

The Evolution of HIV/AIDS Policy in Thailand: 1984-1994

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Table of Contents

Preface.....	iii
I. INTRODUCTION.....	1
II. POLITICAL CONTEXT FOR HIV/AIDS POLICY IN THAILAND.....	3
III. NATIONAL HIV/AIDS POLICY AND SELECTED OUTCOMES.....	19
A. National HIV/AIDS Policy Coordination.....	19
B. Other Manifestations of Thailand’s HIV/AIDS Policy.....	24
IV. ROLE OF THE NON-GOVERNMENT ORGANIZATIONS.....	32
A. NGO Participation.....	32
B. Participation of Private Business Sector.....	33
C. Role of Religious Institutions.....	35
D. Women’s Development Groups.....	36
V. SYNTHESIS AND LESSONS.....	37
References and Informants.....	42

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Preface

In an effort to understand factors that influence national HIV/AIDS policy development, AIDSCAP commissioned a review of the experiences in Thailand over the past 15 years. The country is recognized for its achievements in HIV/AIDS prevention and control. Those programmatic achievements were strongly influenced by the policy climate in several administrations and by policy initiatives taken both before and after programs were in place. The report gives special attention to the “triggers” to policy action. However, the “triggers” were less single events, than accumulated pressures shaped by the national political framework.

As the authors of this report make clear, it was only early in the 1990s that an aggressive HIV/AIDS prevention program emerged in Thailand. Prior to that time, the resistance to open discussion of the epidemic from tourist business interests, incomplete surveillance data, and stereotypical labeling of “AIDS” risk groups allowed the epidemic to extensively penetrate the population. National policy responses were strongly influenced by the political structure and expectations of several governments.

Similar reviews of policy development in Brazil and Kenya are planned, as well as a summary that draws lessons from the three national experiences. Together, these national case studies will fill a major gap in our understanding of processes, events, issues and pressure groups which have informed and influenced the direction and scope of the policy responses to HIV/AIDS.

The original version of this study was published in Thai. Tony Bennett of AIDSCAP’s Asia Regional Office in Bangkok translated the original. Richard Bernstein added information to the English-language version. We appreciate their efforts to provide an English-language version of the report. The table on budgetary allocations to HIV/AIDS prevention was added by AIDSCAP’s Policy Unit. The graph on HIV prevalence rates among women and army recruits was originally developed by AIDSCAP’s Asia Regional Office and has been adapted for use in this report. Minor editing has brought the text into conformity with AIDSCAP procedures.

I. Introduction

It is expected that, with as many as one-third of the world population residing in South and South East Asia, the HIV epidemic of this region could expand widely. Though it remains difficult to estimate the absolute number of HIV-positive persons and AIDS patients, it is possible to confidently forecast a worsening epidemic in South and South East Asia.

There are not many countries in which the governments easily accept the presence or potential of HIV and responds by quickly setting up an effective national AIDS policy. As of the mid-1990s, Thailand was one of the few countries to have both a solid set of policies and a national prevention program, although, initially, the country had been slow to respond.

Thailand's AIDS Control and Prevention Program is recognized by the international community as one of the largest efforts in terms of government per capita budget allocation for prevention, the very wide coverage of the program and the high-level of political support. While others have described various aspects of the policy evolution and response (Rojanapithayakorn, 1994; Ungphakorn and Sittitrai, 1994), there remains a need to examine some of the "triggers" which led to certain policies and to describe the lessons that are applicable outside the Thailand setting. This report was conducted to fill this gap in the analysis of the Thai case. In particular, the report seeks to identify events, activities and structural forces which have shaped and impeded the public policy response to HIV/AIDS in Thailand.

Methodology

Printed technical documents, newspapers, and key informant interviews with policy makers and implementing level administrators, technical experts, researchers, NGO leaders, and representatives from private business all contributed to the development of this report.

The present study is unique in that the investigators conducted interviews with many of the key players when Thai AIDS policy was, and was not, formulated. Key informants were assured that their comments would not be ascribed to them by name so that they could speak frankly. However, the list of persons who served as key informants is shown in an Annex. A total of twenty key informants were interviewed.

Content

Following this introductory chapter, Chapter II provides an analysis of policy developments, using the framework of the five governments from 1982 through 1995 as a structural guide. Chapter III analyzes policy as an operational manifestation of resolutions, laws and directives. Chapter IV describes the role of non-governmental organizations, business, religious and women organizations in shaping both sectoral and national HIV/AIDS policies. Chapter V offers a selection of lessons from this analysis which should be applicable to other settings outside the Thailand case.

II. Political Context for HIV/AIDS Policy in Thailand

There are many steps and levels involved in the policy formulation process in Thailand. Policy may be initiated by the Premier or the ministers in the cabinet. Members of parliament may also introduce legislation or resolutions. Individuals or external agencies can help provoke new policies and the abolition of old policy. The policy environment in Thailand has changed since the first case of HIV/AIDS was reported in 1984. One way to describe these changes is by the responses of the different governments that held and relinquished power before and during the Thai HIV epidemic.

This historical presentation of HIV/AIDS policy development is divided into four periods according to political administrations: Prem Tinsulanonda (1984-88), Chatichai Choonhaven (1988-91), Anand Panyarachun (1991-92) and Chuan Leekpai (1992-95). Organizing the events in this way exhibits the differences between each government and how these variations affected policy development. In general, the policy progressed from being non-existent in 1984 to the comprehensive national AIDS prevention and control program that began to take shape in the early 1990s. Too many people, this progression by which the country's HIV/AIDS policies evolves seems quite natural but, in fact, various elements were responsible for the pace and intensity that the policy matured. The main factors affecting policy were the nature of the political system, participants' involvement, and the spread of the HIV/AIDS epidemic.

Each of the administrations operated in dissimilar political environments. The leading politicians had much greater impact on policy during the less democratic periods of Prem and Anand, because they were not excessively constrained by democratic obstacles. In the Prem period, the spread of HIV/AIDS was still relatively minimal and proponents of AIDS policy development did not have access to the government. Therefore, policy development was limited to some basic measures. During the Anand period, there were clear indications of the epidemic's rapid spread. The administration operated in a political environment free of democratic constraints and AIDS activists were included in the government. Consequently, the Anand government was able to develop policies and enact programs more rapidly than the other administrations. In contrast, the elected governments of Chatichai and Chuan were multi-partied coalitions and the demands for policy development had to weather a complicated policy making process. Policy approval required support at each step of the process. Systematically, AIDS policy development could be blocked at any point in the policy making process.

Prem's political base in the army and position was powerful and government policy generally followed his leadership. Anand, too, was able to proceed with his own agenda without having to worry about party politics or significant opposition from other participants. Both Prem and Anand had the luxury of choosing their political successors. Of course, the opportunities for diverse participation outside the small circle of cabinet

members and political advisors was reduced under these governments. On the other hand, a prime minister in a weak coalition government, such as Chuan, and to a lesser degree Chatichai, was unable to rapidly execute policy, because members of parliament were not necessarily accountable to the prime minister or his party. Chuan and Chatichai also had less input in choosing political appointees because these positions were divided up between the many political parties that made up the coalition governments.

Prime Minister Prem Tinsulanonda (1982-1988)

General Prem Tinsulanonda was appointed Premier from his previous position of Army Commander. He governed the country for six years and five cabinets. This was a period when the Thai government had a strong national policy to restore and develop the country's economy. In that task, it has support from the business sector and the military. The Prime Minister had more decision-making authority than in other governments. In 1984, the first case of AIDS in a Thai was reported. Although most certainly infected while living abroad, this case at least dispelled any myth that the Thai race was immune to HIV.

Policy Developments

Early in the Prem period, development of AIDS policy was in its infant stage because HIV/AIDS had not begun to spread rapidly in Thailand. As evidence surfaced which indicated that the epidemic was taking root in Thailand, there was a limited amount of external pressure on Prem to respond to the AIDS threat. However, proponents of AIDS policy development had little access to the government. In the government, apart from some individual researchers and officials in the Ministry of Public Health (MOPH), few acknowledged the coming epidemic during the initial stage. However, these early proponents of policy development were able to take some basic measures that set the foundation for future programs and policies.

Although there was little evidence that an epidemic was imminent, in 1985, the MOPH took some initial measures to deal with the AIDS issue. On May 1, 1985, the MOPH issued Ministerial Announcement Number 2, under the Communicable Diseases Control Act (1980), to classify AIDS as a reportable disease. There followed the establishment of the Registrar of Reported AIDS Cases (AIDS Registrar) under the responsibility of the Division of Epidemiology. Also, in August 1985, a National Advisory Committee on AIDS, the forerunner of a Thai National AIDS Committee (NAC), was established in the Ministry of Public Health. It was chaired by the Director-General of the Department of Communicable Disease Control (CDC).

In 1987 the government's stated position concerning AIDS was that it recognized the possible dangers, was taking the appropriate measures, and did not want to cause an over-

reaction by the public. Many of the first cases occurred among homosexuals and foreigners. The idea that AIDS only affected marginal populations was promoted by government representatives. The disease was blamed on foreigners, intravenous drug users (IVDUs) and homosexuals, and activities carried out by the government were targeted toward these communities. Once HIV/AIDS became associated with these groups, it was very difficult to alter these perceptions.

To protect the blood supply the MOPH added the regulation that convicts and IVDUs must be tested for HIV if they wanted to give blood (*Bangkok Post*, 1-20-87). By mid-1987, additional objectives aimed at combating HIV/AIDS were being advocated by the government, including reducing exposure to the HIV virus in the gay community, testing high-risk groups, and requiring foreigners entering the country to have AIDS-free certificates.

At this point, the Thai government's AIDS educational focus was limited to commercial sex workers (CSWs), primarily male; the general public was excluded from the information campaign until significant evidence warranted that action. Furthermore, the belief that AIDS was a foreigner's disease led to attempts at regulating the movements of tourists.

Critics argued that it was clear from these objectives that the government did not understand the parameters of the disease or its threat to Thailand (*Bangkok Post*, 7-29-87). The screening of foreigners was seen as a response by politicians to be seen doing something to confront AIDS. However, these measures may have given the country a false sense of security (*Bangkok Post*, 8-11-87).

The media and activists were particularly quick to point out that the development of policy was delayed through much of 1987. The media also claimed that early public education efforts were ignored--some say suppressed--by government fears about adverse effects on foreign tourism. Others believe that not only did the government fail to acknowledge the potential crisis, but efforts to promote tourism by selling sex were intensified. The Tourist Authority of Thailand (TAT), the responsible agency for promoting tourism, has been frequently blamed for placing financial objectives over social issues (Srisang, 1990).

Even as a few dozen Thai and foreigners died from AIDS in Thailand--including commercial sex workers and homosexuals--the magnitude of the AIDS threat was discounted. From the Prime Minister on down, the government and its representatives continued to down play the potential impact of the disease. Prem responded to inquires about AIDS by dismissing it as being "just like any other disease."

Late in 1987, the Ministry of Public Health started to alter its stance. It recognized that HIV/AIDS education campaigns were necessary but still warned that Thais should be prepared for a reaction of panic similar to that which occurred in the West. Thailand's National AIDS Programme began in 1987 following a cabinet decision to develop a national response to the epidemic. In October 1987, the MOPH created a "Centre for Prevention and Control of AIDS" at the division level, under the Department of CDC. This Center would eventually become the national AIDS Division during the Chatichai government, replacing the Venereal Disease Division. The composition of the National Advisory Committee on AIDS was revised in November 1987 to include health administrators, lawyers and technical experts. The responsibilities of this committee were to coordinate activities and foster cooperation among the institutions concerned in the prevention and control of HIV/AIDS, to give advice on research issues, and to appoint ad-hoc committees to study specific critical issues (Prasert, 1989).

A major development in 1988 was the implementation of a short-term HIV/AIDS program. It received technical and financial support from the World Health Organization (WHO). In August 1988, the cabinet approved the *Medium Term Programme for the Prevention and Control of AIDS: 1989-91* which the CDC and the MOPH were responsible for developing (MOPH, January 1991). Other measures that were being implemented in early 1988 included: providing information to IVDUs in drug rehabilitation clinics; discouraging IVDU use; encouraging condom use; urging HIV carriers to discontinue giving blood and having sex; and preparing facilities to treat HIV carriers who were addicted to heroin (*Bangkok Post*, 3-31-88).

During the first half of 1988, testing of IVDUs in Bangkok revealed an exponential increase in the number of HIV infected persons. However, Prem never publicly recognized the threat of the epidemic and it would not be until the start of the Chatichai administration in August 1988, that the government intensified policy development efforts.

The Thai government's financial commitment was negligible in the Prem period as its actual contribution was only US \$180,000 in 1988. In comparison, the WHO donated US \$500,000 in support of the short-term plan against HIV/AIDS which it helped design (AIDS Division 1993). In fact, until 1991, the majority of funds were from external sources, including international organizations (WHO and UNICEF) and bilateral aid (such as USAID) agencies.

Policy Development Process

Prime Minister Prem Tinsulanonda had the ability to greatly influence policy since he held nearly dictatorial powers and had a strong power base in the Army. Until the last year (1988) that Prem was in power, only a handful of persons had reportedly been infected

with HIV and there was little knowledge of the parameters of the disease. While the Prem Government was in power, AIDS was one of many issues vying for government recognition and action. Economic development was considered the utmost priority. The conditions necessary for raising the AIDS issue to a high policy level did not exist.

In the Prem period, the most obvious indicators of the AIDS problem were highly publicized dramatic events, such as the discovery of the first HIV-infected persons, rumors of HIV infection in celebrities, and the discovery of a large number of HIV infected persons in Bangkok jails. Although HIV testing results became increasingly available, there was not an established system of testing, and much of the initial demand for tests were from "worried well" men of Bangkok who had had an STD in the past. The ad-hoc testing results and dramatic events were not considered significant indicators for additional government action. The number of infected persons was limited and furthermore, the marginal nature of the communities that the infected persons belonged to did not allow them an opportunity to voice their opinions to the government. Consequently, HIV/AIDS was defined as a problem limited in nature and not a national priority.

Prime Minister Chatichai Choonhaven (1988-1990)

After Premier Prem Tinsulanonda dissolved the legislative body in 1987, the next Prime Minister, Chatichai Choonhaven, was appointed by election. His was a coalition government in which each party had its own policy. Hence, to integrate the policies of each party to form national policy took time. Formation of laws from regulations was a long process and complicated because of the dual oversight by the House of Representatives and Senate. This was a period characterized by internal and external political pressure as well as pressure from private business.

Chatichai Choonhaven's government developed policies to promote economic development by promoting tourism, domestic investment, and export businesses. It was a period of rapid economic growth and expanding foreign relations. At the same time, it was a highly competitive international trading period. Movement of the population in the peak employment ages increased greatly.

During the Chatichai Period, both the HIV/AIDS epidemic and policies aimed at controlling the disease transformed rapidly. Initially HIV infection was limited to the "marginal" or "high risk" groups, but by the end of the period infection in the general populace was evident. Policy developments and increased budget allocations followed. The government's position shifted from one that closely guarded relevant information towards

"Thai businesses were heavily involved in the government at that time. The general mood was to avoid discouraging investment and tarnishing the image of the country."

--- Government official

one of recognition and openness. However, a more rapid transformation was stalled by obstacles in the legislative process and by key participants who struggled to keep AIDS publicity at a minimum. Although no supporting documentation exists it is plausible that in both the Prem and Chatichai governments high-level cabinet pressure was brought to bear on the MOPH not to publicize the emergence of increasing HIV in the population.

During this period, the AIDS committee in the MOPH was up-graded several times and became a national committee in 1990. The advent of a bona fide NAC helped strengthen the AIDS Division, as the secretariat of the NAC. The Division was given a modest operating budget and was authorized to recruit staff for a greater number of permanent, civil service positions.

This government, however, had numerous conflicts with the military which led to a coup d'etat in February, 1991.

Policy Developments

During the Chatichai Administration, a rapid spread of the epidemic occurred. In 1988, Bangkok IVDUs became the first population to have high levels of HIV infection (over 40 percent); in 1989, there was a burst of infection among northern CSWs; and by 1990 there was clear evidence that HIV was diffusing into the general population of Thai men and women. Policies aimed at combating the epidemic were developed. During the Chatichai period, the AIDS issue was addressed at a high level in the government's decision making process. A substantial increase in funding to the national AIDS program by the government in 1990 reflected the growing commitment. Nonetheless, the prime minister stopped short of giving his unconditional public support.

The major policy developments of this period were the implementation of a medium-term program and implementation of the sentinel surveillance system. Other significant achievements included testing blood donations, behavior change communication interventions targeted toward CSWs and IVDUs, and condom promotion and distribution.

At this time, the MOPH was the central agency responsible for coordinating the national AIDS program. It was instrumental in choosing from the various policy alternatives and in implementing policy. There were also notable improvements in the coordination of efforts between agencies.

For the most part, however, the national measures of the MOPH were narrow in scope and limited to legal and medical solutions. The major proposed legislation, the so-called "AIDS-bill," planned to use classical contagious disease control methods such as confinement of infected persons and mandatory testing. For example, the rationale proposed for establishing "therapeutic communities" for infected persons rested on CDC

principles similar to those used in controlling a communicable disease such as leprosy; that is, to quarantine infected persons or exclude them from many "normal" activities. Another proposed methodology was to regulate CSWs through issuing "AIDS-Free" cards. In August 1989, the Ministry of Interior issued Ministerial Announcement Number 11 which added the AIDS issue to the Immigration Act (1979). The aim of this amendment was to prevent foreigners with HIV from infecting Thais by barring their entry into the kingdom and by deporting infected aliens from the country (Prasert 1989).

As the epidemic continued to spread rapidly in Thailand, studies, both independent and governmental, were made public. A major policy development occurred in June 1989 when the Epidemiology Department of the MOPH conducted its first sentinel surveillance survey. As a consequence of implementing the surveillance system and publicizing its results, many observers recognized that government policy was becoming more progressive. Moreover, making public the sentinel surveillance results paved the way for a greater acceptance of the domestic HIV/AIDS problem.

As HIV/AIDS spread among the CSW population, government agencies began implementing programs aimed at controlling the epidemic in the brothel environment where HIV prevalence was highest. Various models of condom-only policies were being tested at the provincial level in Chiang Mai, Ratchaburi and Khon Kaen. Eventually, the Ratchaburi model became the national strategy for making condom use the norm in commercial sex establishments. The strategy was implemented in province after province by forming a political network between the provincial governor, brothel owners, police officers and health officials to address the issues of commercial sex, condom use and empowerment of women. The campaign targeted CSWs and their clients as a major group of HIV carriers and condoms as an effective protection against infection.

The latter half of 1989 also marked a turning point in the development of HIV/AIDS policies as key participants joined in publicly promoting more advanced and candid measures. With the knowledge that the government was becoming more liberal in its attitude towards the development of policy, prominent activists inside and out of the government lent their credibility and prestige to the anti-AIDS campaign. These participants were able to raise awareness and initiate change. They were joined by a growing number of NGOs that became involved as HIV infection spread into the communities in which they were operating and due to concern over human rights issues. International organizations remained instrumental in providing technical and financial support--the majority of funds continued to be external in origin. The media also played a vital role in educational efforts, raising awareness and as a mouthpiece for other participants to voice their opinions.

Another major landmark in the maturation of HIV/AIDS policies occurred when Thailand became the first Asian nation to begin implementing a comprehensive medium-term plan,

covering the years 1989-1991. The plan followed WHO/GPA's guidelines, including provisions for incorporating internationally-agreed policies and strategies to protect individual rights. It also sought to avoid the discrimination of individuals belonging to population groups associated with AIDS, and infected persons, their families and friends (CDC, 1989). The medium-term plan included measures for program management, health education, counseling, training, surveillance, monitoring, medical and social care, and laboratory and blood safety control. The plan was intended to provide a working framework for government, NGOs and private initiatives (*Bangkok Post*, 3-30-90).

In September 1989, Chuan Leekpai, then the Minister of Public Health, became one of the first Thai politicians to publicly recognize the need to repress the sex industry. His proclamation stunned the country and the sex-entertainment industry (*Far East Economic Review*, 11-2-89). As Chuan began publicly releasing statistics, the tourism industry reacted emotionally and exhibited strong opposition. In fact, TAT head, Dhamnoon Prachuabmoh, suggested that Chuan and the Hat Yai business community keep their argument quiet so as not to hurt tourism and while on a European tour, Prime Minister Chatichai announced that HIV/AIDS was not a problem in Thailand. (*Far East Economic Review*, 11-2-89). Although, the Chatichai Government received some credit for the shift in AIDS policy, particularly for the development of the medium-term plan, Prime Minister Chatichai received more attention for continually refusing to publicly commit to fighting HIV/AIDS as a top government priority.

Nonetheless, on October 31, 1989, the cabinet elevated the AIDS Prevention and Control Programme to an operation to be conducted on a national level (MOPH, November 1991). On February 22, 1990, the Committee for AIDS Prevention was upgraded and renamed as the "National AIDS Committee for AIDS Prevention and Control." The Minister of Public Health was named chairman and the Director-General of the CDC became its secretary (MOPH, November 1991).

Although policy had become more open, HIV/AIDS was still considered solely a public health problem and statistics were held tight. In addition, there were other indications from the government that policies were still in a period of transition. For example, in mid-1990, it was revealed that the MOPH had issued a directive that provincial public health offices prevent the number of AIDS cases from rising over prescribed limits. Although the stated purpose of the directives was to control HIV/AIDS, others believe that its more likely aim was to suppress the facts and limit publicity. Thus, despite the signs that the policy was maturing, clearly the changes were slow and uneven.

It was not until January 1991--shortly before being ousted from power--that in a statement on health policy, Chatichai announced that the official campaign to control and prevent HIV/AIDS would be regarded as national policy. The Prime Minister said that the matter would receive urgent and high priority. The media described the announcement as the first clear-cut government policy stance to combat HIV/AIDS (*Bangkok Post*, 1-10-91).

Chatichai also added that the government would see to it that all relevant agencies, in both the public and private sectors, seriously and continuously battled the virus. Subsequently, an advisory committee to the prime minister on AIDS was set up. The committee was responsible for making policy recommendations to the prime minister and recommendations for broad scale interventions that could be channeled through the ministries of Interior, Defense, Education, Industry, Agriculture, and others (AIDSTECH, 1991).

Financial commitment on the part of the government reflected the change in policy. The Thai government allocated US \$ 400,000 to the MOPH in 1989 while international donors increased their support to US \$3.74 million (MOPH 1993). Finally in 1990, as a reflection of the policy changes occurring in 1989, the government increased its financial commitment to US \$2.63 million. However, foreign donors still contributed the majority of funds, or US \$3.34 million (AIDS Division 1993).

Policy Development Process

During the Chatichai government a rapid change in the environment surrounding the AIDS issue occurred as the epidemic, and the policies developed to control it, transformed swiftly. The Chatichai administration's financial commitment to combating the disease increased significantly. There were also signs that the administration was getting closer to publicly recognizing HIV/AIDS prevention and control as a top government priority shortly before Chatichai was ousted from power.

Chatichai had great skill in commanding public attention, but he was not as strongly entrenched as Prem. Prime Minister Chatichai's government was a multi-party coalition in which divergent views of numerous political parties had to be considered. Furthermore, the process of transforming legislation into law was lengthy and difficult. Within this process, there were many possibilities for the fragmentation of policy making. The division of authority not only included the different political parties but also two houses of parliament. In this democratic period, a growing number of participants both inside and outside the government began to gain influence and prominence while pushing for more progressive HIV/AIDS policies. However, impacting government policy was difficult due to the numerous steps involved in the democratic decision making process.

Prime Minister Chatichai was also faced with various demands from politicians as well as bureaucrats. The ministers were political appointees, many of whom had little knowledge of the issues at hand; public health concerns often became subordinate to political concerns. Leaders in Chatichai's government may have been concerned with the negative impact that HIV/AIDS publicity would have on the nation's reputation. In addition to those advocating changes in the government's position, there also remained a significant

number of interests that supported a limited and less publicized approach to the HIV/AIDS dilemma.

On the other hand, it was much more difficult for Chatichai, than Prem, to ignore the HIV/AIDS issue because of greater public awareness about the epidemic. Although some people believe that there were conscious efforts to suppress facts concerning the spread of the epidemic, the data from serosurveys had begun to surface by 1988. The national sentinel surveillance system provided the necessary indicators for bringing the problem to the attention of policy makers. In addition, dramatic news such as the rapid spread of HIV into the CSWs populace attracted high levels of media coverage. There was also feedback from established programs within and outside the government that indicated the types of problems that needed to be addressed. Nonetheless, problem recognition was limited by government reporting practices that did not fully disclose all of the available information, and at times, down-played the significance of the information.

Prime Minister Anand Panyarachun (1991-1992)

Anand Panyarachun, a successful technocrat out of the business sector, was selected (by the military) to serve as Premier in early 1991. A temporary government, Anand I (March 1991 - April 1992) was formed to reduce political apprehension and to complete the revision of the constitution within one year. Anand quickly gained stature as a leader by initiating brisk changes--many seen as progressive.

A draft of the new constitution was completed during the second phase of Anand's tenure (May-September 1992) and general elections were held in September 1992.

Policy Development

The appointment of Anand Panyarachun as Prime Minister proved to be one of the single most important events that precipitated a rapid development of HIV/AIDS-related policies. Anand quickly became involved with the HIV/AIDS issue and by July had agreed to serve as Chairman of the National AIDS Committee, with the Minister of Public Health serving as NAC Secretary (MOPH, November 1991). Anand promoted an atmosphere of openness and full recognition of the HIV/AIDS dilemma.

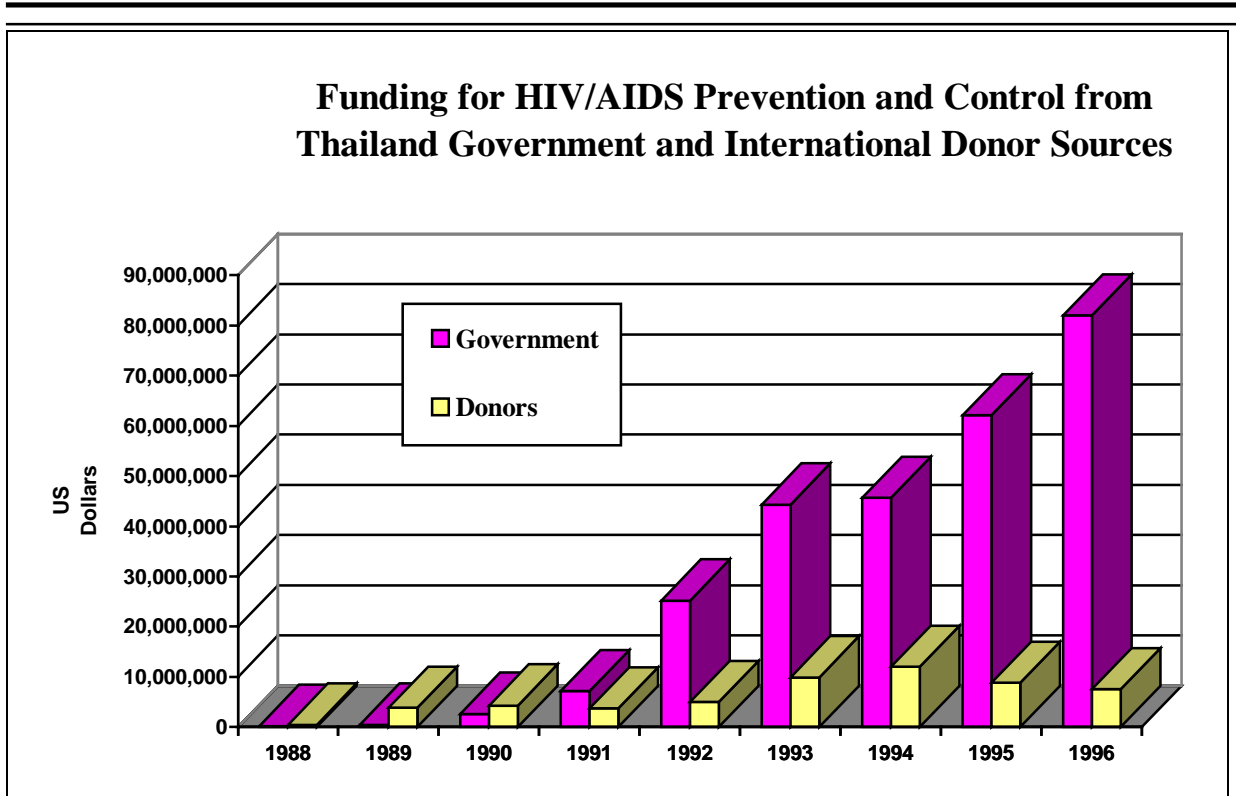
At the same time that Anand was the Prime Minister, the HIV epidemic burst into the general population. Policy and prevention programs could no longer be content to address the high risk groups. Major policy developments included the adoption of a broad-ranging national AIDS plan for the 1992 to 1996 period and a dramatic increase in budget allocations. The primary strategy for the national AIDS campaign emphasized mass media education, AIDS legislation to protect human rights, exert control over the commercial sex industry, and expand the number of participants involved in national HIV/AIDS efforts.

The mass media played a vital role in the administration's strategy to create awareness for the prevention of HIV/AIDS. Television and radio stations aired HIV/AIDS education spots hourly. Additionally, attempts were made to control the commercial sex industry as a method to stem the spread of HIV infection. In this regard, the "100% Condom Campaign" was made a national policy in 1991.

At this time, the government was very forthright with AIDS-related statistics, and if anything, tended to overestimate its projections of HIV/AIDS cases and the epidemic's social and economic costs. There was also increasing concern for human rights of persons with HIV/AIDS. The Anand administration was instrumental in thwarting proposed legislation, including the AIDS bill (described above), which had been criticized as being discriminatory and based on un-sound public health principles.

One of the more visible policy events of this period was a shift of administration of the National AIDS Committee from the MOPH to the Office of the Prime Minister (OPM). Accordingly, control of the national AIDS budget shifted to the OPM as well. This shift was symbolic at that time of the international clamor for multi-sectoral programming of national AIDS budgets. In fact, control of the NAP might have remained within the MOPH (as it did with the national family planning program) had not a schism developed between the NGO community and the MOPH. With NGO representatives in positions of national power during the Anand government, it was a straightforward matter to wrest control of the national AIDS committee and budget from the MOPH and transfer it to the OPM. The GPA and World Bank supported this shift because it had the appearance of a multi-sectoral approach in which all ministries become active partners. As subsequent sections explain, however, multi-sectoralism was not the motivation for this shift of control and a cross-ministry program never emerged. Nevertheless, more significant policy developments in support of HIV/AIDS prevention occurred during this brief government than in any other--before or since Anand Panyarachun.

The government's budget allocation for the anti-AIDS campaign increased dramatically from US \$2.6 in 1990 to US \$7.16 million in 1991 government (see accompanying table on next page). Then in 1992, the budget more than tripled to US \$25.1 million (AIDS Division 1993). Perhaps the greatest legacy of the Anand period was the US \$44 million budget that was designated for 1993 AIDS prevention and control activities (AIDS Division 1993). International organizations played a less prominent role in financing the campaign as donors withheld their funds to protest the overthrow of the democratically-elected Chatichai. Further, many of the policy measures promoted by the WHO were adopted during this period.



Policy Development Process

The nature of the political environment during the Anand period was the deciding factor in elevating the AIDS issue on to the government's decision agenda. The Anand government held power in periods of political transition and were extraordinary in that they were unelected and temporary. The political situation under Anand Panyarachun's administration was a freer climate than the previous elected government even though there was no opposition party or coalition to deal with. Premier Anand appointed cabinet members selected from a pool of politicians and high caliber technical experts from government and non-government organizations (NGOs). Significantly, one of the NGO cabinet members was placed in charge of the HIV/AIDS agenda.

The previous elected government had been forced to answer to interest groups from whom they were dependent on for support. Since Anand and many of his appointees were not politicians and did not belong to a party or a political coalition, there was relatively little pressure on them to please the various political factions. Additionally, Anand was not perceived as a politician; nor as someone who became prime minister to further his own interests. Therefore, Anand was less dependent on the external support of interest groups. While most MPs were busy campaigning and gathering support for the future elections, the Anand administration pragmatically went about instituting changes.

The impact that they were able to make as appointees was outstanding. In previous years, as advocates of policy development, they were unable to make a serious dent in the status quo. But once given formal authority, the political appointees were able to further their interests and beliefs substantially. In sum, the administration was composed of a prime minister and his appointees who gave the AIDS dilemma high priority. Prominent political appointees in the OPM used resources, both personal and institutional, to promote AIDS policies.

Although the administration's highly publicized approach to handling the AIDS issue was unpopular with many Thai leaders, the government was able to proceed largely unhindered. Anand's policy making was considered reasonable and progressive. Critics of the highly publicized approach of Anand's national AIDS campaign, such as some members of the tourism industry, had fewer paths to influence policy. At the same time, however, proponents of AIDS policy which did not have direct access to the Prime Minister also had limited impact on decision making. Furthermore, the system lacked the normal channels to government policy making that are usually accessible in democratic political systems.

Soon after the appointment of the Anand administration in March 1991, the HIV/AIDS issue was elevated to a high priority item up for active decision making. Problem recognition during this period was enhanced as indicators of the problem became increasingly publicized. Rather than hiding the facts or down playing their significance, government representatives instead highlighted the most dramatic indicators to increase awareness and stimulate change. Dramatic events continued to be covered widely in the media. There was also considerable feedback from the existing pilot programs, now nearing completion, which indicated where problems and opportunities existed and the policy developments needed to address these.

"The unusual circumstance of having pragmatic non-partisan technocrats and NGO and academic activists in positions of high government cabinet power with no opposition shows the potential when government and non-government forces merge."

--- University Academic

There were many technically-feasible policy proposals available at this time and many were seriously considered. A major difference, in comparison to the Chatichai period, was that the proposals became relatively free of constraints due to the political commitment of the Anand government. In addition, the proposals were compatible with the values of key leaders in the policy making community. The crucial distinction was that the composition and nature of this community had transformed under the Anand administration.

Prime Minister Suchinda (April-May 1992)

In the Spring of 1992, General Suchinda became prime minister, but remained in office for less than two months. Under his leadership, the government advocated a less visible HIV/AIDS campaign to avoid affecting tourism. In publicizing the threat of the virus, the MOPH would be more careful, a government spokesperson said, noting that the Anand government's public relations campaign had seriously affected tourism (*Bangkok Post*, 4-29-92). The reversal in policy by the short-lived Suchinda government and the belief that his government would not continue to be as open and frank with information, supports the assertion that top leadership is a key participant. It also indicates that the evolution of policy is not a natural process (from denial to recognition), but is rather dependent on the orientation of the key participants and the type of political system in which they operate.

Anand returned as Prime Minister in May 1992. His administration lasted until September, when elections brought a new coalition government to power.

Prime Minister Chuan Leekpai (1992 - 1995)

Policy Development

In spite of the progressive efforts to combat the disease and tremendous amount of resources invested, the epidemic continued to spread rapidly. The national AIDS campaign was able to raise awareness and produce behavior change of those at greatest risk. However the expansion of programs could not keep pace with the epidemic. Consequently, the epidemic worked its way into the general populace. Not only were the wives of Thai men who visit CSWs infected but their babies as well. As the realization set in that no AIDS cure would be forthcoming in the near future, the policy alternatives being generated in Thailand began placing more emphasis on care of HIV-infected persons and learning to live with persons with AIDS.

Under the Chuan administration, the AIDS issue remained a high priority issue. For example, it was during the Chuan government that the first HIV/AIDS policy was formally announced to Parliament in October 1992. The most obvious measure of the government's commitment to support HIV/AIDS prevention was evidenced in the budget proposals which remained at a level similar to the one that the Anand government established. Furthermore, the emphasis continued to be on education programs as opposed to regulations that aim to control AIDS by placing restrictions on infected persons.

Policy Development Process

Chuan Leekpai's elected coalition government was comprised of several political parties similar to Chatichai's government. Decision-making depended on the coalition partners,

the House of Representatives, and the Senate. Some implementation issues were delayed as many approvals were required from several different power centers.

In spite of the transfer of power to an elected coalition government, the HIV/AIDS issue remained a high priority item for the government. The issue was maintained at this level because of the Anand government's notable achievements including heightened awareness about the HIV/AIDS, implementation of HIV/AIDS prevention programs, an exponential increase in the budget for HIV/AIDS prevention and care, and commitment from key leaders to address the epidemic. Subsequently, many prominent Thai leaders also publicly accepted that HIV/AIDS was a serious problem that must be dealt with. The continuing indications of the spreading epidemic by the sentinel surveillance system showed to all that the high policy status and budget were justified. Furthermore, there were too many vested interests in maintaining the high status of the national AIDS program to make a policy reversal. In particular, the enormous budget allocated to the HIV/AIDS prevention and control campaign was vigorously coveted by a wide-range of participants.

Since the Anand government placed the HIV/AIDS issue at the highest level of the government decision making and established a high budget level, proponents of AIDS policy development no longer had to wade through the arduous legislative process. As an established priority item, advocates of AIDS policy development had a forum which to voice their opinions. This formalized structure was transparent and had a large budget. Nonetheless, the development of AIDS-related policies, in particular, choosing from alternatives, was once again slowed by the diverse interests that prevail in a parliamentary government headed by a weak coalition and interest groups still tried to influence policy alternatives. Therefore, the question was not whether the issue would remain a decision agenda item, but which policy alternatives would be chosen and how quickly would policies be adapted?

The high status did not signify, however, that policies continued to develop as rapidly as during the Anand period. Most of the action that shaped the national program response to HIV/AIDS had already occurred by that time. In contrast to the extraordinary political conditions that the previous administration operated under, Chuan led a loose coalition government that maintained a slim majority. Consequently, the government was not able to render quick and rapid changes which distinguished the Anand government. Politics within the government and between government and non-government participants became more prominent in influencing the direction and substance of the AIDS prevention and control campaign. In fairness to the Chuan Government, it should be noted that there were far fewer policies needing high level support than in the Anand period since the significant policy and programmatic strides had already occurred.

The Chuan period offers a stark contrast in terms of the political environment and leadership. Relative to the previous prime ministers, Chuan lacked both organizational powers and command of public attention. Chuan's governing coalition was made up of five political parties and maintained a slight parliamentary majority. The parties joined in an unnatural union in order to wrest power away from the traditionally powerful Chart Thai Party. However, each party had its own agenda, constituencies, and factions. Within the coalition, Chuan's Democracy Party maintained a slight majority. Therefore, Chuan had less input in choosing political appointees. In sum, Chuan did not have the power base to work from that former prime ministers enjoyed.

Although the Prime Minister remained chairperson of the NAC, control of the national AIDS budget mostly reverted back to the MOPH during this period. Chuan Leekpai was an AIDS "activist" as Health Minister under the Chatichai government. He appeared at World AIDS Day rallies and was outspoken on the need to publicize Thailand's HIV prevalence data. However, as Prime Minister he was notably silent on the HIV/AIDS epidemic. The case of Had Yai (see box) may have discouraged Chuan from taking a higher profile on AIDS as the manager of a fragile coalition.

While Minister of Health, Chuan Leekpai traveled to the southern business capital of Had Yai. This city attracts many tourists (mostly men) from neighboring Malaysia and Singapore. During the trip, Chuan publicized some of the emerging Thai data on HIV infections in CSWs. Subsequently, there was a sudden and dramatic decline in tourist arrivals. Local businesses staged protests, asking Chuan to substantiate whether there was any risk for HIV in Had Yai and to confer with them before announcing information that could damage their businesses. The level of tourism gradually returned to previous levels.

III. National HIV/AIDS Policy and Selected Outcomes

This chapter provides a description of Thailand's HIV/AIDS policy as defined by laws, resolutions and promulgations. The key agencies involved in national program planning, management and coordination also are reviewed.

National AIDS Policy

After Anand Panyarachun accepted the Premiership in 1991, he was appointed by the cabinet to serve as chairperson for the National AIDS Committee (NAC). His government announced that confronting the AIDS epidemic was a national level policy, but no formal, legal statement was ever issued to this effect. Government, NGOs, the business sector, and mass media were given guidelines to jointly address this challenge. The Thai government formally declared AIDS as a development threat to the country in a presentation to the international conference of the World Bank, held in Bangkok in October 1991. This conference provided the appropriate forum to present the current estimate of infections, the projected size of the epidemic by the year 2000, and the potential cost to the nation in medical care and lost productivity in the absence of aggressive prevention efforts. From this point onward, Thailand became an oft-quoted case of the consequences of letting the epidemic get out of control.

Despite the very high visibility of AIDS during the Anand government, a formal announcement of an AIDS policy did not occur until mid-October 1992 in a document entitled, "Policy in the National Social Policy," addressed to the Parliament during the Premiership of Mr. Chuan Leekpai. The two clauses concerning AIDS read:

8.3.6: Accelerate all government units, the private sector, and NGOs to coordinate campaigns to educate the public on AIDS in order to encourage behavior change especially those groups with high risk behavior.

8.3.7: Arrange to have care and treatment services for AIDS patients by arranging to have adequate number of personnel and counseling services for infected individuals so that infected persons, AIDS patients, and the public can live in harmony in society.

The NAC passed a resolution to use the national AIDS policy as the principle policy by which every implementing unit must abide. All government units and NGOs were instructed to implement activities concurrently and continuously. Each unit was to have its own budget allocated at the provincial level whereby the governor was to serve as a chairperson to coordinate activities among the relevant government offices. Research activities to examine results of the studies in other countries which could be applied in Thailand were encouraged.

The important point to note from the above events is that, in the Thai case, it was not foresighted policy development that gave rise to such an active prevention program. Instead, policy actually developed *a posteriori* to programs. In other words, while a favorable policy statement may or may not lead to an effective prevention program, sound program actions will give rise to constructive policy--at least judging by the Thai case.

Establishment of Coordinating Agency for AIDS Control and Prevention

The number of Thai agencies involved in AIDS control--government and NGO--increased dramatically during the period of strong government support and convincing documentation of the explosive spread of the virus (early 1990s). Every provincial health office expanded its STD unit to include HIV/AIDS. The membership of the NGO Consortium on AIDS grew from 17 (founding) members to over 30 agencies with funding for HIV/AIDS. The task of coordinating activities to avoid duplication and conflicting effort was formidable and largely unattended. The coordination role was never adequately assigned or implemented. What coordination did exist was based on personal communication among individuals and agencies who were implementing partners or those who trusted each other. Often, discovery that another agency was carrying out prevention activities in the same geographic area among the same target audience occurred after both groups bumped into each other in the field. One attempt was made to compile an inventory of AIDS research--over 200 concurrent studies at one point were noted; another compiled a multi-sectoral list of agencies involved in HIV/AIDS prevention .

During the Anand government an AIDS Policy and Planning Coordination Bureau (APPCB) was established in the Office of the Permanent Secretary of the OPM. The APPCB was the logical focal point for coordinating external and domestic assistance for HIV prevention because it had authority, staff and budget. Despite this, the secretariat of the APPCB never seemed to achieve full capacity and preferred to deal with agencies on a one-to-one basis rather than convening larger coordination meetings. In addition, the office may have alienated some prevention agencies by its attempt to direct program activities and specify communication strategies in a way that was too controlling. The secretariat never produced any publications or documents that served a coordinating function (such as inventories of projects, lists of agencies/contacts, master plan, etc.). Instead, much of its energy was spent in programming the rather large OPM budget for AIDS prevention communication--which it did well during the Anand period.

Because of the large amount of funding for AIDS prevention in the early 1990s, the lack of a functioning coordinating body probably resulted in duplication of effort rather than competition of agencies for scarce resources. Independent of the APPCB, representatives

of funding agencies met often, informally and formally, through a rotational donors coordination meeting. These meetings were first spearheaded by the GPA representatives as a form of pledging activity. They continued spontaneously on a monthly basis spurred by the desire of agencies to know what others were doing and to receive up-dates on technical issues related to HIV/AIDS. However, without a more comprehensive (and full-time) coordination effort, no one could ever grasp the full picture of HIV prevention and care activities that were occurring in Thailand. Thus, it was difficult for planners to identify gaps and accurately assess what policies were needed to advance implementation.

An example of a lost opportunity during this period of abundant resources concerns the crude attempt at centralized multi-sectoralism. The approach has not shown much indication of the intended impact despite the fact that Thailand is cited as a case in support of this approach. Basically, the Thai approach to multi-sectoralism was to levy a tax on each of the line ministries (defense, interior, education, health, agriculture) and to reallocate that to each ministry in the form of an AIDS prevention budget. Thus, ministries with no technical capability in AIDS were suddenly required to submit plans for the implementation of millions of dollars of government prevention funds. In theory, the AIDS Division of the MOPH was supposed to provide the technical inputs but there was no staff or divisions in the other ministries with an AIDS prevention assignment to absorb and apply these inputs. A more carefully coordinated program would have assessed the capacity and needs of the various ministries and steered resources where they could be put to best use. This did not happen and a large percentage of the national AIDS budget was underspent or squandered on meetings, trips and reproduction of mass produced IEC materials. Quite independently, however, a multisectoral approach to AIDS prevention was developed at the provincial level by an enterprising group of four government and NGO staff (described below).

With the announcement of a national AIDS policy in October 1992, the national planning board (NESDB) was appointed as the principle agency to develop an AIDS prevention master plan and implementation strategy. Each ministry was to develop its own sub-plan. AIDS has been included in the 7th National Economic and Social Development Plan (1992-1996) and automatically will be part of the coming five-year plan for 1997-2001. These five-year plans form the basis by which government agencies can request resources from the Bureau of the Budget, i.e., no plan, no budget. It also formalizes the coordination role of the NESDB. To ensure that there is a variety of input for the 1997/2001 plan, the NESDB convened a national technical workshop in 1995. The workshop participants included Thai experts from the academic, NGO and government sectors. Participants were divided into small, multi-disciplinary groups. Each group focused on a particular aspect of the five-year plan and reported back to the plenary group. The final report was edited by an oversight panel and this formed the basis for the AIDS chapter of the five-year plan document. This plan then becomes the blue print for how government funds will be allocated in the areas of prevention, medical care, rehabilitation and the protection of the rights of the infected.

In theory, this approach should produce a sound national prevention and care program, especially given the budget allocations in recent years (approximately \$50-70 million per

year). However, it must be stated that no evaluation of the national AIDS planning and budget allocation process has occurred since the OPM assumed control of the NAC. Until such time as an objective evaluation takes place, judgment should be reserved on the effectiveness of the Thai AIDS budget and planning in the period since 1992.

Milestones in Thailand's National HIV/AIDS Policy Formulation

- 1985 National AIDS Advisory Committee established at the MOPH department level and chaired by Director General of the Communicable Disease Control Department.
- 1987 Center to Prevent and Control of AIDS set up in MOPH.
- 1988 AIDS Advisory Committee up-graded to an MOPH AIDS committee, with the MOPH Minister serving as chairperson.
- 1989 MOPH sets up Administrative Committee for the AIDS Control and Prevention Project, chaired by Permanent Secretary of the MOPH.
- 1990 Cabinet passes resolution to set up National AIDS Control and Prevention Committee; chaired by MOPH Minister.
- 1990 Cabinet approves establishment of an AIDS Division within the Department of Communicable Disease Control of the MOPH as the principle government coordinating agency.
- 1991 Reappointment of multi-sectoral national AIDS committee; chaired by the Prime Minister.
- 1991 AIDS Policy and Planning Coordination Bureau established in the Office of the Permanent Secretary of the Office of the Prime Minister.
- 1991 HIV/AIDS declared a national development threat to Thailand during World Bank conference in Bangkok.
- 1992 National AIDS policy formally proclaimed by the Prime Minister.
- 1993 Reappointment of a smaller but multi-sectoral NAC.
- 1995/96 Decline in national STD prevalence rates.

The formation of multi-ministerial NAC, chaired by the Prime Minister, to replace the Coordinating Committee for the Control and Prevention of AIDS significantly increased the political importance of HIV/AIDS. The head of state was now the National AIDS Committee chairperson, replacing the senior official of the MOPH in that role previously. However, this change also created tension across government agencies because the budget and planning for the national budget allocation shifted from the MOPH to Office of the Prime Minister. Fundamental differences in priorities for use of government funds for AIDS prevention were amplified during this period. NGO activists who were now appointed to high level government positions publicly charged that the Ministry of Public Health gave too much priority to the construction of AIDS rehabilitation centers at the expense of public education programs. Although this example of friction simplifies a rather complex relationship between NGO representatives and the MOPH, the lack of a more united front certainly contributed to a lack of closer coordination and collaboration among Thai AIDS experts during this period. What is more, in the Thai cultural context, public criticism of this sort can permanently sever relationships among individuals. Another indicator of the tension was reflected in the sardonic Thai humor of MOPH officials who (unofficially) referred to government organizations as "GO" (i.e. forward progress) and to NGO's as "ngo" (the Thai word for stupid). Budget that could have been programmed together drawing on the epidemiological expertise of the MOPH and the marketing savvy of the NGO representatives at the OPM could have directed prevention resources more cost-effectively to areas of greatest need. Instead, the national program became bifurcated into a national media campaign (managed by the OPM directly and through line ministries) and massive sentinel surveillance (by the MOPH).

In fact, the 1991 schism between the two camps (OPM and MOPH) had little to do with competing prevention priorities or multi-sectoralism versus a public health approach. The seeds of discontent were sowed in the mid- to late-1980s when the NAC was first formed. Had the original National AIDS Committee (located at the MOPH) embraced the NGO sector from the start as an equal partner there may not have been any conflict later on. Instead, the NAC tended to be dominated by communicable disease control experts who excluded not only NGOs but other departments of the MOPH from the national program effort. This is in clear contrast to the way the Thai National Family Planning Program (NFPP) was successfully managed in the 1970s. Early on, the Thai NFPP included all major family planning NGOs in the national family planning committee and gave them contraceptive supplies and other resources to advance their programs. As a consequence, no major conflicts ever arose and Thailand recorded one of the most rapid declines in unwanted fertility that the world has ever known. Although HIV is a much more difficult foe than unwanted pregnancy, the MOPH still could have spearheaded a united effort when it had the organizing power to do so--but chose to attack the problem single-handedly. Valuable lessons could have been applied from the family planning program of the Department of Health (e.g., condom logistics management) to the AIDS program of the Department of Communicable Disease Control. However, a case of this transfer of

expertise did not take place until condom stock-outs occurred nationwide through government STD clinics in August 1990. Then cross-divisional training and a condom tracking system were hastily implemented.

Another area of missed opportunity was in behavior change communication. NGOs had developed innovative communication materials on reproductive health to reach adolescents yet these were never adapted by the national program. The MOPH preferred to develop new materials from scratch. This cost the program valuable time in reaching out to the vulnerable segments of the population with pre-tested materials.

During this period however there were many more active NGOs in AIDS prevention (30 to 40) than there were family planning NGOs in the 1970s (four to six). Thus, as a group the NGOs gained a sense of confidence and power to confront the MOPH head on. Unfortunately, this approach only served to entrench the MOPH/CDC in its position. To the international community this conflict appeared as a classic transition from a public health approach to a multi-sectoral approach to the epidemic. And this smoke screen provided a respectable front for what was, in fact a power struggle. In reality, the schism was more a conflict of (who is in) control rather than which of two strategies would prevent more HIV.

When the Anand Government was dissolved in 1992, the cabinet-level NGO activists were no longer in power and the surface tension between the OPM and MOPH dissipated. Early in 1993, the MOPH requested a reduction of the number of NAC members from 50 to 21 persons, ostensibly to speed up the decision-making process. Then, in February 1993, the NAC passed another resolution to re-establish control of the national AIDS budget in the MOPH and assign the MOPH to be responsible for the prevention and control campaign. However the MOPH was never to regain the amount of control it had over the NAP as in the pre-Anand period. The Ministry of University Affairs assumed responsibility for research and evaluation responsibility, and the Office of the Prime Minister was responsible for public relations. While a certain amount of control of the AIDS agenda was returned to the MOPH (from the OPM), national planning for AIDS had now shifted to the National Economic and Social Development Board (NESDB) and remains there to this day. However, it must be made clear that multi-sectoralism--at the national level--never played a significant role in the Thai AIDS policy or program.

Other Manifestations of Thai AIDS Policy

Prevalence Data:

Once the sentinel surveillance system was in place in 1989, the MOPH began to utilize data collected to calculate the number of infected individuals. Sentinel populations included: injecting drug users (IDU), direct commercial sex worker, indirect commercial sex workers, male sex worker, men being treated for STDs, pregnant women, blood

donors, and prisoners. Reports on the survey rounds were issued approximately every six months by the MOPH. These data were made available to the prevention community and the public from the first survey round up to the present. The data were significant in attracting both domestic and international attention to the speed and severity of the spread of HIV in Thailand. The most dramatic case of the use of the sentinel data was the release of the finding that 44 percent of Chiang Mai brothel sex workers were HIV positive in mid-1989. Chiang Mai had special significance for Thai acceptance of the epidemic in that, unlike commercial sex tourism in Patpong and Pattaya, most of the customers of Chiang Mai brothel CSWs are mainstream Thai men.

Although the first round of the sentinel surveillance was conducted in June, 1989, the results were not released until several months later. There are two reasons for this delay. First, the extraordinarily high rate among CSWs was not first believed by epidemiologists who suggested that there was either sampling or laboratory errors. Independent teams of Thai and international experts traveled to Chiang Mai to re-test the blood samples and to perform other confirmation checks. Second, senior officials of the MOPH did not want the results released to the press. In a rather courageous move, junior epidemiologists who were managing the sentinel surveillance released the information to the Thai press and the GPA/WHO despite the disapproval of their superiors. The news immediately spread to Geneva (and the world) as well as to all provinces of Thailand through front-page coverage by the mass daily newspapers. Perhaps more than any other communication intervention, this shocking finding, and the resulting publicity it generated initiated the change in Thai male sex behavior that gave rise to subsequent increases in condom use and reduced incidence of HIV. Not all men readily heeded the warning, though. As government officials and NGOs in the upper north sounded the alarm, a certain amount of skepticism began to emerge as there was no empirical evidence of a raging epidemic. It was during this period (circa mid-1990) that charges were leveled that the AIDS scare was a hoax, as something invented by the MOPH to reduce commercial sex. One implication for programs is that too vehement an information campaign may breed denial because of the lack of any personal experience to confirm the existence of a new disease. It cannot be determined how widespread or prolonged this backlash of denial was. However, it is unquestionable that the sentinel surveillance data convinced program managers, policy makers and most of the public that HIV was now a major threat to the nation.

Immigration Act:

Several foreigners with AIDS had entered the country in or around 1985. This prompted the government to amend its immigration policy prohibiting AIDS patients and infected persons from entering the country (Immigration Act 1986). Despite repeated arguments that this law was ineffective in preventing a domestic epidemic, repealing laws and regulations is a difficult process. A most unfortunate consequence of this law was the abrupt withdrawal of WHO funding for an international AIDS conference in Thailand in December 1990--in accordance with GPA policy which prohibited support for AIDS

conferences in countries with restrictive immigration policies for people with AIDS/HIV. WHO was hoping that the threat to withhold funds would pressure the Thai government to abolish the law but the tactic did not work.

It was only during the Anand government in October 1991, when activist NGO members of the Cabinet worked to abolish this law, that the restriction on immigration was dropped. With the absence of any opposition party and the support of the Prime Minister, there was no obstacle to removing or promulgating legislation during this period. Other somewhat impractical or punitive laws were also repealed as well during this period (see next paragraph).

Communicable Disease Act:

In 1984, the MOPH amended the Communicable Disease Control Act to include HIV infection as a reportable disease. This Act required physicians to report AIDS patients and infected persons (including their names and addresses) to the MOPH headquarters in Bangkok. This directive was repealed in 1991 due to the impracticality of tracking tens of thousands of persons with registered HIV infections and to be consistent with the government's policy of confidentiality of serostatus. Official reporting of persons with clinical AIDS was still required however, as this related to estimates of budgets for therapeutic drugs and hospital capacity.

Draft AIDS Act:

During Chatchai's administration (1989-1991), a committee to draft an AIDS Act was established. Staff of the MOPH were key members of the drafting team and the law, as designed, would be administered by the MOPH. Depending upon one's orientation, the law was either repressive or humane--such were the divided viewpoints of the day. The committee's rationale for the law was stated in the December 1990:

AIDS has spread widely in Thailand and all over the world. The spread of AIDS differs from the spread of other communicable diseases and it is not possible to use the measures for the control and prevention of diseases under the law presently in force to control it. It is therefore necessary to promulgate this Act.

The draft law proposed that the national AIDS committee be chaired by the Minister of Public Health and have members from the other key ministries of the government. The law would have created an AIDS Fund to address the following:

- promote education and research on HIV/AIDS;
- disseminate knowledge about HIV/AIDS;
- examine, treat and rehabilitate the infected persons or those suspected of being infected;
- provide occupational therapy for the infected or those suspected of being infected;

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- create plans and programs for AIDS prevention and treatment;
 - provide special compensation to officials of government clinics or the Thai Red Cross who are responsible for the examination, treatment or rehabilitation of HIV-infected persons or those suspected of being infected.

The proposed law prescribed a case-finding approach to HIV prevention by requiring that any case of infection or suspected infection must be reported to the local government health officer within 24 hours of detection. What is more, officials of the MOPH could require examinations of and take body fluid specimens from people identified by government authorities as:

- persons in a high risk group for HIV (e.g., prostitute, IDU, or promiscuous individual);
- a person who has come into contact with a person with HIV/AIDS or a child born to a mother with HIV/AIDS;
- a person who is in custody (i.e., a prisoner).

Finally local health officials could order an individual with HIV or suspected HIV infection to be "rehabilitated" at a local health facility or hospital. Any person who refused to be examined could be detained, confined to an area of residence or prohibited from entering certain zones.

Any infected person or a person suspected of being infected could be prohibited by the draft law from:

- selling or donating, blood, lymph fluid, semen or body organ;
- share a hypodermic needle with another person;
- prostitute oneself;
- submit to medical or dental procedures without informing the health practitioner of his/her infection or suspected infection;
- have sexual relations without using protection (i.e, a condom);
- marrying without notifying the prospective spouse in writing of his/her infection or suspected infection;
- do anything else that might spread HIV.

In contrast to these draconian measures, several liberal articles in the draft law provided for abortion on demand for pregnant HIV positive women and protection of employees from termination on the grounds of being infected with HIV or suspected of being infected unless the person's type of employment carried a risk of infecting others. Various fines were specified to encourage compliance with the law.

Word of the draft law was leaked and numerous NGOs and academics called for a public hearing. Two public hearings on the draft law were held. Subsequently, MOPH administrators became reluctant to submit the draft Act to the House of Representatives and the matter was dropped in 1992. This was the last official attempt to implement a case-finding and quarantine approach to HIV/AIDS prevention in Thailand. It is difficult to conclude which event is more responsible for quashing the draft law: opposition voiced in the public hearing, lack of political support with the OPM or the sheer impracticality of implementing a law to track down and confine the activities of, at that time, 300,000 HIV-infected citizens. Certainly the presence of activist NGOs in the Cabinet in 1991 was a formidable obstacle to the draft law. However, no resurrection of the law occurred after the Anand Government concluded its tenure.

Confidentiality of and Non-Discrimination against HIV-infected Persons and People with AIDS:

A Thai man, Cha-on Suesum, contracted HIV through a blood transfusion and agreed to allow his case and identity to be publicized in 1987. He appeared on national television talk shows and the front pages of mass circulation Thai language daily newspapers. In effect, Mr. Cha-on became the "poster boy" for HIV among Thais. Survey results from independent sources suggest that the public exposure of this ordinary individual with HIV and then, symptomatic AIDS, was a turning point for many Thais who now began to see HIV/AIDS as a domestic issue.

Foremost in promoting media exposure of Mr. Cha-on was the Population and Community Development Association which hired Cha-on as a PWA educator and arranged for him to appear on the Thai version of the "Tonight Show". Front page newspaper coverage was also given to Cha-on's case and this ensured nationwide awareness. The case of Cha-on focused attention on several important debates that led to the further maturation of Thai AIDS policy and society as a whole in dealing with the epidemic. First was discrimination against the infected. Cha-on was fired from his job (as a factory watchman, solely because of his infection. His wife was also fired from the same factory by virtue of being his spouse. The public clearly sympathized with the injustice in this case and the seeds of the rights of the infected were planted. The second impact of the Cha-on case was to establish that AIDS the disease was real, Thais could get infected and die from it. Because Cha-on progressed rapidly to full blown AIDS his worsening condition and death was witnessed by the nation. In effect, Cha-on was the first Thai casualty of the epidemic and this gave force to community level and work site support for prevention programs.

Decentralized Management:

Thailand had become familiar with the concepts of decentralized management and provincial multisectoral collaboration during national programs for rural development,

family planning, and primary health care in the 1970s and 1980s. Hence, decentralized management systems were already in place at the time when AIDS activities were still

centralized. Accordingly, a portion of the national AIDS budget was then reallocated to the provincial level to administer in accordance with the magnitude and severity of the problem. Provincial Governors were accountable, with full authority, for administrative management of the plan and implementing strategies in their province. A notable manifestation of the spirit of decentralization was the emergence of provincial level AIDS programs that were established entirely through local initiative. The case of Pitsanuloke Province is especially noteworthy. Where multi-sectoralism failed at the national level, it thrived at the provincial level--in the case of Pitsanuloke--through a genuine grassroots effort. The following summary describes that situation (FHI/AIDSTECH, 1991).

Pitsanuloke is a medium-sized province in the lower north region of Thailand; about half-way between Bangkok and Chiang Mai. The province first began to attract attention in 1990 when it reported dramatic decreases in the number of new cases of STD appearing at government clinics. Independent checks were made on the central records of the Venereal Disease Division which confirmed the claims coming from Pitsanuloke. The data check supported the abrupt and sustained decline in STD in that province. What is more, three rounds of the sentinel surveillance showed a plateauing of HIV infection among brothel workers in Pitsanuloke approximately seven months after STD began its sharp decline. Finally, the semi-annual screening of military recruits showed that the lowest levels of infection in the North were among Pitsanuloke men. After several trips to the province, it became apparent that the Pitsanuloke AIDS prevention program was functioning at a level that other provinces with similar goals were not achieving. Although its policy of universal condom use for commercial and casual sex encounters was not unique, several features of Pitsanuloke made its implementation of this strategy more effective:

Core team approach: Since there were very few full-time AIDS prevention workers anywhere in Thailand at that time (1990), most prevention workers were taking time away from other jobs to work on AIDS. Thus, no one person alone can manage a provincial intervention of this scale. A small, core team of individuals who have mutual respect and a similar level of dedication was the first noticeable ingredient of this program.

Multi-sectoral coordination: Before this term was coined by the GPA and World Bank, the Pitsanuloke team had already created a model, multisectoral response. The four core team members included one staff person each from the Provincial Chief Medical Office (of the MOPH), the regional communicable disease control office (of the MOPH), the 3rd Army regional headquarters (of the Ministry of Defense) and the regional office of the Population and Community Development Association (a national NGO). These four individuals met at least monthly to plan

and monitor activities. They shared ideas and responsibilities unselfishly, and stood in for each other when one was not available.

Local fund-raising and resourcefulness: The core team raised tens of thousands of dollars from local public and private sources in order to stage semi-annual AIDS prevention fairs and to fund year-round activities. It is most noteworthy that this province received no foreign assistance or financial support from Bangkok ministries before achieving its reductions in STD and apparent reduction in HIV incidence. Leveraging the business sector is one of the most important achievements of the Pitsanuloke model which the national multi-sectoral approach in Thailand did not achieve.

Continuity: The Pitsanuloke team developed their approach to STD/HIV control and adhered to it month after month. They did not squander their effort by attending meetings and speaking engagements to publicize their model.

If the Thai case is representative, then the lessons for other programs are that multi-sectoralism may only be viable at the provincial level and if the above ingredients of success are present in the local program.

Anonymous Testing:

To further counter those who were in favor of a case-finding approach to AIDS control, the activists in the Anand Government managed to promulgate resolutions to restrict arbitrary of compulsory testing for HIV. Although these resolutions did not have the power of law, they formed an official basis to institute programs and activities with government budgetary support. An example of one influential proclamation concerned the blood testing policy. In 1991, the government issued a resolution that stated:

[The Thai Government] does not support blood testing to identify or detect [HIV] infected persons and using the individual test result for purposes other than diagnostic treatment unless the consent of the individual has been obtained.

This led to the establishment of anonymous, confidential testing and counseling centers in every provincial health office at that time. In order to up-grade MOPH staff to operate these centers, budget for training in HIV counseling was allocated. NGO counseling centers also increased, especially in the upper north region of Thailand where demand was greatest. Generally speaking, following the abolition of the law to require reporting the name and address of all HIV positive individuals and the resolution for voluntary anonymous testing for HIV, Thailand had matured to its present policy of HIV screening on the terms of the individual, not the state. Exceptions remain of course. Hospitals will screen blood without always informing the patient, and employers may require HIV tests

during annual physical examinations. While, the current status of the government policy defends those whose blood is tested without their informed consent, the law does not provide a mechanism by which to file a grievance.

* * *

This chapter has presented a number of policy milestones and tried to explore the factors that led up to or "triggered" events that shape the current Thai policy toward HIV and AIDS. It is not necessary to identify who played what roles in this policy evolution but to understand the interplay between the various institutions within an environment of political flux -- which was occasionally abrupt and dramatic. The next chapter explores the non-governmental sector in more detail while a final section synthesizes the findings of this analysis in an interpretation of the catalysts which gave rise to present AIDS policy in Thailand.

IV. ROLE OF NON-GOVERNMENTAL ORGANIZATIONS AND THE PRIVATE BUSINESS SECTOR

Although the Thai government would certainly have had an AIDS policy and a national prevention program without the presence of NGOs, the NGO community helped shaped policy formation and the response in many ways. At the national level, NGOs effectively used the mass media to serve as a check and balance on draft government resolutions and laws. The case of the draft AIDS law described above is the foremost example of this. A lesser know example concerns the attempted introduction of HIV-free cards for CSWs. These white cards contained the name and photograph of the sex worker and she could retain this as long as she tested HIV negative at three month intervals. Brothels, massage parlors and other indirect commercial establishments would be closed down by the governor if CSWs were found working in such places without an up-to-date white (HIV-free) card. Governors could police these establishments without a new law because prostitution was already illegal (and remains illegal to this day) in Thailand. Despite the illogic of an HIV-free card (i.e., it encourages male customers not to use condoms) the card system was vocally protested by NGOs which supported the rights of CSWs not to be branded. Not many months after its introduction, the national HIV-free card system was quietly allowed to discontinue.

At the local level, grassroots organizations defined local policy and set standards by virtue of their education and prevention activities. The agencies discussed in this chapter include non-profit organizations, businesses, religious institutions and women development groups. The chapter concludes with a discussion of mass media and public education because this channel was heavily used by NGOs to try and influence the national policy and response to AIDS.

NGO Participation

When the government accepted HIV/AIDS as a national development threat in 1991, it had stated its policy to promote collaboration among agencies. A subcommittee for government and NGOs was established with representatives from NGOs as members.

The NGOs themselves also set up a Consortium on AIDS in 1990 beginning with 12 members and expanding to 45 NGOs within 3 years. The well-known Thai indigenous NGOs, EMPOWER and ACCESS, were the key agencies which gave rise to the Consortium. A Center to Protect the Right of the People with AIDS was set up to receive grievances associated with violations of rights of infected persons and AIDS patients.

One study on the involvement of NGOs in AIDS found that there were 189 NGOs with some activities related to AIDS in 1994 and 23 percent of these were registered NGOs, 19

percent were foundations, and the rest were either in the form of project centers or groups. NGOs are scattered throughout Thailand, with 39 percent located in Bangkok.

NGOs that implemented AIDS activities during the early years (1984-1991) were development NGOs that were well-established before the HIV epidemic emerged. These included large NGOs with the majority of their work in family planning, community service, and women's development such as the Population and Community Development Association (PDA), Thai Red Cross Society, and the Planned Parenthood Association of Thailand (PPAT), to name a few. As the epidemic worsened, as external funding for prevention increased and as Thailand more clearly articulated its HIV/AIDS policy, many more NGOs became involved in prevention activities.

The role of NGOs emphasized campaigns to help people obtain correct information about AIDS, protect the rights of the infected and AIDS patients, make recommendations to the government regarding policy and reduce the government's burden in caring for AIDS patients and infected persons.

During the time frame of this study (1984-94) at least \$20 million was provided to support NGOs implementing AIDS activities. The majority (96 percent) of the budget was derived from international donor agencies, with the remainder from Thai government sources.

Due to philosophical differences and work style, the strong emotions surrounding HIV/AIDS prevention work and the transient nature of some NGOs, it was inevitable that there would be mistrust between the government and NGOs. At times, attacks and counterattacks were common features of conferences and the print media. Nevertheless, the Thai government never took measures to restrain the indigenous or international NGOs working in AIDS and collaboration has improved in recent years. Direct government financial support for NGOs is still very low relative to government agencies.*

Participation of Private Business Sector

Participation of the business sector in the establishment or implementation of national AIDS policy is a noticeable gap in the history of the Thai response to AIDS. Until recently, most business interest comes from industrialized countries which have experienced large AIDS caseloads. Some examples of the [lack of] business response are discussed below.

* NGO-government relations formalized in 1994. In that year, US\$400,000 of the government's HIV/AIDS budget was allocated to NGOs. By 1996, that allocation had climbed to US\$3.2 million.

Insurance Companies:

Many insurance companies refuse to accept infected persons and require that life insurance clients must have their blood tested for HIV before awarding a policy. This policy of certain insurance companies is counter to the national policy to protect individual's rights. Without a law that prohibits companies from awarding policies regardless of HIV status there is no means for the government to enforce the anti-discriminatory policy. The same applies to companies and medical institutions who perform routine testing to screen out HIV seropositives in order to deny certain services and benefits--usually to the advantage of the institution doing the screening. This is an example of the gap between policy and practice. In the Thai setting, it is solely up to the conscience of the insurance company executives whether or not implement an anti-discrimination code.

In 1994 the Minister of Health voiced the opinion that the HIV test requirement of insurance companies is a "conflict of interest." In an attempt to accommodate different viewpoints, a detailed study of appropriate measures was commissioned and the Sub-Committee on Protection of Individual's Right in AIDS was assigned to carry out this task in 1995 although no report of this sub-committee has been publicized. As recently as February 1996, the policy of local insurance companies is to screen prospective buyers of life insurance for HIV depending on the amount of insurance (over \$30,000) and geographical location of residence (8 northern provinces). These companies will not sell life insurance to anyone testing HIV positive.

Other White Collar Businesses:

Some NGOs received financial support from local commercial banks to launch education campaigns aimed at high risk groups and the general population in 1987-88 before the government had an open prevention policy and program. Other local AIDS committees have been able to tap private businesses for occasional contributions (such as in Pitsanuloke and Udorn Provinces). Only recently (1994/95) has the Thailand Business Coalition on AIDS (TBCA) been able to mobilize the corporate sector in a significant way. Nevertheless, most work site HIV/AIDS education, where it exists, comes from outside prevention agencies with independent funding. Despite the huge profits that many Bangkok-based businesses have reaped from Thailand's double digit economic growth in the late 1980s, contribution to and interest in the national prevention effort is remarkably small. One commonly cited explanation is that white collar business (in Bangkok) feels it already contributes to prevention through Thai government taxes. While theoretically true, disproportionately little of that budget goes to the Bangkok metropolitan area. Consistently, only one percent of the national AIDS budget has gone to Bangkok despite the fact that it houses nearly ten percent of the nation's people.

By contrast some multi-national (mostly U.S.) corporations have been proactive in promoting AIDS education for their Thai work force. This is not surprising in that the U.S. was one of the first countries to experience a large-scale HIV epidemic and because

of the successful example of the U.S. Business Coalition on AIDS. In conjunction with the American Chamber of Commerce in Thailand, the U.S. Coalition helped provide the impetus and example for the Thai land Business Coalition on AIDS (referred to above). To date, the TBCA has enrolled several hundred (mostly Bangkok) businesses. However, 70 percent of the members are multi-national corporations and only 30 percent are locally owned. The TBCA recognizes that to be fully successful and sustainable it must recruit more indigenous businesses into the coalition.

Industries:

A higher priority target for HIV prevention is blue collar industry in that the Thai epidemic is more severe among the lower income segment of the population. Generally owners and managers of blue collar industry have consistently believed that AIDS would not have much impact on the production line because of the labor surplus for low-skilled jobs. Consequently, industrial managers have not shown much interest in participating in any educational activities for their work force despite ample evidence of risk of infection in this population. More to the point, effective HIV/AIDS prevention education interferes with the production schedule. For example, by allowing AIDS communication outreach workers into the work site, a certain amount of productivity is lost without immediate, tangible return to the owner. This has been a major obstacle to outreach programs in Bangkok which are targeting the low-income work force of young men and women. Only by going through local District AIDS Committees are prevention programs able to gain access to blue collar work sites. The authority of the local district chief or the chief of police can arrange access to most work sites. Yet even then, access may be limited to one or two visits only or restricted to lunch breaks or before/after work hours.

In an attempt to study the impact of HIV on industry, an economic analysis was conducted by AIDSCAP in 1995 among two large (250-1,000 workers) factories in Bangkok where HIV prevention interventions were being implemented. The cost (of work force HIV infection) to each factory was estimated to be approximately \$17,000 in 1994 and increasing to \$40,000 per year in 2005. By contrast, the annual recurrent cost prevention education program totaled \$12,000. However, without assurances that all potential HIV-related absenteeism is averted it has been difficult to convince factory owners to invest their own resources to sustain this service when external funding ends.

Role of Religious Institutions

The response from Thailand-based religious institutions to the AIDS epidemic started before the establishment of an AIDS policy. Christian organizations began to implement AIDS education activities, prevention services, home-based care, counseling, testing and anonymous clinics which continue to the present. Areas of implementation include in Bangkok, and provinces with large number of AIDS patients and infected individuals.

The role of Buddhist monks and the monastery has emerged only recently in Thailand. Although Buddhist monasteries have a traditional role in caring for the terminally ill, most abbots in endemic areas were not eager to take on the care of AIDS patients and some still see the plight of the infected as "deserved." As recently as late 1995, a well-know senior monk in Bangkok was sermonizing that "AIDS patients need not be pitied" (i.e., since they led sinful lives). The exception to this are a few monasteries led by charismatic monks who have been able to convince communities of the need to provide in-patient care and support. Increasingly, these monastery-based programs are integrated in the local community.

Women's Development Groups

Women Development and Protection of Women's Right groups have become more active in recent years. They provide knowledge and education to women's groups related to loss of benefits should they not protect themselves, correcting misinformation and invasion of women's right including unfair treatment. Some of these agencies include for example, Women's Rights Protection group, Women in Service, Association to Promote the Status of Women, Friends of Women.

Several groups, based in the upper north of Thailand, have developed projects to provide alternative opportunities to women as a deterrent to prostitution. Also in the upper north, a group of women whose husbands died of AIDS established their own support group in 1994 called "Doi Saket Widows Against AIDS Group" with financial support from international agencies and the Thai government.

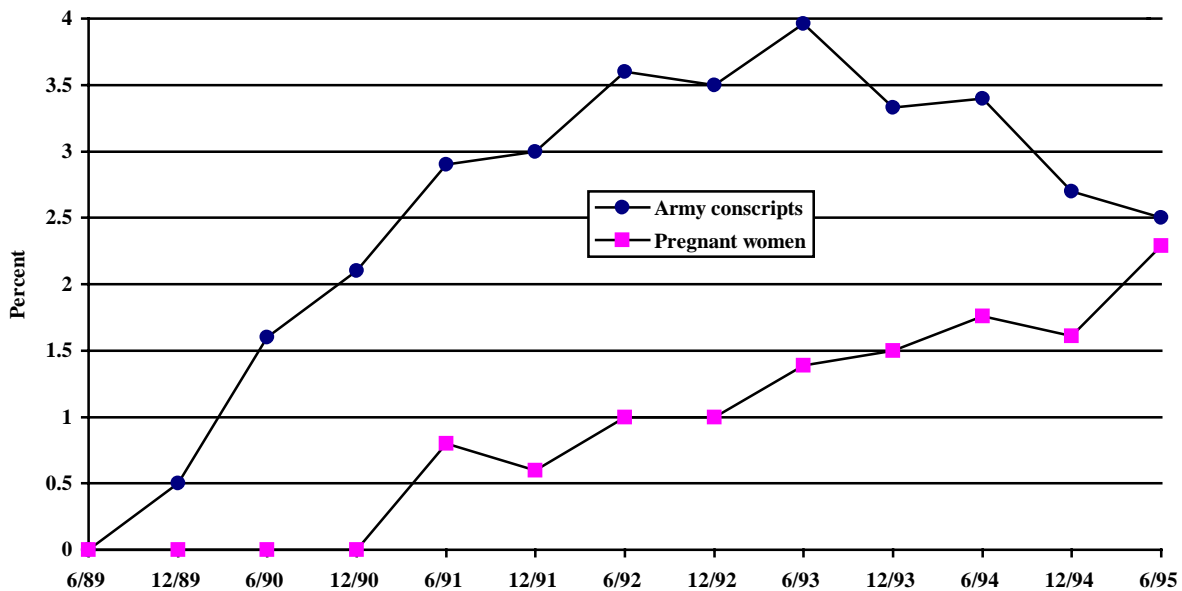
V. SYNTHESIS AND LESSONS

HIV/AIDS policy in any country is the composite of the policies in the work place, the community, the province and the national policy. These micro and macro policies shape the overall response, or lack thereof, to the threat of HIV. The scope of this study was limited to policies at the national level in Thailand.

A national focus on policy is appropriate in the case of Thailand because it is one of the first developing countries to document nationwide behavior change to reduce risk for HIV.

The national trends in behavior change (increased condom use, reduced commercial sex) are being confirmed by published declines in STDs and the emergence of declines in HIV prevalence among national samples of 21 year-old males. However, the upward trend for pregnant women demonstrates that new strategies are needed to offer protection for this group, long considered low risk (see accompanying chart).

HIV Prevalance among 21 Year Old Army Conscripts and Pregnant Women, 1989-1995



Source: Division of Epidemiology Public Health and Royal Thai Army, Army Institute of Pathology

Although Thailand is now recognized as progressive in its approach to HIV/AIDS, it was not always so. However, unless one understands how these programs and policies came about, there is little for other countries to learn and apply from the Thai case. This final chapter will propose a set of the possible factors which gave rise to policy and the program response.

Most of the key events which shape the program today occurred prior to 1992. Thus the information for this case study has relied on newspapers, secondary research and interviews with key Thai people who were active participants during the time that Thai policy evolved. There are three periods of important policy evolution that span the years 1985-1995. The forces which drove and defined policy during this period changed over time.

During each of these three periods certain events served to catalyze or trigger the policy response. The chapter concludes with some observations how the Thai experience may be a useful case for other countries who wish to accelerate the policy evolution process.

1985-88: Business-minded government

The policy triggers during this period included the following:

- Reports of full-blown AIDS cases among Thais;
- Visit Thailand Year tourism campaign; and
- Individual saga of Cha-on: The Thai "Rock Hudson."

Cases of repatriated Thais infected abroad were reported to the public in the mid-1980s. But pressure from high levels of government encouraged officials to play down the importance of these. Ostensibly, the reason for a low-profile approach to AIDS during this period was the combination of a business-oriented cabinet and the launch in 1987 of "Visit Thailand Year"--a multi-million dollar campaign to boost tourism.

"The situation is under control. The cases of AIDS are among populations with extensive risk. The general public need not be alarmed. Thai-to-Thai transmission is not in evidence."

--- Government Official, late 1980s

Toward the end of this period the case of Cha-on probably contributed more than other events to move the discussion of AIDS out into the open. Cha-on was a guard at a factory who was infected by a blood transfusion in 1986. He was diagnosed in 1987 and lost his job and suffered the general discrimination that PWAs experience in countries where HIV is still new. With his full consent, Cha-on agreed to go public and appeared on nationally televised talk shows, received front-page coverage in the press and made personal visits to

offices and other work sites to de-stigmatize HIV disease. As the case of Rock Hudson in the U.S. marked a turning point toward openness and discussion, Cha-on had a similar impact on the mainstream of Thai society. Whatever national forces were promoting suppression of discussion of AIDS in Thailand, these could no longer compete with the demand by society to know more.

1989-90: A wealth of seroprevalence data

The factors which triggered policy reform during this period include the following:

- National sentinel surveillance: Chiang Mai shock;
- Screening of military recruits: Confirming the worst; and
- Estimates of HIV caseloads: From confusion to consensus.

With the topic of HIV/AIDS now out in the open, national policy shifted to the need to characterize the epidemic through one of the most extensive serosurvey systems in the world. The initial results were met with disbelief. The finding--and public release of the finding--that 44 percent of Chiang Mai brothel workers were infected in June 1989 was a significant trigger which led sequentially to outreach for CSWs, massive distribution of free condoms to brothel bedrooms and the well-publicized structural approach of 100 percent condom brothels.

At this same time in 1989, the Thai military established its universal national screening of army inductees, all age 21, and mostly coming from the poorer rural areas of Thailand. Ad hoc behavioral surveys of subsamples confirmed how widespread brothel patronage was prior to induction and how an infection bridge was well established into every region of the country.

Key individuals within the military and within the Ministry of Public Health ensured that these data were shared among prevention agencies. And although their superiors might have been uncomfortable with the publicity, the irreversible atmosphere of openness prevented any further suppression of data.

These serosurveys were instrumental in enabling a more accurate estimate of the national caseload of disease. Although reporting of HIV was a requirement since 1985, reported cases grossly underestimate caseload since very few people sought testing. One informant noted: "The contradiction between publicized estimates of total caseloads and the reported caseloads undermined the credibility of the government data in the eyes of the public."

"The explosive epidemic in brothels, whose patrons are mostly Thais, was a prime factor which shifted the scope of policy inward to Thai men instead of outward to the red light zones with foreign customers."

--- Government Official

The first estimate of the national caseload of HIV infections came from a GPA MTP assessment team in April 1990 which announced an estimated 50,000 persons infected. Since only 15,000 had been reported at this time, charges of suppression resumed until it was understood that reported cases and estimates of total caseload had different meanings. Government, NGOs and academia joined to reach a consensus the next year that there were 300,000 infected Thais as of mid-1991. Without the serosurveys, these estimates would have been impossible. Without the estimates, the policy gains of the next phase might have been thwarted or delayed further.

1991-92: Activists in the NGO and Government Sectors

The policy catalysts during this third and formative period have shaped the current Thai policy and include the following:

- Direct lobbying of the Prime Minister;
- Media coverage of threat to mainstream society; and
- Call for a change of social norms.

A military coup d'état in February 1991 resulted in the installation of an interim prime minister and a cabinet of technocrats and activists. With the direct ear of the Prime Minister and no opposition parties to contend with, the technocrat activists were able to overturn past HIV/AIDS legislation and introduce progressive resolutions that resulted in the three distinctive manifestations of national policy that remain to this day:

- The Prime Minister chairs the national AIDS committee;
- A national AIDS budget close to \$1 per capita per year was created; and
- A comprehensive national AIDS plan was formulated and integrated into the five-year development plan.

This open era of public debate and swift change was also characterized by an increased media coverage of the individual and social consequences of HIV/AIDS--instead of the sensational reporting which had prevailed in the late 1980s. Prime time TV spots broadcast on national television increased dramatically during this period as well.

The interaction of policy makers and the national media was frequent and intense during this period. This gave rise to

Frequency of HIV/AIDS Spots on National Prime Time Commercial TV	
<u>5-month Interval</u>	<u>Number of Spots</u>
Jun '91 - Oct '91	0
Nov '91 - Mar '92	60
Apr '92 - Aug '92	138

consistency between the messages being broadcast to the nation and the resolutions that were being passed.

The presence of activist women on the Cabinet was a key policy trigger in spot lighting the need for social reform. Broadside attacks were launched on the commercial sex industry and foreign media were encouraged to expose the reality of this disgrace to the world.

Lessons for Other Countries

Many of the aspects of AIDS policy evolution in Thailand are unique to its situation and are not replicable. However, there are some lessons that are relevant especially for countries in Asia.

- The sooner governments recognize that their HIV/AIDS epidemics will sprout from within their borders from the behavior of their own citizens, the sooner can constructive policy emerge to control spread.
- Sentinel surveillance to detect HIV must be directed to local sex networks with the highest turnover if they are to detect the emergence of a potentially widespread epidemic and influence policy makers to act.
- Estimates of HIV caseloads should be carried out by multi-disciplinary working groups and the results publicized and endorsed by government and NGO agencies in order to maintain government credibility and as a realistic guide to policy makers.
- Nationwide publicity of an individual with HIV disease - with his or her full, informed consent - is an effective way to personalize HIV for a society and accelerate policy toward compassionate prevention measures instead of punitive.
- Constructive policy for HIV prevention emerges most rapidly when non-government and government resources are merged.
- An open and unrestricted commercial mass media gives credibility to government information about the epidemic and provides the only forum for a national policy dialogue for reformation of societal norms to combat HIV.
- Since formal policy may only emerge after programs are mounted, the lack of policy should never be an excuse to delay the launch of a prevention program.
- If a multi-sectoral approach is to be adopted as policy, then implementation should begin at the community level, not the national. A national level multisectoral approach to AIDS is not necessarily supported by the Thai case.

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