

# Chapter 1

## Introduction and Summary

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### *1.1 Introduction*

The first AIDS case in Thailand, a homosexual patient, was diagnosed in 1984. Since then, the country's Ministry of Public Health has established HIV/AIDS surveillance systems to monitor the trends of HIV infection and AIDS cases as well as to track the changes in sexual behavior of selected population groups. In the early stage, the HIV/AIDS epidemic was confined to homosexuals, intravenous drug users, and commercial sex workers. Later, it spread to heterosexuals and the general population, including children. The epidemic steadily increased until the mid-1990s. Thereafter, it began to gradually decline as a result of the many HIV/AIDS intervention programs implemented by the Thai government and other concerned parties. Infections of females by husbands and sexual partners has gradually increased, however, and once women have contracted HIV, some transmit the virus on to their newborn children. The first case of a pregnant woman with HIV virus was found in 1991.

A March 2001 projection of the Thai Working Group on HIV/AIDS indicated that approximately 4,000 Thai children are infected with HIV each year. The National Economic and Social Development Board (NESDB), in turn, estimates that 63,000 children were infected with HIV and 47,000 had died of AIDS-related illnesses as of year-end 2000. Estimates indicate that some 109,000 children under the age of 15 had lost their mothers to the disease by the end of the same period. The number is slated to reach 232,000 by the year 2005. Children infected with HIV fall into two classes. Members of the first group, perhaps 15-20 percent of the total, develop AIDS very rapidly and die within one or two years of birth (The Thai Working Group, March 2001). Children in the second group, by far the largest, progress towards AIDS more slowly and live for a longer period of time.

This means that a growing number of children will be living with HIV. Most will require ongoing medical treatment and counseling support. As a result of the costs associated with AIDS-related illnesses and deaths, many will also be unable to continue their education. Some will have to leave school because of illness while others will need to work and care of family members. A large number of these children will experience trauma related to the illness and death of family members. At the same time, they will also experience discrimination and social stigmatization. Children orphaned by AIDS will face far more extreme problems; the loss of family members and relatives will leave them without the traditional economic safety nets afforded by family and community. In light of these concerns, a review of previous plans and policies for addressing the impact of HIV/AIDS on children assumes a critical importance.

Using funding from UNICEF Thailand, this report examines the following issues: (1) the long term socio-economic impact of HIV/AIDS on children and Thailand's policy responses in the areas of prevention, treatment and mitigation; (2) lessons learned in

Thailand which might be applicable in other countries around the world; and (3) appropriate policy recommendations derived through consultation with key informants, a review of current literature, and the research team's own conclusions.

## *1.2 Organization of the Report*

This study was conducted as a desk review supplemented by qualitative research in specific areas. The study team examined and analyzed past and projected HIV incidence and AIDS mortality data for Thailand. Policies/systems and intervention programs designed for the prevention, treatment and mitigate of HIV/AIDS and related illnesses were also studied and analyzed to determine efficacy of response to the epidemic and the needs of society and children. In order to build upon data derived from secondary sources and existing research works, as well as to develop recommendations for future planning in the area, it was deemed necessary to gather additional information and responses from patients, patient's relatives, and key informants on the HIV/AIDS situation. Towards this end, a number of in-depth interviews and focus group discussions were conducted. In undertaking both, efforts were made to: (1) determine the demand for, and satisfaction with HIV/AIDS prevention and control programs; and (2) assess the needs of service providers and recipients in order to better develop effective policy and implementation plans.

Particular attention was given to provinces with the highest incidence of HIV/AIDS in each region of the country: Payao Province in the North, Khon Khaen Province in the Northeast, Rayong Province in the East, and Phuket Province in the South. Bangkok was utilized for pre-testing of questions used in focus group discussions. Target groups included support service providers (public and private providers as well as NGOs and communities) and people living with HIV/AIDS. The sample size was 15 people for each group per province (for a total of 150 samples). For provider groups, steps were taken to have local service provider personnel (school principals, public health workers, doctors and nurses, NGO and community members) participate in the discussion. The recipient group consisted of people from households that had lost a member of the family to HIV/AIDS and households that had HIV-positive members, as well as relatives and community members whose lives had been affected by the HIV epidemic.

Sampling was undertaken by the research team at area hospitals, NGO offices, and public health offices with the full consent of all concerned. Provider groups were asked to comment upon: (1) service and resource management, work cooperation, and referral system between units; (2) the socio-economic impacts of HIV/AIDS on infected children, infected/non-infected orphans, abandoned children who had lost one or another of their parents to AIDS and had no other relatives, discrimination against and stigmatization of children with infected parents; and (3) the appropriateness and effectiveness of HIV/AIDS prevention and control programs, including proposals to minimize problems. For recipient groups, discussion centered upon welfare services and social/economic assistance obtained from various funding sources. Other topics included the impact on children's education, recognition from social, community and peer groups, employment discrimination and the types of assistance that the government and other agencies ought to be providing.

This report has been organized into five chapters. Chapter 1 provides an introduction to the study. Chapter 2 examines the evolution of Thailand's HIV/AIDS epidemic among children and includes a discussion of policy responses. Chapter 3 discusses the long term socio-economic impact of HIV/AIDS on children, including the results from case study responses. Chapter 4 considers public and private policy responses specific to the problem of HIV/AIDS and children. Finally, Chapter 5 presents the study's conclusions, along with recommendations and suggestions for handling the problem effectively.

### ***1.3 Summary***

Although Thailand has had considerable success in preventing the spread of HIV, close to 30,000 new infections occur each year (The Thai Working Group, March 2001). In 2000, some 750,000 Thai people were living with HIV/AIDS, creating a serious demand for primary medical care and social support. As has already been noted, Thailand's first AIDS case was diagnosed in 1984. As the HIV/AIDS epidemic spread, it was initially viewed as a medical problem, a chronic disease which posed concentrated health risks for specific population groups. During this early period, the epidemic was limited to homosexuals and individuals who had had sexual relations with foreigners. Thereafter, the epidemic spread to intravenous drug users (IDU). The infection rate among these groups increased rapidly, from below 1% in the late 1987 to over 40% in the late 1998 (Division of Epidemiological, Ministry of Public Health). Subsequently, the epidemic spread to heterosexuals and men who had sexual relations with sex workers. In June 1989, the first round of national epidemiological surveillance found that 44% of the brothel-based sex workers in the northern town of Chiang Mai were infected with HIV. A separate 14-province study suggested a prevailing level of 1% to 5% infection elsewhere (Department of Communicable Disease, Ministry of Public Health). By 1994, HIV/AIDS had spread to the general population.

The 18<sup>th</sup> Round HIV Serosurveillance of Thailand in June 2000 indicates that the slow pace of reducing transmission via commercial sex has set the stage for an inevitable outward spread of HIV to low-risk partners and children. Antenatal clinic data suggests that between 1997 and 1999, HIV prevalence among pregnant women rose from 1.74% to 2.02%. More recent data, although partial, indicates that infection rates among pregnant women have continued to rise in every region of the country.

With respect to children, the Thai Working Group on HIV/AIDS projections discussed above indicate that approximately 4,000 children contract HIV each year. In conjunction with NESDB estimates that 63,000 children had contracted HIV by 2000, this suggests that as many as 71,000 children will have been infected by year-end 2002. As already been noted, NESDB predicts that the number will climb to as high as 232,000 by 2005. Given that roughly 80% of all children infected with HIV remain alive for an extended period of time, Thailand will be faced with a growing number of children living with HIV. Most of will require a range of support services: ongoing medical treatment, counseling support, and assistance with educational expenses.

Between 1984-1990, as a growing number of NGOs made use of international assistance to conduct prevention activities, the government response to the epidemic was confined almost entirely to the Ministry of Public Health (Health Focus). In 1987, however, the Ministry's Department of Communicable Disease Control (CDC) began coordinating with NGOs and other groups under the auspices of the National Advisory Committee on AIDS. In 1998, the World Health Organization (WHO) began providing technical and financial support for the development and implementation of short-term national HIV/AIDS plans emphasizing "risk group" education programs, surveillance, blood screening, and training of health care workers. Acknowledging that HIV/AIDS prevention and control needed to be a national priority, the government and the NESDB included a National AIDS Prevention and Control Program in the National Plan shortly thereafter in 1990.

During the 1991-1996 period, Thailand's response largely consisted of gathering information on and increasing awareness of the HIV/AIDS epidemic. Extensive HIV/AIDS research was conducted on a number of fronts. Quantitative and qualitative studies of risk behaviors and their determinants were undertaken utilizing a conceptual framework based on social vulnerability and expanding policy infrastructure. Meanwhile, the growing number of AIDS cases among adults and children gave rise to increasing community awareness of the extent of HIV infection in the population as a whole and the likelihood that all members of society could be affected.

During this period, national and social planning efforts increasingly began to make use of a "holistic approach" to development. Focus was shifted to community capacity building in order to expand participation in the development process. This human-centered approach to development, one emphasizing community and family empowerment, was subsequently incorporated into national plans from 1997 onwards in order to strengthen civil society and National AIDS Program management schemes to better respond to the epidemic.

The results of this combined public and private effort have been dramatic. The most recent epidemiological projections by the Thai Working Group on HIV/AIDS (March 2001) show that the number of new infections peaked in the early of 1990s and have since declined by more than 80%. It has been estimated that an additional 200,000 people would have been infected with HIV, had the epidemic remained unchecked.

Work remains to be done, however. Mother-to-child infections are still increasing, from 0% of all AIDS cases in 1990 to 14% in 2000. The number of females contracting HIV also continues to rise and as a result of AIDS-related deaths, the number of orphans infected with HIV has increased from 15,400 in 1997 to 23,400 in 2001. As a result, society is faced with carrying the increasingly heavy burden of treatment and care for mothers, children, and orphans living with AIDS.

Thailand's response to the AIDS epidemic has been one of the most successful in the world. The country's pro-active, multi-sectoral prevention and care efforts have led to risk reduction and reduced incidences of HIV and other sexually transmitted diseases. The Thai experience demonstrates that institutional and traditional approaches can be employed together with efforts to empower individuals, families, and communities to protect and care for themselves to develop an effective national response.

The evolution of Thailand's AIDS policy and the country's success in containing the HIV/AIDS problem provide a number of important lessons that may be of use

to other countries in the region and the world. The principal lessons are as follows. The commitment of national leaders at the highest levels is required for effective action. Political leaders must recognize the devastating scale of the epidemic and be willing to openly discuss the problem.

Social capital and civil society are also important ingredients for success. In Thailand, key actors have emerged not only from the public sector but also the private. NGOs, communities, and religious groups as well as families have all played a significant role in caring for PHA and mitigating the impact of HIV/AIDS.

Effective programs lead to effective outcomes. As Porapakham and colleagues (1996) note in a recent review, well-crafted programs can result in the development of good policy. Pilot programs can and should be employed to demonstrate effective outcomes before national policy is formulated. Policy, in turn, should take shape as a result of operational research and evidence-based decision-making.

Pilot programs are likely to have the strongest influence on policy when program impact is well documented. By way of example, in 1997 MOPH implemented two pilot programs to provide AZT short courses to pregnant women and their infants. The results showed that short course AZT can reduce mother-infant HIV transmission (PMTCT) by 50% among non-breast feeding women with HIV. The findings led to a subsequent policy decision to provide free AZT short courses to pregnant mothers for two months prior to delivery and their children for six months after delivery in order to decrease infant mortality. The '100% condom program,' discussed in greater detail below, is another example of a successful pilot project that helped to shape AIDS prevention policy.

A people-centered approach to program development should also be adopted. At the core of this approach is the idea that a solution cannot be one-sided. To the contrary, its underlying premise is that societies and environments are comprised of complex and delicately balanced relationships, linkages and networks that must be taken into careful consideration. The importance of doing so in addressing the AIDS problem can be seen from the fact that PHA suffer not only a serious medical problem but also economic vulnerability and social discrimination.

As a cure for HIV/AIDS has yet to be found, attention should be placed upon prevention programs, especially for individuals in high-risk groups such as MTCT, teenagers, and intravenous drug users. At the same time, preparations should also be made to cope with the increasing problems of orphans and abandoned children. This can be done by strengthening the capacities of the government, communities, and families to provide supportive environments for orphaned girls and boys infected by HIV/AIDS. Activities should include the provision of appropriate counseling and psychosocial support, as well as the promotion of non-discrimination and children rights.

Increased linkage between the AIDS response and development programs as well as more effective and expanded coordination for AIDS planning at the national and provincial levels is also warranted. The emphasis should be upon enhancing the role of local authorities and communities as well as strengthening and promoting the role of PHA and related groups affected by AIDS, CBOs and NGOs to provide better care for PHA and their families. Efforts should also be made to improve and mobilize existing local funds and social

capital from all sectors to help PHA and their families. If these steps are undertaken, the AIDS response will be at once more consistent and sustainable.

As AIDS is a human crisis, the challenge for government bureaucracy is to make the necessary adjustments to empower communities and create enabling environments in which communities have the chance to successfully respond on their own. At the same time, mechanisms should be developed and procedures established for the protection of rights, particularly the rights of PHA, their families, and children.

# Chapter 2

## The Evolution of Thailand's HIV/AIDS Epidemic among Children

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### *2.1 Introduction*

After AIDS was introduced into Thailand in 1984, the Ministry of Public Health adopted a number of medical and health-related programs in an effort to stem the epidemic. Initially, it was assumed that only a few individuals and high-risk groups were at risk of contracting the disease. Clearly, this assumption was not correct. As year 2000 drew to a close, approximately 984,000 people (951,000 adults and 33,000 children) had contracted HIV and 289,000 of them had died of AIDS-related illnesses. During the course of 2001, the total grew by another 29,000 new cases, including 4,200 children. Around 55,000 Thais developed serious AIDS-related illnesses and sought medical treatment. Rough the same number died of AIDS complications.

### *2.2 The Evolution of the HIV/AIDS Epidemic*

Throughout the period, the Thai government conducted a number of campaigns to reduce HIV transmission. Policy response evolved over time as the HIV/AIDS situation change. In terms of prevention and control policy, three major phases can be distinguished.

#### *Phase I : Health Focus 1984-1990*

❖ **Situation:** During the first wave of HIV/AIDS infection, the epidemic was viewed as a medical problem that was likely to have limited impact on the general population. Initially, the epidemic was confined to homosexuals and individuals who had had sexual relations with foreign nationals and thereafter, it spread to intravenous drug users. As has already been noted, infection among this latter group increased rapidly, from below 1% in late 1987 to over 40% in the late 1998. At roughly the same time, the disease began spreading to heterosexuals and men who had sexual relations with sex workers, many of whom had already contracted the disease.

❖ **Policy:** As a disease, AIDS was seen to be the responsibility of the Ministry of Public Health (MOPH) and its Department of Communicable Disease Control. During

1984-1990, both organizations put considerable effort into the medical and health aspects of prevention with particular effort being directed towards HIV surveillance among at-risk groups. The aim was to find a way to control the epidemic. Towards this end, in 1985 MOPH declared AIDS to be a communicable disease to be reported according to the Communicable Disease Act of 1980. In 1986, it also took steps to have AIDS included as a prohibited disease under the Immigration Act of 1979. As only a few groups were perceived to be at risk, little effort was made to disseminate information on HIV/AIDS to the general public.

❖ **Organization Structure :** In this initial stage, AIDS problem-solving was mainly done by the MOPH. At the same time, the Department of Communicable Disease Control provided care and treatment to HIV/AIDS patients. In 1987 an AIDS Coordination Committee was established to coordinate the AIDS control programs of public and private hospitals. With the rapid spread of the disease in 1988, an AIDS Prevention and Control Committee was also set up under the chairmanship of the Communicable Disease Control Department director general. In 1989, chairmanship was shifted to the permanent secretary. As AIDS continued to spread in 1990, the government established the National AIDS Prevention and Control Organization (NAC) with the Minister of Public Health as chairman to help in formulating national AIDS policy. The organization's major task was to develop strategies for HIV/AIDS prevention and control. At roughly the same time, the government also acknowledged the importance of mobilizing different sectors of the society to help in containing the epidemic. Towards this end, in 1990 the government established the National AIDS Prevention and Control Committee, chaired by the Prime Minister and with the Permanent Secretary of MOPH as the Secretary. Subsequently, this committee appointed seven subcommittees to coordinate HIV/AIDS activities among public and private agencies and NGOs (Figure A 1) (AIDS Division, MOPH).

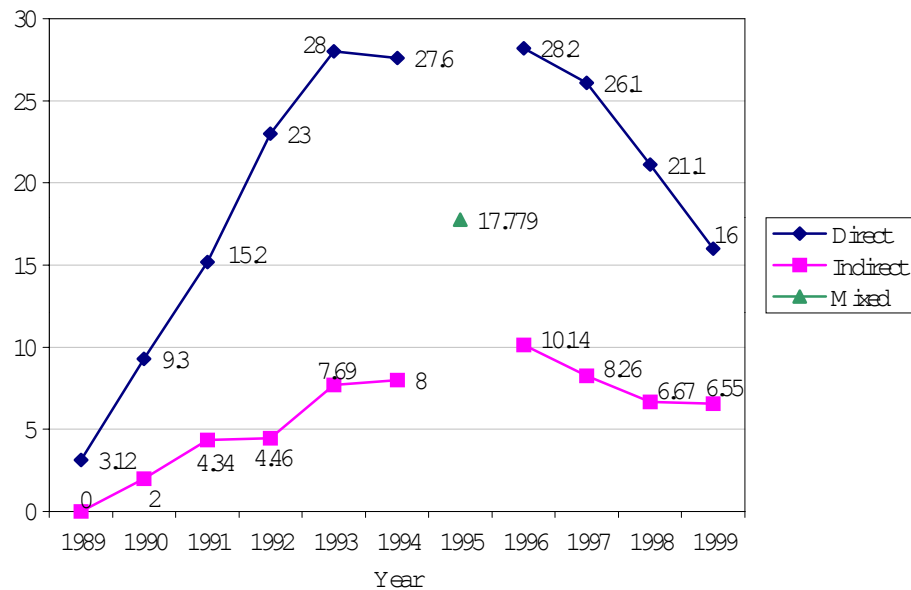
❖ **Programs and projects:** As has been noted, the AIDS epidemic was initially considered to be the responsibility of the Department of Communicable Disease Control, MOPH. It was only in 1988 that a special budget (4.6 million baht) was allocated for AIDS prevention and control programs, however. In 1989, the budget was increased to 11.1 million baht and by 1990, it had risen to 66.6 million baht (Table B1). Following WHO guidelines of the period, most of the projects undertaken were short and medium term efforts. The main emphasis was to provide health education and promote activities that would: prevent and control HIV/AIDS infection among IDU; encourage condom use/distribution and promote safe sex to prevent transmission through sexual relations; promote blood screening tests to prevent transmission through blood transfusion; provide social welfare; and conduct research, monitoring and evaluation.

## ***Phase II: Social Focus 1991-1996***

❖ **Situation:** HIV/AIDS spread to the general population. By 1994 HIV prevalence among brothel-based sex workers reached 31% nationwide, up from only 3.12% in 1989. (18<sup>th</sup> Round HIV Serosurveillance in Thailand, June 2000). Infection among this group was caused by virus subtype E which was more easily transmitted than subtype B, the virus subtype infecting IDU and male homosexuals. Among direct sex workers (SW) in general, HIV prevalence rose from 3.12% in 1989 to around 28% in 1994. Among indirect

SW, HIV prevalence increased more slowly, from 0 in 1989 to 8% in 1994. In 1995 HIV prevalence among mixed SW (both direct and indirect SW) was 17.8% (Figure 2.1). From 1996 to 1999 HIV prevalence decreased due to active HIV/AIDS prevention and control activities implemented by both public and private agencies.

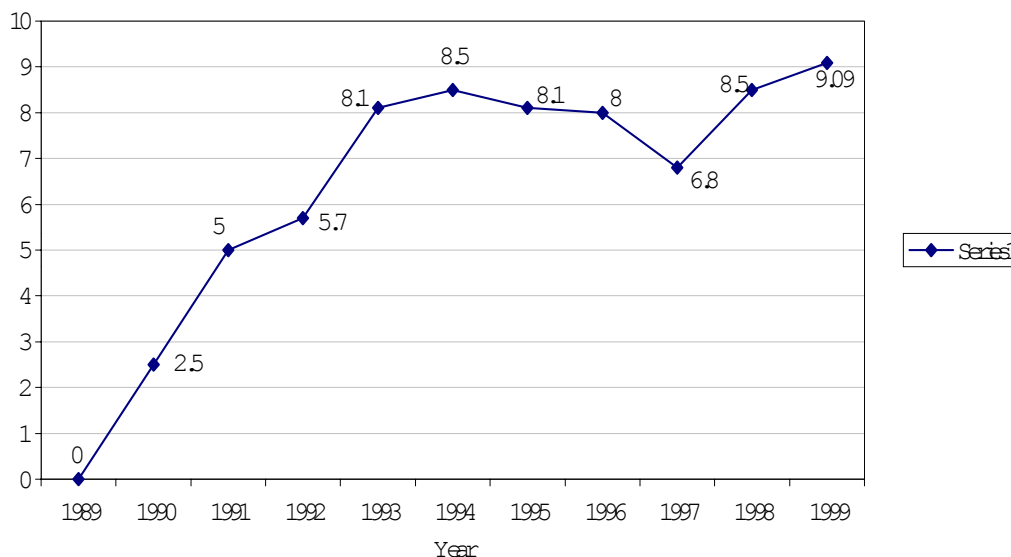
**Figure 2.1 : HIV Prevalence among Direct and Indirect Sex Workers in Thailand, 1989-1999.**



**Source: Division of Epidemiology, Ministry of Public Health**

HIV infection spread from SW to their clients and then was transmitted on to wives and their sex partners.

**Figure 2.2 : HIV Prevalence in Male STD Clients in Thailand, 1989-1999.**

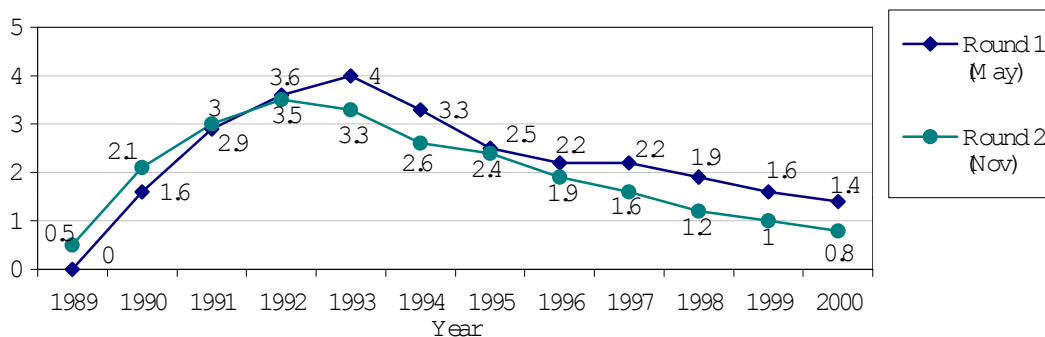


**Source: Division of Epidemiology, Ministry of Public Health.**

HIV prevalence in males at STD clinics increased from 2.5 % in 1990 to 8.5% in 1994. The figure dropped to 6.8% in 1997 but rose again to 9% in 1999 (Figure 2.2).

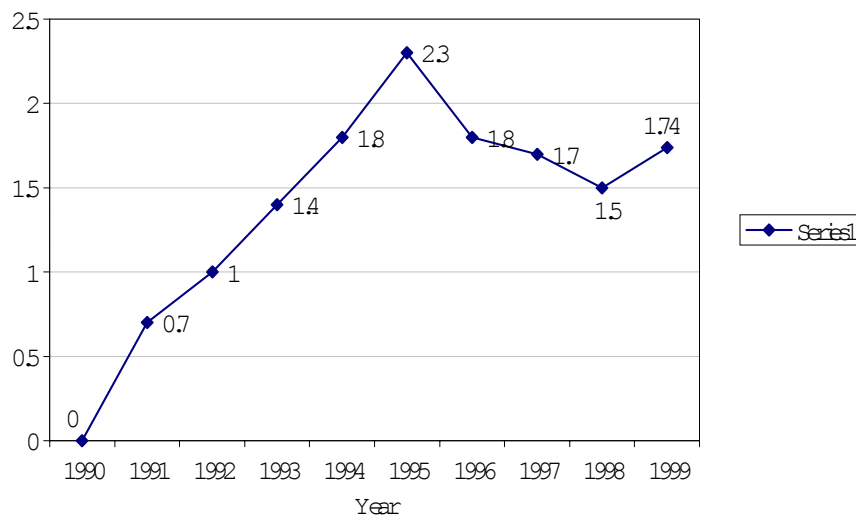
Among military conscripts, the HIV infection rate has peaked and continues to decrease. Information from the AIDS Division, MOPH and the Armed Forces Research Institute of Medical Sciences revealed that HIV prevalence in successive cohorts of 21-year-old conscripts in the Royal Thai Army (a nationally representative sample of young men who are prime clients of SW) rose from 0.5% in 1989 to peak at about 4% in 1993. Thereafter, it decreased to 0.8% in 2000 (Figure 2.3).

Since army conscripts are young, it can be assumed that their infections are recent. For this reason, trends in HIV prevalence among cohorts of conscripts are often considered as representative of broader social trends in HIV incidence (18<sup>th</sup> Round HIV Serosurveillance in Thailand: June 2000). However, as conscripts generally have comparatively low economic and educational status, they tend to have higher rates of infection than the general male population.

**Figure 2.3: Prevalence of HIV Infection among Thai Military Conscripts**

Source: Division of Epidemiology, Ministry of Public Health.

Thereafter, however, a growing number of pregnant women attending antenatal clinic were found to be infected with HIV and the disease began spreading to children in the general population. The infection rate increased through time from 0.7% in 1991 to a peak of 2.3% in 1995. It subsequently dropped to 1.8% and 1.5% in 1996 and 1998 respectively. In 1999, however, it increased again to 1.74% (Figure 2.4). The result has been the birth of an estimated 4,000-6,000 HIV-infected children annually (18<sup>th</sup> Round HIV Serosurveillance in Thailand: June 2000).

**Figure 2.4: HIV Prevalence in Women Attending Antenatal Care Clinics in Thailand 1990-1999.**

Source: Division of Epidemiology, Ministry of Public Health.

❖ **Policy:** With the rapid spread of AIDS, it became clear that the epidemic would have far-reaching social consequences. At the same time, an understanding began to emerge that the disease was passed by individual behavior and reflected broader social problems in the society. As a result, AIDS came to be viewed as a social problem that needed to be addressed by multiple sectors of the society. The government of the period gave high priority to solving the problem. Then Prime Minister Anand Panyarachun requested that the national parliament formulate social policy to: "accelerate the prevention and control of communicable diseases, particularly AIDS, in coordination with the business sector and non-governmental non-profit agencies, in the area of public information in order to convince the population of the seriousness of this disease and instill a feeling of individual responsibility to join the prevention effort to resolve the problem" (Office of the Prime Minister, 1992-1996). The National AIDS Prevention and Control Committee (NAC) also emphasized the need for cooperation among all sectors of society in adopting appropriate attitudes and minimizing the impact of the disease.

❖ **Organizational Structure:** In order for promote effective coordination among various agencies, the Prime Minister agreed to chair the NAC in 1991. NAC's role was to set policy on AIDS prevention and control programs. As six provinces in the upper northern region (Chiang Mai, Chiangrai, Lampang, Payao, Lamphoon and Mae Hongson) had the highest number of HIV infections and AIDS patient in Thailand, the NAC established the Upper-North AIDS Administration Committee in 1994 to administer and alleviate problems in these areas. The committee was tasked to analyze budget disbursement, collect and monitor operational plans, prevent the duplication of subcommittee operations, and help the administrative committee to operate efficiently.<sup>2</sup>

❖ **Programs and Projects:** During this period, major programs and projects were adapted from the National AIDS Prevention and Control Plan of 1992-1996. There were four program areas: public information, treatment and care, human rights, and research and education. Since AIDS was at this stage being treated as a social problem, all relevant parties were encouraged to participate according to their respective capabilities and areas of responsibility (Table A1). To fund the effort, budgets for the 1991-1994 period were increased significantly, to 182.7, 637.5; 1,121.5 and 1,142.5 million baht respectively.

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<sup>2</sup> This committee had 4 subcommittees: the Subcommittee on Coordinating Information; the Subcommittee on Coordinating and Analyzing Plans; the Subcommittee on Monitoring Plan Implementation; and the Subcommittee on Public Relations.

**Table 2.1: Roles of Agencies in Prevention and Control of AIDS**

Programs Agencies	(1) Public information	(2) Treatment and Care	(3) Human Rights	(4) Research and Evaluation
1. Office of the Prime Minister	***	-	**	***
2. Ministry of Public Health	**	***	**	**
3. Ministry of Interior	***	**	***	*
4. Ministry of Education	***	*	*	*
5. Ministry of Defense	***	**	*	*
6. Ministry of University Affairs	***	***	*	***
7. Ministry of Justice	*	-	***	*
8. Ministry of Finance	*	-	*	*
9. Ministry of Industry	**	-	*	*
10. Ministry of Transport and Communication	*	-	*	*
11. Ministry of Commerce	**	-	*	*
12. Ministry of Science and Technology and Energy	*	-	*	*
13. Ministry of Foreign Affairs	*	-	*	*
14. Ministry of Agricultural and Cooperatives	**	*	*	*
15. State Enterprises	**	*	*	*
16. Non-Government, Non Profit Agencies	**	**	*	*
17. Business Sector	*	***	*	*
Total	17	9	17	17

**Source: National AIDS Prevention and Control Plan , 1992-1996**

**Note :** \*\*\* High Involvement  
 \*\* Moderate Involvement  
 \* Limited Involvement

The AIDS epidemic changed rapidly during the 1995-1996 period, making it necessary to modify prevention and control programs accordingly. Emphasis was given to educating people about changing at-risk behavior and getting a growing number of agencies involved (Table 2.2). At the same time, the government also allocated additional resources for HIV/AIDS prevention efforts. The budget increased from 9.3% in 1995 to 14.3% in 1996. The budget for assisting PHA was also increased, from 2.5% in 1995 to 7.5% in 1996, with most of the resources - about 65% - being allocated for treatment programs. These included primary care, prevention of infection (comprehensive precautions) in hospitals and clinics, training of health personnel to work with HIV/AIDS patients, construction of HIV/AIDS inpatient wards, etc.

**Table 2.2: Policy Plans/Programs and Budget Allocations, 1995-1996**

Policy Plan/Program	1995		1996	
	Million Baht	%	Million Baht	%
1. HIV/AIDS Behavioral and Social Prevention Program.	144.5	9.3	294.7	14.3
2. Health Promotion and Medical Treatment and Care Program.	1,019.3	65.4	1,350.9	65.7
3. Consultation Services Program.	20.0	1.3	33.0	1.6
4. Promotion of People Living with HIV/AIDS and Legal Measures Program.	39.0	2.5	154.4	7.5
5. Research and Evaluation Program.	16.2	1.0	50.4	2.4
6. Management Development Program.	319.3	20.5	173.6	8.4
<b>Total</b>	<b>1,558.4</b>	<b>100</b>	<b>2,057.1</b>	<b>100</b>

Source: Bureau of Budget, Ministry of Finance.

A number of prevention activities, including a “100% Condom Use Project” to promote condom use in commercial sex establishments, were adopted nationally in 1991 (Rojanapithayakorn and Hanenberg, 1966). Once the epidemic spread to families, including pregnant women and new born infants, programs were also developed to provide powdered milk to HIV-positive mothers. Other programs included the establishment of HIV sentinel surveillance in risk groups.

### ***Phase III: Civil Society Focus 1997-2001***

❖ **Situation:** The number of infections continues to grow, albeit at a slower rate. HIV infection rates among many high-risk groups also remained unacceptably high. Other than during brothel-based sex, condom use remains low and there is evidence of rising HIV prevalence among sex workers in some regions, especially in Bangkok (HIV Sero-surveillance in Thailand: result of the 18<sup>th</sup> Round, June 2000). The epidemic continues to spread outward to ostensibly low-risk populations of housewives, women of reproductive age and their children.

The 18<sup>th</sup> Round HIV Serosurveillance indicates that limited progress in reducing HIV transmission through commercial sex has set the stage for an inevitable outward spread of HIV to previously low-risk sexual partners and their children. Data from antenatal clinics indicates that in 1997, HIV prevalence among pregnant women was 1.74%. This increased to 2.02% in 1999. There is no region in Thailand where infection rates among pregnant women have declined. Research suggests that without medical intervention, roughly 25-35% of all HIV-positive pregnant women will pass the virus to their children during pregnancy, childbirth, or breast feeding (Shaffer et al, 1999). It also indicates that a short course of AZT during pregnancy and labor can reduce the probability of mother-child transmission to about 8.2% (Kanshana et al, 2000). As for the life expectancy of children who are not helped by intervention, it has been determined that half will die by the age of 5 (Dabis et al, 2000)

(Table B2). While young children can benefit from the prevention and treatment of opportunistic infections, parents suffering from illness themselves find it difficult to cope with the illnesses of children. As a result, the children of PHA often receive inadequate care when they fall ill.

Meanwhile, infected individuals continue to become ill, placing new demands on health services. Preventing new outbreaks, in turn, requires sustained effort to change behavior as new cohorts of young people enter adulthood. The public sector continues to have limited financial and human resources to cope with this vast and complex problem.

❖ **Policy:** AIDS policy planning during this period shifts towards the adoption of a holistic approach. A part of this change comes from the recognition that controlling HIV/AIDS is not the responsibility of the government alone. Instead, success is contingent upon strengthening the role of all related actors - private businesses, NGOs, communities, families, and individuals as well as PHA - in working to prevent and control the disease according to their specific capabilities (National AIDS Committee, 1997).

❖ **Organization Structure:** In 1997 two national committees were established under the NAC. One was the AIDS Program Executive Board, which consisted of four subcommittees: Development of AIDS Vaccines, International Cooperation on AIDS, Problem Solving on AIDS Vaccine and Procurement, and Coordination between Public and Private Care Providers. The other was the Committee on Managing the Fight Against AIDS in the Upper-North. The NAC also maintained seven subcommittees: Public Information on HIV/AIDS Control; Research and Education on HIV/AIDS Control; Community Involvement in HIV/AIDS Control, Universal Precautions in Medical Settings for HIV/AIDS Control, Strengthening Indigenous Knowledge, Wisdom and Research for HIV/AIDS Control, and Provincial-Level HIV/AIDS Prevention and Control.

During this period, the NAC revised the structure of the subcommittees in order to facilitate effective work efforts. A National AIDS Foundation was also established to solicit funding in support of activities being undertaken by NGOs, HIV/AIDS self-help groups, and community organizations working on AIDS issues.

❖ **Programs and Projects:** The programs and projects during this period were implemented under the framework of the National Plan for the Prevention and Alleviation of HIV/AIDS (1997-2001), which stipulated eight strategies as follows:

1). Developing the potential of individuals, families and communities to prevent and alleviate the HIV/AIDS problem as well as strengthening community awareness of HIV/AIDS, promoting a spirit of mutual assistance, and preserving community culture in order to help ameliorate the problem.

2). Creating a social ambient conducive to the prevention and alleviation of HIV/AIDS, developing a positive socio-economic environment by promoting and strengthening business activities that are not destructive of Thai culture, traditions and lifestyles. This strategy included the dissemination of information through the mass media.

3). Emphasizing the psychosocial development of PHA so that they can lead normal lives in the society without discrimination.

4). Modifying the basic components of the social and economic systems to be more effective in dealing with the AIDS problem. This included the development of basic social services, particularly educational services, in order to promote a sound understanding

of healthy behaviors. Care and counseling services for affected people by both the public and private sectors were also emphasize.

5). The application of health promotion schemes and medical care services. This strategy emphasized the provision of appropriate medical services to HIV/AIDS patients, and encouragement of home care for PHA by their families and communities.

6). The utilization of cultural wisdom, existing knowledge, and the promotion of relevant research. This strategy emphasized the planning and implementation of research projects, exchanges of knowledge domestically and internationally, and the development of industries essential for the production of HIV/AIDS prevention technologies and control vaccines.

7). Enhancing international cooperation in assessing and exchanging HIV/AIDS-related technologies and state-of-the-art techniques for prevention and alleviation of the HIV/AIDS problem.

8). Revising and strengthening managerial processes and related mechanisms so as to create a holistic approach to program management from the national level to the regional level.

From 1997-2001, the average budget for HIV/AIDS was 1,500 million baht per year (Table 2.3). Budgets were allocated under two programs: HIV/AIDS Prevention and Alleviation.

**Table 2.3: The National HIV/AIDS Program Budget in Thailand During 1997-2001**

Unit: Million Baht

Program Components	1997	%	1998	%	1999	%	2000	%	2001	%
<b>HIV/AIDS Prevention and Mitigation</b>	<b>516.3</b>	<b>26.0</b>	<b>382</b>	<b>25.8</b>	<b>334.9</b>	<b>23.3</b>	<b>314.8</b>	<b>21.6</b>	<b>351</b>	<b>23.6</b>
<b>Programs</b>										
1). Subprogram on developing the capacity of the individuals, family and community.	217.3	10.9	138.3	9.3	108.9	7.6	110.5	7.6	123.0	8.3
1.1) Strengthen community capacity in Preventing and alleviating the HIV/AIDS problem.	118.8	6.0	66.6	4.5	45.7	3.2	49.6	3.4	59.1	4.0
1.2) Strengthen the learning processes and Knowledge in preventing and alleviating HIV/AIDS problem.	98.5	5.0	71.6	4.8	63.2	4.4	60.9	4.2	63.9	4.3
2) Subprogram on social and psychosocial Services.	85.2	4.3	102.1	6.9	89.5	6.2	87.6	6.0	88.4	5.9
2.1) Provision of welfare services in Mitigating the impact of HIV/AIDS.	76.9	3.9	91.7	6.2	83.2	5.8	82.0	5.6	82.7	5.6
2.2) Develop and strengthen the economy of Infected individuals and families.	6.0	0.3	8.1	0.5	4.7	0.3	4.2	0.3	4.2	0.3
2.3) Protection of human rights of infected People.	2.3	0.1	2.3	0.2	1.6	0.1	1.4	0.1	1.5	0.1
3) Coordination of policy and HIV/AIDS implementation programs.	213.8	10.8	141.6	9.6	136.5	9.5	116.7	8.0	140.0	9.4
<b>HIV/AIDS Prevention and Control Programs</b>	<b>1,469.7</b>	<b>74.0</b>	<b>1,099.5</b>	<b>74.2</b>	<b>1,104.1</b>	<b>76.7</b>	<b>1,145.3</b>	<b>78.4</b>	<b>1,135.9</b>	<b>76.4</b>
1) Subprogram on health promotion and medical services.	1,436.9	72.4	1,052.8	71.1	1,049.5	72.9	1,095.6	75.0	1,081.4	72.7
1.1) Health promotion for HIV/AIDS prevention and control.	57.5	2.9	72.0	4.9	144.3	10.0	147.8	10.1	146.7	9.9
1.2) Treatment and care services for infected people.	972.4	49.0	894.9	60.4	892.8	62.0	937.0	64.2	924.9	62.2
1.3) Provision of supporting facility for treatment and care.	0.6	0.0	0.6	0.0	0.7	0.0	0.9	0.1	0.9	0.1
1.4) Pre and post counseling services.	25.2	1.3	11.6	0.8	11.8	0.8	8.9	0.6	8.9	0.6
1.5) Initiate homes for HIV/AIDS patients.	381.1	19.2	73.7	5.0	-	-	-	-	-	-
2) Subprogram on developing the wisdom of the people and research studies.	32.9	1.7	46.7	3.2	54.6	3.8	50.7	3.5	54.5	3.7
2.1) Development of the people's wisdom and researches on the HIV/AIDS problem.	32.9	1.7	46.7	3.2	54.6	3.8	47.7	3.3	51.7	3.5
2.2) Research and development on AIDS vaccine.	0	0	0	0	0	0	3.0	0.2	2.8	0.2
<b>Total</b>	<b>1,986.0</b>	<b>100</b>	<b>1,481.5</b>	<b>100</b>	<b>1,439.0</b>	<b>100</b>	<b>1,460.1</b>	<b>100</b>	<b>1,486.9</b>	<b>100</b>

Source: Bureau of the Budget. Figures for 1997-1999 are actual expenditure and figures for 2000-2001 are budgeted

Main activities were coordinated by formulating the AIDS plan, supporting NGOs and private activities, developing the potential of individuals and the communities in preventing and alleviating the AIDS problem, and implementing the “100% Condom Use Program”. Programs also emphasized care for children born of HIV-positive mothers, care for abandoned children and orphans, as well as skills training and development for PHA and their families to provide them with greater employment opportunities.

The AIDS Prevention and Control Program consisted of two sub-programs: health/medical services and development of traditional learning and research. Between 1997-2001, approximately 70% of the budget was used for health and medical services. During this period, the impact of HIV/AIDS on children was enormous (Figures 4 and 5). Programs implemented placed emphasis upon providing medical treatment for patients suffering AIDS-related opportunistic infections; safe blood donation and transfusion; supporting anti-retroviral therapy (ART); and providing free HIV testing to pregnant women. HIV-positive mothers received a short regimen of AZT before and after delivery, AZT syrup for the child, and supply of breast milk substitute (powdered milk) for a period of one year. Other programs supported the development of traditional learning as well as research and evaluation efforts.

The evolution of the government's national AIDS policy, programs, and strategic management plans are summarized in Table 2.4.

**Table 2.4: Summary of the Evolution of AIDS in Thailand**

	1984 - 1990	1991 – 1996	1997 - 2001
<u>Policy</u>	Health Focus	Social Focus	Civil Society Focus
<u>Organization Management</u>	Committee (National level since 1990 Minister as a chair)	National Committee (Prime Minister as a chair)	National Committee (Prime Minister as a chair )
<u>Projects and Programs (under the plans)</u>	Short term (1998) and medium term in AIDS prevention and control program (1989-1991)	Medium term in AIDS prevention and control program (1989-1991) - National AIDS Prevention and Control Plan (1992-1996) - Operation plan for AIDS Prevention and Control (1995-1996)	National Plan for Prevention and Alleviation of HIV/AIDS (1997-2001)
<u>Situation</u>			
Total AIDS cases (accumulate)	268	68,419	172,760
• Male	236 (88%)	56,060 (82%)	131,424 (76%)
• Female	32 (12%)	12,359 (18%)	41,336 (24%)
• Ratio male to female	7.4 : 1	4.5 : 1	3.2 : 1
<u>Death (cases)</u>	139	20,186	47,798

Children AIDS cases (0-14 years old)	22	3,682	4,184
• Male	14 (64%)	1,972 (54%)	2,241 (54%)
• Female	8 (36%)	1,710 (46%)	1,943 (46%)
Highest Risk behavior	sexual transmission (73%)	sexual transmission (81%)	sexual transmission (83%) (Others 17% e.g. IDU=5%, mother to child=5% etc.)
Highest in occupational AIDS group	wage earner (32%)	wage earner (42%)	wage earner (44%) (Others 56% e.g. agriculture=21%, merchandize=4% etc.)
Province with highest AIDS cases	Chiang Mai	Chiangrai	Chiangrai

Source: Division of Epidemiology, Ministry of Public Health, June , 2001.

# Chapter 3

## Long Term Socio-Economic Impact of HIV/AIDS on Children

### 3.1 Introduction

From 1984 until 31 October 2000, some 156,309 AIDS cases were reported in Thailand. During this period, the disease resulted in 43,069 deaths (Epidemiological Department, MOPH, 2000). According to a 2001 study of the Thai Working Group on HIV/AIDS Projection, HIV infection patterns over the course of Thai epidemic have changed. Infection of males by sex workers has been reduced from 78% of all cases in 1990 to 31% and 12% in the years 1995 and 2000. If the trend continues, the rate will be 9% in 2005. Males infected by sharing needles, on the other hand, is slated to rise from 5% of all cases in 1990 to 30% in 2005. Meanwhile, HIV/AIDS infection is moving to families and children. As a percentage of all cases, non-sex worker females infected by husbands or other sex partners increased from 8% in 1990 to 42% in 2000. As a result, the number of children infected by mothers also constitutes a larger percentage of all cases, from 0% in 1990 to 6%, and 14% in 1995 and 2000 respectively.

**Table 3.1: Changing Infection Patterns over the Course of the Thai Epidemic in Baseline Scenario. Percentage of New HIV Infections by Gender and Means of Infections**

Infection Route	1990	1995	2000	2005
Males infected by visiting sex workers	78%	31%	12%	9%
Males infected by sharing needles	5%	10%	18%	30%
Males infected by non-commercial female partners (wife or girlfriend)	0%	3%	7%	8%
Females sex workers infected	8%	7%	4%	3%
Females infected by husbands or other sex partners	8%	42%	42%	29%
Females infected by needles sharing partners	1%	2%	3%	4%
Children infected from mothers	0%	6%	14%	17%
<b>Total number of new infections</b>	<b>137,000</b>	<b>61,000</b>	<b>29,000</b>	<b>18,000</b>

Source: The Thai Working Group on HIV/AIDS Projection, *Projections for HIV/AIDS in Thailand: 2000-2020*, March 2001, Division of AIDS, Ministry of Public Health.

After people contract HIV, it takes several years for them to develop AIDS, although much depends upon the health and treatment obtained by the individuals in question. Most AIDS infection occur among people of productive age (25-45 years old), (Table B 3). AIDS cases among children, including children with symptomatic HIV, are

generally within the 0-4-year-old bracket. The trend of AIDS and symptomatic HIV in children is decreasing over time (Table B 3 and B 4), but the consequences remain enormous.

In addition to the physical and mental health problems caused by various opportunistic infections, PHA and their family members also face social discrimination and stigmatization. As for the children of PHA, the economic and social difficulties of parents will inevitably have consequences for offspring as well. In examining these problems, this section will first discuss the socioeconomic impacts on PHA and their children, with particular attention being given to health, education, psychosocial, and rights issues. Thereafter, an examination will be made of the epidemic's long-term impact on the country as a whole, if circumstances are allowed to remain unchanged.

## ***3.2 Social Impact***

### **1. Exposure to HIV Infection**

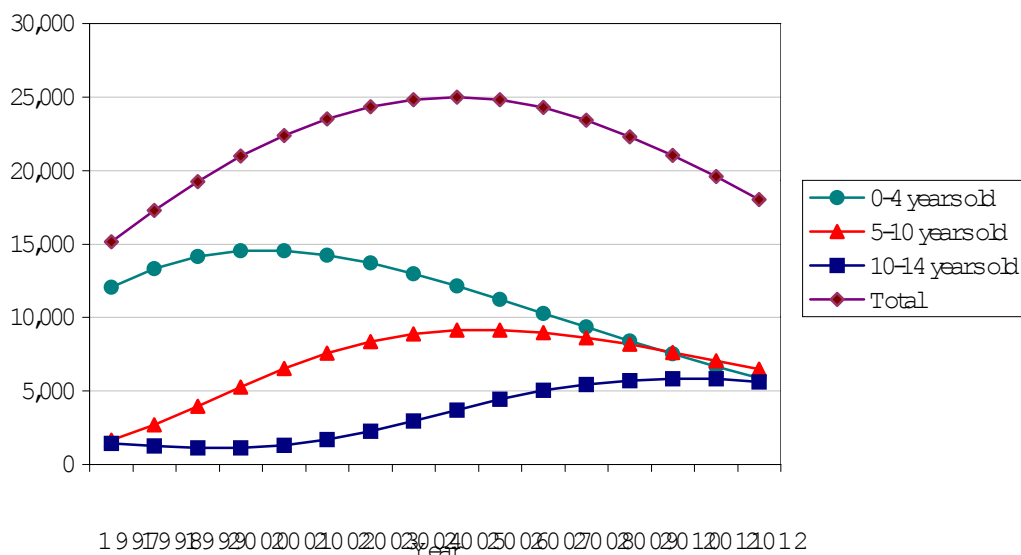
A recent study employing the base line scenario indicates that 22,388 children in the 0-14 year-old age bracket had been infected by HIV by the end of 2001. The figure is higher than in 2000, when 20,969 children were thought to be carrying HIV. And the number of HIV-infected children is projected to rise to 24,801 by 2006 before falling to 18,044 in 2012 as shown in Figure 3.1 (The Thai Working Group, March 2001).<sup>3</sup>

Most people are stunned when they first learn that they are HIV-positive. Emotional instability, deepening worry about illness, and apprehensiveness about the future are standard responses. Some are unable to sleep or eat. Others slip into depression and consider suicide. In 1996, suicide rates among people with HIV/AIDS rose steadily in the upper north (Mahatnirandkul, S.). Males with HIV infection had suicide rates some 60% in excess of normal (Brown and Sittitri, 1996). Responses also include terror, rage, a growing sense of injustice, as well as somatic, moral, and interpersonal concerns. A Chiang Mai-based study comparing the economic impact of HIV/AIDS on households with AIDS death and without AIDS death (Pitayanond, S; S. Kongsin and W.S. Janjaroen, 1996) noted that in 48% of 116 households with AIDS death, the PHA experienced significant community discrimination prior to succumbing to illness. Another 15% reported discrimination against family members as well. Family members were forced to quit jobs. Those with businesses lost customers. The report also noted that in 20% of all households with children, the children were ostracized by playmates. In several cases, they were also forced to leave school.

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<sup>3</sup> **Baseline scenario: (1)** It was assumed that prevention efforts were sustained and risk behaviors were maintained at year 2000 levels. **(2) Behavioral Targets.** Beginning with the situation as described for the period prior to 2000, the following behavioral trends were assumed in preparing the baseline scenario: (a) percent of males visiting sex workers remains stable (9%) at the 2000 levels through the end of the projection in 2020. (b) Condom use in commercial sex remains at 85% level through the end of projection. (3) Sexually transmitted disease (STD) infections remained at 1.6% through the end of projection. (4) Needle sharing remained at 20% through the end of projection.

Figure 3.1: Projection of Children with HIV infection



Source: The Thai Working Group on HIV/AIDS, Projections for HIV/AIDS in Thailand : 2000-2020, March 2001, P. C2-C7.

Despite intensive campaigns over many years to increase awareness, understanding, and public acceptance of PHA, discrimination continues to be felt. Groups of HIV/AIDS infected women in Bangkok, Khon Khaen, Payao, Rayong and Phuket Provinces report similar experiences. Some previously sold food but had to stop due to a lack of customers. Some have been denied permission to enter hair salons to have their hair cut. Some have had to arrange the funerals of husbands who died of AIDS alone. Members of the community remain fearful of associating with PHA, even if they now have more sympathy for AIDS victims than they did in the past. Thus, the moral and financial support of families and relatives, as opposed to the broader community, is often critical in encouraging PHA to carry on with their lives.

## 2. Impact on pregnant women and infected mothers

Pregnant women and infected mothers are the most vulnerable group. They face complex problems and severe emotional turmoil if the disease is passed to their children. This can cause great physical and mental suffering. Following birth, the hopelessness and despair of mothers can also lead to inadequate care of children (Limrourong, 1997). As mothers infected with HIV play the same roles as normal mothers, they face additional stress when considering the health and future of their children, relationships with partners, and a battery of related economic concerns.

## 3. Abandoned Children and Homelessness

Newborns abandoned by HIV/AIDS-infected mothers are becoming a big problem. Many women abandon their babies because they are afraid of poverty and feel they lack the ability to take care of a child that has a high probability of being HIV-infected. Many

are also afraid of being stigmatized by their families and the community. The problem is particularly severe for hospitals located in areas with high HIV infection rates. The likelihood of abandonment in these institutions is 5.4 times higher for mothers with HIV/AIDS than it is for mothers without infection (Table 3.2).

**Table 3.2: Abandonment Rate of Newborns: Comparison Between HIV/AIDS Infected Mothers and Non-Infected Mothers**  
(Unit : per 1,000 after birth)

Year	Abandoned from HIV/AIDS mother	Abandoned from non-HIV/AIDS mother	Ratio between abandoned newborn from mother with and without HIV/AIDS infection
1992	3.48	0.56	6.2
1993	3.39	0.64	5.3
1994	2.79	0.57	4.9
<b>Total</b>	<b>3.16</b>	<b>0.59</b>	<b>5.4</b>

Source : Sombat Tanprasertsook and others, "Problem of abandoned children from HIV/AIDS infected mothers: a case study from big public hospital, 1992-1994", *Journal of Public Health*, Y. 6, Vol. 3 (Jul-Sep 1997), p. 498.

The number of newborns deserted by HIV/AIDS-infected mothers is 3.16 per 1000 births, very high when compare to the abandonment rate of 0.59 per 1000 births by mothers without HIV/AIDS.

Studies by the Department of Communicable Disease Control, Ministry of Public Health, indicate that the number of pregnant women with HIV is increasing over time. Clearly, this is likely to increase the total number of orphans and abandoned children as well. This suggests the growing need to maintain effective programs to prevent the spread of AIDS among the reproductive population group. In the aftermath of the economic crisis of 1997, however, the budget for HIV/AIDS programs has been reduced, further exacerbating the problems of abandoned children and homelessness (Figure A2 and Table B1).

#### 4. Orphans

Most AIDS orphans are born before their parents are infected with HIV/AIDS. Others have avoided infection from HIV/AIDS mothers through pediatric transmission prevention programs using AZT. A study in 1994 estimated that the number of orphans under five years of age will increase over time. Most children in the 5-12 year old age bracket with infected mothers will be orphaned within the next two years (Vatinee Boonchalaksri and Philip Guest, 1994). Tim Brown and Werasit Sittitri (1995) estimated that there were 95,000 orphans in 2000 and the number will increase to 160,000 by 2005 (Table 3.3).

Many of these children have a difficult time adapting to their changed circumstances. Some are fortunate in that they can live with relatives. Others are obliged to live in orphanages. Many must struggle to survive and may even contribute to social problems - committing crimes, turning into drug addicts, or becoming commercial sex workers.

**Table 3.3: Estimate of Orphans Whose Mothers Died of AIDS**

Year Age	New Orphans				Cumulative Orphans			
	0-4	5-9	10-14	Total	0-4	5-9	10-14	Total
1997	5,274	6,199	3,987	15,460	10,491	20,187	13,791	44,469
1998	6,073	7,280	5,061	18,414	12,667	27,151	20,642	60,461
1999	6,684	8,142	6,057	20,883	14,473	34,238	29,005	77,716
2000	7,045	8,698	6,788	22,531	15,788	40,940	38,378	95,106
2001	7,193	8,999	7,234	23,426	26,596	46,878	48,112	111,585
2002	7,240	9,193	7,529	23,962	17,023	51,820	57,698	126,540
2003	7,255	9,382	7,813	24,450	17,174	55,632	66,878	139,684
2004	7,259	9,568	8,112	24,939	17,190	58,359	75,478	151,057
2005	7,252	9,731	5,428	25,412	17,151	60,257	83,415	160,823

Source: Tim Brown and Weravit Sittitrai, *The Impact of HIV on Children in Thailand, Program on AIDS, Thai Red Cross Society, 1995, p. 130.*

The above information suggests that the impact of HIV/AIDS on children is severe, requiring the attention of all parties in the society: policy-makers, health personnel, social workers, NGOs, and CBOs. Children infected with HIV/AIDS have the additional burden of health problems. Many come from poor families and lack access to medication for relieving symptoms and forestalling opportunistic infections. As a result, they become ill more frequently. They are often malnourished and have a low growth rate as well. In such circumstances, treatment costs are a major problem, although the government's new "30 Baht treatment" policy may alleviate some of the hardship.

## 5. Changes in household and family structure

Before discussing the impact of HIV/AIDS on household and family structure, it is important to note how the population structure has already changed as a result of successful family planning programs in Thailand over the past 30 years. The rate of population growth has declined from over 3% to approximately 1%. During the same period, family size was reduced from 6 children in 1970 to 2 children in 1999. A forecast by NESDB (2001) estimates that the percentage of population in childhood will decline from 23.8% in 1998 to 18.6% in 2016. The work-age population will also face a similar decline, but to a lesser degree. On the other hand, the percentage of older people in society is expected to increase sharply from 8.9% in 1998 to 15% in 2016. The characteristic household has also been transformed from an extended to a nuclear family. The number of people remaining single is also increasing. Such trends and transformations affect policy considerations in a number of respects which will be discussed later.

In terms of the medium-term impact of HIV/AIDS, family patterns are likely to change. More males than females have been infected with HIV/AIDS and those infected have 5-10 years to live. PHA life spans are shorter, approximately 2-3 years. As a result, family dependants of PHA are faced by the certain loss of economic support. There will also be more single mothers, some infected with HIV and some not. All are likely to face a number of economic difficulties. The children of mothers infected by HIV/AIDS are also obliged to cope with the reality of being left in the care of relatives or the community.

## 6. Psychosocial distress

The above noted problems explain the causes of many children's psychosocial distress. Those who are HIV/AIDS infected often come from poor families and have less access to adequate medical treatment. Children from poor families also have a tendency to get sick more often, are often malnourished and generally have lower growth rates.

Infected children not only have physical problems, they are often emotionally unstable as well. As a result of "emotional deprivation," children will be depressed and pay less attention to their surrounding environment (Suthira Wacharakup, 1992). Healthy children with infected parents tend to feel grief and loneliness when facing parental illness and death. They frequently carry these emotions to school. Instead of experiencing positive socialization, they feel they are operating in an uncaring and unsupportive environment, with detrimental consequences for their mental health (The Life Skills Development Foundation). Schools play a significant role in the socio-emotional development of children. Only recently have efforts been made to enhance school abilities to support children in general and children from families affected by AIDS in particular. Children in the latter group are often stigmatized and socially isolated from their peers, resulting in depression, withdrawal, and eventual withdrawal from school. Outright social rejection creates more problems for these children than they would have if they merely trying to survive without social support.

There is no direct evidence to indicate precisely how many children are in such circumstances at present. However, given the growing number of abandoned children and orphans, as well as a number of all HIV/AIDS infected children, the problem is likely to be immense. The period of impact will also be an extended one, unless appropriate steps are taken to address the problem. In Chiang Rai, a 10-year-old boy who lost his mother to AIDS has become extremely aggressive, isolating himself from friends and refusing to go to school. The development of a child such as this one has consequences for society as a whole. Children constitute the future of the country and children in crisis will may pose significant social problems in the long run.

## 7. Fewer opportunities for schooling and education

Discrimination against infected children still exists. They commonly experience rejection by peer groups. Those with visible symptoms are also occasionally forced to resign from school. Others are compelled to withdraw from school by their parents. Children from households that experience HIV/AIDS-related deaths, particularly poor households, are frequently taken out of school to work, help with household chores, take care of younger children and sick relatives (Pitayanon, Kongsin and Janjaroen, 1993; Janjaroen, 1996; Brown and Sittitrai, 1996). Taking young children out of school, especially girls from poor rural northern villages (Table B5), may leave them with few marketable skills besides those required by the sex industry, indirectly exacerbating the spread of HIV/AIDS. To alleviate this problem, the government provides education subsidies in the form of scholarships to young children from needy families. Infected families with children are able to receive 1,000-2,000 baht per one child-family or 3,000 baht in cases where the family has more than one child. This amount is provided only once. Focus group discussions also revealed that this money is often used for purposes other than education. In the long run, such welfare is not appropriate due to the country's budget difficulties. Instead, more vocational

education programs are needed so that school dropouts will be able to find reasonable employment.

## **8. Social capital and civil society**

During the first 10 years of the AIDS epidemic in Thailand, the pictures and images of AIDS patients shown in the media led to fear of the disease amongst the population, resulting in the stigmatization and discrimination against HIV/AIDS persons. As a result of educational campaigns, people also came to understand that AIDS is an incurable disease. In addition, AIDS was early on associated with marginal behaviors, leading to a characterization of the disease as being one of "passion" (Kamolman et al., 1995). This gave rise to judgmental attitudes in which members of the community without HIV/AIDS regarded people living with the disease as "bad." Since 1991, campaigns to reduce such attitudes have been introduced and carried out nationwide. Up to the present, however, the negative attitudes of people and communities towards HIV/AIDS-affected and infected persons have not been significantly improved. Levels of acceptance vary. In some communities, high-levels of discrimination still exist, resulting in the isolation of PHA from the society. An incidence in Phuket Province is a case in point (Focus Group, 2001). There, PHA continue to try and hide their condition out of concern that they will otherwise be expelled from their communities.

In some communities, however, PHA and their families receive support, encouragement, and sympathy from neighbors. Some communities provide information on where to receive medical treatment and welfare. Others mobilize resources and establish saving funds for PHA. Part of the money is set aside to provide members with assistance for a range of needs including cremation ceremonies. Some PHA have also formed self-help groups to provide each other with physical and emotional support. Religious leaders and institutions such as Thammarak Nives have also taken part in helping HIV/AIDS-affected and infected persons. In several places, assistance from the government has been used to create hospices for PHA in the final stage of illness as well.

Regardless of the AIDS epidemic, Thai society has been dramatically changed over the past few decades. In the past, Thai people had cohesive families and strong communities to rely upon. Today community and family ties have weakened as a result of the increased labor migration to urban areas, leaving children and seniors in the countryside. Thai society is now at risk of losing valuable social capital and the AIDS epidemic is not the sole cause. As discussed above, it is also the result of economic development policies over the last 40 years. Having recognized the long-term negative consequences, elements of the public and private sectors have begun a concerted effort to restore social capital so that families and communities can provide shelter for individual members.

## **9. Human rights**

**Violations of child rights** Children affected by HIV should have rights or entitlements equal to other children, without being discriminated against. In reality, however, their rights are violated long before they are born in various ways and they face discrimination on a number of fronts. The problems can be summarized as follows:

◆ **Education** Most governments have adopted policies of non-discrimination against HIV/AIDS-affected children and many have launched campaigns to change people's attitude toward these groups. Under the Constitution of the Kingdom of Thailand, all children have the right to be protected and receive basic social services. In addition, under the National Education Act B.E. 2542 (1999), children also have the right to receive a free education for nine year. As shown in figures A3 and A4 (Appendix), the budget for primary education has remained stable, even during the economic crisis of 1997-1998. The number of students attending primary school has also been stable over time, suggesting that education has been a high-priority government policy. In practice, however, both communities and schools regularly violate the educational rights of HIV/AIDS-affected children. Communities continue to believe that if parents have AIDS, then children must also have the disease. As result, children of PHA have periodically been denied access to schools by parents concerned for the safety of their children and dependants. In some instances, school administrators have also played a part in compelling guardians to pull affected children out of school. If allowed to continue, such practices will leave many affected children without an education, fostering related social problems. Thus, steps should be taken to protect the educational rights of children.

◆ **Abortion** A child has the right to be born. A pregnant woman should not be forced to have an abortion. However, some occasionally still are. During focus group discussions, several HIV-positive women revealed that they were compelled to have abortions by their doctors. While the cases may be exceptional, it suggests that at least some doctors still have an inappropriate understanding of HIV/AIDS and women's rights.

◆ **Abandonment** By law, it is forbidden to abandon a child, to advertise in order to give away or receive children from others, or to exchange a child for goods or money. Although a great number of children are at risk of being abandoned, most children can still count on receiving appropriate care from relatives, communities, NGOs and the government. With the demise of a growing number of PHA, the number of abandoned children is expected to increase, however. Attention, therefore, should be paid to the role of the family and community in taking care of these children. As social and family structures are changing, the elderly in particular will need to play an increased part in providing support.

◆ **Blood Testing for Children** It is the right of a child and his or her legal guardian to choose whether or not they would like to have a blood test. Without the consent of a child or a guardian, no agency or person can conduct a blood test on the child. The point is one that has generated controversy in communities, particularly with regard to children being admitted to schools. In a number of places, children are still pressured into taking blood tests before they enroll. In such cases, all parties are obliged by law to protect the child's rights.

◆ **Rights to receive standard health care** All children have the right to receive public health services. Health care providers or hospitals cannot refuse them treatment or deny health services. In the early stages of the epidemic, such discrimination occurred regularly, but as a result of greater understanding at present, the situation has improved.

◆ **Rights to live** No one can take a child's life under any circumstance. One recent case suggests that even this most fundamental right is not uniformly recognized.

*Mr. Mei, a 35-year-old, his 30-year-old wife, and their 5-month-old daughter were found dead in a pond in Songkla Province in Southern Thailand. The police investigation revealed that the couple took their daughter's life and then committed suicide after a blood-screening test revealed that they were HIV-positive. Their daughter was not infected.*

*Songkla Province, September 8, 2001.*

### 3.3 Economic Impact

Children are indirectly affected by the economic impact of HIV/AIDS through their parents and families. HIV/AIDS-affected families have to face a number of economic problems, from loss of income and employment, to increased expenditure and decreased assets and savings. Cumulative economic problems at the micro level of the individual household eventually constitute a national crisis.

#### 1. Loss of Income

HIV/AIDS-affected families experience income loss for a number of reasons, as follow:

◆ **Foregone Income.** Infected members of households lose income because they often cannot work due to illness and opportunistic infections. HIV/AIDS infection is highest among people in the labor force (15 to 40-year-olds). AIDS patients are admitted to hospitals an average of three times a year, with each admission averaging twelve days. The income loss per patient works out to around US\$180. As to the income lost as the result of premature deaths of HIV/AIDS patients, the figure per population cohort was almost US\$8.8 million a year 1993 (Kamonmal et al,1995).

◆ **Stop Working.** Most PHA were previously either self-employed or wage earners. After becoming ill, they are often obliged to quit working because they are too weak. Some also face job discrimination from employers and colleagues and are forced to resign. Interviews conducted with members of 591 HIV/AIDS-affect households in Chiang Mai showed that the working hours and incomes of many PHA had been severely disrupted. Some had to close down their business or resign from jobs (Im-ame, V. and S. Pongsajjai, 1999). Parents, spouses, children and other members of the household were also affected when PHA left work. Most families attempted to maintain existing lifestyles. However, in some households, members had to work harder while taking care of elderly, infant, and sick relatives. The study shows that while the percentage of income earned by PHA in HIV/AIDS households decreased, family expenditures rose. As a result, household savings decreased and debt rose. Households with family members who died of AIDS had 65% to 77% less in the way of savings than households in which PHA were still living. Households with HIV/AIDS illness have excessive expenditures, especially those relating to health care and treatment.

◆ **Increase in Expenditure** Health care costs depend on the duration of an illness; funeral expenditures are an integral part of terminal diseases. AIDS patients generally fall ill for a period of 1.1 years. Direct expenses on treatment and funeral ceremonies averaged out to approximately US\$973 and US\$1,537 per case in 1993 (Pitayanond, S; S. Kongsin and W.S. Janjaroen, 1996). As the average household income during this period was US\$2,600 year, HIV/AIDS affected families obviously faced great difficulties (Table B6).

The economic consequences of HIV/AIDS have been significant. The situation was worse during the 1997 economic crisis when labor-intensive industries such as garment, textile and electronics firms had to close down, resulting in lay-offs and growing unemployment. A majority of the workers in these factories were women. Some 61% were married and had children. In 1998, 29,106 women were laid-off by factories. How many of these people had HIV/AIDS is not known. However, surveys conducted by the Division of Epidemiology, Ministry of Public Health (June 2001) found that wage earners as an occupational group had the highest infection rate between 1984 and 2001. Presumably, then, a number of the laid-off workers were PHA.

## **2. Loss of Labor**

As discussed earlier, the AIDS epidemic has had an impact on the demographic structure of Thailand. According to an NESDB forecast (1994), AIDS will cause a reduction in the population growth rate between 1990 and 2025. Figures indicate that by the year 2020, the population will total 69.5 million, down 3.44% on earlier forecasts as a result of the AIDS-related deaths of women in their reproductive years. Initially, it was predicted that the total population would rise to 72 million. While this reduction is insignificant in quantitative terms, it does impact upon the size and quality of the labor force. As shown in Table B3, a majority of all AIDS cases, around 85%, occur in the 20-44 year-old cohort, or people in the labor force. Many have accumulated expertise and experience. Their deaths will not only decrease the country's comparative advantage in terms of labor but will also result in the need to invest in training replacements. In consequence, loss of labor to AIDS is likely to have an impact on Thailand's overall economic productivity. It should be added that PHA not only contribute less labor but they and their families also have decreased purchasing power. In this way, AIDS directly impedes economic development (Kamolmal et. al., 1995).

## **3. Migration**

Located in the center of mainland Southeast Asia, Thailand harbors several ethnic minority groups and migrants from neighboring countries. As a result of poverty and relative vulnerability, members of these groups are frequently infected with a range of diseases, from elephantitis and malaria to tuberculosis and HIV/AIDS. Coming to Thailand as alien workers, they often carry these diseases with them. Illnesses such as malaria that had all but disappeared in Thailand are now returning in consequence. To combat these diseases, the country has to spend a great deal, both in training health personnel and to provide humanitarian health care and treatment. In 2000, for example, Ranong Province had around 46,000 migrant Burmese workers. The total Thai population of the province is 160,907. Ranong has 5 public hospitals with 31 medical doctors, which amounts to a doctor/patient

ration of 1:5,190. With such a large number of migrants, however, it has been necessary to set resources aside to serve people of other nationalities.

#### **4. Increase in Social Sector Expenditure**

Due to the government's commitment to social development, overall social sector expenditures gradually increased in the period prior to 1997. As the economic crisis began, however, across-the-board budget cuts in response to falling revenue resulted in an 18.7% reduction in this area. Cuts with the greatest impact on children included education, public services, and social services. Thereafter, social sector expenditure for all areas but health increased slightly in 1998. The health sector experienced additional budget cuts in 1998 and 1999 of 9.3% and 2.4% respectively. The AIDS budget was severely affected. The situation improved slightly after 1999, as allocations have subsequently remained constant.

In education, during the five-year period prior to the crisis the growth rate of nominal budgeted expenditure averaged 19% per year. The crisis halted this increase. The government's education expenditures remained constant in real terms between 1997 and 1998. After 1998, the budget has gradually increased from US\$4,584.3 million in 1998 to US\$ 5,036.2 million in 2001, a 9% rise (and a further increase of 0.6 percent is anticipated for 2002). As regards the budget for the social welfare and services, it only dropped in 1998, the year following the crisis. After that, it sharply increased, particularly in 1999-2000 when the budget rose 20.73% to US\$1,047.8 million in 2000. The increase reflects real need as the number of people affected by the crisis rose as well.

**Table 3.4: Public Expenditures in the Social Sector**

		Million US\$						
Budget	Year	1996	1997	1998	1999	2000	2001	2002p
- Total budget		19,163.6	21,454.5	18,181.8	18,750.0	19,545.5	20,681.8	23,250.0
- Education Budget		3,808.2	4,669.6	4,584.3	4,711.7	5,014.1	5,036.2	5,066.8
% of total budget		19.9	21.8	25.2	25.1	25.6	24.4	21.8
- Social Welfare Budget		817.6	890.1	773.6	830.6	1,047.8	1,171.9	1,608.7
% of total budget		4.3	4.1	4.3	4.4	5.4	5.7	6.9
- Health Budget		1,359.3	1,602.7	1,454.1	1,419.7	1,482.0	1,505.8	1,663.2
% of total budget		7.1	7.4	7.7	7.3	7.4	7.1	7.2
Aids Budget		46.8	45.1	33.7	32.7	33.2	33.8	23.2
% of health budget		3.4	2.8	2.3	2.0	2.2	2.2	1.4

Source : The Bureau of The Budget

Note : US \$ equivalent of Baht

1997 = 31.38

1998 = 41.37

1999 = 37.84

2000 = 40.16

The above table suggests that the AIDS epidemic was not a major factor in the overall change in social sector expenditure. Rather change occurred as a result of internal and external forces that placed high priority on human and social development, and the realization that quality human resources are a major driving force in sustainable development.

## 5. Decreased Assets and Savings

Falling revenue and increased expenditure has created unavoidable problems for families. Some households without assets to sell slipped into debt. In 1993, 60% of all Chiang Mai households affected by HIV/AIDS used saving for health treatment, approximately 22,000 baht or 88% of the total household expenditures (Pitayanond, S; S. Kongsin and W.S. Janjaroen, 1996). At the same time, 19% of the households were obliged to sell family assets - land, vehicles, and livestock - to pay expenditures. Financing was obtained from relatives, informal moneylenders, banks and financial cooperatives. The amount of money borrowed ranged from 9,000 to 239,000 baht per case. Interest rates were usually high. Some households were lucky enough to get support from relatives and friends working outside of the province in the form of remittances. The value of remittances was approximately 8,200 baht per year.

## **6. Impact on the economy: micro level and macro level**

It is now widely accepted that the AIDS epidemic is not only a medical problem but a social problem. At the same time, it is also acknowledged that social problems have a direct impact on economic growth, the economy being driven by human beings after all. When the future of children is in question, the long-term development of the country is at risk. At the micro level, the impact of AIDS on individual households has had detrimental consequences for the development of children. It has also reduced the size and impaired the quality of the labor force, undermining the long-term competitiveness of the country. HIV/AIDS, then, has direct consequences for the country's macro-economic development.

# Chapter 4

## Policy Response to HIV/AIDS and Children

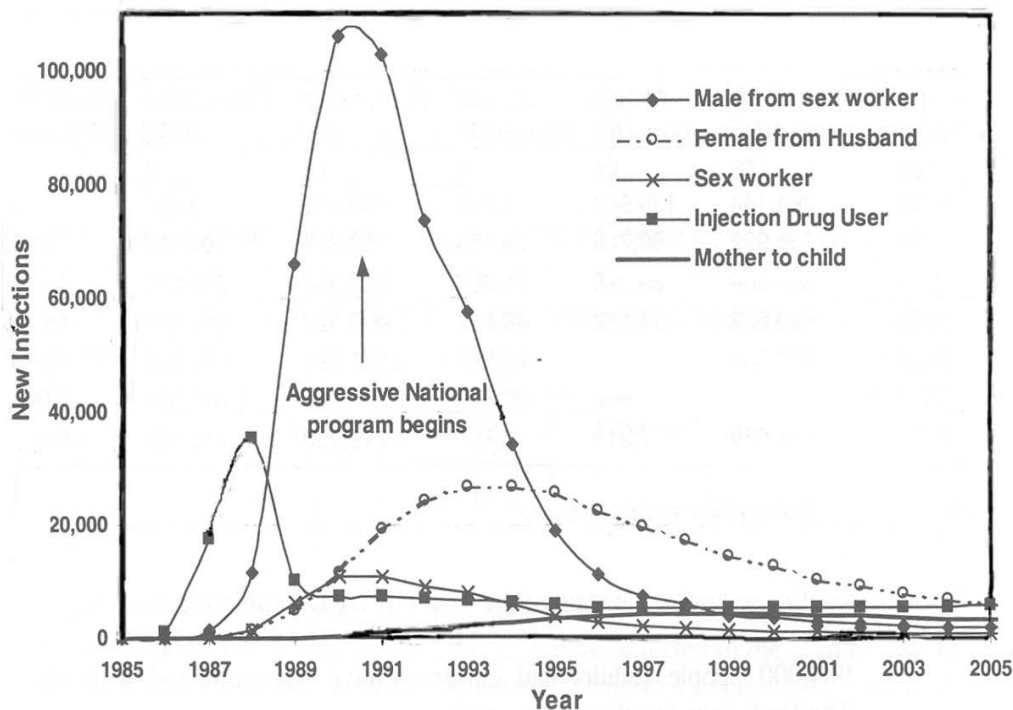
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### *4.1 Introduction*

Thailand is a country that has been relatively successful in controlling HIV/AIDS. In the period after 1984, projections for HIV/AIDS infections in country ranged from a low of 984,000 to as many as 3 million cases by the year 2000 (Virvaida et al, 1993). Thanks to the combined efforts of the Thai government and public, the total number of HIV/AIDS cases at that time was less than 700,000 and new infections had fallen to around 29,000 per year (The Thai Working Group, March 2001, Table A1).

The situation still warrants concern, however, as changing infections routes could have enormous consequences. Although a "100% condom use" program started in 1989 and fully implemented on a national scale in 1992 effectively reduced the incidence of commercial sex worker to client infection, those infected have nonetheless transmitted HIV on to their wives, sexual partners, and newborn children (Figure 4.1). The number of infants infected by mothers has been increasing over time from 6% in 1995 to 14% in 2000. Projections suggest that the number could be as high as 17% by 2005 (Table 3.1, Chapter 3 in this report).

**Figure 4.1: Changing Routes of HIV Transmission over the Course of the Thai Epidemic as seen through the Baseline Scenario.**



Source : The Thai Working Group, March 2001, page 28.

## 4.2 AIDS Prevention Programs

Over the past decade, the Thai government has given a high priority to the prevention of HIV/AIDS. In recent years, the framework and strategies of prevention programs have undergone a major change. As has already been discussed, the AIDS epidemic was initially viewed in strictly medical terms and only later came to be seen as a social problem that required the cooperation of the broader public to be solved.

During this period, governmental allocations for AIDS prevention programs were in the order of 140 million baht per year. This constituted 9% of the total AIDS budget, or approximately 2 baht per capita. While the government has been criticized for spending far less on prevention than it has on treatment, outlays for prevention and treatment often times overlap. Efforts to protect the blood supply and provide powdered milk to infected mothers, for example, are usually counted as outlays for treatment. At the same time, AIDS prevention activities in Thailand have also received considerable financial support from international agencies, foreign governments, and NGOs.

Assuming aggressive prevention measures are continued in 2001-2, the number of new infections may fall to as low as 9,400 cases in 2006, down from 143,000

cases in 1991 (The Thai Working Groups, March 2001). Major strategies and approaches for preventing new HIV infections during this period are as follows:

### ***4.2.1 Improving Public Health Education***

When the AIDS epidemic first hit Thailand, most people lacked an adequate understanding of the disease. As a result, individuals infected by HIV/AIDS were often ostracized as the sexual behavior of the general population remained unchanged. Later, however, strategies and programs were established to disseminate information on AIDS prevention to the public at large as well as to special risk-groups, such as students, fishermen, commercial sex workers, truck drivers and migrant laborers.

Public information campaigns made use of various media, from radio and television spots to cartoons and posters. Steps included improved health education and the establishment of peer counseling groups for young people. The conceptual framework for public health education was also modified over time. Once perceived as being the responsibility of the government alone, it was subsequently recognized to require the participation of all relevant parties and agencies according to their specific areas of capability.

**NGOs.** Public efforts to control the AIDS epidemic have been assisted by some 400-500 NGOs and self-help groups. In addition to working with the general public, steps have been taken to reach minority groups in remote areas, commercial fishermen, and migrant laborers, both domestic and foreign. Included in the latter group were migrant sex workers who otherwise would have had limited access to AIDS information. Generally, the activities of NGOs in AIDS prevention has proven to be more flexible than those of the public sector, especially among the high-risk groups. It is frequently necessary to interact with such groups over an extended period of time before they can be persuaded to modify 'at-risk' behavior. The government began allocating budgetary support NGOs working in AIDS prevention in 1992. During 1997-2001, funding averaged out 80 million baht per year - approximately 5% of the total AIDS budget. During 2000-2001 a Social Investment Project (SIP) loan of 90 million baht was also used to support NGO AIDS prevention activities.

**Private Business.** A number of private businesses have cooperated in providing HIV/AIDS training to employees. In 1993, the Thailand Business Coalition on AIDS was established to assist businesses in disseminating information on HIV/AIDS prevention more efficiently and effectively. This organization also assists community campaigns to strengthen AIDS prevention awareness.

**Communities.** Communities have played a very important part in AIDS prevention activities. Networked with NGOs and public agencies, they have demonstrated a high capacity to promote collective activities, generating close relations between members. Communities have also been instrumental in promoting appropriate values and changing inappropriate ones. As communities are the starting point of appropriate social norms, it is important to foster community understanding of lifestyle and cultural differences, promote positive values and practices, encourage volunteer groups to care PHA and their families.

Community leaders must also be motivated to initiate group interaction and promote appropriate values supportive to group interaction. Thereby, strong and healthy communities will emerge and the 'at-risk' behavior of individual members will diminish.

**PHA.** PHA have increasingly joined together to help each other. There were only 11 groups of HIV-infected people in 1994. By 2000, the number had increased to 275. These groups not only provide consultation and support to members but also disseminate knowledge about the disease to people who have direct and indirect contact with AIDS patients, creating a deeper understanding of the disease that can lead to a reduction in 'at-risk' behavior.

The combined efforts of the public and private sectors have succeeded in reducing transmission from commercial sex workers to clients and among intravenous drug users. However, studies suggest that new 'at-risk behaviors' continue to emerge. Males who previously purchased sex from sex workers now have relations with women outside of entertainment establishments. Meanwhile, young people have begun having sexual relations at an earlier age than in the past (AIDS Division, MOPH). The risk behavior of such groups is not easily assessed as they are difficult to approach.

#### ***4.2.2 Strategies for the Promotion of Condom Use***

As more than 80% of all HIV infections result from sexual relations, one of the simplest methods in preventing transmission is condom use. With this end in mind, the 100% condom use program was initiated in 1989 to reduce infection among males who purchased services from commercial sex workers and high-risk groups. In August 1991, the National AIDS Committee declared that the policy should be expanded to every province in Thailand. Money was allocated for the policy and condoms were distributed free of charge. As a result of the economic downturn in 1997, the government was obliged to reduce the budget for condom acquisition. Thereafter, although the supply of free condoms was insufficient to meet demand, program results remained satisfactory.

The program includes financial support for a nationwide network of STD clinics, condom quality certification, and free distribution of condoms to commercial sex workers, who were also able to obtain health check-ups and STD treatment every 1-2 weeks. In instances where male patients of STD clinics indicate that they did not use a condom, health personnel have also taken steps to locate the source of HIV infection. Excellent cooperation between the public, private, and business sectors has contributed to high rate of condom use. Information retrieved by the Department of Communicable Disease Control

showed that the rate of condom use increased from 25% in June 1989 to 99% in June 2001. This, in turn, led to a decrease in STDs and new HIV infection among conscripts to 1.4% in May of 2000, down from a high of 4% in 1993 (HIV Surveillance, Division of Epidemiology, MOPH).

### ***4.2.3 Strategies for Comprehensive Precautions at Health Facilities***

In 1992, comprehensive precautions were adopted to assure that health personnel were not at risk of infection from the provision of services to HIV/AIDS patients. The important measures include: (1) accident prevention from needles and sharp objects, (2) the use of protection barriers such as gloves, glasses and masks and (3) good hygiene and sanitation practices such as appropriate hand wash, use of disinfectant and appropriate disposal of waste. Figures suggest that these precautionary measures reduced the infection rate among health personnel by more than 80% (Manual for Comprehensive Precautions in Providing Medical and Health Services, 1995, page 11).

### ***4.2.4 Services for Safe Blood Supply***

The Thai Red Cross is responsible for assuring a safe blood supply for every patient in the country. In the year 2000, around 1.4 million units of blood were donated. Once it became apparent that transfusions were a vector for the transmission of HIV/AIDS, the government stipulated that every bottle of blood donated should be tested. When it subsequently emerged that testing could only detect HIV in the blood of individuals who had been infected for longer than a two week "window period," the government imposed additional regulations stipulating direct testing for HIV antigens. When this dual testing system proved to be less than 100% safe, additional measures were introduced. Hospitals and health centers were asked not to receive blood donations from at-risk groups such as drug addicts, sex workers, and prisoners. Blood donors were encouraged to evaluate their sexual behavior before donating their blood by answering the questionnaires and discussing their situations with counselors. People were also asked to donate blood only when it was necessary and were encouraged to keep blood for their own use. As a result of these measures, the infection rate among blood donors was 0.30% in June 2000, down from almost 1% in June 1992 (HIV Surveillance, Division of Epidemiology, MOPH).

### ***4.2.5 Prevention and Treatment of STDs***

Sexually transmitted diseases (STDs) increase the potential for HIV infection and accelerate AIDS-related illnesses. As a result, prevention and treatment of STDs can reduce new HIV infections up to 40% (Grosskurth et al, 1995).

Previous STD prevention and control programs concentrated on secondary prevention, e.g. case finding, provision of treatment, and follow-up. This method helped control the spread of STDs to a certain extent. When sexual activity was discovered to be the primary HIV transmission route, prevention and control programs were adapted by emphasizing safe sex. The strategies included promoting, disseminating and exchanging HIV/AIDS and health information, promoting 100% condom use, implementing surveillance on CSW, encouraging peer counseling activities, and providing appropriate consultation to vulnerable groups. Integrated HIV/AIDS programs included normal health services, such as family planning, mother and child hygiene, and the establishment of STD clinics in every district of the country. As to the impact of these measures on the STD situation, from 1986 to 2000, the incidence of venereal disease dropped from 7.85 to 0.25 (Thailand Health Profile 1997-1998, MOPH and Venereal Disease Division, MOPH, 2001).

The vast majority of HIV infections occur among productive adults in the 20-44-year-old age bracket (Table A 3). Infections among children can be completely prevented if sexual partners are aware of each other's HIV status and make informed decisions about using preventive measures such as condoms when having sex. With this aim in mind, prevention and control programs should include the promotion of voluntary premarital HIV counseling and testing and voluntary HIV testing and counseling in integrated reproductive health services.

### ***4.2.6 Prevention of Mother-to-Child HIV Transmission (PMTCT)***

Surveillance of HIV-infected women during the 1989-2000 period indicated that the infection rate of pregnant women was around 2% per year. Out of 1 million pregnant women, about 20,000 persons would be infected per year. A study conducted by a team of US physicians suggests that the HIV transmission rate from mother to child is 30%. This means that the number of children infected by their mothers would be approximately 4,000-5,000 per year. If children receive AZT for 32 weeks prior to delivery, mothers receive AZT intravenously during labor, and newborns are given AZT for their first 6 weeks, the transmission rate can be reduced to 8% (Thai Red Cross).

In 1997, the Ministry of Public Health started a pilot program to provide AZT to pregnant women with HIV and powdered milk to the children of infected mothers in CDC Regions 7 and 10. The program was strongly supported by UNICEF. Sentinel surveillance reports of HIV-infected pregnant women indicated that the median of HIV infection in women using government services was rising, from 0.8% in 1990 to 1.76% in 1999. Were no

treatment provided, more than 4,000 infants would have been infected with HIV each year. In March 1998, a CDC trial in Bangkok showed that the AZT short-course reduced mother-infant HIV transmission by 50% among non-breast feeding HIV infected women.

#### **Guidelines for Implementation of PMTCT in Thailand**

1. All service providing institutions must organize counseling services for premarital couples and testing for HIV. Tests must be of high quality and the results must be strictly confidential. Only the pregnant woman and those to whom she has given permission will receive the test results.
2. All pregnant women will receive voluntary testing for HIV antibody according to the standards set by the MOPH.
3. All HIV-infected pregnant women who decide to continue their pregnancy will be offered AZT as follows:
  - 3.1 Starting at 34 weeks of pregnancy, morning and evening, with each dose totaling 300 mg until labor pains commence.
  - 3.2 During labor, the dose provided will be 300 mg every 3 hours until delivery.
4. For babies born to HIV infected mothers:
  - 4.1 All babies of HIV infected mothers who have taken anti-retroviral drugs for 4 weeks or more during pregnancy and delivery will get AZT syrup, starting immediately after birth at a dose of 2 mg per 1 kg body weight for every 6 hours for 7 days.
  - 4.2 All babies of HIV infected mothers who have taken anti-retroviral drugs for less than 4 weeks during pregnancy and delivery will get AZT syrup, starting immediately after birth at a dose of 2 mg per 1 kg body weight for every 6 hours for 6 weeks.
5. All babies born to HIV infected mothers will receive infant formula to substitute breastfeeding until 12 months of age.
6. All babies born to HIV infected mothers will get a blood test for HIV antibodies at 12 months of age. If the result is positive, the babies will be retested at 18 months of age.
7. All mothers and infants who receive anti-retroviral drugs will receive proper medical care and treatment.

Results of the PMTCT implementation: The 1998–2000 report on PMTCT program implementation in regions 1, 2, 3, 6, 7 and 12 indicated that out of the total 27,401 women who delivered at public hospitals under the supervision of MOPH, 98% attended antenatal care, 75% of those who came for ANC agreed to have their blood test for HIV. The rate of HIV infected women who delivered and had their blood tested during pregnancy was 1.2%. 64% of HIV positive women who came for delivery under ANC care received AZT.

Several other HIV/AIDS vaccine trials and the "30 Baht Treatment Project" also provide anti-retrovirus drug for HIV pregnant women to promote the reduction of HIV transmission from mother to child. However, as HIV testing cannot be done without consent, some pregnant women do not know they are HIV positive and fail to receive AZT in consequence.

#### ***4.2.7 Counseling Services***

Counseling services cover both supportive and preventive counseling. In the initial period of HIV epidemic, existing counseling services were insufficient to meet

demand. Subsequently, however, the government gave high priority to increasing the availability of counseling services for HIV/AIDS patients in clinics run by both public and private operators. Public sector support is provided for direct counseling services as well as staff recruitment and the development of training programs. The public sector has also worked to strengthen networks of counseling services in order to provide adequate support for PHA, and to promote public-private collaboration in providing quality pre- and post-test counseling services.

#### ***4.2.8 HIV/AIDS Surveillance***

HIV/AIDS surveillance was first implemented in Thailand in June 1989 in 14 provinces. It was extended to cover the whole country the following year. The primary aim of the project was to monitor HIV infection among nine risk groups: blood donors, intravenous drug users, pregnant women, males who visited STD clinics, commercial sex workers, indirect commercial sex workers, commercial fishermen, male prostitutes, and foreign migrant laborers.

During the first wave of the epidemic, HIV testing was conducted in two rounds each year in June and December. Despite the rapidly changing nature of the AIDS epidemic, the new infection rate in risk groups was comparatively stable after 1995 and HIV testing was scaled back to once a year in June. Regular surveillance has contributed to a decrease in new infections by reflecting in the effectiveness of existing HIV/AIDS prevention and control programs.

### ***4.3 Treatment Interventions for Mothers and Children Living with HIV/AIDS***

The National HIV/AIDS Plan of 1992-1990 recognized that the AIDS epidemic had the potential to overwhelm the existing health care system. As a result, the plan proposed to develop formal and informal treatment programs for people living with HIV/AIDS. Medical strategies consisted of ensuring a safe blood supply, strengthening health system capacity in diagnosing and treating HIV/AIDS, strengthening counseling services, ensuring comprehensive precaution practices, training health personnel, and supporting family and community-based treatment and care. The policy also emphasized the development of drug procurement measures to ensure low costs through bulk purchasing, generic drug competitions, and the arranging of special contracts with pharmaceutical companies.

During this period, the health system was ill prepared to cater the increasing demand for health services of PHA. Only a few general hospitals were able to provide HIV testing and blood supply screening services. Many health personnel had not received proper training on precaution practices. In addition, there were a growing number of complaints about incidences of discrimination, stigmatization, and rights violations against PHA in health care settings.

The response was to focus on improving the health system and promoting positive attitudes towards PHA. Public hospitals down to the community level developed the capacity to provide diagnostic, counseling, and testing services. They also became more adept at treating opportunistic illnesses. To foster a more positive attitude towards PHA and encourage community support for AIDS patients, religious leaders were encouraged to play a pivotal role in establishing several community-based care models. One was Rattanaurak Community Center in Lampang Province; the other Thammarak Nives in Lopburi. Initially, both centers served as training centers for families affected by HIV/AIDS. Rattanaurak was supported by the government and has maintained its mission up to the present. Thammarak Nives, which received partial support from government, has developed into a hospice for PHA in the terminal stage of illness.

As a result of the evolution of the AIDS epidemic, the number of PHA in the upper northern provinces increased rapidly, placing a considerable burden on public health services in the region. The problem was compounded by the fact that AIDS cases continued to be put in isolation wards, in violation of planning policy to integrate patients into general wards and use infection prevention measures. In addition, there was a time lag before medical and health personnel gained a proper understanding of PHA diagnosis, treatment, and rights to confidentiality.

To improve service provision and cope with a number of other AIDS-related economic and social problems, an Operation Plan for 1995-1996 was formulated with an eye towards emphasizing expanded response. With nearly half of all reported AIDS cases and a fair number of the AIDS-related deaths occurring in six northern provinces, there was an urgent need to increase the capacity of health services and facilities. This included everything from beds, equipment and personnel to the provision of treatment for opportunistic diseases and the strengthening of referral systems among hospitals. There was also a need to establish day-care system for AIDS patients and their families.

The plan aimed to accelerate the development of family and community capacity to provide health care to PHA by integrating chronic disease treatment back into the community. As a result of difficulties in implementing this policy, however, health personnel in the region continued to shoulder a heavy workload. To address the problem, rotation of personnel from other areas was encouraged to assist in the northern provinces. The cooperation of all agencies was also requested in seeking temporary solutions and in providing remuneration to help alleviate urgent problems.

### ***4.3.1 Treatment and Care for People Living with HIV/AIDS***

Since most reported AIDS cases were individuals from low socio-economic backgrounds and as the price of treatment drugs<sup>1</sup> was quite high, the government was pressured to provide anti-retroviral drugs (ARVs) such as Zidovudine (AZT) for PHA. A program was started in 1992 with the Department of Communicable Disease Control allotting a budget to supply ARV free of charge to 350 PHA facing economic difficulties. By 1995, the program had been extended to 3,600 PHA. Expansion of the program was made possible by generic drug manufacture that allowed the Government Pharmaceutical Organization to manufacture AZT and sell it at a comparatively low price.<sup>2</sup>

As indicated in Table 4.1, government spending for health services during the period totaled approximately 70 percent of the total national AIDS program budget. Of this, 50 percent was spent for procuring anti-retroviral drugs and drugs to treat opportunistic infection, a disproportionately large amount when compared to the allocation for care of other diseases. Because of this, it became necessary to reconsider policy in terms of equitable distribution of resources among disadvantaged groups.<sup>3</sup> In late 1995, NAC, through MOPH, received support from WHO to conduct a cost effectiveness study of the use of anti-retroviral drugs in the AIDS program<sup>4</sup>. The study showed low medication compliance among patients due to side effects as well as lack of follow up by physicians. In addition, it also found that the number of program beneficiaries was limited, that full-scale implementation of the treatment regimen was unaffordable, and that the clinical effectiveness of mono-therapy was limited in that it only extended survival up to 6 months.

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<sup>1</sup> In 1992 the price of AZT was still costly. 5 tablets of AZT a day cost higher than minimum wage.

<sup>2</sup> Initially the government bought imported AZT from original manufacture - Glaxo-Wellcome. Later on when AZT became generic drug, GPO was able to manufacture and sold them to the government. This brought the price of AZT down from almost 2 USD a tablet to less than 50 cents a tablet.

<sup>3</sup> Government financed anti-retrovirus AZT (cost 9 Baht a tablet in late 1995) & DDI (cost 31 Baht a tablet) for PWHAs. Much concern has been raised as to the inequity and appropriateness of the HIV/AIDS programs financed by the government considering that AZT cost 45 Baht a day per one PWHAs, while the government financed school lunch program cost 5 Baht per meal per student.

<sup>4</sup> This unpublished study was conducted by the late Dr. Nicholas Prescott, Senior Economist at the World Bank, with joint collaboration of the MOPH, WHO and the World Bank.

**Table 4.1: Burden of HIV/AIDS Illnesses**

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
No. of PHA at end of year <sup>a</sup>	11,202	20,195	31,002	41,863	51,712	59,752	65,333	68,311	68,677	67,057
No. of PWH/ at end of year <sup>a,1</sup>	547,227	640,356	701,566	736,992	751,522	751,235	740,349	719,765	694,564	665,344
No. of Reported PHA <sup>b</sup>	1,761	6,900	13,855	20,604	24,478	26,342	26,410	22,267	12,839 <sup>1</sup>	
No. of PA receiving ARV from public finance <sup>c,2</sup>	350	700	1,752	3,600	2,200	2,200	2,200	2,200	2,200	2,100
PHA receiving publicly finance ARV as % of Reported PHA	19.88	10.14	12.65	17.47	8.99	8.35	8.33	9.88	17.13 <sup>1</sup>	
PHA receiving publicly finance ARV as % of No. of PHA at end of year	3.12	3.47	5.65	8.60	4.25	3.68	3.37	3.22	3.20	3.13
Public spending on ARV including medical materials (in million USD)	1.44	3.45	13.97	19.36	15.84	11.74	8.68	8.51	7.07	6.60
Total Public Spending on HIV/AIDS Program (in million USD)	25.10	58.32	54.17	65.55	86.33	63.31	35.81	40.07	35.40	33.87
Estimated Financial Requirement to Provide ARV for all PHA, as percent of HIV/AIDS Program <sup>(3)</sup>	184.19	170.78	456.40	343.41	431.22	503.82	719.46	659.68	623.65	622.22

- Source:** (a) **The Thai Working Group on HIV/AIDS Projection, 2001, *Projections for HIV/AIDS in Thailand: 2000-2020*, Karnsana printing press, Bangkok Thailand, Table B1i, p B-11.**
- (b) **Epidemiology Division, Ministry of Public Health, *Reported AIDS Situation, various years.***
- (c) **Bureau of Budget, Office of Prime Minister, *Budget Document of Ministry of Public Health, various years.***
- Note:**
1. Reported cases as of October 2000.
  2. As indicated in the budget document in the corresponding year.
  1. Calculation assumed the same treatment regimen as publicly funded program.

This study was important in defining the need for policy change. It also established the importance of clinical trials as a mechanism for research-based decision-making prior to the application of new treatment regimens—even ones such as triple combination therapy that had already proven effective in western countries. As a consequence, the government subsequently shifted treatment regimens from mono-therapy to combination therapy. As Table 4.1 indicates, public expenditures for ARV was only able to safeguard a limited number of drug recipients and left the rest financing the drugs out of their own pocket.

Fiscal constraints were not new however. Paying for treatment had long been an issue as a result of limited resources and the increasing number of PHA who needed support. Increased public expenditure for medical care and assistance from such organizations as the Global Fund for HIV/AIDS provided temporary relief but also produced greater demand for care, drawing resources away from health programs for asymptomatic HIV. Hence, it was determined that the appropriate solution for managing HIV/AIDS problems in the long run was to streamline public services for PWH— which included health promotion, medical services, psycho-social and other social services.

### ***4.3.2 Treatment and Care for Mothers and Children Living with AIDS***

As the country started to campaign for prevention and control of HIV/AIDS in the late 1980s and early 1990s, comprehensive measures were initiated to prevent vertical transmission of HIV. Interventions consisted of massive health and sex education campaigns among children and youth starting from grades 5 or 6, pre-marital counseling, and voluntary anonymous testing for HIV. The Ministry of Interior was involved in providing AIDS education to couples when requesting marriage registration. When it was reported that the number of pregnant women having HIV was increasing, the government also issued guidelines to assure comprehensive prevention and care for pregnant women and their babies. Health personnel were also cautioned to strictly respect patients' rights with respect to HIV testing and screening. Below is a partial list of the measures proposed for the prevention and care of HIV-positive pregnant women and mothers.

- *Support the provision of both ante-natal and post-natal care for HIV-pregnant women and children born of HIV- mothers.*
- *Increase the capacity of governmental and private health facilities in diagnosis and treatment of venereal disease and sexually transmitted diseases by integrating ante-natal care and family planning services.*
- *Encourage government and private sector assistance for infant abandoned as a result of AIDS.*

*(Operation Plan for HIV/AIDS Prevention and Control 1995-1996)*

There were, however, occasional complaints about policy discourse. For example, some pregnant women were screened for HIV without their consent, making it difficult to provide post-test counseling for those who tested HIV positive. In several cases, abortion was apparently suggested as well, although evidence was insufficient to bring charges of malpractice.

Before AZT treatment regimes were proven effective, infant formula was initially provided to babies born of lactating mothers with HIV for a period of two years in order to prevent HIV transmission through breast milk. This was later modified to one year. In implementing the program, difficulties arose as a result of pediatric wards administering different feeding programs, allowing some children to be breast-fed while others were bottle-fed. In addition, when mothers and babies were discharged from the hospital, they were supplied with infant formula sufficient to last until their next check-up. In most of these cases, however, the mothers failed show up.

Later when it was proven that AZT076 could yield effective results, this latter treatment was provided to pregnant women with HIV/AIDS in order to reduce transmission from mother to child. The treatment was provided during pregnancy, labor, and for a short period after delivery. Due to associated costs, it was not extended to cover the remaining life span of mothers with HIV. With support from UNICEF, the Thai Red Cross Society took the lead in campaigning for program resources, making appeals to both the general public and the government. Table 4.2 shows the number of children born from HIV positive pregnant women that were able to receive powdered milk, AZT, and financial assistance in consequence. In 2002 the government will start to provide a combination of therapeutic

treatments to roughly 500 mothers with HIV. This accounts for a scant five-percent of those who require treatment to prevent HIV transmission to their newborn children.

**Table 4.2: Burden of Care for Pregnant Women and Children with HIV/AIDS**

	1993	1994	1995	1996	1997	1998	1999	2000	2001
No. of Children 0-2 years born from mother with HIV received powder milk	1,000	1,000	2,000	2,381	3,108 (800)	3,210 (1,100)	7,147 (800)	7,500 (800)	9,700
No. of Children born from mother with HIV received ARV	-	-	-	-	-	-	7,500	7,500	9,700
No. of mother with HIV received ARV	-	-	-	-	-	2,500	7,500	7,500	9,700
Estimated public expenditure on powder milk for Children 0-2 years born from mother with HIV (in million USD)	0.37	0.88	0.82	0.79	0.86	0.73	2.12	2.02	1.44
Estimated public expenditure on ARV for Children and mother with HIV (in million USD)	-	-	-	-	-	n.a.	0.70	0.69	0.90

**Source:** (a) Bureau of the Budget, Office of the Prime Minister, Budget Document of the Ministry of Public Health, various years

**Note:** (.....) = children 13-24 months old

Recently, the Thaksin Government has adopted a universal health care coverage system that appropriates 30 baht per each health service visit. This scheme includes treatment of opportunistic infection but does not cover provision of costly anti-retroviral drugs. Apart from treatment, the scheme also integrates HIV prevention. The success of such integration will help to mitigate the burden of costly treatment. Conversely, its failure would burden the health system with increasing demand and pose financial difficulties for HIV/AIDS-affected families.

## 4.4 Policy/Program Measures for Mitigating HIV/AIDS Impact

Despite an overall reduction in infection rates in the period after 1995, HIV/AIDS continues to pose a number of problems for Thailand. Individuals whose lives have been disrupted by the disease face enormous difficulties, including the need to cope with a battery of stress-related psychological problems. Social discrimination and stigmatization also continue to impede the ability of PHA to provide for their own livelihoods. In addition, a growing number of senior citizens are faced with rearing children whose parents have died of AIDS. Financial problems are common at all levels.

**Table 4.3: Comparison of Reported AIDS Patients and AIDS Related Cases in the Upper Northern Part of Thailand and the Whole Country**

Year	Upper North region (Region 10)		Whole country 12 regions
	Number of people	% of Total	
1990	88	17.9	492
1991	374	42.8	873
1992	1,359	52.4	2,610
1993	3,757	46.7	8,042
1994	7,324	41.0	17,644
1995	9,176	35.6	25,785
1996	9,013	51.1	17,638
1997	3,307	28.9	11,451
Total	34,932	40.7	84,535

**Source:** Office of Communicable Disease Control, Region 10, Chiang Mai.

**Note:** Data until June 1997.

The impact of HIV/AIDS is more serious among children. In addition to the risk of contracting HIV from their mothers, children of AIDS-affected families experience economic and psychological problems as well as discrimination from school friends and the community. Although a number of mitigation and alleviation programs have been implemented, the results have been less than satisfactory and in many cases have failed to meet real needs.

**Table 4.4: The HIV Prevalence Route Among Various Groups in the Upper North and the Whole Country**

Groups of people	Upper north (region 10)	Whole country (12 regions)
Blood donation	0.82	0.57
Injection drug user	46.64	40.00
Pregnant women	5.00	1.68
Male patients at the STD clinic	18.81	6.79
Directed commercial sex workers	57.14	26.14
Disguised commercial sex workers	13.74	8.20

**Source:** Division of Epidemiology, Ministry of Public Health

**Note:** Surveillance data from specific area in June 1997

#### ***4.4.1 Mitigation Reflected in Public Expenditure on AIDS Prevention and Control***

In 2000, the Royal Thai Government spent 1.4 billion baht (US\$37.9 million) from its national AIDS program budget to prevent HIV transmission, treat AIDS patients, mitigate the impact of AIDS, and support AIDS research (Table B.1). Some 64% of total expenditure was for care and treatment, including anti-retroviral and opportunistic infection drugs for clinical trials, HIV testing and counseling, blood screening, and comprehensive precautions to prevent HIV infection in medical settings. The second largest expenditure (16%) was on services to mitigate the impact of AIDS. These included programs to prevent mother-child HIV transmission, provide orphan care, subsidize housing for unemployed PHA, and provide skills training and legal counseling for PHA and their families. Programs to prevent the spread of the epidemic accounted for only 8% of the budget, covering public information, condom promotion, and other community prevention activities. An additional 6% of the AIDS budget was distributed as grants to NGOs for community-level AIDS prevention and care activities. The remaining 7.2% of the AIDS budget was allocated to management and research.

Due to the economic downturn, the total funding for AIDS programs declined by 9% between 1996-97 (from 2,187.5 million to 1,986.1 million Baht) and fell by another 27.8% in the period leading up to 1999. The hardest hit was prevention expenditure, which dropped by half since 1997, declining from 11% to 8% the total AIDS budget. As a result of this decline, HIV/AIDS programs were subjected to severe cuts. Some of the reduction was due to a policy decision on therapy effectiveness, which led to a much-diminished budget for anti-retroviral therapy for AIDS patients. Another cut was the result of a pre-crisis policy decision to reduce free distribution of condoms and encourage cost sharing. This latter move has met with some opposition. UNICEF-EAPRO, for one, has expressed concern that controlling the spread of HIV/AIDS could be hampered by a reduction in the distribution of free condoms from 45 million to 12 million items at a time when a growing number of unemployed workers are returning to rural areas.

With respect to women and children, in 1998 the government modified the budget in order to maintain program coverage for maternal and child health and HIV/AIDS activities by:

- levels;
- 1) maintaining the budget for safe motherhood activities at FY 1997 levels;
  - 2). allocating additional funds (estimated at 80 million baht) to cover the higher cost of essential vaccines imported under the Extended Program for Immunization; and;
  - 3). restoring the HIV/AIDS budget to FY 1997 levels by allocating additional resources (estimated at 105 million baht) for prevention, community development, and NGO activities.

During 2001 the budget allocated for supporting PHA quality of life has been maintained at 2.2% of the total health budget, or US\$33.8 million. In 2002, the budget is expected to decrease to US\$23.2 million, or 1.4% of total budget. The decline will be offset by implementation of the government's 30-baht per health visit policy, which will cover expenditure for treatment of opportunistic diseases (Bureau of the Budget, 2001).

#### ***4.4.2 Importance of Networking Process in the Provision of Social Services***

The problems of HIV/AIDS patients and their families are sufficiently complex that a single agency or organization is often times incapable of providing a solution. For this reason, good collaboration and co-operation among agencies at all levels is critical in alleviating and mitigating AIDS-related suffering.

**Figure 4.2: Pattern of Social Services**

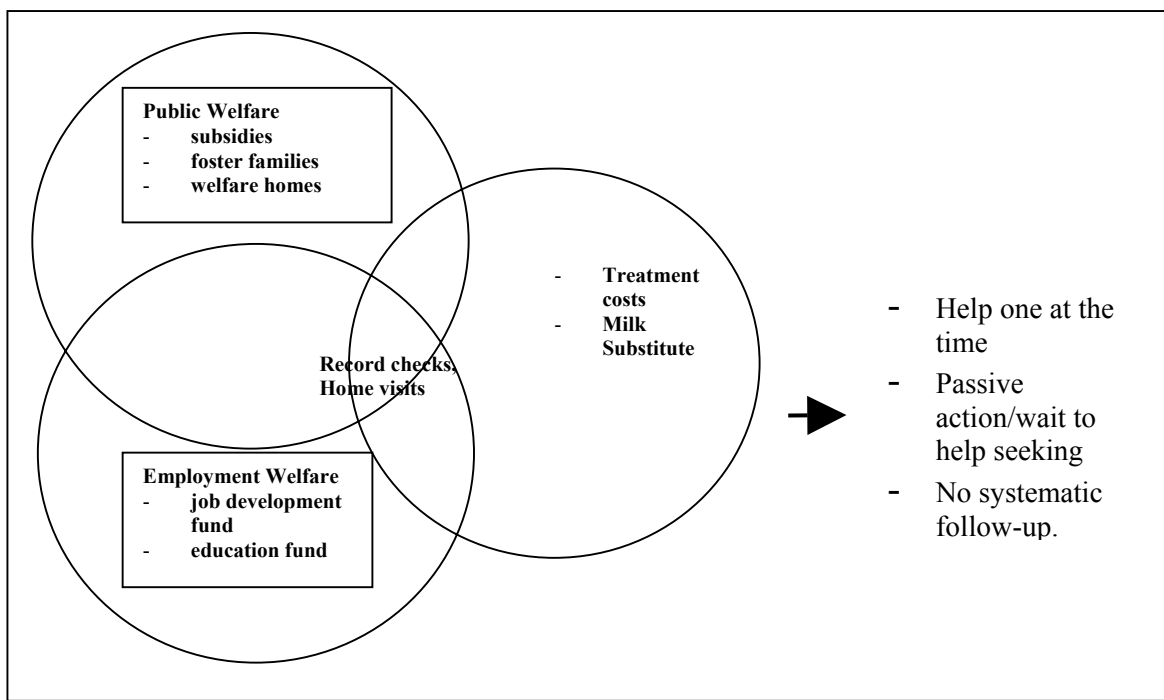


Figure 4.1 shows that the provision of social services involves many agencies. Level of commitment varies from one body to the next. Some may consider alleviation work to fall outside of their major area of responsibility and choose to send PHA back to their homes in the provinces. The process is still hindered by a lack of good networking and referral systems that can serve to enhance effective implementation. Many agencies lack staff resources to provide services. At times, the patients themselves are also reluctant to make use of services. As a result, the AIDS-related problems of children continue unabated.

Although the government has given a high priority to HIV/AIDS prevention and control programs designed to mitigate the impact of HIV infection, the policies of related ministries are frequently vague and have little impact on target groups at the provincial level. Thus far, the development of collaborative networks among related agencies and organizations such as the Ministry of Education, the Ministry of Labor and Social Welfare, the Ministry of Agriculture and Cooperatives, and the Ministry of Interior has been limited to NAC-delegated efforts. The process of transforming policy into action requires a more systematic approach to provide continuous services to the groups.

#### ***4.4.3 Inadequate and Ineffective Provision of Social Services to PHA and their Families***

Heretofore, the provision of social services has consisted of consultation, provision of milk substitute, home visits, family financial assistance, career training, education funds, peer counseling, hotline service, and anonymous consulting units. These services are inadequate to meet the needs of AIDS patients and their families.

With regard to nutrition intervention, for example, the government provides free milk substitute to infected and affected children as a part of its free school lunch programs for primary school students. Prior to the economic crisis, 30% of all children were eligible for the free lunch program. After 1997, the program was expanded and currently 50% of all children are deemed to be eligible. However, as disadvantaged children are the priority target group, the program does not guarantee that all HIV-infected and affected children will receive benefits.

The relationship between AIDS and development has long been recognized in Thailand. Positive development indicators such as civil rights, educational access, and lower fertility levels are acknowledged to play a part in HIV/AIDS prevention. Conversely, the high number of people in the productive age bracket who have contracted HIV/AIDS poses an immediate threat to agricultural production, business activity, development of the labor force, and the overall health of the economy as a whole.

AIDS also has an immediate impact on the welfare of children and the elderly. As a result of the disease, a growing number of older people not only lose the support of their children but are also obliged to provide financial and material support to surviving

grandchildren. To assist with the problem, public assistance to the elderly was increased from 200 baht to 300 baht/month per person. The number of the elderly eligible for such transfers was also expanded from 300,000 persons to 400,000 persons (Department of Social Welfare, 1999). This program does not cover a large number of seniors, however.

#### ***4.4.4 The Importance of Effective Management and Inter-Agency Cooperation***

At present, over 500 private organizations in Thailand offer some form of welfare service. Approximately 100 registered NGOs work in the area of youth development alone. Increasing efforts have been made to coordinate initiatives within the NGO community and build partnerships through greater networking (i.e. NGO Coalition on AIDS and National Council for Social Welfare). NGOs have also been working more with the government, with positive results for community mobilization and development (UNICEF 1997, cited in Thailand Social Monitor, World Bank 2000). Due to the economic downturn, however, public and private agencies were both obliged to reduce programs.

To support private HIV/AIDS prevention and control efforts during the period, the Ministry of Public Health distributed 90 million baht in World Bank funding to development agencies in six regions: Bangkok, the Upper North, the Lower North, Northeast, Central and the Southern Regions. The private agencies that received funding were to:

- 1) cooperate with local government in activity planning;
- 2) develop effective prevention, care, and related programs;
- 3) facilitate transfers of technology to local organizations;
- 4) explore the need and promote collaboration among networks of private NGOs that are working on AIDS problems in other regions;
- 5) explore and develop mechanisms that receive support from the government budget; and
- 6) conduct monitoring and follow up to improve program efficacy and sustainability.

The results of a mid-term evaluation were quite positive. Additional policies may be required in order to strengthen the capacity of private partners, however.

#### ***4.4.5 The Role of Social Capital and Local Organizations in Providing Care and Mitigating Impact***

Social capital originates with the formation of social connections and networks based on principles of trust, mutual reciprocity and shared norms. The relationships and connections can either be egalitarian (horizontal) or characterized by unequal power relationships (hierarchical). However, the networks and associations formed must serve to facilitate coordination and interpersonal cooperation for mutual benefit.

Presently, the rate of participation from various community organizations is increasing. While charitable contributions are also a major part of communal mobilization and Thai society, specific data is lacking. During the past five years, however, there has been

an increase of saving groups, most of which have been created with the assistance of the Community Development Department.

The Thai government recognizes the importance of social capital. In the aftermath of 1997, it designated a portion of a World Bank loan as community development funds for social investment. This social investment fund (SIF) amounted to US\$120 million and was used by local and community grassroots organizations to implement development projects. The budget allocated was managed under a new 'bottom-up' management system, channeled through the Social Fund Office (SOFO) of the Government Savings Bank. The SOFO grants money for projects aimed at strengthening community organizations. Projects had to be initiated by local community organizations, municipalities and other informal groups. SIF projects were based on the theme of promoting 'civil society' and 'good governance.'

SIF projects were divided into five categories: i) community economy, ii) community welfare and safety, iii) natural resource management and cultural presentation, iv) community capacity building and networking, and v) emergency community welfare. The second category included projects to provide assistance to PHA. Community welfare and safety programs such as child development and day care centers, community playgrounds and shelters for the elderly and AIDS patients were initiated by the community itself. Since the beginning of September 1998, SIF has supported 3,131 projects under this category worth 352.27 million baht.

More recently, several government policies have been aimed at encouraging self-reliance and the strengthening of local capacity for self-help. The best-known policies are the "*1-million-baht per village revolving fund*" and the "*one village, one product scheme*". Both programs encourage local communities' to generate income by using revolving funds provided by the government to create commercial products. Income gained from such sales is then used to pay back the revolving fund, compensate producers and to contribute to community welfare savings. In the future, such savings will play an important role in helping and caring for those in need. It will be particularly useful to PHA, a majority of whom end their lives at home.

## ***4.5 Response from Focus Group Discussion***

The results of focus group discussion and in depth interviews conducted in this study reveal that the impacts of HIV/AIDS on children and families are as follows:

## **Bangkok**

Health status and health care: Access to health care remains complicated. Moving from one public health unit requires re-registration. The price of AZT remains very expensive.

Other impacts: PHA rights continue to be violated. Some are refused employment because of their condition. Infected pregnant women have been denied access to hospitals to deliver their babies. Infected parents experience discrimination from teachers and school officers. Infected and affected children experience discrimination and stigmatization by schools and communities. Infected individuals lack sufficient income. HIV-infected individuals and PHA complain of feeling insecure within the confines of their own communities.

Felt needs and demands from HIV-infected persons and PHA: More funds should be given to children's education, homes for orphans, and abandoned children. PHA families and relatives need more community moral support and recognition.

## **Khon Kaen**

Health status and health care: Health personnel in provincial and district hospitals are more willing to provide health services than those in local health centers. Service recipients were more satisfied with NGOs than with public-sector bodies. Alternative medical treatments should be used together with modern treatments. Moral support from family members and relatives is very important.

Welfare service: HIV-infected individuals are obliged to reveal their condition in order to receive welfare support from the government. Education funds for infected children are often misappropriated by teachers. Orphans from AIDS-disrupted families often have to depend on relatives who are poor.

Other impacts: Child day-care centers will not accept infected children. This problem is not as significant in the schools because personnel from MOPH and MOE are ready to help these children.

Felt needs and demands from HIV-infected persons and PHA: Support for education fees is needed. Financial support should be increased for infected families and released directly to the families. More jobs should be created for infected persons and AIDS patients. Markets should be created for their products. Lower the prices of drugs or provide them free of charge. Communities should not discriminate against these people. Public and private agencies should train and educate infected people so that they can educate their peers, in turn. More clubs should be established to distribute health and HIV/AIDS information to target groups.

## **Phayao**

Health status and health care: Patients prefer district hospitals to health centers and provincial hospitals because there is discrimination at the health centers and provincial hospitals are crowded. HIV/AIDS patients are often the last ones to receive treatment because they use low-income cards for services. Alternative medicines should be used. The government should link up with the vaccine research project being conducted by Harvard University. Initiate more associations where infected persons can network with others to share knowledge and experiences.

Welfare service: Services include monetary support for families with HIV/AIDS and families looking after orphans, funds for children's education, supplies of powdered milk, and job assistance.

Other impacts: Some individuals were forced to take blood tests at their work places. Some children were tested for HIV without their parents' consent.

Felt needs and demand from HIV-infected persons and PHA: An adequate supply of AZT should be provided to HIV/AIDS infected persons. More jobs for infected person and AIDS patients should be created and markets for their products should be found. More educational support is needed for children who are affected by HIV/AIDS.

## **Phuket**

Health status and health care: Most HIV/AIDS patients seek treatment and care at provincial hospitals. Some have been denied equal service and refused treatment. Day-care services at the community and provincial hospitals are valuable. Alternative medicines should be used. The activities of HIV/AIDS associations should be promoted and supported to increase the dissemination of information, counseling services, and the promotion of patient's rights.

Welfare service: Most HIV-infected persons believe that it is not worth revealing their condition to receive a small amount of assistance from the government. There are no standard hours for counseling services at various public hospitals. Powdered milk should be provided to infected mothers for two years. Mothers have experienced discrimination in neighboring communities.

Other impacts: Some patients were forced to take blood tests in workplaces. Some males who wanted to enter the monkhood were forced to take blood tests. Infected laborers were pressured to leave their jobs. Discrimination and stigmatization against children exists in schools and communities. Abandoned children without official documents have difficulty in obtaining assistance.

Felt needs and demand from HIV-infected persons and PHA: An adequate supply of AZT should be provided to HIV/AIDS infected persons and the cost should be shared among providers and patients. Jobs should be created for infected persons and AIDS patients and markets for their products should be found. Knowledge relating to prevention and care should be strengthened. Social attitudes towards HIV/AIDS infected persons still need to be changed. Pregnant women should have the right to an abortion.

## **Rayong**

Health status and health care: Most patients use community hospitals instead of health centers out of concern that their neighbors may learn of their illness. Many prefer to use social security cards as low-income card carriers receive poor service. There is discrimination in terms of treatment. Some received prescriptions without having to go through any physical examination. Alternative medicines such as herbs should be used. The government should join in the vaccine research project being conducted by Harvard University. Infected people need to organize themselves into clubs and networks, provide moral support to AIDS patients, conduct home visits, empower communities to fight AIDS, and distribute information to HIV-infected persons and PHA.

Welfare service: None of the children applied for education funds because they did not want to disclose their condition.

Other impacts: Discrimination and stigmatization still exist in communities. Infected laborers are pressured to leave their jobs.

Felt needs and demands from HIV-infected persons and PHA: AZT and Bactrim should be provided on a continuous basis for free to every person who has CD4 less than 200. Education funds should cover books and uniforms. Doctors should provide more information on treatments. The number of public health personnel and village health

volunteers should be increased. HIV-infected persons and PHA should be provided with information on how to take care of themselves and their infected family members.

# Chapter 5

## Conclusion and Recommendations

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### *5.1 Conclusion*

As of 31 June 2001, some 172,760 AIDS cases had been recorded in Thailand. Of these, 47,798 cases have died. Over the course of the epidemic, the infection pattern has changed. Calculated as a percentage of all cases, the number of males infected by sharing needles increased from 5% in 1990 to 18% in 2000 and is projected to rise to 30% by 2005. Most will be in the 25-45 year-old age bracket. Meanwhile, the number of infected non-sex worker females as a percentage of all cases is projected to decrease from 42% in 2000 to 29% in 2005.

The most disturbing pattern is among children. As a percentage of all cases, the number infected by mothers has risen from 6% in 1995 to 14% in 2000 and will increase to 29% in 2005. As a result of AIDS-related deaths, the number of orphans also increased from 15,400 in 1997 to 23,400 in 2001. NESDB projections suggest that 63,000 children were infected with HIV and 47,000 had died of AIDS by late 2000. It also estimated that 232,000 children under the age of 15 will have lost their mothers to the disease by 2005.

Specific policy responses in the areas of prevention, treatment and mitigation are required to deal with the long-term socio-economic impact of HIV/AIDS on children. In the near future, the treatment and care of mothers and children, as well as the growing number of AIDS-orphaned children, can be expected to place a considerable burden on social support systems and the economy.

Policy responses have evolved over time from an initial focus on health (1984-1990) to take into consideration social factors (1991-1996) and relevant aspects of civil society (1997-2001). Since the Eighth National Economic and Social Development Plan, planning efforts have taken a “holistic approach,” building the capacity of communities to participate in the development process. The results of these efforts have been dramatic; the most recent epidemiological model showed that the annual number of new infections declined by more than 80% after peaking in the early 1990s.

The government AIDS budget increased until 1996 and thereafter fell slightly as a result of the economic downturn. The average budget for the period was around 1,500 million baht per year (Table 2.3). Despite the decline, efforts were made to keep the budget

for maternal and child health and HIV/AIDS activities at FY 1997 levels. The government also recognized the importance of NGO and CBO involvement in HIV/AIDS prevention and control by allocating additional funds to such organizations.

AIDS awareness campaigns, educational efforts, and the promotion of condom use have been core components of the battle to control the epidemic. Campaigns to end discrimination and win greater acceptance for PHA were later introduced to alleviate suffering. Policy responses were gradually expanded to take into account social and developmental factors that had an immediate bearing upon the adoption of 'at-risk' behavior. Still, policy continued to be formulated from the top down, with each ministry taking responsibility for its own target groups. Although prevention efforts had been comparatively successful, a need remained to increase the participation of communities, PHA, and other groups affected by HIV. Subsequently, however, NGO-government partnerships at the local level have begun to develop appropriate linkages between programs and services by providing joint training of counselors, educators, and trainers.

Although efforts to control the AIDS epidemic are heading in the right direction, some adjustments are needed to deal with the changing nature of problem. While estimates suggest that the number of AIDS cases in Thailand will not increase, the disease continues to have negative repercussions for many families, communities and society as a whole. Current and future infections will result in significant income losses and reduced household savings. PHA and their family members also continue to face a degree of social discrimination. To prevent the disease and alleviate AIDS-related suffering, it is still necessary to improve public awareness and understanding while enhancing the cooperation of all sectors in the society.

A holistic approach which addresses not only health issues but also the human, social, economic and cultural aspects of the HIV/AIDS problem is thus warranted. Consideration should be given to the causes of the epidemic and the modification of 'at-risk' behavior. At the same time, steps should be taken to control the spread of AIDS within families.

## ***5.2 Lessons Learned***

The evolution of Thailand's AIDS policy and the impact of programs in reducing HIV/AIDS problems suggest important lessons that may be of use to other countries in the region and the world. The key lessons are as follows:

**1. The commitment of national leaders at the highest levels is required for effective action.** Political leaders must recognize the devastating scale of the epidemic and be willing to discuss openly the enormity of the HIV/AIDS problem. In Thailand, such commitment was made manifest by the establishment of NAC under the chairmanship of the Prime Minister. The policy-making body currently includes government, NGO, business, community, and PHA representation. Commitment was also reflected in the allocation of budgetary resources for prevention and control. These increased from US\$2.6 million in 1990 to US\$24 million in 1992.

**2. Social capital and civil society are also important ingredients for success.** In Thailand, key actors have emerged not only from the public sector but also the private. NGOs, communities, and religious groups as well as families have all played a significant role in caring for PHA and mitigating the impact of HIV/AIDS. Having recognized their vital role in assisting vulnerable people in communities, the government has encouraged local people to form such groups by providing financial and technical support.

**3. Effective programs lead to effective outcomes.** As Porapakkham and colleagues (1996) note in a recent review, well-crafted programs can result in the development of good policy. Pilot programs can and should be employed to demonstrate effective outcomes before national policy is formulated. Policy, in turn, should take shape as a result of operational research and evidence-based decision-making.

Pilot programs are likely to have the strongest influence on policy when program impact is well documented. By way of example, in 1997 MOPH implemented two pilot programs to provide AZT short courses to pregnant women and their infants. The results showed that short course AZT can reduce mother-infant HIV transmission (PMTCT) by 50% among non-breast feeding women with HIV. The findings led to a subsequent policy decision to provide free AZT short courses to pregnant mothers for two months prior to delivery and their children for six months after delivery in order to decrease infant mortality throughout the country.

The '100% condom program' is another example of a successful pilot project that helped to shape AIDS prevention policy. Factors contributing to the program's success include clear policy objectives and strong support from the central, provincial and local levels of government in providing technical advice, free condoms and intensive public relation campaigns. Decision-making on the allocation of resources and coordination was also decentralized to allow for timely and effective response to local conditions. Lastly, the involvement of small groups of core actors with clear roles and responsibilities at the provincial level helped to minimize duplication of activities and waste of resources.

**4. A people-centered approach to program development should also be adopted.** At the core of this approach is the idea that a solution cannot be one-sided. To the contrary, its underlying premise is that societies and environments are comprised of complex and delicately balanced relationships, linkages and networks that must be taken into careful consideration. The importance of doing so in addressing the AIDS problem can be seen from the fact that PHA suffer not only a serious medical problem but also economic vulnerability and social discrimination.

## ***5.3 Recommendations***

With reference to the above points, the following recommendations are proposed.

1. As a cure for HIV/AIDS has yet to be found, attention should be placed upon prevention programs, especially for individuals in high-risk groups such as MTCT, teenagers, and intravenous drug users.

2. Preparations should be made to cope with the increasing problems of orphans and abandoned children. The number orphans under the age of 14 is expected to increase to 160,000 in 2005. Currently there is no specific policy in place for these children. Many, particularly those affected by HIV/AIDS, will need special assistance from the government.

3. There should be a national policy for strengthening the capacity of the government, communities, and families to provide a supportive environment for orphans infected by HIV/AIDS. It should include the provision of appropriate counseling and psychosocial support. A strategy should also be adopted to ensure non-discrimination and equal rights.

4. Increase the linkages between AIDS response and developmental programs as well as expand and improve the efficacy of AIDS planning coordination at the national and provincial levels.

5. Enhance the role of local authorities and communities as well as strengthen and promote the role of PHA, groups of people affected by AIDS, CBOs and NGOs to provide better care for PHA and their families. Efforts should also be made to improve and mobilize existing local funds and social capital from all sectors to help PHA and families on a kinship basis.

6. Develop counseling and mental care services to address the specific problems of target groups. This includes providing professional counseling on a regular basis and providing counseling training to government personnel and volunteers (family and community counseling volunteers). Establish a risk factor warning system at the community level so that risk groups can be assisted in a timely manner.

7. As AIDS is a human crisis, the challenge for government bureaucracy is to make the necessary adjustments to empower communities and create enabling environments in which communities have the chance to successfully respond on their own. At the same time, mechanisms should be developed and procedure established for the protection of rights, particularly the rights of PHA, their families, and children.

8. Further research and development is crucial and should emphasize the following points:

a). Encourage drug-exporting countries, international organizations, regional organizations, institutions, and pharmaceutical companies to be actively involved in HIV/AIDS vaccine and treatment research and development. The aim should be to make

HIV vaccines and HIV/AIDS-related drugs more readily available and affordable for those who need them.

b). Encourage the development of national and international research infrastructure, laboratory capacity, improved surveillance systems, and improved data collection, processing and dissemination.

