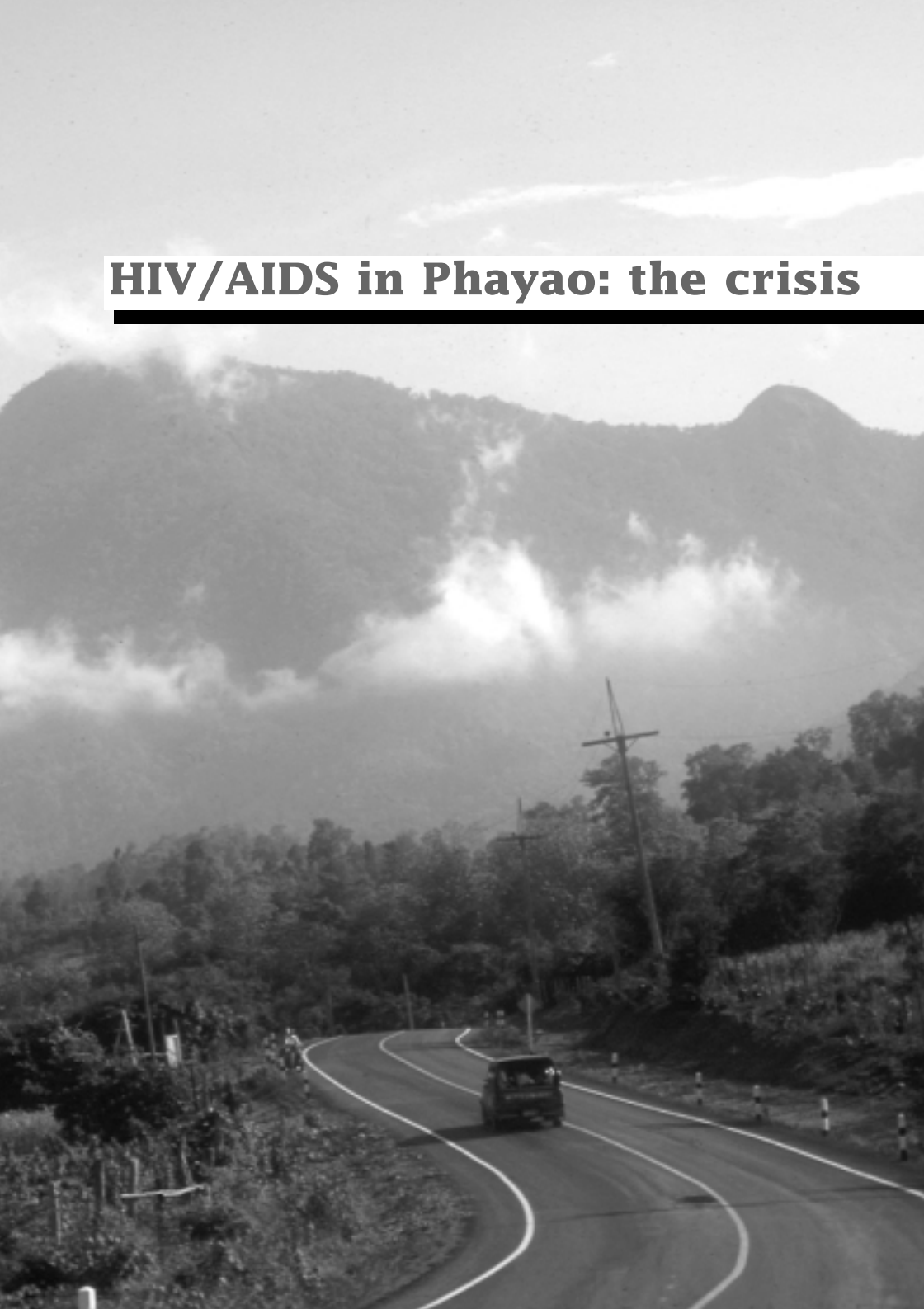
The '*HIV test*' would consist of a set of criteria against which to review national reforms. For instance the HIV test to the health sector would include the following questions:

- Does the health reform cover all three goals (lower mortality and morbidity rates; less suffering; less dependence, more autonomy)?
- Does the health sector perform the three roles: provide health care; catalyse community action; support integration of health concerns in society?
- Are the three principles in health-care organization addressed: integration; continuity; people-centred focus?
- Does human resources development for the health sector address technical, attitudinal and spiritual issues?
- Are the processes of achieving reforms documented as importantly as the output?

Figure 1: Two complementary approaches (action and theory) to achieve an AIDS-competent society



HIV/AIDS in Phayao: the crisis



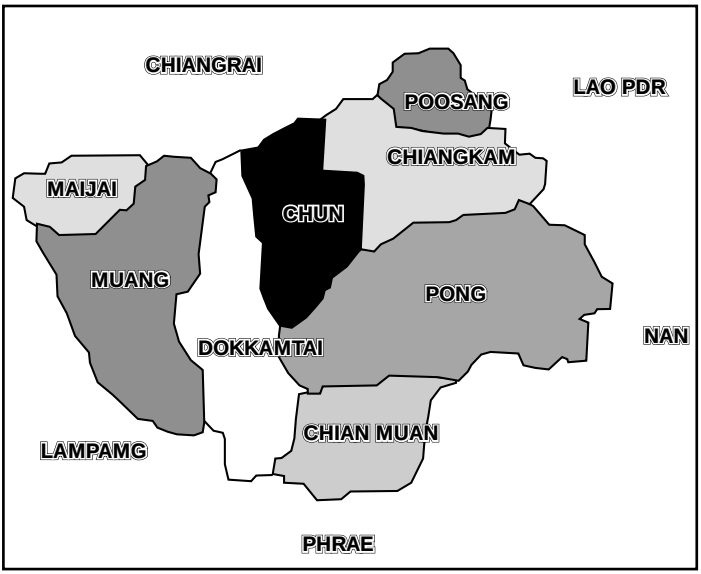
HIV/AIDS in Phayao: the crisis

Welcome to Phayao Province! The people of this beautiful rural province, struck by the disaster of AIDS, are turning the situation around for the better. In fact, this province has seen the highest HIV levels than anywhere in Asia. It is also witnessing the greatest declines in HIV levels. Progress, however, is not limited to reductions in HIV seroprevalence levels. Individuals, communities and institutions have responded to the crisis in remarkable fashion.

Phayao province

Phayao is a relatively small province. It is adjacent to Lao People's Democratic Republic (Lao PDR) and to the provinces of Chiang Rai, Lampang, Nan and Phrae. Chiang Rai is a 90-minute drive away. Coming from Chiang Mai, after a three hours drive on a mountainous road, one discovers Phayao Municipality, spread along Kwan Phayao, a beautiful lake, in the middle of rice fields, against a backdrop of the majestic mountains of Doi Mae Jai. Indeed, observing the sunset over the mountains across the lake is a rare experience of natural beauty.

Figure 2: Map of Phayao province



Part of the Mekong Basin, Phayao has been a gateway for much of its history. It was built in 1095 by the king of Chiang Saen, and the people led a prosperous life as part of that kingdom. Phayao became an independent kingdom in 1340 for 245 years. Between 1558 and 1843, Phayao vanished from history, as the result of Burmese invasion. Some chronicles report that at some point during that period its population was sent to Vientiane, in the current Lao PDR. King Rama III then rebuilt Phayao in 1843 as a frontier post of the Thai kingdom. The administrative status of Phayao varied greatly over the following century, to become a Phayao Province in 1977. Today, some half a million people live in its eight districts (Figure 2, Table 1).

Table 1 : Population Distribution per District

District	Tambon	Village	Household	Total population	Highland population
Muang	18	176	46,16	153,1151	430
-Municipal area	*2*	*-*	*7,495*	*21,757*	*-*
-Non-Municipal area	*16*	*176*	*38,669*	*131,358*	
Maejai	6	61	10,888	38,892	597
Dokkamtai	12	117	22,268	77,717	311
Jun	7	68	15,915	55,288	-
Pong	7	79	14,042	54,317	7,659
Chiangkam	10	110	22,397	81,334	3,982
Chiangmuan	3	29	6,216	20,257	1,117
Poosang	5	48	9,646	36,928	368
All eight districts	68	688	147,532	517,85	14,464

Figure 3: Population pyramid of Phayao province

(1988) from household survey

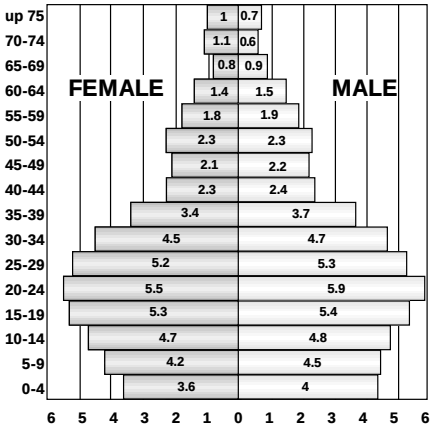
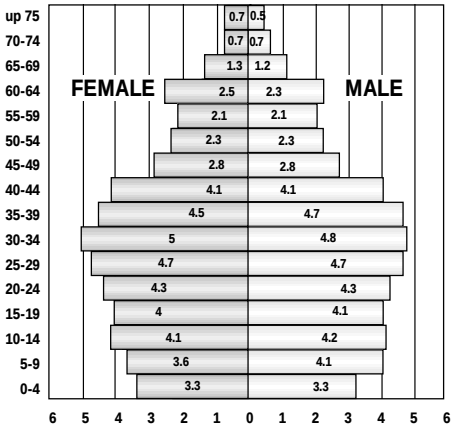


Figure 4: Population pyramid of Phayao province

(1996) from household survey



Source: Phayao Provincial Health Office

The population of Phayao is ageing. The age pyramids in Figures 3 and 4 show that Phayao population is ageing, a result of combined low mortality and birth rate. Children under 15, who represented 25.6 per cent of the population in 1988, represented only 22.1 per cent of the population in 1996. In 1986, before AIDS hit the province, the crude death rate was 5.3 per 1000[1]. The crude birth rate is stable at about 12.7 per 1000. Some 90 per cent of couples use contraceptives (but not condoms).[2]

The infrastructure in Phayao is good. Over 99 per cent of the villages have access to electricity. The road system is excellent, with very few villages situated away from a paved road. The province has 313 schools, 3381 classrooms, 4803 teachers and 86,948 students.[2]

People work hard in Phayao. A full 70 per cent of the 255,794 people constituting the workforce work 50 hours and more per week. Household income however is low, with 28.7 per cent of

[a] *During the period covered by this report US$ 1 = Baht 25, but subsequently the rate has varied considerably, currently being at US$ 1 = Baht 35.*

the rural population making less than 6000 baht per year[a].
The main source of income is agriculture, which employs 44 per cent of the workforce. The main crop is rice. Rice producers get a yield of less than 600 kg per rai, and about 18 baht per kg. No wonder, then, that 33 per cent of holders of less than five rai (who themselves make up 32 per cent of all holders) rely mainly on income from non-agricultural sources. On average, Phayao households (size 3.3 members) spent in 1994, 4340 baht per month, of which 193 baht was on medical and personal care.[2]

To make ends meet, one option is to migrate. In some villages, however, that percentage is much higher. According to a detailed survey of four villages in 1994,[3] almost 50 per cent of men and women aged 17-24 had lived outside the village for at least one month in the previous year. About one quarter of the migrants leave for education. The rest leave to find short-term jobs, mostly when there is a lack of local work in agriculture. Men leave for blue-collar jobs such as construction worker and taxi driver. Typically they leave in groups. Married men leave their wives behind.

For women, one frequent option is to enter the commercial sex workforce. The number of Phayao women entering sex work is unknown. However the numbers are thought to be quite large. A survey of 63 villages in Chun District in 1991 revealed that 1692 women age 15-34 years, or 14.6 per cent of the female population of that age group, were working as sex workers. Of those workers, 245, or 14.5 per cent, were working in other Asian and European countries. Most women leave "voluntarily", as the result of perceptions about their role in society. They behave as their parents, their community and themselves understand they should. Parents see their daughters as the agent responsible for family survival. Communities condemn prostitute daughters less than those who do not help their families.[4] Daughters internalize that role, and many women implement their dream: help the family build a new house and buy consumer goods, help the brothers through college, and come back to get married. As we shall see AIDS is changing this pattern.

HIV spreads in Phayao Province

HIV has been spreading silently into Phayao, probably since the late 1980s. People then were paying little attention to the virus:

"We fear famine, not AIDS"

was the answer to early information and education efforts. By 1993 AIDS

started showing its face in most communities. For many people, it was too late. HIV prevalence levels among military recruits and pregnant women had already reached 20 and ten per cent, respectively.

Table 2: Reported HIV symptomatic and AIDS cases, by year, Phayao Province, 1989 - 1997 (May)

Year	AIDS cases	HIV symptomatic cases	Total	Male:Female ratio in Phayao	Male:Female ratio at national level
1989-1990	3	0	3	3:00	11.0:1
1991	7	9	16	4.3:1	6.8:1
1992	79	41	120	5:01	6.1:1
1993	212	151	368	4.7:1	6.6:1
1994	456	256	712	3.7:1	5.5:1
1995	1082	416	1498	3.0:1	4.7:1
1996	1256	264	1620	2.7:1	4.0:1
Total	3344	1327	4671	3.1:1	4.8:1

Source: Phayao Provincial Health Office

The number of reported AIDS cases increased steadily. HIV and AIDS spread in both sexes, while the male to female ratio evolved from 5:1 in 1992 to 2.7:1 in 1996, with women relatively more represented among AIDS cases in Phayao than at the national level (Table 2).

Table 3: Reported AIDS cases from 1984 through 1997 (February), by region.

Region	Number of reported cases (per 100,000 population)
Northern	25,082 (212)
North-eastern	7738 (38)
Central	19,060 (101)
South	3564 (48)
Total	55,443 (95)

Source: Division of Epidemiology, Ministry of Public Health

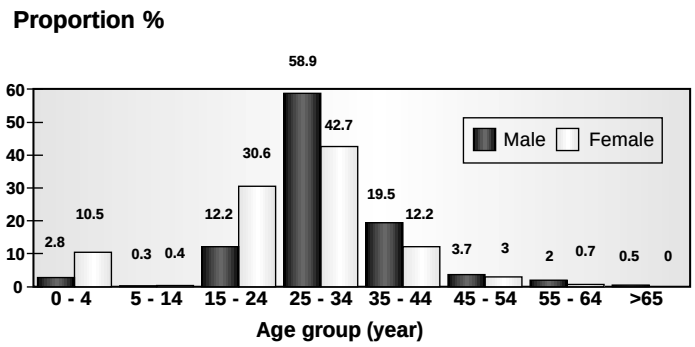
Table 4: Reported AIDS cases per 100,000 population, by province, upper northern region, Thailand, 1984 - 1997 (February)

Province	Number of reported cases (per 100,000 population)
Phayao	3,252 (629)
Chiang Mai	7,401 (477)
Chiang Rai	5,771 (462)
Lampoon	1,570 (388)
Lampang	2,633 (328)
Mae Hongsorn	361 (170)

Source: Phayao Provincial Health Office

Phayao became the Province with the highest rate of reported cases in Thailand. At 212 per 100,000 population, the Northern Region of Thailand has the highest rate of AIDS reported cases. In the North, the Provinces constituting the upper North report the highest levels, with Phayao at the top, reporting 629 AIDS cases per 100,000 population from the outset of the epidemic until February 1997 (Table 4).

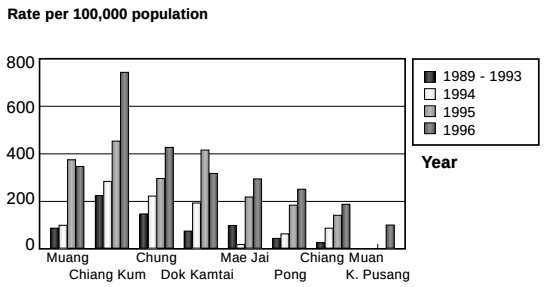
Figure 5: Reported AIDS cases and HIV symptomatic cases by age and sex, 1989 - 1997



Source: Phayao Provincial Health Office

Women with HIV/AIDS are younger than men, but only slightly. The majority of cases of each sex group occur in the 25-34 age group (Figure 5).

Figure 6: Distribution of AIDS and HIV Symptomatic



Source: Phayao Provincial Health Office

In all districts, people started to seek care for HIV-related symptoms.

Figure 7: Occupation Specific Morbidity Rate

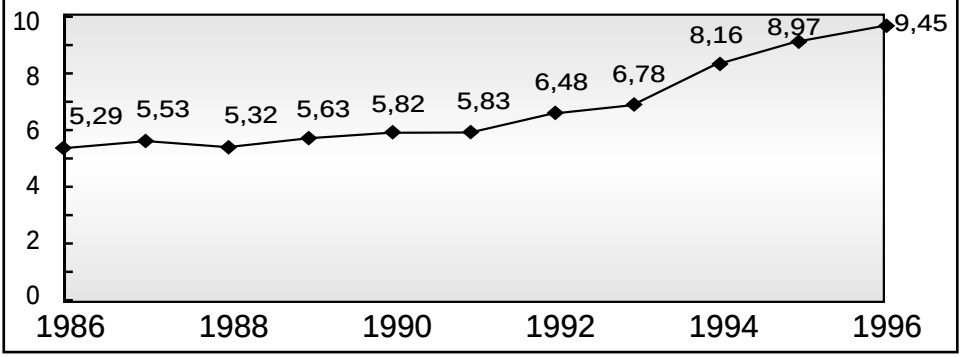
Source: Phayao Provincial Health Office

The morbidity rate seems to be higher among those who gave agriculture as their primary occupation (Figure 7). Agriculture workers are most likely to seek temporary work outside the province when there is low demand for their labour in Phayao.

A tremendous impact on the people

The crude death rate increased dramatically, from 5.3 per 1000 in 1986 to 6.8 in 1993 and 9.5 in 1996 (Figure 8). No other condition than HIV/AIDS can explain this increase. By 1994, AIDS had become the leading cause of mortality in the Province. It represented 11.3 per cent of all deaths, and 18.2 per cent of all deaths if one includes those cases where AIDS is the suspected cause of death but was not medically confirmed. The AIDS death rate in 1994 was 1.53 per thousand, hitting men 5.2 times more than women, at age 25-34 (55.3 per cent of the total). Some 40 per cent of them were single.[1]

Figure 8: Crude death rate, Phayao Province, per 1000 population



Between 1986 and 1996, mortality among men, aged 25-34, and among women, aged 20-29, increased eight to nine-fold.[5]

There is no accurate information about the infant mortality rate in Phayao. The rate of infant deaths to live births registered in the province shows a dramatic increase instead of further decreases as expected (Figure 9).[6]

The population growth rate (Figure 10) declined to reach almost zero. The population in Phayao Province is now expected to decrease, as the result of increased mortality and decreased fertility among women with HIV.

Figure 9: Measured and projected infant mortality rate (IMR) in Phayao, 1987 - 1994

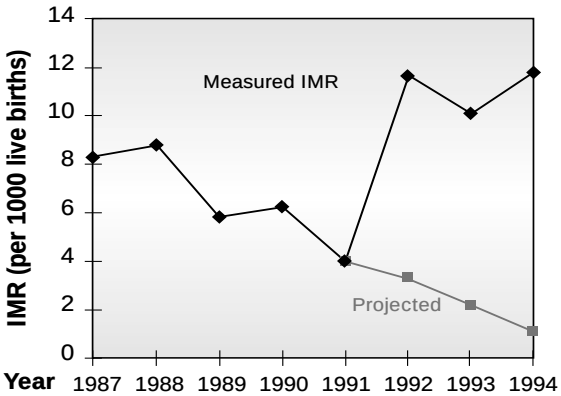
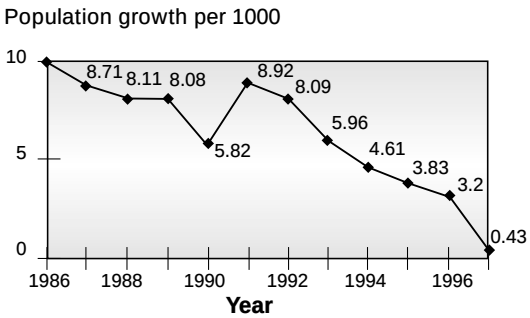


Figure 10: Population growth rate in Phayao, 1986 - 1997



Women who know they have HIV are less likely to want to have a child. In addition, there seems to be a biological reduction in fertility among women with HIV.[6, 7]

AIDS made its economic impact deeply felt. Treatment costs of opportunistic infections are very high. Costs of antiretroviral therapy are even higher (See Tables 5 - 8).[8]

Table 5: Cost of treating opportunistic infections according to National Guidelines[8]

Opportunistic infection (OI)	Cost per episode (1000 baht)
Tuberculosis	3200
Cryptococcal meningitis	68,668
Other systemic fungal infections	22,889
Candidiasis	300
Pneumocystis carinii pneumonia	25,2
Cytomegalovirus infection	118

Table 6: Costs of antiretroviral agents

Drug	Unit cost (baht)	Daily dosage (times)	Daily cost (baht)
Zidovudine (100 mg)	12.0	3 x 2	72.0
Didanosine (100 mg)	45.5	2 x 2	181.9
Zalcitabine (0.75 mg)	64.4	1 x 3	193.1
Stavudine (40 mg)	97.0	1 x 2	194.0
Lamivudine (150 mg)	99.0	1 x 2	198.0
Indinavir (400 mg)	83.3	2 x 3	500.0
Ritonavir (100 mg)	50.0	6 x 2	600.0
Saquinavir (200 mg)	54.4	3 x 3	490.0

Table 7: Costs of double combination therapy

Double combination	Cost per day (Baht)	Cost per month (Baht)
Zidovudine/didanosine	253.9	7617.0
Zidovudine /zalcitabine	265.1	7953.0
Zidovudine /lamivudine	270.0	8100.0
Stavudine/didanosine	375.9	11277.0
Stavudine/lamivudine	392.0	11760.0
Average cost	*311.4*	*9341.4*

Table 8: Costs of triple combination therapy

Triple combination	Cost per day (baht)	Cost per month (baht)
Zidovudine/ didanosine/ indinavir	753.9	22617.0
Zidovudine/ didanosine/ ritonavir	853.9	25617.0
Zidovudine/ didanosine/ saquinavir	743.9	22317.0
Zidovudine/ lamivudine/ indinavir	770.0	23100.0
Zidovudine/ lamivudine/ ritonavir	870.0	26100.0
Zidovudine/ lamivudine/ saquinavir	760.0	22800.0
Average cost	*792.0*	*23758.5*

Direct costs are not only related to western medicine. Having heard from doctors and nurses "that there is no cure for AIDS", people with HIV and AIDS understand that modern medicine has no cure for them. They then turn to alternative sources of treatment, where they tend to spend all of their savings, selling their assets or going into debt. As a result, people with some financial means commonly spend from tens of thousands to hundreds of thousands of baht on treatment [9, 10].

In addition, AIDS causes major income loss, as it mostly affects people age 25-34 years, at the peak of their productive years. And, as if the direct consequences were not enough, discrimination against people with HIV and AIDS compounds the economic losses experienced by people with HIV/AIDS (PWHA) and their families. That discrimination was at least partially induced by attitudes and practices of health personnel.

As a result, people lost their jobs, their customers, their employees, and their suppliers. Children were sent away from day-care.

Body bags

At the early stages of the epidemic, rejection of AIDS patients in the community was partially caused by hospital medical procedures related to AIDS deaths. When a patient died at the hospital, the body was put into a plastic bag. The family was told not to perform traditional bathing rites, but to go straight ahead with cremation. Noting how strictly the hospital dealt with the corpse, villagers worried that the virus could perhaps be transmitted from the body in some way.

From Havanon [11]

The consequences of AIDS went far beyond the economical sphere. Once people realized that AIDS had come in to their community, people were so frightened that they cut relationships with neighbours and friends affected by HIV/AIDS, including refusing to attend their funerals or joining in traditional community ceremonies.[11]

No wound!

[My friends] tell me not to go with them when they seek for jobs any more. They are afraid I will eat and drink with them. I told them that I am all right. I don't have any wound in my mouth.

Kampan's husband died of AIDS. She has to take care of her nine-year old son by herself.

From Havanon [11]

Not wanted at the wedding

I burst into tears in front of all the guests. I carried a bowl of rice, but they would not take it from me. They said I didn't have to serve and should have let other people do it instead.

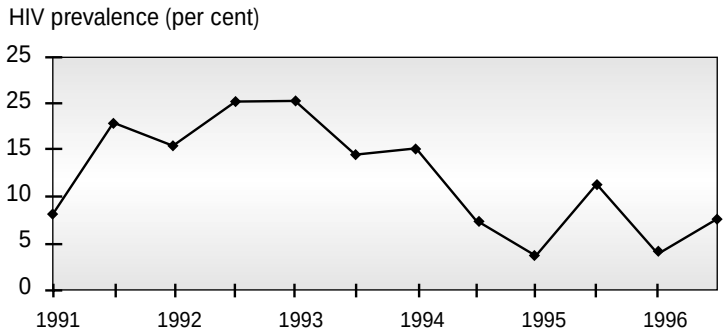
Wan, serving at a wedding party. She learned about her HIV infection during her first pregnancy.

From Havanon [11]

Phayao people make great progress

Phayao people wasted no time in responding to HIV, individually and collectively.

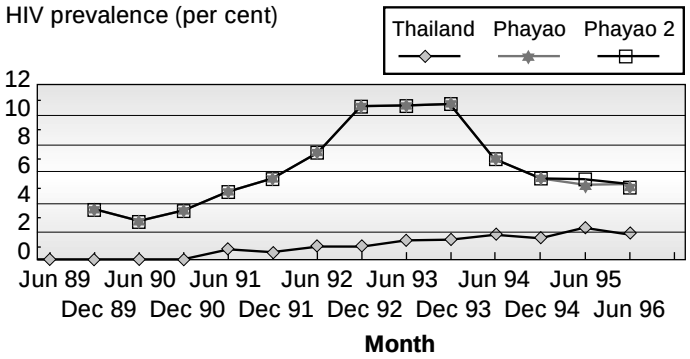
Figure 11: Prevalence of HIV among military conscripts, Phayao



Individuals adapt their sexual behaviour

In June 1993, HIV seroprevalence levels among military conscripts from Phayao Province started to decline (Figure 11). In 1997 they have reached a plateau at about seven per cent, or about one third of the peak levels reached in June 1992 and in January 1993. In principle, all young men aged 21 are subject to military service but a sample is recruited through a lottery system. All conscripts are tested for HIV. A positive result does not exclude them from the military service.

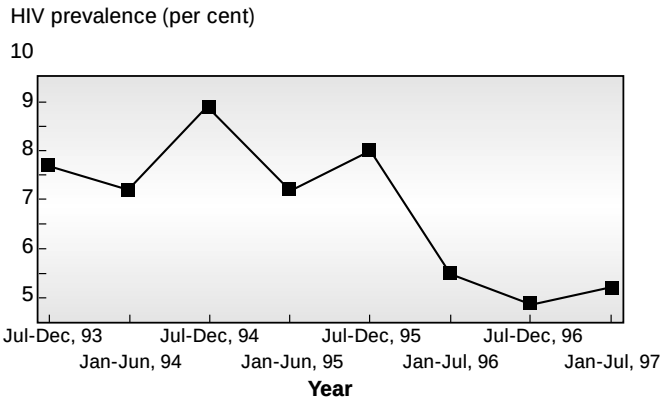
Figure 12: HIV sentinal serosurveillance among pregnant woman, Phayao, 1989-1996



Source: Division of Epidemiology, MInisty of Public Health

In June 1994, the prevalence of HIV among pregnant women in Phayao Province started to decline as well (See Figure 12, *note: the results from Phayao 2 does not include Pong District*).

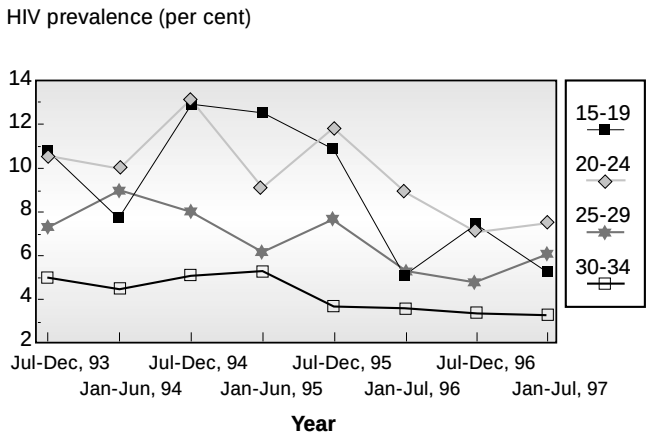
Figure 13: HIV prevalence among pregnant women Phayao, 1993 - 1997



Source: Hospital Prenatal Record

The hospital data from prenatal clinic records for 1993 - 1997 (Figure 13) show the same trend. Testing is voluntary. More than 90 per cent of pregnant women take the test.

Figure 14: HIV prevalence among pregnant women by age group, Phayao, 1993 - 1997

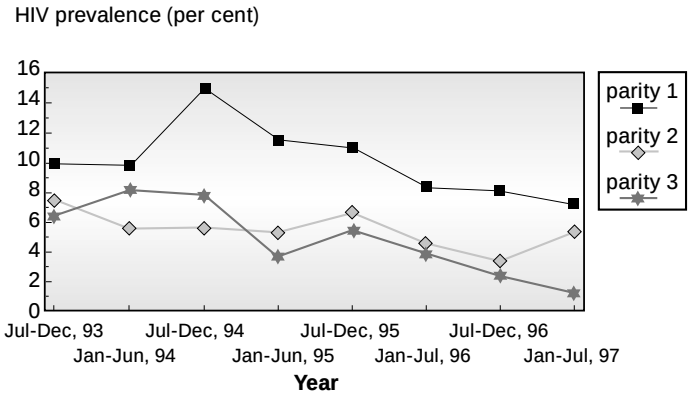


Source: Hospital Prenatal Record

The same downward trend is observed when the HIV prevalence data are disaggregated by age (Figure 14). As expected, the decline is greatest among younger women.

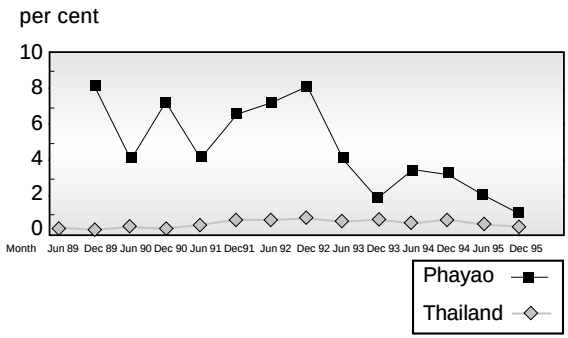
Primigravidae show also greatest decreases in HIV prevalence (Figure 15). Premarital counselling started in Phayao in 1996 and cannot explain the downward trend among primiparae, which started in December 1993. Moreover, only about five per cent of couples use premarital counselling services. The slower decrease (if any) among second pregnancies may reflect transmission within married couples.

Figure 15: HIV prevalence among pregnant women by parity, Phayao, 1993 - 1997



Source: Hospital Prenatal Record

Figure 16: HIV sentinel serosurveillance among blood donors, 1989-1996



Source: Division of Epidemiology

HIV infection among blood donors shows a similar downward trend (Figure 16). That trend might, however, result from self-exclusion of

Young men approved of commercial sex in 1994...

It is something which people see all the time.

The attractiveness of women draws men to them like a magnet, it really influences one's mind.

It is a "cool" thing to do.

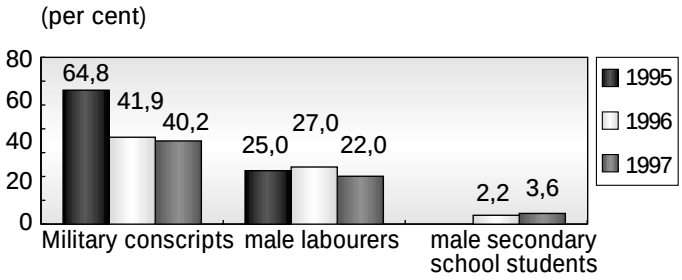
Young men from Chiang Kham on pre-marital commercial sex in 1994

Source: Pramualratana et al[12]

potential donors who suspect they might test positive for HIV.

In the past, Phayao people viewed the practice of men buying sex as normal. Almost every unmarried man used to frequent sex workers. Many married men would sneak out to brothels, although perhaps not as regularly as when they were single. For men who work in other provinces, visiting sex workers far from home used to be considered as a life enhancing experience. Previously, young men normally had their first sexual experience with a prostitute.

Figure 17: Proportion of military conscripts, male labourers, male secondary school students who had sex with commercial sex workers in previous 12 months



But as villagers have come to understand that AIDS is a killer and results from transmission through sexual intercourse the community's norms on sexuality have changed significantly. Now, men visit sex workers much less than before (Figure 17). The pattern of young men's initial sexual relationship has changed also. Now the majority of young people think that having sex with prostitutes is too risky. Male teenagers often delay initial experience of sex until they find a girl friend.[11]

Sexual behaviour surveillance data tend to indicate that young men visit commercial sex workers less frequently. In 1997, 40.2 per cent of military conscripts from Phayao declared to have visited a commercial sex worker over the past year down from about 65 per cent in 1995.[13] In 1997 and 1996, under four per cent of male secondary school students had visited a commercial sex establishment over the past year. Because Phayao Province started implementing a sexual behaviour surveillance system in 1995, the trend cannot be traced back accurately before that year. But it is possible to get an impression of the dramatic changes that took place by comparing Phayao behavioural surveillance data with earlier point estimates. For instance in 1991, 85 per cent of male secondary schools students in one district declared that they regularly visited commercial sex establishments.

As a result of these changes in behaviour, brothels had to close. In 1990, there were 78 commercial sex establishments in Phayao Province with 449 commercial sex workers. In 1996 there were 12 commercial sex establishments and 76 commercial sex workers left (Figure 18). This

...but now brothels have closed for lack of customers

Men in the village used to visit sex workers near the village. They didn't have to go to town. All men, from teenager to middle aged, visited sex workers. Over six or seven years, since AIDS arrived, those sex establishments didn't make enough money to go on operating. The brothels had women, and they had to pay all the expenses without any customers, so they had to close down.

A village headman

Source: Havanon[11]

decrease is, however, compensated to some extent by an increase of sex workers at restaurants and karaoke bars, where men pick up women for sex outside. The number of known indirect sex workers to the province increased from 16 in 1994 to 88 in 1996 (Figure 19). They tend to sell their services much less often than direct sex workers do [14]. We shall discuss the significance of that phenomenon.

Figure 18: Evolution of sex work establishment, Phayao Province

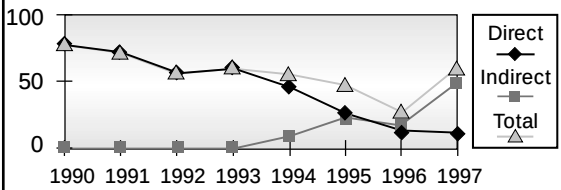
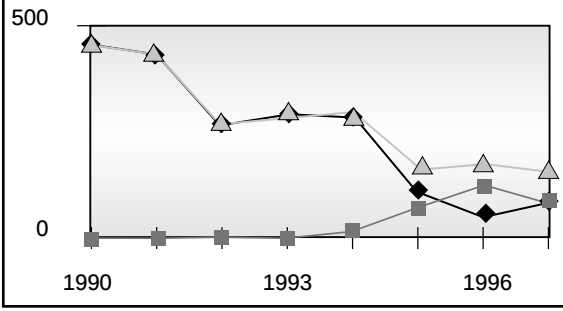


Figure 19: Evolution in number of sex workers (SW),Phayao Province, 1990 - 1996

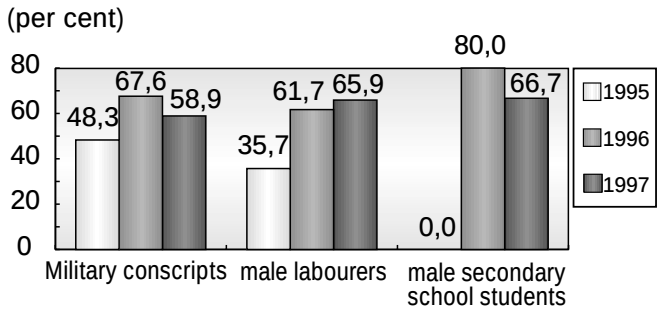


Source: Phayao Behavioural Surveillance System

When they do visit sex workers, an increasing number of men use condoms consistently. Ten years ago, condoms use with sex workers was at best erratic. But in 1996, 66 per cent of Phayao conscripts report consistent condom use with sex workers and 56 per cent in 1997, up from 48 per cent in 1995 (Figure 20).[15]

Consistent condom use among male labour visiting sex workers was 66 per cent in 1997, up from 36 per cent in 1995. A large majority of the few students who went to the brothel used condoms consistently. Condom distribution by the Phayao Provincial Health Office shot up from 164,548 units in 1990 to 942,874 in 1997.

Figure 20: Proportion of reported consistent condom use with commercial sex workers in past 12 months



Communities respond

First inspired by fear, community attitudes towards people living with HIV/AIDS (PWHA) started to change. They are now increasingly inspired by compassion. In focus group interviews, most PWHA report loving attitudes from

their families, in particular from the blood relatives (parents, brothers and sisters). Moreover, in one study, awareness by the husband that his pregnant wife was infected never caused marriage break-ups.[11]

Figure 21: A person with HIV/AIDS helps out at a social event

In fact, people with HIV/AIDS often are agreeably surprised by the support they get from their relatives.[16]

Communities have adapted their customs to make it possible for PWHA to live in their midst. Changes in tradition focus on food and eating habits, which have great importance in Thai soci-

ety. Traditionally families in the north sit in circle with the dishes in the middle, using their fingers to roll chunks of sticky rice into balls and dabbing them into flavoured dishes. At first families would reject people with HIV from the meal. Now some families keep their traditional practice, realising that HIV cannot be transmitted through communal eating HIV-positive people.[11] Other families are introducing the use of a helping spoon to serve the condiments on separate dishes for each participant to the meal.

People with HIV/AIDS are also better accepted in the community at large. People with HIV/AIDS are now invited to participate in social events, and to help in chores that are not food-related (Figure 21). The Phayao AIDS Action Centre interviewed 81 businesses employing more than ten workers (44 per cent of the total in the province), 131 chief monks (30 per cent of the total), 92 school principals (30 per cent of the total), and 89 day-care centres (30 per cent of the total). Eighty-eight per cent of the businesses have the explicit policy of keeping people with HIV at work. Over two in three (67 per cent) of the chief monks allow PWHA to organize activities in the temple – although 98 per cent of them will not accept people with HIV as monks, and candidates are required to take a blood test. Among schools and day care centres interviewed, 92 per cent and 83 per cent respectively have explicit policies of keeping children with HIV at school.[16]

People with HIV/AIDS are building communities of their own (Figure 22). Irrespective of the psychological support they get from their families, they find great comfort in the solidarity of people with whom they can share their experience. There are 24 groups of people with HIV/AIDS in Phayao, with 1609 people participating. That number is rising rapidly.

Communities have started to deal with the causes of their vulnerability to HIV. According to a community survey done by village health workers of one district, the number of women (age 15-35) leaving the district to work as sex workers decreased from 1692 in 1991 to 299 in 1996. Rather than sending their daughters to town “to make some money”, they now tend to keep them in school, a result of an active effort from the Ministry of Education partly motivated by HIV/AIDS.[16]

Government and NGOs respond

From 1984 to 1992: Focus on sex workers

When HIV was first detected in Thailand, the Government appointed the sexually transmitted diseases (STD) clin-

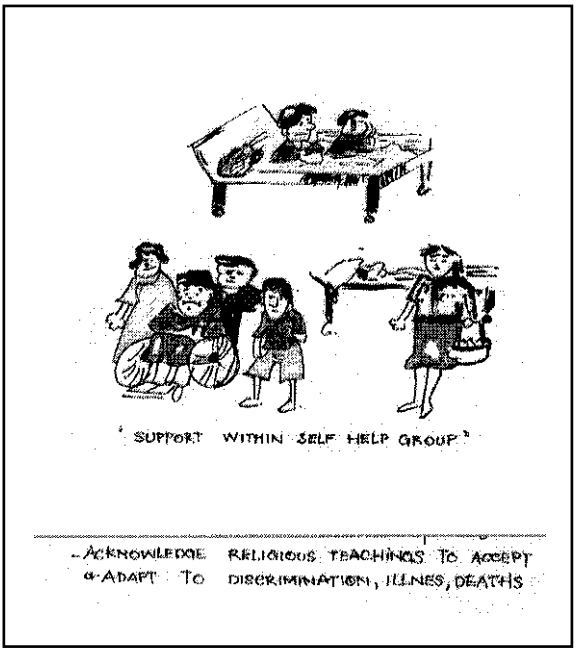
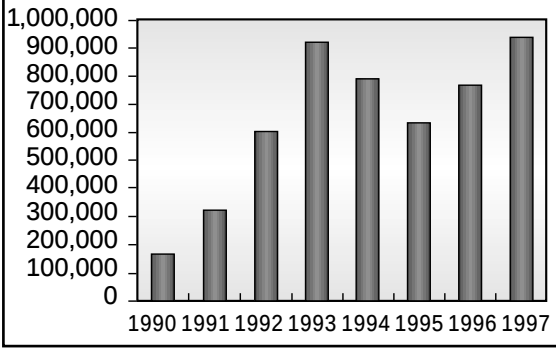


Figure 22: People with HIV/AIDS organize self-help groups

ics as the main agencies to deal with this new disease. They were put in charge of a prevention campaign focused on "risk groups', mainly sex workers and their clients. In 1991, the Government created the National AIDS Prevention and Control Committee (NAPCC) chaired by the Prime Minister. The end of that year the NAPCC announced the "100 per cent condom use campaign" for commercial sex establishments. The goal of that continuing campaign is to ensure that each sex act in commercial sex establishments be protected by a condom. The Government has provided strong media support for the campaign and also organizes condom distribution.

Figure 23: Condom distribution in 1990-1997



Source: Phayao Province STD Clinic

In Phayao as in other Provinces, staff from the STD clinic took charge of implementing the 100 per cent condom-use campaign. They visited commercial sex establishments and taught sex workers, rallying support from the establishments' owners. Condom distribution picked up dramatically (Figure 23).

The STD unit also collaborated with other sectors. However, at first it was difficult to imagine what role the other sectors might play, beyond participating in information campaigns in support of AIDS prevention.

Expanding the response

But in 1993 AIDS became more and more apparent. And with AIDS came discrimination, partly fuelled by the earlier AIDS campaigns – which were based on fear – and also by overly cautious health personnel, misinterpreting universal pre-

caution policies. Soon, the provincial leadership realized that "care, not scare" had to be at the centre of their action.

With AIDS also came the realization that everyone was at risk. The problem was not limited to sex workers and their clients. Sex work is a job, not a status. Sex workers become housewives. Their clients are husbands and lovers. HIV is not only transmitted in commercial sex establishments. It is also transmitted at home between married partners.

It also emerged that something deeper than risk was involved. The province had to deal with the specific factors of "vulnerability", the propensity of people to put themselves in situations of risk. This meant tackling social norms. It meant promoting girls' education. It meant creating economic opportunity, especially in those communities most affected by HIV/AIDS. It meant expanding care for AIDS patients beyond simple medical care. It meant being holistic, bringing in the contributions from monks, social workers, labour and other sectors.

Clearly officials of the Ministry of Public Health alone could not do this job. The province as a whole had to be mobilized. In 1989 the Provincial Committee for AIDS Prevention and Control was created, followed by the creation in 1994 of the Phayao AIDS Action Centre. The Governor of Phayao leads the action on HIV/AIDS. He chairs the Provincial AIDS Committee, which sets policies, goals and strategies, approves operational plans and oversees monitoring and evaluation.

The Provincial AIDS Action Centre formulates the policies, goals and strategies for approval by the Provincial Committee, links up with the media, coordinates implementation of HIV/AIDS-related activities, and assists the Phayao Provincial Health Office (PPHO) with fundraising and allocation of funds to HIV/AIDS projects. The Centre consists of the following sections: information, planning and budget, technical and training, research and evaluation, and administration. The AIDS Action Centre hosts the representative of the nongovernmental organization (NGO) CARE Thailand, which liaises with other NGOs active on HIV/AIDS in the province. Moreover, in five districts[b], local AIDS action centres are active, extending the work of the Phayao AIDS Action Centre. The Centre keeps the institutional memory of the province on AIDS. Its entire staff participated in this study.

Each year, in accordance with the budget

[b] *Chiang Kam, Dokkamtai, Chun, Pusang, Muang*

cycle, the PPHO - assisted by the AIDS Action Centre - submits to the Provincial Committee a set of guidelines for project development.[17] In line with the National Plan 1997-2001,[18] these guidelines recommend a set of strategies which various sectors should adopt in the development of their projects.

The Response in 1996: a brief overview

An intense level of activity

From 1993 to 1996, the response to HIV/AIDS by Phayao institutions steadily increased in intensity. In 1996, public and private institutions in the province implemented 75 projects, with a budget of 30 million baht, or a little more than 2 US$ (at the then rate of exchange) per capita.

The scope of these projects was broad, as they aimed at reducing risk as well as building capacity. They directly benefited many categories of people in the province. And many sectors were involved in implementing them, particularly at district level. Project funding came from various sources, but mainly from the Ministry of Public Health. Annex 2 describes the framework used to carry out the review described in the following paragraphs.

Project resources directly support the private response to HIV/AIDS

Around the world, it is too often the case that HIV/AIDS project resources remain confined to the organization of meetings and seminars, targeted at staff of organizations supposed to be involved in the response to HIV/AIDS. But in the first instance, it is ordinary men and women who respond to HIV and AIDS. In Phayao, this point was recognized, and 41 projects (55 per cent of the total, representing 76 per cent of 1996 project resources) aimed at supporting the “private response” to HIV/AIDS – relating to how people respond to AIDS in their private lives.

Furthermore, Phayao province recognized that people do not only respond as private individuals, but also as members of families and communities. So out of the total resources allocated to the private response, 39 per cent aimed at individuals, five per cent at families, and 11 per cent at communities.

Support to the private response: focus on various target groups

Members of most groups relevant to the epidemic received support through one or more projects. As Figures 24 and 25 illustrate, projects focused on people with HIV/AIDS and their families, as well as on

Figure 24: Distribution of projects targeting the private response, 1996

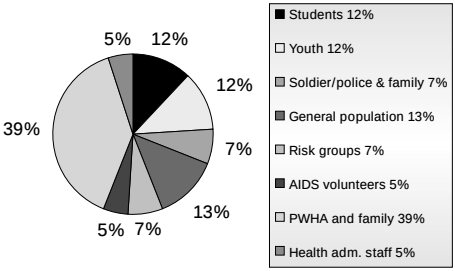
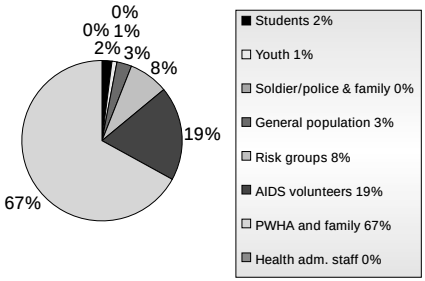


Figure 25: Distribution of project resources targeting the private response, 1996



school and out-of-school youth. Other targets include sex workers and their clients, the general population. Project resources in support of the private response have been targeted mostly to people with HIV/AIDS.

While projects in support of the institutional response have targeted the health sector they did reach out at other institutions, such as coordinating committees, monks and teachers (Figures 26 and 27).

Figure 26: Distribution of projects supporting the institutional response, by target groups, 1996

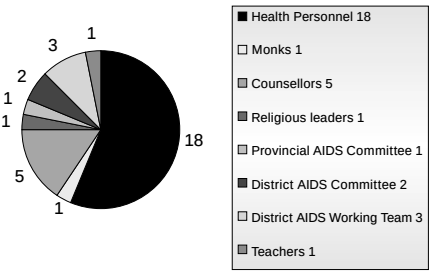
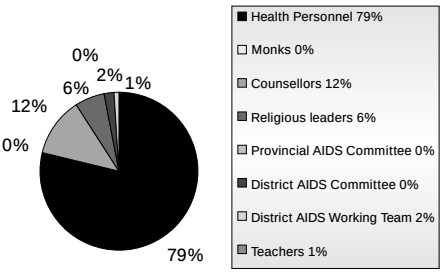


Figure 27: Distribution of project resources supporting the institutional response, by target groups, 1996



In aggregate, the scope of projects is comprehensive

Figure 28: Distribution of projects in support of the private response

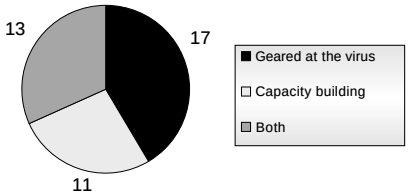
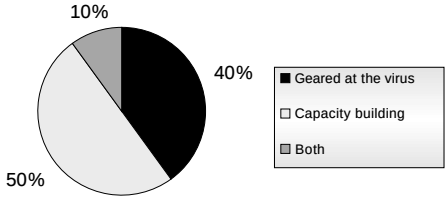


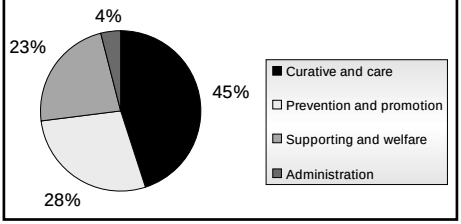
Figure 29: Distribution of project resources in support of the private response, 1996



As projects tackle various factors of vulnerability and risk, their scope, on aggregate, is quite comprehensive (Figures 28 and 29). Projects addressing risk factors include condom distribution and information campaigns. Capacity building activities include life-skills development in young boys and girls; financial support for low income families with a person with HIV/AIDS; and the development of local action plans, using the Participatory Rural Appraisal (PRA) method which was used by all sub-districts in Phayao province.

Using more traditional criteria, 46 per cent of the project resources were allocated to cure and care; 28 per cent to prevention and promotion; 23 per cent to support and welfare. Less than four per cent of project resources were used to cover administrative costs (Figure 30).

Figure 30: Distribution of project resources by type, 1996



A total 29 out of 75 projects were implemented outside the health sector, to which the latter 61 per cent of the resources were allocated. Some of the Projects are implemented by NGOs [c]. NGOs play a very important, complementary role. In the more labour-inten-

[c] *CARE, FARM, World Vision, ACT, the Sisters of Charity, DISAC Phayao, the Church of Christ*

sive projects, they develop approaches that are then later adopted in the public health system. For instance, NGOs are playing an important role in the further definition of the comprehensive support package to people with HIV/AIDS.

Many partners from public and private sector implement projects

Figure 31: Distribution of projects, by implementing sector, 1996

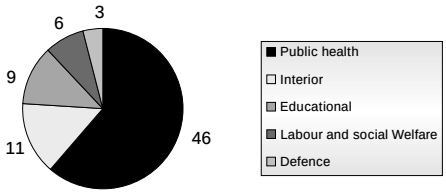
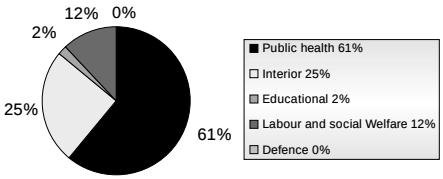
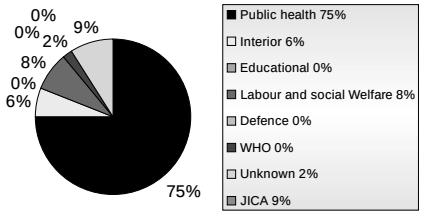


Figure 32: Distribution of project resources, by implementing sector, 1996



Substantial financial resources were mobilized from various sources

Figure 33: Origin of project funding, by sector (1996)



The PPHO was designated to act as fund-raiser for all sectors. As most of the public resources for HIV/AIDS come from the budget of the Ministry of Public Health, the PPHO took the lead in fund-raising on behalf of all its partners (see Figure 33) The Provincial Committee then allocated those resources to projects submitted by institutions from various sectors (see Figures 31 and 32). This collective effort of the Province led to the mobilization of considerable funds from the national budget. The 1996 budget for HIV/AIDS amounted to 30 million baht (then US$ 1.2 million,[d] or 60 baht per capita (then US$ 2.4). This budget represented 23 per cent of the public health budget of the province (127,635,580 baht), or 14 per cent of 206,343,980 baht if we include private payments to the public system) and 2.5 per cent of the provincial budget (1.2 billion baht).

[d] *During the period covered by this report US$ 1 = Baht 25, but subsequently the rate has varied considerably, currently being at US$ 1 = Baht 35.*

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Turning crisis into opportunity

Mainstreaming AIDS

At the beginning of 1997, the Phayao Provincial Health Office (PPHO) found itself at a strategic crossroad[11]. Much had been achieved, but much remained to be done. It began to be felt that continuing to tackle AIDS as a "special problem" through "special projects" might be counterproductive. Mainstreaming might be required from now on: the inclusion of HIV/AIDS as a new dimension of the core business of all relevant sectors.

As the province was to embark on health-care reform, it had the opportunity to explore what this mainstreaming meant for the health sector. For that purpose, the PPHO needed an articulation of the lessons it had learned while responding to HIV/AIDS over the past ten years.

The HIV and Health-Care Reform Study

Hence, through the "HIV and Health-Care Reform Study", the PPHO attempted to articulate what it had learned from the response to HIV/AIDS. The objectives were to:

Adopt a strategy whereby Phayao's people could move from progress to success on HIV/AIDS, and shape Phayao's health-care system to enable effective implementation of that strategy.

Study design

This study belongs to the PPHO, which has been in the driver's seat throughout the study. The office set up a study team, composed of members of the Phayao AIDS Action Centre and staff from various branches of the PPHO, including those working on health-care reform, to undertake the study. The team was organized into groups working on epidemiology, social science and economics. The study team mobilized support from Thai experts in these fields from the Ministry of Public Health, and universities namely, Chulalongkorn and Srinakarin. The primary audience of the report is the PPHO itself and its constituents. The main product of the study consists in eventual follow-up actions in Phayao and elsewhere, and in their impact on health-care.

Stock taking, not research

The team took stock of experience by reflecting on its own experience with HIV/AIDS over the past ten years, and by using existing data in support of that reflection. The team held several sessions to reflect on what might be the key factors in an effective response to

AIDS, and to what extent these "secrets" have been at work so far. At the same time, the team exploited existing data to review progress and support their reflection. No additional research work was carried out, with the exception of focus group discussions with key participants to the response to HIV.

An attempt at a comprehensive review

Because the PPHO is responsible for mobilizing the overall response to HIV/AIDS in the province, the scope of the study is deliberately comprehensive. HIV/AIDS is challenging every aspect of society, and reviewing the response to HIV/AIDS tends to become an overwhelming task. Hence, reviews are often limited to smaller geographical entities (a district, a community), a set of activities (condom distribution, care, etc.) or a "target" group (people with HIV/AIDS, children). As a result, reviews seldom address systemic characteristics that can only be explored by looking at the response to HIV/AIDS as a whole.[19] Therefore, the team resisted the temptation to limit the scope of the study, as the review had to inspire the overall strategic direction in Phayao. Rather, through its reflection on its understanding of HIV/AIDS, the team attempted at identifying the systemic implications for an effective response to AIDS.

The secrets of an 'integrative understanding' of HIV/AIDS

By articulating its experience, the Phayao Study Team attempted to develop an 'integrative understanding' of HIV/AIDS. That understanding is essential, to create a common vision of progress and success among the many partners who must collaborate to make action effective (see box).

From the understanding of the epidemic and the response to it, key factors of progress – "secrets" – emerge. Once recognized, these secrets can serve as criteria for designing more effective responses to AIDS.

Moreover, HIV/AIDS is typical of the several socio-behavioural problems to which health systems need to adapt. Better understanding the response to AIDS amounts to better understanding of how people maintain and enhance their health. Hence, a health-care reform that would benefit from the integrative understanding of HIV/AIDS and of the response to it would be better able to deal with the socio-behavioural problems of the next century.

What is an integrative understanding?

People and institutions looking at the HIV/AIDS epidemic see different things, and hence respond differently, sometimes in contradictory ways. Biomedical scientists focus on the virus and look for technological ways to get rid of it. Others taking a sociological perspective focus on the societal determinants of the epidemic and recommend social re-engineering. Such views can be harmonized by combining them into a common, expanded framework, or 'paradigm'.

" ...the next stage of the journey from counting to understanding and solidarity involves acknowledging diverse perspectives on and around HIV/AIDS... While some proponents of the mainstream approach...act as though it is the only perspective in town, it is one perspective among many. Acknowledging this widens the existing pathways to a range of possible understandings and responses to AIDS. There is a need for an integrative understanding which... opens the way for wider and more synergistic connections between HIV/AIDS interventions and other less obviously related interventions when the walls between the two at least in theory have been broken down. There is now more scope for organic rather than just mechanical, connections or integration…" [20]

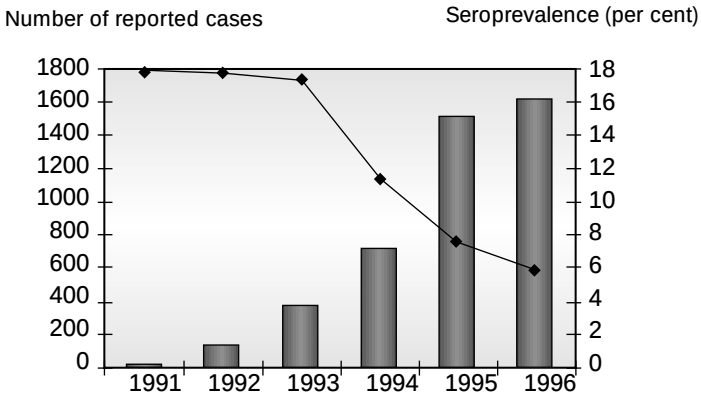
The first fundamental secret: the community's own response determines progress

These are dealt with in more detail below. But there was a more fundamental lesson that Phayao Province learned over the past ten years.

This was that the outcome of the battle against AIDS is decided within the community. People, not institutions, ultimately decide whether to adapt their sexual, economic, social behaviour to the advent of HIV/AIDS. Governmental and nongovernmental organizations can only influence, constrain or facilitate, people's responses to HIV and AIDS. Hence, the single most important factor of progress lies within communities: the capacity of people to assess how AIDS affects their lives, to act if needed, and to learn from their actions. Supporting individuals, families and communities in such a process represents both a key role and a major challenge to institutions involved.

Phayao people demonstrated their capacity to adapt to the reality of HIV. Once informed about the emergence of a new and deadly sexually transmitted dis-

Figure 34: HIV seroprevalence among conscripts and number of reported HIV/AIDS cases



ease in their midst, they adapted their sexual behaviour, even before communities started experiencing AIDS cases and death from AIDS. As Figure 34 shows, HIV prevalence among young men decreased significantly in 1994, a reflection of behavioural change prior to 1994, when many young men reacted to the initial information campaigns. That was also the year when the number of HIV/AIDS increased dramatically. Men had already changed their sexual behaviour, even before they knew someone living with AIDS.

By contrast, it appeared that with the exception of the 100 per cent condom promotion campaign, few projects were likely to make a significant contribution – because they have yet to reach a sufficient proportion of people in need. Secondary school children in only two out of eight districts benefit from intensive sexual health and life-skills training. About five per cent of couples use premarital counselling services. Some key groups, such as depart-

ing and returning migrants, injecting drug users and men having sex with men have yet to benefit from project resources. And in the final analysis, what people do with whatever information and support institutions might provide is their decision. What they decide depends on their capacity, real and perceived, to take charge of their lives.

The second fundamental secret: people's own capacity to observe, understand and act determines their response

Economic opportunity in Baan Tom

One day in 1993, Khun S. was visiting Tom Dong, a village bordering the forest in Muang District. That village was having more than its share of AIDS-related deaths. Young women who had left the village to enter the commercial sex industry were coming back with HIV and eventually dying from AIDS. There he met Khun Z. a young lady who came from Bangkok to visit her mother.

"What are you doing in Bangkok?" asked Khun S.

"I work in an artificial flower factory", she responded.

"You represent 'human capital' for this village", said Khun S., "why don't you talk to your boss, and propose to open a factory right here?"

"OK," she said.

The factory was opened some years later. Women work at home, and sell components for artificial flowers to the factory, which now injects 200,000 baht per month in the local economy.

Suwat Lertchayantee

According to the Study Team, *the capacity for people to assess their own factors of vulnerability and of risk* explained progress achieved so far. This held for individuals, families and communities, whether villages or self-help groups.

Phayao people have made progress because they went beyond their first reaction of fear to assess their own situation with respect to HIV/AIDS. They saw that they were vulnerable to HIV, were able to predict what would happen if they did not do anything, and refused that eventuality by acting on their major factors of vulnerability and risk. Their capacity to adapt to the advent of AIDS was critical in achieving progress. Making further progress will hinge on developing that capacity even more. Hence, in the eyes of the people of Phayao, *facilitating community level responses* constitutes the key role for institutions involved in the response to HIV/AIDS.

So what should the institutions do?

Given these two fundamental secrets – that the community's response determines progress, and that their capacity to observe, understand and act determines their response – what then are key ingredients of an effective *institutional* response? It must be to support these two fundamental insights. In practice, the Phayao Study Team identified several key factors of institutional progress, or "secrets" of successful HIV/AIDS control.

The AIDS Action Centre concluded that the following *institutional* factors might have contributed to progress over the past ten years:

- combination of short-term action to reduce risk and longer term action to reduce vulnerability;
- establishment of multi-sector partnerships whereby planning, decision making and resources are shared;
- dynamic, continuous adaptation of strategy as the province was learning how to deal with AIDS, and
- human development strategy emphasizing not only technical skills but compassionate, client-oriented attitudes as well.

First institutional secret: combine short-term action to reduce risk with longer-term action to reduce vulnerability

Over the past ten years, Phayao province has learned the limitations of targeting only situations of risk (immediate danger of HIV transmission) and has progressively evolved to address factors of vulnerability

(conditions leading people to place themselves in danger) as well.

At the outset, the province gave immediate priority to the prevention of HIV transmission through the promotion of condom use by sex workers and their clients. Yet, this could only be a short-term action. Even if a majority of men started using condoms consistently, and reduced their visits to commercial sex workers, HIV would eventually spread into the community, and the next line of battle against the virus would be the use of condoms by couples after they discover they have HIV.

While this approach needs to be undertaken, it does have obvious limitations. Which couples need to be tested for HIV? At what frequency?

Clearly, risk-reduction strategies need to be complemented by strategies leading people (whether infected with HIV, or not) to avoid risk situations. Within households, this involves improving communications, providing enhanced economic opportunity (see box: Economic opportunity in Baan Tom), prolonging education, and training in life-skills. Within communities, this involves changes in social norms, particularly in the expectations regarding the economic contribution of girls to their parents – which often drive girls into commercial sex work.

Second institutional secret: multisectoral collaboration

As soon as the factors of societal and individual vulnerability are recognized, the need for effec-

"Formerly we did not recognize the importance of collaboration. We thought that we could work by ourselves. When AIDS came, we realized that it is impossible to work alone."

Dr Aree Tanbanjong, Phayao Provincial Health Office

"You need to let each sector do their thing, not be redundant. Not every sector doing an education program. During these 3 years we had a lump sum budget in addition to the normal budget. It catalysed a dialogue on how to use it and created good collaboration."

Dr. Petchsri Sirinirund, Chief Medical Officer, Phayao Provincial Health Office

Source: Interviews by Dr. Heidi Larson [21]

tive multisectoral collaboration to reduce that vulnerability becomes obvious.

Intervention to reduce HIV/AIDS affects the core business of every sector. For instance, agricultural extension workers can give priority to villages where land ownership is low, to promote job opportunities to landless villagers who would otherwise migrate out of the Province. For instance again, the Phayao Provincial Health Office is now advocating an AIDS-sensitive poverty-reduction strategy: the economic sectors of the province need to take the advent of AIDS into account in their plans, by targeting those villages that are most vulnerable to HIV with economic development projects.

Third institutional secret: dynamic adaptation of strategic planning

To play their facilitating role, institutions in the province had to adapt their action as their understanding of the epidemic was improving. For example, at first, youth health education began in the form of biology classes focusing on the virus and its transmission. Now, the focus is moving away from the virus and even from AIDS per se towards life-skills education. Before, the training was done in separate classes given by health workers; now the strategy is to incorporate the work into the school curriculum and have the classes given by the regular teachers. The same process is at work in health education given in health facilities: before, HIV was the focus of the teaching given to individuals, now the strategy is to focus on communication about life and sexual matters within the household.

Fourth institutional secret: the need for compassion

Facilitation requires compassion or empathy, the process of putting oneself without prejudice in someone else's situation. Compassion is a rational attitude, and should not be confused with sentiments such as pity, or commiseration. Given that people will decide the outcome of the epidemic, and compassion is needed to understand and influence their situation, the alternative to compassion is failure. Only compassion can lead the health worker and other front-line workers to put their health advice in the proper context. Health-care workers who promote condom use by married couples for safer sex and fail to understand the perspective of housewives might hurt their feelings, as they see the condom as the mark of dishonesty. If they understood the housewives' perspectives, they might find common ground, for instance by promoting condom use as a contraceptive as well.

A kaleidoscope of anecdotes and impressions (see box page 53) illustrates many facets of compassion. The challenge, however, is to put in place systemic incentives to compassion, so that this attitude is not just the feature of a few exceptional actors, but becomes a key characteristic of all institutions addressing the HIV/AIDS issue.

The Phayao Provincial Health Office has done much to foster compassion. Health workers have been trained in meditation techniques, as one has to be at peace with oneself to reach out to others. They are encouraged to think, analyse and act on their own to adapt to the situation of the people they are to serve. Beyond the health sector, compassion has replaced fear as guiding principle for setting HIV/AIDS-related policy in the province.

A kaleidoscope of compassion

"When my brother died of AIDS", says Kaew, a nurse in a health centre, "I gave him the ritual bath before his funeral. Before that day, no one would bathe people who died of AIDS. Maybe that gesture did contribute to the reduction of discrimination I observe in the sub-district?"

"During home visits, families affected by HIV just look at how you hold their baby, said Jiab. "If you don't hold the child or show that you are scared, they will write you off".

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"There is not much I can do in that village," says Sister X, who assists self-help groups of people with HIV. "There, people with HIV/AIDS have a difficult time getting organized, because local health centre staff don't welcome them. They miss a place to start from".

"We have reflected on the factors involved in our psychological recovery after we had learned that we had HIV," said a leader of a self-help group. "In each of our experiences, meeting a caring person is the key to our accepting our situation, and our moving on with our lives."

When Ying was asked what role she thought Buddhism was playing in Phayao's response to HIV/AIDS, she responded: "It is always on our minds."

People in Phayao

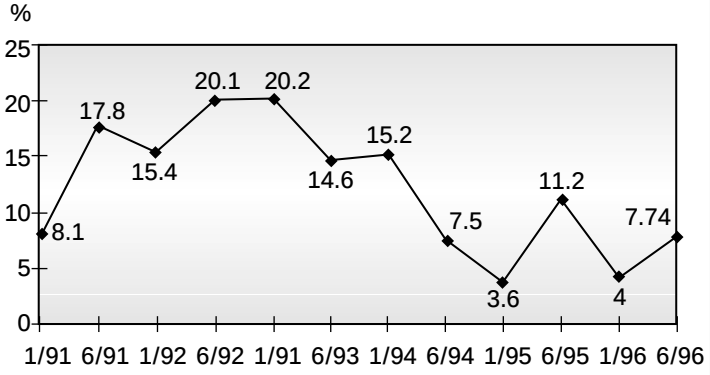
Of course, none of those factors is fully implemented in Phayao. The next section discusses what strategic shifts the province is considering as a result of the study. Implementing such strategic shifts would entail major changes in the health sector. They are discussed in Annex 1, "*Health-care Reform in Phayao*".

Progress in Phayao may be stalling

After a rapid decrease in the early 1990s, HIV prevalence levels among pregnant women and among conscripts have levelled off at seven and five per cent respectively (see Figure 35) since early 1995.

These prevalence rates are still among the highest in Thailand and in Asia. They translate into unacceptable levels of morbidity, mortality and suffering. Clearly, there is no room here for complacency. The current dynamics of HIV transmission might explain lack of recent progress and provide strategic clues for the way forward.

Figure 35: Prevalence of HIV among military conscripts, Phayao, 1991 -1996



Source: Hospital Prenatal Record

Changes in the dynamics of HIV transmission

The dynamics of HIV transmission are changing in Phayao, as the epidemic matures and patterns of sexual networking change. Here we shall describe the most likely scenario of HIV transmission, based on a mix of data and of qualitative information. This scenario is serving as the basis for further planning, while it is being confirmed and refined as knowledge and understanding of the epidemic in Phayao and elsewhere improves.

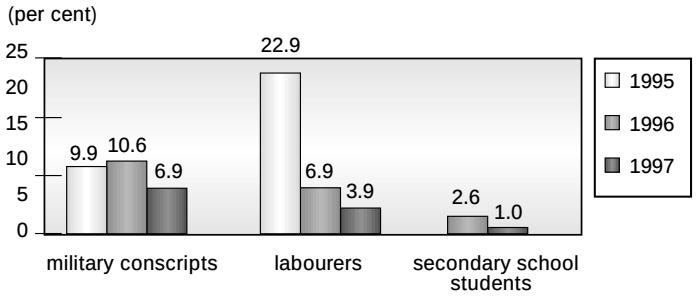
HIV infections still occur to a large extent among people who migrated outside the province. The first waves of HIV/AIDS patients were men who returned from blue-collar work outside the Province. Then, an increasing number of sex workers came back with AIDS. Given the incubation period of HIV, that pattern depicts infections acquired five to ten years ago, and current infections may follow a different path. However, the pattern is likely to remain highly relevant, as men continue to migrate for work, still go to commercial sex establishments, and do not use condoms consistently with commercial sex workers. Still 40 per cent of 1997 military conscripts had visited a commercial sex worker over the past 12 months. Among them, 41 per cent had not used a condom consistently. The comparable figures for male labourers are 22 and 34 per cent, respectively. Moreover, significant numbers of men report having had sex with men (Figure 36), and that most of that sexual intercourse was unprotected (Figure 37). Consistent condom use by men having sex with men was 38 per cent among male labourers (five per cent of these men reported sex with men over the past 12 months). The corresponding figures for conscripts were 24 and six per cent.

Some women have rectal STDs, an indication that anal sex is practised with women as well. Women who left the province for commercial sex work continue to return with HIV from other provinces and from other countries. When asked about their previous occupation, 14 per cent of pregnant women detected with HIV infection in 1996, responded they had worked in the commercial sex industry.

Not all people have been infected with HIV outside Phayao. Many get infected within the province, through sex both outside and within marriage. Commercial sex activity still exists. The HIV prevalence among commercial sex workers in Phayao is about 60 per cent (Figure 38). This high rate

hardly comes as a surprise, as the 100 per cent condom policy is not implemented at 100 per cent, with the result that, while the client who uses condoms is protected, the sex worker is still at risk from those clients who do not use condoms. (Given the high mobility of commercial sex workers, they may have acquired the infection in another province).

Figure 36: Proportion of men reporting having had sex with men in previous 12 months



In addition to commercial sex establishments, sex workers increasingly offer their services in some restaurants, karaoke bars, traditional massage parlours and motels. The province has no known commercial sex establishments offering services by males. Men would pick up young men in karaoke bars and restaurants. This is a changing scene and it is difficult to remain abreast of the new "spots". However, while the "indirect" commercial sex activity is a source of real concern, customer turnover is likely to be much lower than in commercial sex establishments, leading to relatively less new infections.

Figure 37: Proportion of reported consistent condom use by men when having sex with men in previous 12 months

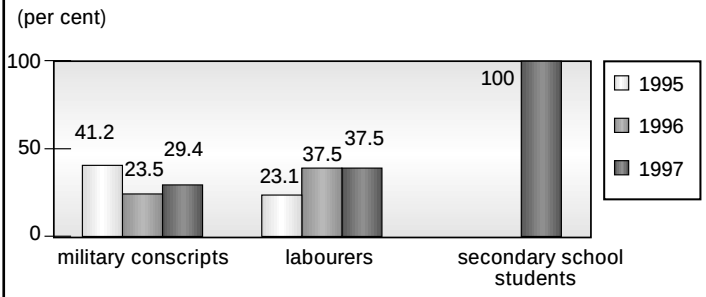
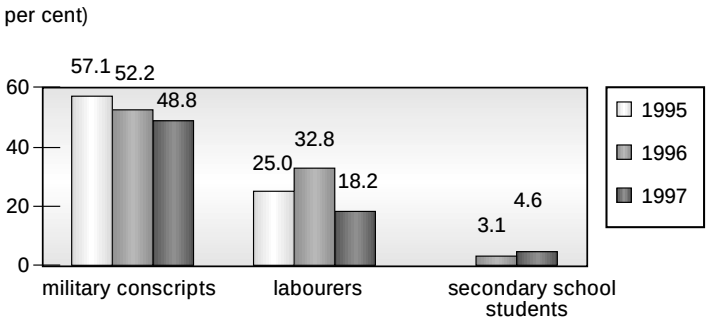


Figure 38: Proportion of male respondents reporting casual sex in previous 12 months

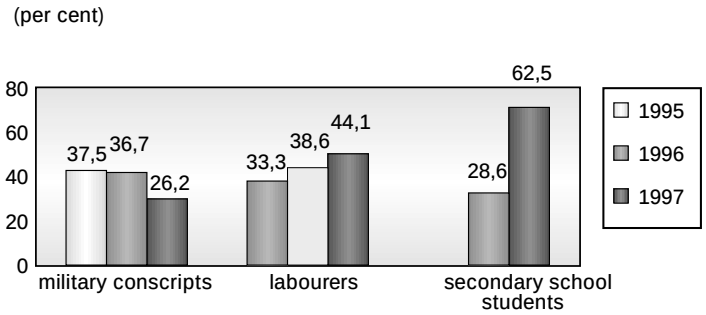


Injecting drug use exists in Phayao Province (and is reported principally in Pong and Chiang Kam districts). A few HIV infections are attributed to injecting drug use since the outset of the epidemic in Phayao. Over the last quarter of 1997, 45 heroin addicts were treated at one of the drug rehabilitation clinics. There are no community-based data on the prevalence of injecting drug use. Use of non-injectable drugs such as amphetamines appears to be widespread, leading to concern that some users might shift to injecting drugs.

Some infections are acquired through casual sex, as significant proportions of both male and female respondents in the Phayao behavioural surveys report having been in that risk situation over the past year. Contrary to the speculation that men would turn more to casual partners after giving up visits to commercial sex workers, Phayao behavioural surveys do not indicate that casual sex is on the increase – rather the opposite (Figure 38). Condom use in those structures remains low (see Figure 39).

In Phayao, most new infections may now be acquired within marriage.

Figure 39: Proportion of consistent condom use among men when having casual sex in previous 12 months



There is limited evidence that about 20 per cent of the partners of women with HIV are not infected. Assuming that 50 per cent of the 2500 women aged 25-35 (10 per cent of the population, HIV prevalence five per cent) living with HIV are married, this would translate into 250 men living with an HIV-positive wife. The same assumptions about marriage ratio and ratio of discordance would translate into 500 uninfected wives of men, aged 25-35 living with HIV. Some 750 spouses would live with a person with HIV in that age category alone.[1]

In addition, approximately 280 HIV-positive women in Phayao (or five per cent of the population of pregnant women) gave birth to an estimated 70 infected children (1997).[22]

Much remains to be done on the social front

More progress is needed on the social front as well. People with HIV/AIDS observe that unaffected families still look down on them. They find it difficult to have access to credit and to insurance. They are unable to become monks even for short periods: only 11 per cent of the chief monks interviewed allow people with HIV to become monks. Still 10 per cent of the businesses interviewed use HIV status as a recruitment criterion. Parents known to have HIV still have a hard time sending their children to preschool.

Fundamental causes of vulnerability persist.

The first source of vulnerability is the lack of information about one's HIV status. Most people know only too late that they have HIV: when symptoms of HIV lead doctors to perform an HIV test. By then, they may have unknowingly transmitted HIV to a person they love. Only couples attending premarital counselling, pregnant women, and people applying for overseas work get a test early on. Similarly, communities are only informed of the occurrence of HIV when people are sick or die. They only see "the tip of the iceberg" and might take more forceful steps to respond to HIV if they were appraised of the full extent of HIV infection in their midst.

A second source of vulnerability is silence about sexual matters. "We do it; we don't talk about it!" Here, as in so many other parts of the world, men and women have not learned how to discuss matters pertaining to sexuality. In a way, everyone lives in a make believe world. Fathers pretend that their daughters work as maids and entertainers, but not as sex workers. Wives want to believe that their husband is different and does not cheat on them. Girls, who declare in an interview they would never engage in sex work, will say a few minutes later that they performed such work before. The issue is how to break the barrier of silence without breaking relationships, how to face reality without being overwhelmed by it.

A third source of vulnerability is the use of drugs, in particular alcohol. While there are no data on alcohol use in Phayao Province, alcohol is consumed on a large scale.

A fourth source of vulnerability is lack of land ownership and migration. In focus-group interviews people make a clear link between lack of land ownership, migration and HIV/AIDS. Some

villages may be more vulnerable to HIV than others depending on whether villagers own the land or not.

A fifth source of vulnerability comes from ill-adapted social norms, both old and recent. For example, girls engage in commercial sex work not necessarily out of sheer poverty, but out of a deep desire to help their families. In today's materialistic lifestyle, their desire translates into building a new house and/or purchasing consumer appliances. Tradition values girls who support their families effectively. In such a context, usual prescriptions, such as increasing female literacy – may not work as effectively as modifying their attitudes. "We love to come to school, and to learn English: that way, we will become super stars, and earn more money", answers a girl to a scholar studying the link between sex work and school education. Only when society stops expecting that girls materially help their parents will the pressure on them be released.

New social norms may be ill adapted as well. The 100 per cent condom policy in commercial sex establishments has portrayed the image that condoms are only good for use in those circumstances. As a result, people associate condoms with commercial sex, and perceive them as unacceptable in a loving partnership. While 90 per cent of the couples use a contraceptive method, condoms are not used for contraceptive purposes. A partner proposing to use a condom will immediately be suspected of promiscuity. Women will tell their partner: "What? Do you think I am a prostitute?"

Now comes the hard part

Now comes the hard part. As we saw in the section on *Turning Crisis into Opportunity* (page 45), those who would adapt to HIV and AIDS on their own have done so. For many people, however, whether individuals or communities, general information about AIDS and mass distribution of condoms is not what they need. They either need personal information about their own status, need general information of a different kind, or resist to behavioural change altogether.

Most people living with HIV are not responding to their concrete situation because they are unaware of their status. What they need is access to early testing and to counselling, to help them in assessing and acting on their own factors of vulnerability that put themselves and others at risk.

Some people might not consider themselves at risk: for instance they might be unaware of casual sex or

anal sex as situations of risk for HIV transmission.
Others are "late acceptors" or "resistors" to behaviour change who have yet to face the implications of the advent of AIDS in their lives[23]. Injecting drug users and men who persist to have unprotected sex in commercial sex establishments fall in that category. More radio shows and more mass information will not help such people. To help people face their reality and deal with it, personal and peer-based, rather than media-based approaches will be needed, combining interventions from various sectors, mixing information, services and changes in social norms.

From progress to success: a triple strategy

Despite evident progress on HIV/AIDS in Phayao, that progress has been stalling in recent years. To turn progress into success, a triple shift is required:

focus on people, including people with HIV/AIDS as key participants to the response to HIV/AIDS;
generalize early testing and counselling, to allow more people to adapt to their own situation;
create packages to combine the support from various sectors to key participants to the response to AIDS.

Focus on people: who might make a difference?

From the scenario described in the previous chapter, key participants to the response to AIDS can be identified. For the immediate future, it is clear that the following people could contribute most to further progress on HIV/AIDS:

- people with HIV/AIDS, including pregnant women;
- departing and returning migrants, both male and female;
- youth;
- men who have unprotected sex in commercial sex establishments;
- men who have sex with men;
- injecting drug users.

People with HIV and AIDS

People with HIV are not the problem; they can play a great part in the solution.[24] We know that given appropriate testing and counselling, people with HIV/AIDS will prevent transmission of the virus to the ones they love: their sexual partners, and for pregnant women, to their future children.[25]
The more people will know their status, the more effectively will they respond to HIV. This however supposes that, through its various institutions, society holds to its part of the deal.

Pregnant women with HIV now have the chance of preventing transmission of HIV to their babies. For that purpose, the Phayao Provincial Health Office has organized support to pregnant women with HIV with encouraging results. From October to December 1997, almost 100 per cent of the 1177 pregnant women attending antenatal clinics in Phayao Province accepted to be tested for HIV. Some 62 per cent of those women found to have HIV received zidovudine prophylaxis, thereby preventing an estimated six cases of pediatric AIDS in a four-month period. Preventing 24 cases of pediatric AIDS per year has to be done. This intervention will, however, have no impact on HIV incidence, estimated at 7799 new infections in Phayao in 1997.

Departing and returning migrants

The greatest antidote against HIV in Phayao might be AIDS-sensitive economic development, which would create economic opportunity within the province. Migration, however, is not likely to end any time soon. The issue, therefore, is to reach migrants before they depart and after they return, to encourage them to protect themselves, their loved ones, and society at large.

Young people

The future of the epidemic is of course determined by the response of young people, both young men and women, whether at school or out-of-school. Only by keeping the new cohorts of young men and women free of HIV will Phayao sustain progress. Both young men and young women need to be considered. Even if in Phayao Province many young girls engage in sex work, more young men are infected with HIV than young women. Young people of both genders will have to look at their specific factors of vulnerability (which will no doubt include drug use), and act on them.

Men insisting on unprotected sex

Commercial sex workers have been and are playing a major role in the progress observed to date. They are not the problem. They are part of the solution, as they attempt at protecting themselves, their future children, and their customers. Direct sex workers[26] can make the greatest contribution to progress, because on average, they serve a greater numbers of clients than indirect sex workers.

The issue is to reach core resistors to condom use among their clients: men who despite years of information and despite their experience of AIDS in the community continue to have unprotected sex in brothels. It is even more complicated by the fact that most visits for commercial sex take place outside the province.

Men who have sex with men

Meanwhile, the specific needs of men who have sex with men will need to be addressed. Furthermore, the practice of anal sex with women must be assessed and eventually addressed.

Injecting drug users

Currently, Phayao has no information about the extent to which injecting drug use contributes to the epidemic in the province. This practice needs to be ascertained and harm-reduction programmes need to be put in place.[27]

Generalize early testing and counselling

Early testing and counselling can be applied in two ways:

- to individuals and couples
- to the community

Early testing and counselling of individuals and couples

Currently, most testing and counselling is done for people who have HIV. Hence they are tested many years after the outset of the infection, and the probability is great that they have transmitted the infection to people they love, simply because they did not know that they were infected. As a result, a very substantial proportion of new infections in the province probably takes place within marriage.

Yet, a significant proportion of such "discordant" couples will use condoms if they know their situation. Discordant couples who don't know their situation won't, unless all couples change their attitudes towards condom use. A change in attitude among all couples is unlikely to happen at a sufficient scale any time soon.[28]

Discordant couples have a strong incentive to override current negative perceptions against the condom.

The detection and counselling of discordant couples could be carried out at least on four occasions:

- premarital testing and counselling
- family planning consultation;
- the ante- and post-natal clinic;
- on first detection of HIV infection.

The advantages of early counselling would not be limited to the couples. Indeed, the process of counselling applies to communities as well, and would produce great benefits.

Premarital testing and counselling

There is growing social pressure in Phayao for young people to test for HIV before they marry for the first time.

Such pressure does not seem to exist for remarriages. Most widowers and widows (many of them having lost their spouse from AIDS) remarry without checking their HIV status or that of their partner. Overall, premarital testing and counselling cover only a small proportion of the total number of marriages. As data are kept individually, and not per couple, it is difficult to assess either the proportion of discordant couples among clients, or their decisions regarding marriage once they are appraised of the test results. Most discordant couples, however, decide not to go ahead with their plans to marry.

This raises a major public health issue. If premarital testing and counselling were covering all marriages and would systematically result in discordant couples not marrying, people with HIV would then never find a stable sexual partner until they find a person who has HIV as well. This is already taking place to some extent, as some people with HIV find a partner in self-help groups. Social pressure for discordant marriage candidates not to marry should be addressed; measures for facilitating marriages among people living with the virus should be considered.[29]

Family planning consultation

With a contraceptive prevalence rate of more than 90 per cent, family planning clinics represent a major entry point for detecting discordant couples. Providers of family planning consultations could promote counselling and testing for HIV as a matter of course. The problem, however, is that women come alone to family planning clinics. The first step towards implementing this strategy would consist in insisting on the joint responsibility of couples for their reproductive health, and therefore in systematically inviting men to join their partner for family planning consultations.

Ante- and post-natal clinic

While women typically refuse to share with their partner the news of their infection at the time they learn about it, it might be possible to convince women after delivery to do so, before they are likely to resume sexual relations.

On first detection of HIV infection

The diagnosis of HIV represents another opportunity for detecting discordant couples. This may have important benefits, as the infection of people with HIV is likely to increase when viral load increases. Other opportunities include blood testing at anonymous clinics.

Community counselling

Community counselling can be considered in three contexts:

- villages and neighbourhoods;
- among peer groups;
- at the tambon level.

Villages and neighbourhoods

In addition to early counselling of couples and individuals, communities could be further empowered for action. That empowerment starts with information on the level of HIV prevalence. Communities are only aware of the "tip of the iceberg": they typically know who in the village has AIDS, but have no knowledge of the prevalence of HIV. At this stage of the epidemic, AIDS cases represent only about ten per cent of the prevalence of HIV. Communities could be given that information, on the basis of the average prevalence in the district. However, communities would be further empowered if health-care system providers were to inform them of the actual prevalence of HIV (obviously, without disclosing the identity of those who have HIV). This may be important, as there is strong suspicion that communities are not equally vulnerable to the epidemic. This information would stimulate community members to analyse their specific factors of vulnerability and of risk, and to act on them.

Peer group counselling

Peer group counselling is already being carried out among people with HIV/AIDS who participate in self-help groups. The province could provide support to the development of more and stronger self-help groups of people with HIV/AIDS, as more and more people would be aware of their status. At the same time, the province could reach out to, and build on existing networks of sex workers, men who have sex with men and injecting drug users to assist in the joint analysis of risk and vulnerability, and stimulate action to tackle those factors.

This supposes that sub-district level staff, in health centres and in other sectors have the skills and attitudes to facilitate (and not control) such joint analysis (see next section). Further, the empowerment assumes that communities and self-help groups can wield sufficient financial resources and services in support of their response to HIV/AIDS.

Joint assessment, analysis and action at Tambon (sub-district) level

Health centre staff would play a pivotal role in this process, as they have privileged access to HIV/AIDS-related information. Communities would look at general factors of vulnerability and risk, while existing groups of people with HIV/AIDS and of young people would analyse the specifics of their situation, and their specific support needs they require for effective action. The synthesis would take place at the level of the

local Tambon Administrative Organizations, where action plans of communities and of specific groups would be reviewed and assessed. Representatives of the various sectors and members of the community would make specific commitments in support of the action plans of the various key participants in the response to HIV and AIDS. The Tambon Administrative Organization would not control the process, but rather ensure that each party delivers according to its commitment. Health centre staff, community leaders and members of the self-help groups would assist the Tambon in monitoring effective implementation of the plan.

The proposed process of community counselling would work best if institutions from various sectors effectively supported community action to reduce factors of vulnerability and of risk. Rather than continuing to develop sectoral projects, institutions would need to focus on combining their support for key actors in specific communities, in their response to HIV and AIDS.

To tailor the action plans to local needs, Tambon Administrative Organizations would use their own budget, for which they are acquiring increased autonomy. They would be informed of the existing commitments made by the various sectors in the province to the various key partners in the response to HIV/AIDS, and would receive an indicative list of possible additional commitments from various sectors, with the costs to the Tambon of the commitments.

How would such a difference be made? Combining multi-sectoral support into packages

That is where Phayao institutions can make most progress. Seen from above, projects cover on aggregate the whole spectrum of activities characteristic of a holistic response. However, the support people receive from institutions is still fragmented.

Whatever support people get depends on the ability of local institutions to formulate projects, and to submit them to the Provincial AIDS Committee. As a result, people with HIV/AIDS have access to a day-care centre only in two districts. Projects to reduce the vulnerability of young girls still reach only a minority of them. A few health centres offer counselling and testing services; most do not. Building on ten years of experience, Phayao Province can now define packages of interventions in support of key participants to the response to HIV/AIDS, and strengthen local management to ensure their combined delivery.

Given the particular contribution of people with HIV/AIDS to further

progress on HIV/AIDS, a package for them is described in detail below. Similar packages would be developed to support other key participants in the response to HIV/AIDS. The testing and counselling approach will only work if institutions in the province are ready to support people with HIV in a holistic fashion, both as individuals, and as members of self-help groups. As we have seen in the section *Phayao people make great progress* (page 27) Phayao province is already providing most of the elements of that support. The challenge is to combine that support in a package effectively provided to all people with HIV/AIDS in the province. Elements of such a package are presented in Table 9. The package addresses factors of vulnerability and risk; supports people with HIV/AIDS as individuals and members of the self-help groups.

Similar packages could be developed in support of each key group in the response to HIV/AIDS. These packages would represent the sectoral commitments to the various groups. Each sector would accept responsibility for the effective provision of the respective package elements.[30]

Table 9: Example of a package (multisectoral support to people with HIV/AIDS)

Level	Health Care	Education	Religion	Labour	Social welfare
District	IPD* and OPD* Testing and counselling Referral care Day-care Centre Palliative care and referral care Group therapy Meditation practice Referral to other sectors Support to self-help groups	Secondary schools Admit children of people with HIV/AIDS		District office Target job opportunities to most vulnerable communities Inspect non-discrimination at the work place	District office Approve funding for poor families affected by HIV/AIDS
Sub-district	Health centre Testing and counselling Palliative care and OI* Counselling of self-help groups Referral of issues to TAO* and other sectors Supervises home-based care	Primary Admit children of people with HIV/AIDS Temple allow people with HIV/AIDS as monks Welcome self-help groups for activities in the temple Support basic needs: such as shelter and food Traditional therapy, counselling, meditation	Tambon agent Job training Education grants Small grant for capital investments		Village social welfare Assist in application for funding Provide monthly subsidy
Community	VHW* and home nursing Follow-up on therapy Psychological support Help in daily activities Self help groups Information on care Encourage members to comply with standards Participation in community counselling	Nursing Schools Admit Children of people with HIV/AIDS	Families Invite people with HIV/AIDS in ceremonies and solicit their playing a role	Families Recruit people with HIV/AIDS in family businesses Purchase goods and services from people with HIV/AIDS	Village Leader Encourage self-help group activities Supports job creation Detect and report exploitation of people with HIV/AIDS by crooks and charlatans Families Support basic needs: such as shelter and food

* IPD: In-patient department OPD: Outpatient department OI: Opportunistic infections TAO: Tambon Administrative Organization VHW: Village Health Workers

Getting the most bang for the baht

Moreover, the importance of achieving strategic specificity is enhanced by the current financial crisis. In 1997, the province's budget for HIV/AIDS was reduced. Most of the public resources were coming from the HIV/AIDS budget of the Ministry of Public Health. That budget will likely be reduced further in the following years. At the same time, other ministries are going to be cut even more, so that there is little hope for these ministries to shoulder a greater proportion of the HIV/AIDS budget. Hence, the need for a cost-effective strategy becomes even more apparent. The direct involvement of the community, as described above, could be highly cost-effective.

Daring to aim at success

There is a need to generate a vision of success, which would mobilize people in their private and public lives. That vision might be:

One day in Phayao, HIV/AIDS will become a minor problem, because we all, in our private and our public lives, will have learned the lessons of the epidemic. Then, whether infected or not, we will be able to live with HIV and AIDS.

On our path towards success, we propose objectives to the people of the Phayao. These objectives are ambitious, but we believe that together, we can achieve them:

- within five years, young people would prevent themselves from acquiring HIV, as demonstrated by HIV prevalence levels among conscripts and primigravidae below one per cent;
- the incidence of pediatric AIDS will decline by 50 per cent;
- more than 80 per cent of people with HIV/AIDS would be satisfied with the quality of their lives;
- more than 80 per cent of communities in Phayao Province would routinely assess and act on local causes of vulnerability and risk.

To transform this vision into reality, we need to implement the above strategy effectively. Much will depend on the capacity of the health sector, particularly at the local level. In the next section, we will scrutinize the health-care reform now being undertaken in Phayao, and propose specific measures for ensuring that the reformed health-care system passes the HIV test.

Passing the HIV test

Linking HIV with health-care reform

To enable further progress on HIV/AIDS, profound health-care reforms are needed. The advent of AIDS is challenging the health sector at the level of purpose and roles. AIDS reminds us that the purpose of the health sector is not just to achieve better health outcomes through the delivery of health-care packages. Society does not only expect the health sector to provide care. The health sector has to counsel individuals and communities, and catalyse other sectors towards action for health. These latter roles have been advocated since Alma Ata. Now, however, it is a matter of life and death that "health" effectively plays those roles: no other sector will jump in.

It will not be an easy task. *First*, counselling individuals and communities throughout the province requires major changes in structure and process of a system used to control disease rather than influence other people's behaviour. *Secondly*, reaching out to authorities and colleagues from other sectors constitutes a hard task for health workers who are easily fitting in vertical chains of command. *Thirdly*, the incorporation of HIV/AIDS-related procedures into "the core health service", the standards for health-care system output in Phayao, remains a challenge. The entry point for this triple adaptation of the health sector has to be the health centre. At the interface with communities and close to the Tambon, the health centre is ideally placed to effectively implement the required changes. To develop excellent, AIDS-competent health centres, Phayao will need to make profound changes in its management structure and further develop its human resource strategy.

The health-care reform now underway in Phayao is described in more detail in Annex 1.

Criteria for the overall success of health-care reform in Thailand and in Phayao are being developed. For the Phayao Provincial Health Office, however, one criterion of success is clear: the reformed health-care system has to "pass the HIV test". It must be more competent to deal with HIV and AIDS, for two reasons. First, the system has to be competent to respond to AIDS, the first cause of mortality in the province. Secondly, AIDS is typical of the socio-behavioural problems that the system has to address more effectively through its reform. The response to HIV/AIDS over the past ten years may harbour many lessons that apply to health in general.

How HIV/AIDS challenges health-care reform

AIDS forces health reformers to re-examine both the purpose and the roles they typically ascribe to the health sector.

The purpose of health-care systems

Faced with the AIDS crisis, Phayao Province did not aim solely at health status improvement. Yes, the prevention of HIV transmission and the related reduction of disease and mortality due to HIV were fundamental objectives. But the PPHO saw as equally important the improvement of the quality of the lives of people with HIV/AIDS and their families, and building the capacity of individuals, families and communities to deal on their own with HIV and its consequences.

AIDS is modifying Phayao's vision of health. Prolonging life and reducing morbidity are not the only purpose of health care systems, and of health-care reform. Producing health-care procedures, "interventions", is not its only output. Health-care reform has to aim at more than good health status. As soon as one accepts that people, not health-care systems produce health, then one realises that relief from suffering, irrespective of health outcomes, and autonomy, the capacity of people to maintain their health on their own, become equally important purposes of the health-care system.

If autonomy and relief from suffering are equally important goals assigned to the health sector, then its capacity to counsel individuals and communities, and to mobilize other sectors becomes even more important.

The role of health-care systems

Communities, individuals and counselling

AIDS is not just challenging the private behaviour of individuals. It is challenging professional behaviour of health workers as well. From traditional training, nurses and doctors have been led to think that they were in control. AIDS is telling us that they are not, but that people themselves are in control. We thought we were powerful. We now realize our limitations a little more. Health workers are used to ask people to participate in their health programmes. Now, health workers have to realize that they have to try to play a small part in people's lives, and to play it well. There is no easy way for achieving this transformation.

'Give me a place to stand on', [Archimedes] said, 'and I could move the earth'. Intermediaries follow that principle: the way for the weak to move the strong is not by force but by modifying their relationship, changing the angle of approach.

Source: Zeldin[29]

Develop a new and shared understanding of health, and modify the mode of interaction with individuals and communities. These seem to be the two avenues for effectively achieving this transformation. On the basis of the experience in Phayao, here are a few lessons learned for achieving the required shift in health workers' attitudes and behaviour. Training will not suffice to obtain the required attitude changes throughout the system. Constraints in structures and processes have to be addressed as well.

- Formally recognize that individual and group counselling is a legitimate use of staff.

It needs to be written in job descriptions.[15]

Ms Saowanee, Chief of the AIDS/STD section in Phayao Provincial Health Office

Traditionally, counselling (and before, health education) was seen as "soft". The "real work" would involve interventions, involving consumption of material inputs, with some measurable output: a Cesarean section, an immunization, for instance. Now, we have to recognize that the process of counselling itself is the output, to give time and ample space for that activity, and recognize best performers.

- Give staff the necessary autonomy.

Train staff to think by themselves, assess situations and design responses. Rather than being told what to do.[16]

Dr Petchsri Sirinirund, Phayao AIDS Action Centre

Empower staff with the responsibility, the related authority and the skills to integrate all information regarding a particular patient, and put it in the context of his/her family and community. Empower staff to participate in community assessment of health problems including HIV/AIDS.

- Trust *a priori*.

If health workers have to let go of their control, and accept that their clients will decide what to

do, then their supervisors too have to let go. Their trust in their staff is the main fuel for their staff self-confidence. Self-confidence is critical to the performance of their new role as facilitators in personal and community decisions. That trust, however, should not be understood as a "free for all" attitude. Trust should be accompanied with a clear understanding of tasks to be performed, and support to the resolution of problems encountered in the implementation of those tasks.

- Training in understanding self.

Beyond technical skills, training has to encompass key aspects of human development. This includes training in core management functions, but also in key spiritual values and skills. To be able to counsel others, one has to be at peace with oneself. To understand others, one should start with understanding oneself.

- Foster happiness to learn.

Maybe the key is to change staff attitudes towards learning – to make staff understand that there is much wisdom out there in the community; that they can grow personally if they are eager to learn at the contact with the people they are serving.

Training is not the only avenue towards staff development. Constraints in structure and processes need to be eliminated if they are to play their new role effectively.

- Organize patient flow to encourage privacy and confidentiality.

For example, open STD clinics in places and at times that are convenient for the clients. Now, the STD clinic is located in the Phayao Provincial Health Office, making it difficult for anyone but

At first, around 1992, the role of the counselling clinic was unclear. Counsellors would tend to rebuff people with a positive HIV test, because we lacked the self-confidence to provide counselling to them. As numbers increased greatly, we would have to deal with 50 patients a day. Eventually, we became depressed, and burned out. In 1994, I was saddled with stress, anger and weakness. I would argue with my husband for no reason, and started drinking. In 1995, I told my boss I wanted to quit. My case was not the only one. So, the Phayao Provincial Health Office set up a special course for us. We received training in self- and family psychology. Now I feel that I am a new person. Now that I know how to help myself, I think I know better how to help others.[21]

Khun Nongkran Meesub, Technical Nurse at the Dokkamtai Community Hospital.

socially recognized commercial sex workers to consult. Make sure that curative consultations in health centres and outpatient departments allow for a private discussion. Now those consultations are sometimes done in the presence of others, or behind a simple partition. This is perhaps acceptable if the health centre cares for babies with measles, but not to give the chance to the mother to share her anxiety that her husband might be transmitting HIV to her. Similarly, make sure that patient loads allow for a private discussion. Currently, in Phayao outpatient departments, staff hardly have the time to address the patient's main complaint. How can they possibly take the time to put that complaint into a more holistic context?

- Include the clients' perspective in the review of staff performance.

Develop an objective and transparent way for clients, including people with HIV and AIDS, to give feedback on staff performance and attitudes. Link this assessment with staff promotion.

We see that the Tambon is very busy building roads. I wonder who will travel on those roads, if they don't do anything to help us stop AIDS? [9]

A person with AIDS during a focus group interview

Catalysing other sectors

To respond to HIV/AIDS effectively, people need the combined support from many sectors. Health, however, has a specific role to play. With support of the co-ordinating authority, the health sector is uniquely placed to catalyse other sectors: to reach out and make them respond to the challenge AIDS places on their own core business. In a first phase, other sectors typically respond to AIDS by replicating activities that are usually done by the health sector. For instance, agricultural extension workers would once in a while include an "AIDS talk" in their discussions with farmers. While

worthwhile in itself, this does little to bring the support people would need from the agriculture sector. This requires that each sector adapt its core business to the advent of AIDS. For instance, an agricultural extension worker would discuss what labour-intensive crop the same farmers could introduce to keep more young people in the village, or how severely affected families could adapt their farming activities to the presence of people with HIV/AIDS in their midst or to loss of their main breadwinner. Time is ripe to try this approach in Thailand, and more specifically in Phayao.

First, the Eighth National Social and Economic Development Plan puts people at the centre of all development activities. When advocating that each sector review how AIDS affects its core business, the Phayao Provincial Health Centre can count on the support of top authorities.

Secondly, the 1997 Constitution calls for the strengthening of the Tambon (sub-district) level of the administration, through the creation of the Tambon Administrative Organization (TAO). Formerly, the Tambon was in charge mainly of implementing infrastructure projects, such as building roads. Now, the TAO will be in charge of supporting all aspects of development, and will be authorized to retain and spend some tax revenue.

Thirdly, Phayao has learned how to collaborate among sectors at the provincial level (see *Turning crisis into opportunity*). This is a major asset when it comes to encourage local level collaboration.

Instruction from the top to collaborate at the local level will not suffice. Somebody has to catalyse sectors locally. Given the necessary authority and skills, health centre staff are best placed to play that catalytic role. Once they play their counselling role effectively, they will combine technical and local knowledge in a unique fashion. Health-care reform represents a unique opportunity to recognize the potential of local health staff to play a catalytic role in the response to health problems including HIV/AIDS, and to explore effective implementation of that role.

Providing HIV/AIDS-related care

To be able to counsel communities and catalyse sectors in response to HIV/AIDS, health staff have to be recognized as competent care providers. Two issues need to be resolved in that respect: the inclusion of preventive and curative care for HIV in the core health service, and the organization of continuity of care throughout the health-care system.

Core health service: from minimum to optimum

With the help of the Phayao health-care reform team, the Phayao Provincial Health Office intends to guarantee to its constituents access and quality of a specific set of health-care procedures, called the core health service. The province faces a choice: either continue the work it has undertaken following a normative path, or go along a positive path instead. By following the normative path, the health-care reform team would fully define in theory the core health service, including its costs and financing before it is implemented. Alternatively, it is considering adopting a positive path, whereby it would define content, costs and financing of the core health service in the process of its implementation.

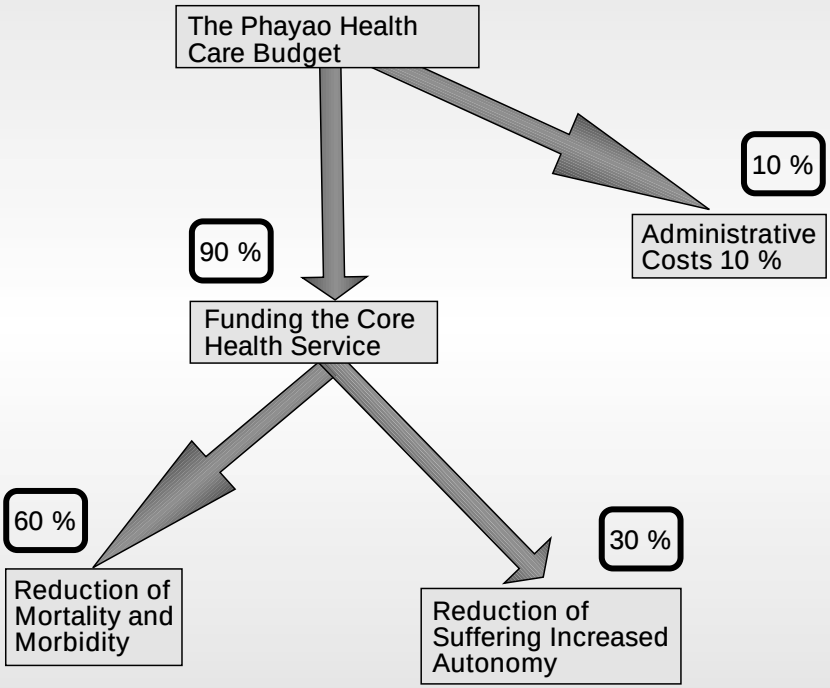
So far, a list of activities to deal with the top ten health problems has been developed. The specific tasks (or standards of work) constituting each activity are now being identified. For the inclusion of HIV/AIDS-related activities in the core health service several concerns will need to be addressed.

First, costs of care for HIV/AIDS could easily correspond to the total health care budget. As a result, the Phayao Provincial Health Office would not be able to ensure access to the core health service. In selecting HIV/AIDS-related procedures in the core health service, the Phayao Provincial Health Office needs to know with what element of the core health service those procedures are competing. This is not possible if the core health service addresses only the top ten priorities.

To address that issue, the health-care reform team would need to develop the full list of procedures included in the core health service, and not just those related to the top ten health problems. The next step would then consist in defining the costs of performing each task. Finally, the health-care reform team would fine-tune the core health service to ensure that the constituents of the province can afford it through a mix of public and private financing.

Secondly, the health-care reform team would need a method for selecting procedures that would consider their impact on people's quality of life and autonomy. On the basis of reduction of morbidity and mortality as the only criterion, very little palliative care and treatment of opportunistic infections would be included in the core health service. In that case, health-care resources would be better allocated to other procedures with a greater effect on mortality and morbidity. How then could the health-care reform team proceed with the definition of the Phayao core health service?

Figure 40: Defining the budget for the core health service



A proposed approach follows for discussion before it is tested as part of health-care reform activities. (See Figure 40).

First, the health-care reform team would determine the public budget available to support the core health service. This it would do by deducting from the total provincial health budget a proportion allocated to administrative costs, using the current breakdown as baseline, and taking into account planned efficiency gains in administration.

Secondly, the health-care reform team would determine the proportion of the provincial health budget to be allocated to procedures aiming at reducing mortality and morbidity. This is a political decision, which the

team would facilitate through a review of practice elsewhere and by consulting constituents through a series of public hearings.

Thirdly, the health-care reform team would exhaust the budget for the reduction of mortality and morbidity by selecting the most cost-effective procedures. These are technical decisions involving public health specialists and health economists.

Fourthly, the health-care reform team would allocate the remainder of the budget to activities most likely to reduce suffering and to enhance people's autonomy. These technical decisions would need the support of health economists, medical doctors, nurses, and development specialists.

Fifthly, throughout the process, the health-care reform team would ensure adhesion of all parties to the core health service by holding regular public hearings, including of specific groups such as people with HIV/AIDS.

The output of this elaborate process would consist in a blueprint for a core health service, including cost and financing of its elements. This has been done elsewhere, most recently in Zambia.[30] The development of the blue print has led to a common understanding among a multitude of partners of what services the Government would guarantee to its population. However, the "proof is in the pudding", in this case in the effective implementation of the package.

Why not then define the core health service by trial and error, through the implementation of all its elements at the various levels of the system? Costs and financing possibilities would be assessed on the basis of experience, rather than in theory. This would mean, however, that at least one unit at each level functions effectively, efficiently and in a sustainable manner. A proposal to address this issues contains the following three steps:

1) *From supplying a continuum of care to organizing continuity of care*

We can see in Annex 1 that the Phayao health-care system offers most of the elements that would constitute a continuum of preventive and curative care for HIV/AIDS. The challenge of continuity of care for HIV/AIDS, however, remains that once clients seek HIV/AIDS-related care and support, health services are organized to assist the client in getting the care they need when and where they need it.

Two main measures are required to ensure continuity of care: the reform

of outpatient departments, and the curative upgrading of health centres.

2) Reform of outpatient departments

The curative consultation in the health centre faces unfair competition from the hospital outpatient department. In the outpatient department, the patient gets direct access to a doctor. In the absence of agreed standards of work, the doctor is likely to prescribe more diagnostic tests and more drugs than the nurse at the health centre is. Patients needing admission to hospitals are readily admitted, while those referred by the health centre are screened again at the outpatient department. This situation has serious drawbacks. Outpatient departments tend to be crowded, with adverse consequences on the quality of the contact between client and provider. The health centre is by-passed, its potential remaining untapped. Doctors are overworked treating first-line cases, and have no time to devote to upgrading the quality of the overall system.

3) Upgrading curative care in health centres

To stop overcrowding of outpatient departments, the first step would consist in developing agreed standards of work for first-line contact, whether at the health centre or at the outpatient department. This would assist providers in making the most of available resources at each contact with a client, and in using agreed referral criteria for both health centres and outpatient departments. The consultation with the doctor at the outpatient departments would be phased out, so that these staff are more available for referral care (whether ambulatory or inpatient), and for technical supervision of curative care throughout in outpatient departments and health centres.

Making the health centre the cornerstone of success

To bring Phayao people on the road towards success on HIV/AIDS, and towards better health in general, the health centres need to be reformed beyond what was initially envisaged. Situated at the first line of contact with individual clients, at the interface with the community and close to the Tambon, the health centre is uniquely placed to counsel individuals and communities, provide the care they require, and to catalyse the support from all sectors in response to AIDS. Health centres need real reform, and not the addition of an AIDS component to existing activities. Although justified on the grounds of HIV/AIDS alone, such reform would give the public health system the means for addressing the socio-behavioural

issue characteristic of the turn of this century.

Our original plans for health-care reform

So far, the Phayao Provincial Health Office was well satisfied with the design and organization of health centres. After all, these units have greatly contributed to our progress in achieving primary health-care objectives. The issue seemed rather to make our health centres work better, and to improve urban primary care. Hence, health-care reform has been aiming at: (i) improving overall performance of health centres, and (ii) expanding urban coverage through the implementation of family practice.

The message from HIV/AIDS

There is growing evidence that, while health centres have done a great job in dealing with acute infections which make up the bulk of the case load before the epidemiological transition, it is much less equipped to deal with the socio-behavioural health problems typical of our current health situation. Before that transition, health-centre staff were in control: they could target people (mainly children and their mothers) through effective, mostly preventive interventions. The health centre now has to facilitate health decisions made by individuals, families and communities. They were not conceived and are not organized for such a facilitating role. HIV/AIDS is pointing at the need to reconsider the very design and organization of health centres:

- *People with AIDS are least satisfied with the performance of health centres. This is quite understandable, as we have yet to develop standards of care for HIV/AIDS in health centres. This can only be done however in the context of a general upgrading of curative care standards for health centres.*

- *People with AIDS wish that health centres operated weekends. That they were closed over weekends was understandable given the preventive role formerly assigned to them. This is unacceptable if health centres are to become the gatekeepers of the referral system.*

- *Health centre staff are still kept out of the information loop regarding HIV status of their clients. For instance, all consenting pregnant women are sent to the community hospital for an HIV test. If the result is positive, they are followed at that hospital, and given zidovudine to prevent mother-to-child transmission of HIV. If the result is negative, they continue the prenatal visits at the health centre. As the list of names is kept confidential at the level of the hospital, health centre staff can only suspect that women*

who do not come back for the prenatal care have HIV. Of course, all women who went together to the first prenatal clinic know who has HIV, as the latter women continue their prenatal care at the hospital. Ironically, the measure to protect confidentiality amounts to a public disclosure of HIV status, and disables the health centre to support pregnant women with HIV.

- *A formal mode of interaction between health centre and its (intended) users also needs to be established. In some health centres, self-help groups of people with HIV/AIDS have shown the way. They discuss with health centre staff how to improve the health centre contribution to their well-being, and to the community's response to HIV/AIDS. This is the exception, rather than the rule, and health centre staff need to be trained and encouraged to nurture such interaction with the community about health matters.*
- *The health centre could play a key role in multisectoral action for health. We have seen in section 4 how the province intends to encourage the Tambon Administrative Organizations (TAO) to adopt local strategies in response to HIV. Health centre staff would play a major role in stimulating this process, informing the TAO about the HIV/AIDS situation (while respecting people's right to confidentiality), providing information on the costs and effects of strategic options, and assisting in monitoring implementation. Such a key role could be expanded to various health problems, such as alcoholism, drug use, and teenage pregnancy.*

Excellent health centres

We think that the case is made for a thorough reform of health centres. But how would the reformed health centre really look like? How would its new functions be fulfilled? How would its staffing be organized? Which physical layout would best support its revised mission? No amount of seminars will ever resolve these questions. Only practice will tell. Hence, each district would be transforming each health centre into an Excellent Health Centre, or *"Satani Anamai Dee Tisut"*. The reform of health centres would be done one by one, to allow a maximum of learning of the full operation of the reformed health centre before moving to the next one. As much as possible, the health centre reform would be done in pace with the strengthening of the Tambon Administrative Organization.

Conclusion and next steps

A great learning experience

All participants in the study of health-care reform and HIV in Phayao have learned something. Those of us who thought that the Phayao Provincial Health Office (PPHO) might have had a major impact on the epidemic now know that so far Phayao people have made most of the difference. We all realize now that progress against HIV/AIDS in Phayao, while real, is fragile and even has been stalling for the past few years. Now comes the hard part: making individual and community counselling a matter of course for the whole health-care system, and combining effective support from various sectors to key participants to the response to HIV and AIDS. Initially, we thought that there might be some merit in exploring health-care reform from the angle of AIDS. We now realize that on the road to success on HIV/AIDS, effective health-care reform is a must. We intend to act without delay.

Action without delay

We are decided to start "doing everything" at tambon level to respond to HIV/AIDS. Together with colleagues from other sectors, we shall build on our understanding acquired through the implementation of more than 200 projects over the past three years, to firm up our commitments towards communities and key participants to the response to AIDS. To support tambon level action we shall progressively transform each health centre into an AIDS-competent health centre, able to combine provision of care, community counselling, and catalysis of multisectoral action. To support this health centre reform, we are reorganising the responsibilities for provision and management of health-care among providers and purchasers.

Preparing for the future

Our knowledge gaps have come out very clearly in the course of our study. As we took the decision to exploit existing sources of information, and not to gather additional data, we often have been frustrated in our efforts to understand the epidemic, and the responses to it. We will adopt four complementary strategies to build and maintain our knowledge base: further assess the current situation; equip ourselves to monitor the epidemic and the response to it; address major AIDS-related policy issues; network within Thailand and elsewhere to exchange experience and resolve common issues.

Assessing the Current Situation

Understanding the Dynamics of HIV Transmission

Our capacity to deal with the future starts with better understanding the present. We need to better grasp the dynamics of HIV transmission. What is the distribution of HIV in Phayao villages and towns? Are there geographical factors of vulnerability, making some communities more vulnerable to HIV than others? What is the rate of migration in Phayao? Are women and men migrating less or more, and why? What is the relative contribution of various factors of risk and vulnerability to HIV transmission? How prevalent is the practice of anal sex among Phayao people? How prevalent is injecting drug use? What proportion of current HIV infections are acquired inside and outside Phayao Province?

Getting to grips with costs

We have seen the need to identify unit and total costs of the core health service, including health-care procedures for HIV symptomatic patients. We also saw that patients are charged very different prices, depending on the financing scheme they belong to. These differences in price might just reflect cross-subsidization from users of the more liberal schemes to those of the less liberal ones. However, prescribers might in fact adhere to different standards of care according to the financing schemes of their patients, thereby leading to major inequities in access to care.

Understanding private health care expenditure

To tailor our health-care system to current level of resources, we need to better understand direct health-care expenditures. How much do people spend for health care? So far, we have only access to anecdotal reports from focus group interviews, and to hospital-based data. Every year the Provincial Statistical Office carries out a very extensive economic survey. This survey does not include specific questions about health-care expenditures. We plan to approach the Phayao Statistical Office to propose incorporation of health-care expenditures in their upcoming survey. Given the particular importance of HIV/AIDS in the province, we propose to add to the survey a specific inquiry regarding health-care expenditures by HIV/AIDS patients.

Monitoring the epidemic and the response to it

The study has also highlighted the need for developing a monitoring system of the implementation of the response to HIV/AIDS. We will

develop such a monitoring system, testing a draft instrument developed by UNAIDS for that purpose.

Addressing major policy issues

Revisiting our population policy

In Phayao, so many young people are dying from AIDS that the population may already be shrinking (see Figures 3 and 4). What are the facts? Is the information accurate? If so, is there a need for action? What can be done about it? Would a simple reduction of emphasis on family planning be enough to boost natality? Is there a need to introduce incentives that would stimulate increases in desired family size? What do Phayao people think about it? What policy options are available?

Preparing for the triple therapy

Realizing the key role of people with HIV/AIDS in the solution to the AIDS problem, we are determined to do our part and resolve to start immediately to prepare our health-care system for the eventuality of a combination therapy of acceptable cost and efficacy. The conceptual framework of our proposed action-research is presented in Figure 41 (page 92).[31, 32]

Contributing to global learning and gaining from it

Phayao Province is not alone in its effort to better understand AIDS and its implications for health reform. It can count on exchanges within Thailand and with other countries. It is looking forward to the exchange of experience with other Thai Provinces participating in health care reform.

Moreover, it is looking forward to worldwide interaction with colleagues working on the same issue. At the suggestion of UNAIDS and its co-sponsors, some countries in Asia and Africa[e] are reviewing their Health Reforms in the light of HIV/AIDS. Even in the most affected countries, health systems remain relatively unchallenged by the HIV/AIDS pandemic.[33] Countries have tended to satisfy themselves with the creation of a separate HIV/AIDS programme, while failing to adapt their health systems to the new needs stemming from HIV/AIDS. The UNAIDS *HIV and Reforms for Health Agenda* represents an attempt to resolve that issue. UNAIDS will act as a catalyst, both *locally* to support the review and *globally* to facilitate the interaction among participating countries and disseminate lessons learned.

[e] *Burkina Faso, Ghana, Thailand, United Republic of Tanzania and Zambia*

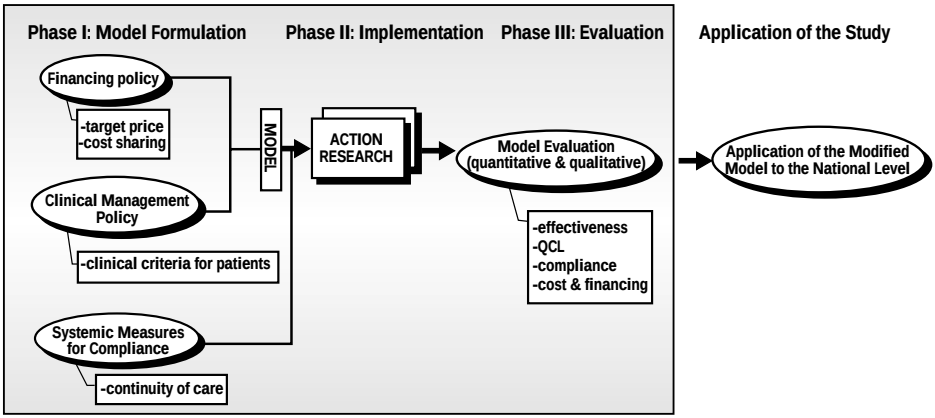
Look at all these figures. Do you think we will ever understand HIV/AIDS from these figures? What we need is to take part in people's lives. To understand what is going on, we will need to use both parts of the brain."

Khun Suwat, Phayao AIDS Action Centre

Combining the two sides of the brain

If we had one last word, it would be to call for balance in our approach to HIV/AIDS. Let us use both sides of the brain, mixing figures with qualitative information. Let us consider both biological factors of risk and social factors of vulnerability. When we work with people, let's use both heart and brain.

Figure 41: Proposed conceptual framework for a feasibility study on provision of antiretroviral combination therapy for HIV-infected patients



Annex 1:
Health-care reform in Phayao

The Phayao health-care system

Phayao Province is equipped with a considerable health-care infrastructure (see Table 10).

Table 10: Health-care infrastructure in Phayao

Government facilities	Private facilities
2 General hospitals 5 Community hospitals 1 Military hospital 88 Health centres 17 Health posts 1 Municipal health centre	1 Hospital 31 Medical clinics 7 Dental clinics 32 Midwife stations 3 Laboratories 45 Drug stores
Health personnel	**Health volunteers**
51 Doctors 13 Dentists 14 Pharmacists 374 Professional nurses 325 Technical nurses 1317 Other	13,960 people

Several village health volunteers live in each village. A motorbike ride to the health centre takes a maximum of a few minutes. For most inhabitants of the province, even the community hospital is close by, and two general hospitals offer a wide range of referral services. In towns, patients can choose between visiting the municipal health centre, the outpatient department of the hospital, or one of the 63 private clinics (31 staffed by a qualified physician).

Health-care workers in Phayao made considerable progress towards primary health-care goals. Many communities in Phayao have reached the standards presented in Table 11.

Table 11: Indicators of basic minimum health needs

Indicators	Target (per cent)
1. Birth weight > 3000 g	70
2. Low weight for children age < 5 years	
Grade 1	< 10
Grade 2	< 1
Grade 3	0
3. Normal weight in children age 6 – 14 years	> 93
4. Households eat cooked food	> 60
5. Households eat ready-made food registered by FDA	> 75
6. Clean houses with good surroundings	> 90
7. Households have and use latrines	> 95
8. Households have sufficient clean water	> 95
9. Households have no pollution	> 80
10. Pregnant women receive ante-natal care	> 75
11. Pregnant women receive birth delivery and postpartum care	> 80
12. Children less than 1 year receive full immunization	> 95
13. Primary school students receive full immunization	> 99
14. Households whose members age >14 years know about AIDS	> 80
15. Households whose members age >14 years know how to prevent HIV	> 80
16. Households receive useful information	> 85
17. Households are safe from accidents	> 60
18. Couples (wife age 15-44) practise birth control	> 77
19. Couples (wife age 15-44) have less than two children	> 75
20. Households are members of development groups	> 60
21. Households have no alcoholic members	> 90
22. Households have no cigarette addicts	> 90
23. Households take care of elderly	> 90
24. Households join environment protection activities	> 90

Statistics displayed in each health facility consistently confirm that progress. The staff is competent and at work. Health-care facilities stand out by their cleanliness and level of maintenance. Essential drugs are readily available.

At the crossroads of need and opportunity

Phayao province, however, left no room for complacency, and decided in 1997 to join four other Thai provinces in the Ministry of Health's Health Care Reform Project, supported by the

European Union (see Box: The Thai national health-care reform).

That decision was based on a combination of need and opportunity: (i) the mismatch is growing between what the health-care system offers and what people need; (ii) economic growth calls for the redefinition exactly what health-care the province can afford; (iii) the growth of the private sector challenges the province in its traditional role of health-care provider. Moreover, dramatic reductions in communication cost make it possible for the province to learn from experience elsewhere as it occurs.

Growing mismatch between health services and population need

The population of Phayao is ageing fast (see *HIV/AIDS in Phayao: the Crisis*, page 14), and its health-care needs are changing accordingly. The health-care system that was designed to deal with acute infections in a young population is now challenged to address those new needs. Socio-behavioural diseases, both old (such as alcoholism) and new (such as HIV/AIDS), are taking a much greater importance. The health-care system has to learn how to deal with those problems, against which there is no "magic bullet", neither treatment nor vaccine. Total fertility rates may now have fallen below replacement levels, through the combined effects of effective family planning and increased infant and childhood mortality due to HIV/AIDS. Again, there is no technological solution to this issue, and the health-care system has to adapt its fertility message and interventions to this new state of play.

Taking advantage of economic growth

Phayao gross provincial product increased 47 per cent in five years, from 5.9 million baht in 1989 to 8.7 million baht in 1994.[f] Total expenditure for health care increased from 41,587,430 baht in 1989 to 236,257,942 baht in 1994. The challenge to the province is to mobilize public and private resources towards the utilization of a core health service: the services that the province can afford, and that would contribute most to health.

A private challenge: inequity of financial access to health care.

While services are geographically accessible, the concomitant existence of four different health-care financing schemes perpetuates major inequities (see Table 12).

[f] *At 1988 constant prices*

Table 12: Annual expenditure of inpatient departments per patient, according to a health insurance scheme[2]

Health insurance scheme	Thai baht
Low income	317
Civil servant	916
Social security	815
Health card	141
Worker compensation fund	421
Private insurance	933

There is an urgent need to harmonize those various schemes. The private health-care sector grew dramatically in the province over the past five years. As many as 38 per cent of the primary health care facilities are now private.

The private sector represents both a threat and an opportunity:

as a *threat*: (i) the private sector might "cream" the health labour market from its best elements, who would cater only for a minority after their move from the public to the private sector; (ii) the private sector might invest excessively in high-tech equipment, and then turn to the public sector for meeting operating costs.

as an *opportunity*: (i) private family practitioners might represent a viable option for the provision of the first level of care in towns; (ii) private clinics might provide an outlet for those who demand services outside the core health service and can pay for it.

The Thai national health-care reform

Most countries initiate reforms of their health care systems during an economic downturn. Such reforms, for example in the US, South Korea and Chile, have focused on major administrative changes that would cut costs without prejudice to the quality of health services.

Thailand actually launched its health care reform before the current economic crisis set in, but recent events have certainly added momentum to it. Practically speaking, the aim of the reform is twofold: to establish a nation-wide health insurance system and to strengthen primary health-care across the country. So far, five provinces (Ayudhya, Yasothorn, Khon Kaen, Phayao and Songkla) have volunteered to carry out reforms in health-care and two of these are reforming their health-care financing on a pilot basis. -->

Health-care financing reform

Health-care financing reform is expected to contribute greatly to the efficiency of the Thai health-care system. Currently most patients pay a fee for the service provided directly to their hospital. This payment mechanism incites hospitals to provide more services and medicines than really necessary, thereby reducing the efficiency of the whole system and the affordability of the services it supplies. Following the reform, service providers will be paid on the basis of the number of people registered with them and of diagnoses made.

Health-service system reform

The Thai economic boom of the past eight years has mainly benefited hospital development, while primary health-care facilities have only received a little attention. For all illnesses people go directly to hospitals, which are often overcrowded and provide services at a higher cost than is necessary owing to high overheads.

However, strengthening primary medical-care facilities can be an effective way to lessen the workload of hospitals while decreasing costs for patients. Local and small-scale health-care centres are less crowded than the larger hospitals and therefore provide services at a reduced cost. The reform should transform the way primary health-care is delivered. New methods to ensure the continuity of care such as the registration of the patients with the provider of their choice, a change in the record system, home visits, follow-up of the patients who have been referred to the hospital. The prevention and the promotion will be totally integrated to the curative care at this level because the centre will have the responsibility for the line facility level. The more personal service usually improves the climate of confidence between patient and doctor or nurse and increases the efficiency of care. Such centres are only effective, however, if education and training of staff is of a high standard and if there are positive financial incentives for the patients. It is envisaged that such primary health-care centres would provide basic health-care services, while patients would still be referred to hospitals for special examinations or special treatments.

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Capacity building of people and communities

Services that affect people's everyday life can only be a success if they are developed and carried out in co-operation with their users. This is undoubtedly true in the case of health-care. Beneficiaries or potential beneficiaries of health-care services should be able to shape these services to make sure they correspond to their needs. One way of achieving this is to promote consumer choice in selecting individual and family health service facilities. Another way is to include community representatives in advisory or decision making bodies taking care of the health service management of communities. The Health Care Reform Project will help to implement both these methods.

The health-care reform plans

An overview

The Phayao provincial health-care reform plans are summarized in Table 13.

Separating purchasers from providers.

A particularly important reform now under consideration is the separation of purchasers and providers. Today, doctors do not consider technical supervision of the health centre as their job. Rather, that is the job of a public health nurse and his/her team. That team is very competent in the programmatic areas of traditional primary health care, such as immunizations and family planning. However, it has little to offer to upgrade the health centre in curative care, and in the required shift from controlling disease to facilitating community responses to health problems.

To address that issue, the Phayao Provincial Health Office plans to divide health workers in the civil service into two groups: purchasers and providers. *Purchasers* would consist of some members of the current provincial and district health offices. In each district, public sector providers would be organized in one team. *Providers* would be accountable for the quality and coverage of a specified population by the core health service. Purchasers would negotiate the core health service, offer technical resources to enhance quality and coverage, audit quality and coverage data, ensure adequate flow of information between users and providers at individual and collective levels, and serve as brokers in case of conflict. Providers from the

private sector would be encouraged to join the scheme: they would agree to adhere to those standards of work relevant to family practice.

Table 13: The Phayao provincial health-care reform plan

Scope	**Activity**
Development of essential elements for health-care reform	
Development of the core health service	**Defining the services that Phayao people can access without any barriers**
Development of quality control system	**Defining the standard of care and the system ensuring the quality of services**
Development of management information system	**Design the information system to be utilized for management and services units**
Human resource development	**Training various categories of personnel**
Development of service providers units	
Health centre development	**Reorganising the services corresponding with the core health service and local health problem**
Drug stores development	**Involving drug stores in provision of qualified services**
Private clinic development	**Seeking modes of co-operation between private clinics and the public sector**
Community and general hospital development	**Reorganising the services system aiming at better quality and more efficiency**
Development of administrative units	
District health office development	**Determining the health service provider functions and reorganising the office accordingly**
District health co-ordinating committee development	**Determining co-ordinating roles between health service purchasers and providers**
Provincial health office development	**Determining the health service purchaser functions and reorganising the office accordingly**
Evaluation	**Assessing the healthcare reform process and its impact on health status of Phayao people**

Annex 2:

Framework used to analyse the response to HIV/AIDS in Phayao province

The private response

Whether people respond to HIV/AIDS effectively depends on two main factors: a) the biological factors affecting their specific risk of acquiring HIV, and, once infected, to keep the virus under check, and b) their capacity to avoid risk situations, and, once affected, to mitigate the impact of HIV/AIDS.

Factors affecting the probability of HIV transmission include: i) the virulence of particular HIV strains; ii) the presence of STDs in one or two partners, which can increase the risk to ten percent and more; iii) the transmission route, where the risk of transmission through anal sex is much higher than through vaginal sex; iv) whether the male partner is circumcised or not, as circumcision reduces the risk of HIV transmission; v) personal resistance, as the evidence is growing that a minority of individuals resist multiple exposures to the virus. By the same token, people with HIV depend on a range of biological factors that determine the outcome of their infection.

Figure 45: Risk and vulnerability factors and the response to HIV/AIDS

Protection	*Reduce risks*	*Reduce vulnerabilities*
Whether HIV positive or HIV negative	use condoms when having casual sex reduce anal sex practices have concomitant std treated use clean needles (in the case of injecting drug users)	enhance economic opportunity reduce alcohol consumption enhance self esteem reduce drug use

People are more or less vulnerable to HIV, individually and collectively. Their capacity to respond to HIV depends first on their knowledge of HIV/AIDS. That knowledge, however, is not the only factor involved. In strong communities, people value mutual fidelity, men and women have equal status, are independent from alcohol and drug addiction, and have their basic needs met. Seasonal migration is less prevalent, or takes place in couples. Men may have affairs, but don't visit sex workers. Maybe most importantly, in strong communities, people are ready to face problems, analyse them, and act on them. This may lead to rapid adaptation of local cultural values, and translates in

behavioural change. Conversely, in vulnerable communities, people attach less importance to mutual fidelity, women have a lower status than men do, and consumerism combined with poverty leads them to trading sex. Maybe more importantly, weak communities do not assess their problems and act on them, but attribute suffering and death to causes beyond their reach. They tend to adhere to cultural traditions and maintain corresponding behaviours even when they become harmful in the new situation created by HIV/AIDS. By the same token, several factors influence the degree to which HIV affects people and communities.

Once they are faced with the reality of AIDS, (whether through information or through the direct experience of disease and death) people respond. They resort to their networks of relatives, friends, and communities to obtain additional information and adapt their behaviour to the new situation. For instance, men migrating for work might take a partner with them; some people may stop drinking alcohol; men might stop visiting sex workers, but have a second wife instead. Other men might have anal, rather than vaginal sex, thinking that this practice might be safer practice. They might also exploit the services of younger and younger girls. Families affected by AIDS might draw girls from schools to attend to the sick relative; they may shift agricultural production from labour intensive crops to less intensive crops. All these changes combined can be called the "community" or the "private" response. It is the response by people in their private capacity.

The response by institutions

The private response to HIV/AIDS is imperfect. Communities left on their own are unlikely to be totally effective in dealing with AIDS and in mitigating its impact. They need information (such as the high transmission rate of HIV through anal sex) and supplies (such as tests and condoms) which they cannot mobilize on their own. Some factors of vulnerability stem from policies (such as job discrimination, which lead women with HIV to return to sex work as their only option to earn a living) that are beyond their immediate control. Hence the need for an institutional or organized response. Public and private organizations can provide services and ensure a supportive policy environment to the community response.

Provision of services

Private and public institutions can provide services that modify risk of their clients or constituents in various ways. For instance, health-care institutions can treat STDs, treat opportunistic infec-

tions, prevent transmission through blood, and prevent mother-to-child transmission of HIV. A whole range of public and private institutions can distribute or sell condoms. Schools can provide information about HIV transmission, and teach the appropriate use of condoms.

Private and public institutions can also provide services that modify vulnerability of communities and their members. A few instances follow. Health-care institutions can put in place testing and counselling facilities. Schools can put in place life-skills programmes, while non-governmental organizations can reach out-of school children. Churches and government services can help modify harmful traditional values and related practices. Community extension workers can assist communities in assessing their own factors of risk and vulnerability, and in developing their own response; welfare agents can help poor families through the difficult period when they lose their income earner.

Policies

Through their policies, private and public institutions affect people's risk and vulnerability to HIV, either positively or negatively.

Through a hospital handling corpses of people with HIV as though they were carrying a risk of HIV transmission reduces the community's understanding of HIV, and hence its capacity to respond.

Monks refusing men with HIV into monkhood put a stigma on people with HIV, even if their individual behaviour may not have been different from that of the community in general. That stigma, in turn reduces the capacity of the community to assess the situation objectively, and act on it. Churches condemning condom use increase the risk of HIV transmission even within married couples. By saying that condoms are ineffective in resolving the AIDS problem, they turn away people from its use, without providing any viable alternative for discordant couples, for sex workers, or for people who are unable to be 100 per cent faithful to their spouse or remain abstinent before marriage.

The government response

Private and institutional responses are greatly influenced by Government policy, whether these policies are geared towards AIDS or not. Leadership, fiscal policy, laws and regulations are inalienable roles of Government.

Leadership

Only Government can exert the necessary leadership to face the facts, create the debate that is essential for adopting a national strategy, orient all partners according to that strategy.

Government can also weaken the response by the promotion of factually incorrect messages. For instance, a campaign focusing exclusively on "risk groups" gives a sense of false safety to many people who do not identify with those groups.

Fiscal policy: subsidies and taxes

Only government can subsidize those activities that benefit the community at large: the treatment of STD's, the distribution of condoms, counselling and testing services, and training of staff.

Governments that grant subsidies to the beer industry thereby increase vulnerability of consumers; those that tax beer consumption reduce vulnerability.

Law and regulation

Government can use its legal instruments to protect the rights of both infected and uninfected persons. It can make it illegal to exclude someone with HIV from the workforce; it can also make it a crime for men to have sexual relations with under age girls, or for people diagnosed with HIV to have unprotected sex without the knowledge and consent of their partner. It can also mandate testing for HIV at the entrance to university, or before conscription in the army.

Government can also take measures that enable the social sector as a whole. Governments can modify legislation that discourage marriages, or modify inheritance laws to protect widows and their children. It can take measures to strengthen the status of women, or decentralize the management of sector operations, to enable them to be more responsive to local needs and facilitate multisectoral action.

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

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