Chapter 3

First Period: Government and Public Responses From 1983 to October 1988

In this third Chapter, the responses of the Thai government and the public towards the AIDS epidemic until October 1988 will be described. During this period, the Department of CDC of the MoPH took a central role in dealing with the AIDS epidemic and implemented AIDS prevention measures. The response of the government in general towards AIDS was one of denial in this period. Ministers wanted to keep silent or tried to give the impression that the AIDS situation of the country was not serious. Even the then Prime Minister came to the MoPH and asked the officers not to talk much about AIDS as it could affect tourism in the country. On the other hand, the Department of CDC, as the agency which was responsible for the prevention and control of communicable disease, did make efforts to prevent and control the spread of HIV. However, most attention in this period was given to the detection of HIV/AIDS cases. Many AIDS tests were conducted especially among gays and female CSWs at famous tourist destinations. These activities were often called 'campaigns' although their major objective was to reach the so-called "high risk groups" and to conduct AIDS tests

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on them.

Concerning public responses, some social incidents symbolizing the public attitude towards AIDS will be described including responses for people who were directly affected by the AIDS epidemic, such as gays, owners of gay bars, and people infected with HIV, as well as the general public. Also the responses of certain NGOs will be mentioned. In the early period of the spread of HIV, NGOs working on AIDS were mostly limited to those whose target population had been affected by AIDS. Therefore, information about AIDS provided through those NGOs activities was received only by their target groups, such as male and female CSWs and IDUs, and therefore, did not reach the public.

3.1 Responses of the Department of Communicable Disease Control, Ministry of Public Health

As HIV spread throughout the world during the first half of the 1980's and the first AIDS case was reported in Thailand in August 1984, the Thai government needed to deal with AIDS as an epidemic. Since AIDS is an infectious disease, it was natural that the Department of CDC first undertook the responsibility of the prevention and control of AIDS. Even though the prevention measures taken by the Department of CDC faced many obstacles in its operations, such as the mobilization of human resources

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and obtaining a sufficient budget, the Department of CDC in Thailand played a very significant role in the prevention and control of AIDS in the first period. Though the Thai government in general tried to cover up the existence of an AIDS problem in Thailand, and it took a negative attitude toward dealing with the AIDS epidemic in its first period, this did not apply to the Department of CDC. The Department of CDC followed its duty and faithfully conducted an epidemiological investigation.

3.1.1 Epidemiological Investigation

(1) Before the First AIDS Case was Found

In 1983, before the first AIDS case was found in Thailand, no research for the detection of AIDS cases had yet been conducted. The Department of CDC propagated information about AIDS to medical and health personnel and carried out campaigns to provide knowledge about AIDS under the campaign week for sexually transmitted diseases (STD) in 1983.(MoPH,1993 fiscal year:2) Basic public education was also provided through some government STD clinics.(Wiwat,August 1994:9) However, because these campaigns were carried out within the STD campaign, and the people who benefited from those campaigns were only medical and health personnel and STD patients who visited some specific government STD clinics, the effectiveness of

the campaign was extremely limited. Therefore, people who did not go to these STD clinics, men, women, and youth those who were later identified as being in the high risk groups for HIV-infection were not informed of the danger of AIDS.

(2) Case Finding

In 1984, case finding began even before the first AIDS case was found. The Department of CDC investigated the lymphocytes of patients who had symptoms suspected to be caused by HIV-infection.

After the first case of AIDS was found, which was a person thought to be infected with HIV abroad through homosexual intercourse, case finding especially focused on male CSWs.* Afterwards, serological surveys were conducted among the high risk groups; such as male and female CSWs, IDUs, and prisoners, in order to detect infected individuals. Contact tracing was also carried out for those found to be infected with AIDS and having ARC.

Case investigation activities first carried out in Bangkok and Pattaya were later expanded to local regions, especially to the provinces which are major tourist destinations.

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* As male homosexuals in Thailand who are related to HIV-infection are almost equivalent to male CSWs, the word 'male homosexuals' could often be replaced by the word 'male CSWs.'

However, AIDS tests for gays and CSWs were almost forcibly carried out with the cooperation of bar owners and the police. For example, in the middle of 1987, about 300 prisoners and CSWs were tested for AIDS in Chiang Mai under a programme of Chiang Mai University. However, because no one turned up to take the test which was free of charge, Dr. Vicharn Vithayasai, head of the Microbiology Department of the university said "the university had to seek cooperation from the police."(Bangkok Post,July 24 1987)

As this case indicates, it is difficult to test CSWs for AIDS without cooperation of the bar and brothel owners, because at almost all brothels in Thailand, girls working there as CSWs are under the strict watch of their owners or people hired by the owners. Moreover, because prostitution is illegal in Thailand, but "law enforcement is poor," and "there could be remedies against malpractices, the low quality of law enforcement personnel, at times compounded by corruption, detracts from the potential efficiency of the law"(Vitit,1994:68,Thai), those bar owners often have connections with the police for their survival, and the police have power against these bar owners. Therefore, it was effective to seek cooperation from the police to offer conveniences in the conducting of AIDS tests on CSWs. The result of this power connection among the police, bar owners, and CSWs, was that the tests could be administered regardless of the

CSWs' own attitude towards the tests. When bar owners ordered their workers to undergo AIDS tests, "the women have no choice on whether to be tested," and the results of the tests were given to bar owners not to workers themselves, according to Apisuk Chanthavipa, an organizer of EMPOWER, one of the NGOs working for female CSWs in Patpong.*(Apisuk,March 1989:205-206) Without being given any notice or information, CSWs were tested for HIV and the results were used for the sake of bar owners.

(3) Special Clinic for Male CSWs

In order to provide AIDS tests and advice for male CSWs, a special AIDS clinic for men was set up in March 1985 in Patpong where many male CSWs work. This center was also "the focal point of approach for this high risk population in the screening of HIV infection and providing health education."(Prasert,1989:28)

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(4) AIDS Ward

A special ward for AIDS patients was opened at Bamrasnaradura Hospital, the infectious disease hospital of the Department of CDC in Nonthaburi. Later this

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* Patpong is known as the most famous place for night life entertainment in Bangkok. Sexual services are provided openly and without fear of the public eyes.

hospital would become the model for providing medical care for AIDS patients.

(5) AIDS Listed as a Notifiable Disease

To analyze the AIDS situation of the whole country, the MoPH issued Ministerial Announcement No.2 of 1 May B.E.* 2528 (1985) under the Communicable Disease Control Act B.E.2523 (1980) and included AIDS in the list of notifiable diseases in order "to assist in the early detection and prevent transmission of the disease."(CDC, April 1989:2)

Under this ministerial announcement, either AIDS or HIV-infected individuals might be reported to the authority. Whenever detected, directors of hospitals, clinics and laboratories were requested to report to the relevant authorities at the earliest convenience. (Prasert,1989:24)

For government agencies within Bangkok, the report had to be made directly to the Health Office Division of the Communicable Disease Control of the Bangkok Metropolitan Administration, and private hospitals and clinics in Bangkok had to directly report detected cases to the Permanent Secretary of the MoPH. In other provinces, both government agencies and private organizations had to

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* B.E.: Buddhist Era, compared by adding 543 years to Christian years.

report their findings to the Provincial Chief Medical Officers.(Prasert,1989:24) Then, all AIDS cases were to be reported nationwide. By making the report of all found AIDS cases to the MoPH a legal obligation, the MoPH expected to build a systematic nationwide investigation network to assess the spread of HIV situation.

(6) Ban on Foreigners with HIV

Following the intention of the Department of CDC, the Ministry of Interior was required by the MoPH in October 1985 to include AIDS in the Immigration Act to prevent aliens infected with HIV from entering the country and to provide for the deportation of aliens infected with HIV.* As previous investigations showed that almost all of AIDS and ARC cases found at that time were Thai men who had had homosexual experience with foreigners, the Department of CDC determined the ban was a necessary and effective way to prevent the spread of AIDS in Thailand. Accepting the request from the MoPH, the Ministry of Interior issued Ministerial Announcement No.11 of 26 August B.E.2529 (1986) to include AIDS in the Immigration Act B.E.2522 (1979). As a result of the announcement, the refusal of entering to and deportation from the country for foreigners infected with HIV became legally accepted.

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* Aliens with permanent residence status and aliens born in Thailand were excluded.

(7) Draft AIDS Legislation

However, before the approval of the amendment of the Immigration Law by the Ministry of Interior, a stricter draft law was discussed. Had the draft been implemented, AIDS patients and HIV positives could reportedly be legally institutionalized, illegal gay bars and massage parlors could be closed down, and foreigners with AIDS or HIV could be deported from the country. Dr. Anuwat Limsuwan, one of the doctors who had taken care of the first AIDS case in Thailand, said about the draft law: "Right now we can stall the disease for a while but if this draft is not implemented, I do not know how we can stop it ... Without this law we have no way of controlling the activities of those 22 persons who may already be spreading the disease."(Bangkok Post,November 25 1985) At that time, there were 6 persons who were confirmed to have AIDS and 22 more persons who were HIV positive in Thailand. House Public Health Committee chairman, Dr. Arkhom Sornsuchart also claimed that the new law was immediately necessary so as to prohibit foreigners with AIDS from entering the country. He also said HIV would be widespread in Thailand without such a law.(Bangkok Post, February 1 1986)

Those claims were denied when such strict measures had not been included in the amendment of the Immigration Law in September 1986. However, some calls for such strict

legal action had not yet ceased. Even though the strict legal measures were not largely accepted because of their potential detrimental effects on the tourism industry, the House Public Health Committee made a proposal to request AIDS screening for tourists before they entered Thailand. Paitoon Mokkamakul, a member of the House Public Health Committee insisted that AIDS was a serious threat so although the screening might have a negative effect on tourism (Bangkok Post,July 17 1987) he still supported the strict legal action against tourists. Prasong Buranapong, chairman of the Public Health and Environment Committee had expressed the necessity of AIDS-free certificates for tourists before leaving their countries and proposed an international agreement about this matter.(Bangkok Post, July 23 1987)

However, these proposals were opposed by the House Culture and Tourism Committee. The committee was against the implementation of such strict legal action saying that the requirement of AIDS screening for tourists before leaving their countries would damage tourism in Thailand, and also claimed that "Thailand should push for all countries to make sure their citizens are free of the deadly disease to prevent its spread here."(Bangkok Post, August 8 1987) Moreover, a member of Parliament from Phang-Nga, one of the popular beach resorts in the southern part of Thailand, also opposed the proposal on the grounds that it would have serious repercussions on

the tourism industry, which was one of the main industries earning foreign currencies. He also said that a blood test for tourists was no guarantee for AIDS-free tourists because the AIDS virus takes about a month to be detected after it is contracted.(Bangkok Post,August 8 1987) Further, 1987 was "Visit Thailand Year" and the 60th birthday of His Majesty the King, so tourism was largely promoted in Thailand.

At that time, there were at least 29 countries which had undertaken some kind of regulations related to the entry of foreigners infected with HIV.(The Panos,1990: 265-266)*

(8) The National Coordinating Committee on the Prevention and Control of AIDS

In August 1985, The National Coordinating Committee on the Prevention and Control of AIDS was established in the MoPH. It was chaired by Dr. Vinij Asawasena, the director-general of the Department of CDC to deal with the AIDS epidemic.

The first meeting was held on August 20 1985 and was attended by medical experts from four medical centers and private hospitals. It discussed the blue card plan,

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* This information "is not comprehensive and absence of information does not mean that no regulations apply." The Panos,1990:265

(Bangkok Post,August 25 1985) a plan to issue AIDS-free cards for male CSWs after they had undergone blood tests and been found to be HIV-negative. Until then, 5 AIDS cases had been confirmed and three of whom were reportedly foreigners. There were also two more suspected patients and five more asymptomatic people.

(9) Center for the Prevention and Control of AIDS

The Center for the Prevention and Control of AIDS was established in October 1987 at the division level under the Department of CDC as a unit for implementing and coordinating activities between the government and the private sectors. It was also responsible for AIDS prevention and control planning and evaluation, epidemiology, health education and public relations, organizing training and seminars, medical and social counseling, laboratory services, promotion of study and research.

All information about AIDS cases managed and/or being followed-up was reported by all responsible officers and was updated at the Center, with bi-weekly epidemiological reports being released to related agencies since November 1987.(Prasert,1989:24)

In cooperation with the Public Relations Sub-committee, the Center also prepared the general answers about AIDS given to the public on the AIDS Hot Line, which was set up by the MoPH in October 1987 in order to provide

correct information about AIDS to the general public. Counseling, education, and psychological management were also arranged.

The Center was responsible for implementing and coordinating the counseling, education, and psychological management for persons found to be infected with HIV or AIDS when their conditions were followed up every one or two months to monitor the progress of their infection. (Prasert,1989:24)

(10) Conclusion

During this first period from 1983 to October 1988, activities taken by the Department of CDC stressed epidemiological investigations, such as the detection of AIDS cases and HIV-infected persons.

Behind the Ministerial Announcement of No.11 B.E. 2529 of the Ministry of Interior, there was a belief that AIDS was an imported disease by foreigners with HIV. In fact, this belief was not false at that time, so, the MoPH, with the cooperation of the Ministry of Interior, legalized the refusal of entering to and deportation from the country for foreigners infected with HIV.

At the same time, there was a belief behind the discussion of the draft AIDS bill that Thai AIDS patients and people infected with HIV should be under the strict control. To control the source of infection, such as the

high risk groups consisting of male and female CSWs, prisoners and IDUs, it was possible for personal privacy to be violated for the purpose of public health. However, what the Department of CDC should have focused on was the high risk behavior, such as promiscuity or unsafe sex, not the control of specific high risk groups. On this matter, the government would later be criticized by the NGOs as it was one of the main causes of the general public's misunderstanding that AIDS was a disease only for those groups, and that they themselves were safe from AIDS. This misconception contributed to the fact that the general public did not change their risk behavior and did not care about protective measures against HIV-infection.

3.1.2 The Thai National Programme on the Prevention and Control of AIDS, 1988-1991

In August 1987, the Thai National Programme on the Prevention and Control of AIDS, 1988-1991, was approved by the Cabinet. This was the first national programme on AIDS in Thailand to be established and aimed at taking comprehensive prevention measures based on a clear government policy on AIDS. This national programme was drafted by the Department of CDC in May 1987 to obtain more national budget for the expansion of AIDS prevention activities already being taken.(CDC,May 1987:2-3,Thai)

At that time, AIDS-case detection was actively carried out by the Department of CDC, mainly in Bangkok among male and female CSWs, and 7 AIDS cases, including 4 foreigners, and about 30 people infected with HIV but without any symptoms were officially reported in Thailand. (CDC,May 1987:2,Thai) Most of the AIDS and ARC cases were related to homosexual or bisexual intercourses with foreigners.* At the same time, a HIV-positive case was found among foreign prison inmates at Bang Kwang prison in Nonthaburi, near Bangkok,(Bangkok Post,April 10 1987)** which indicated the wider spread of HIV. The Department of

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* As of 15 January 1988, all 8 detected Thai AIDS cases had contracted from infected foreigners, and 18 AIDS related complex cases out of 27 were homosexual/bisexual male.(Teera,January-March 1988:38)

** Concerning this, because the media reported that there were AIDS cases among some 400 foreign inmates, the deputy chief of the Correction Department, Siri Srisawasd, had to explain later that "there was no confirmed AIDS case in any of the Thai prisons."(Bangkok Post,June 2 1987) Although the then head of a joint AIDS control committee at the MoPH, Dr. Winit Asawasena, used to mention when he publicized the foreign HIV-positive case in a prison for the first time that being HIV-tested positive did not necessarily mean that the person had AIDS,(Bangkok Post,April 10 1987) the media seemed to have confused HIV-positive with AIDS case.

In another case, the then Prime Minister's Office Minister Chirayu Isarangkura na Ayutthaya said "Thailand has 81 confirmed cases of Acquired Immune Deficiency Syndrome,"(Bangkok Post,July 22 1987) but the next day he issued a retraction which said that "the number of people actually suffering from AIDS at present was four."(Bangkok Post,July 23 1987)

As seen in these cases, this kind of confusion was often found both in the remarks of people concerned and in news reports at that time. Minister Chirayu's remarks, particularly, made people not only more confused, but also consequently suspicious of the government's attitude towards the country's AIDS situation.

CDC was concerned about the spread of HIV among the Thai population and recognized the necessity of effective preventive measures.

However, because such activities were taken within the ordinary budget for the prevention of sexually transmitted diseases of the Department of CDC, the expansion of those activities was too limited to deal with this new communicable disease. Therefore, it was necessary to develop this programme in order to request the national budget to address the AIDS issue. That was an official reason the Department of CDC established the national programme at this time.

Why did the Department of CDC establish the national programme in May 1987 when only about 30 cases of HIV/AIDS were then reported in the country? The reason was related to responses from the WHO. In February of that year, WHO formally established the Special Programme on AIDS, and its technical and/or financial support proposal for member states for 1987 was publicized together with its strategies in March.(WHO,March 1987) Among the strategies, it was clearly mentioned that the programme's two major tasks were "to support and strengthen national AIDS programmes" and "to provide global leadership, help ensure international collaboration, and pursue global activities of general value and importance."(WHO,March 1987:9) To implement these programmes, US$ 37.12 million was allocated for the 1987 budget. National programme

support was especially emphasized and 63.8% of the total the total budget or US$ 23.71 million was allocated to this. It also described that "Member States will generally require between *$250,000* and *$500,000* (on average *$375,000*) for their first-year activities."(WHO,March 1987:17) Following this, The Third Meeting of Participating Parties for the Prevention and Control of AIDS was convened in April, and in the consensus statement it was said that the meeting recommended and endorsed "strongly that WHO assert the international leadership and coordination role in support of national AIDS programmes", and recommended "strongly that countries establish, strengthen and implement national programmes for the prevention and control of AIDS in accordance with the WHO global strategies; and urges WHO to strengthen its capacity to support countries in this task."(WHO,April 1987:5)

Just after WHO indicated its overall strategies of Special Programmes on AIDS in March, the National Programme on the Prevention and Control of AIDS was drafted in Thailand in May, and the Thai government succeeded in receiving US$500,000 from WHO as financial support for its first-year activities, that is, for the Short-Term Plan for 1988 which will be mentioned next. It was the maximum amount allowed in WHO's Special Programme on AIDS. It is clear that the Department of CDC established the national programme on AIDS at that time because it was stimulated by the WHO's recommendation which said

WHO would support member countries' AIDS prevention activities mainly through national AIDS programmes. Therefore, the Department of CDC drafted the national programme in a hurry, with the aim of receiving support from the WHO.

The objectives and strategies of the national programme are shown in Table 3.1.

Main strategies were formulated for every transmission mode. The Department of CDC planned to carry out prevention measures for each mode of the disease. It was natural that the Department of CDC gave the highest prevention priority to activities aimed at sexual contact, because most all people infected with HIV at that time were considered to have been infected from sexual intercourse. This also reflected the conceptual framework of WHO's Special Programme on AIDS.* Prevention measures for IDUs were, however, not highlighted because the explosive spread of HIV among them in 1988 was still not clear at that time.

Of the national budget allocation for each prevention measure in the programme, of the total 43

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* The conceptual framework of the Special Programme on AIDS is outlined in the six strategies as below; 1)Prevention of sexual transmission, 2)Prevention of transmission through blood, 3)Prevention of perinatal transmission, 4)Prevention of transmission from HIV-infected persons through use of therapeutic agents, 5)Prevention of transmission through the development and delivery of vaccines, 6)Reduction of impact of HIV infection on individuals, groups and societies.(WHO,March 1987:3-4)

Table 3.1 Objectives and Strategies of the National Programme on the Prevention and Control of AIDS, 1988-1991

Objectives:

To prevent HIV infection among the Thai population, and to reduce morbidity and the AIDS infection rate

Main Strategies:

1. To prevent transmission from sexual intercourse
2. To prevent transmission from blood
3. To prevent transmission from mother to child
4. Cure of HIV/AIDS patients and usage of vaccine

Supportive Strategies:

1. To coordinate the government and the private sectors
2. Effective application of the present law
3. Training of health care workers
4. Improvement and procurement of instruments for experiments
5. Medical and social counseling support to people with HIV/AIDS

Source: Ministry of Public Health, May 1987, Thai.

million baht, the largest amount of 25,555,560 million baht, or 58.9%, was provided for an epidemiological survey, including the improvement and preparation of laboratory equipment, blood tests for risk groups and for blood and blood products at blood banks, and contact tracing and case follow-up of AIDS patients and their sexual partners.(Table 3.2)

The amount planned for health education was 33.2% of the total budget. Health education in this programme included teaching about AIDS in high schools; training of health education teachers above the high school level; AIDS education for students beyond high school, male and female CSWs, prison inmates, male homosexuals or male STD patients, and IDUs; and health education for the public through the media. Activities for which the budget was not allocated used the ordinary budget of the agency, funds from abroad, or from the budget of other programmes.

3.1.3 Short-Term Plan (1988)

In December 1987, soon after the Thai National Programme on the Prevention and Control of AIDS was approved by the Cabinet in August 1987, the Department of CDC developed a one-year Short-Term Plan with the cooperation of WHO. In the plan the Department of CDC clearly said that this plan was formulated to be submitted to the WHO for financial support.(CDC,April 1988:3) Its

Table 3.2 Activities planned in the Thai National Programme on the Prevention and Control of AIDS, 1988-1991, and the budget requested by the Department of Communicable Disease Control

(Thai Baht)

Activities	Budget(1988-1991)	Rate(%)
1. Public Health Education	14,432,000	33.2
2. Finding of People Infected with HIV	24,955,560	57.5
3. Contact Tracing and Case Follow-up of AIDS Patients	600,000	1.4
4. Establishment of Information Center	*	–
5. Care of AIDS Patients	672,000	1.6
6. Training of Health Care Workers	2,752,000	6.3
7. Establishment of Counseling Center for People with HIV	*	–
8. Coordination with other agencies	*	–
9. Support of Research	**	–
10. Promotion of Condom Usage	***	–
Total	43,411,560	100.0

Remarks: * To use the ordinary budget of the agency
** To use the budget of the agency and fund from abroad
*** To get condoms from Family Planning Programme
Activities of the number 2 and 3 are the epidemiological surveys.

Source: Department of Communicable Disease Control,Ministry of Public Health,May 1987:2-3.

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aim was realized when this plan received financial support from WHO.

When the Short-Term Plan was developed in December 1987, the Department of CDC had noticed the increase of HIV-infected people among IDUs, especially in prisons, and reported that 84% of the 527 HIV-infected people were IDUs.*(CDC,April 1988:1) Therefore, the Short-Term Plan gave priority to the "Health education of the groups considered to be at the highest risk" including "homosexual gay men, prostitutes, prisoners, and drug addicts." (CDC,April 1988:4)** Among the 527 people infected with HIV, homosexual or bisexual men accounted for only 12% and had already become the minority. Thus, the increase of AIDS and ARC cases in the near future could be expected to emerge among IDUs.

However, of the $373,280 (9.3 million baht) budget allocated to health education, 70.2% was planned to be used for public health education, namely, providing information through the mass media, video tapes, posters, and pamphlets, etc. Only 0.4% was allocated for prison visits by mobile health education teams for IDUs.(See Table 3.3) In addition, the visits of mobile teams to prisons was planned to be implemented by the VD (venereal

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* Even though, none of the 9 AIDS and 27 ARC cases as of 15 April 1988 were related to intravenous drug use.

** All 116 AIDS/HIV cases among IDUs found as of December 28 1987 were prison inmates.(Debhanom,June 1988: 64-65)

Table 3.3 (1) Planned Activities of the Short-Term Plan for the year of 1988 and Budget

(US Dollar)

Planned Activities	Thai National Budget (12 months)	WHO(GPA) Support (6 months)	Total Budget	Rate (%)
1. Health Education	212,480	160,800	373,280	31.3
2. Case Follow-up and Contact Tracing	2,400	7,600	10,000	0.8
3. Data Processing Microcomputer	10,000	5,000	15,000	1.3
4. Treatment	63,440	10,000	73,440	6.1
5. Training of Health Care Workers	48,880	44,160	93,040	7.8
6. Patient Consultation Support	–	2,000	2,000	0.2
7. Coordination Meeting	–	12,000	12,000	1.0
8. Laboratory Equipment and Supply	356,400	258,400	614,840	51.5
Total	693,600	500,000	1,193,600	100.0

Source: Department of Communicable Disease Control, Ministry of Public Health, April 1988: 12-14.

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Table 3.3 (2) Detailed Budget Use for Health Education

Health Education	Total Budget	%	Implementing Agencies
1.1 Seminar for inclusion of AIDS topics into high school curriculum	8,000	2.1	Ministry of Education Ministry of Public Health
1.2 Mobile Education Teams	103,370	27.7	
(a) Visit to 1,000 schools	(36,400)	(9.7)	VD Division Regional CDC Centers Center for Prevention and Control of AIDS(CPCA) Bangkok Metropolis Administration
(b) Workplaces of male and female CSWs (2 visits/year, 4,000 places)	(65,600)	(17.6)	VD Division Regional CDC Centers CPCA Provincial VD clinics
(c) Visit to prisons (3 visits/year, 115 places)	(1,370)	(0.4)	VD Division Regional CDC Centers CPCA
1.3 Public Health Education	261,910	70.2	Regional CDC Centers Health Education Division CPCA (etc.)
Total	373,280	100.0	

Source: Department of Communicable Disease Control, Ministry of Public Health,April 1988: 12-14.

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disease) Division of the Department of CDC, who were not really suited to educate prison inmates since needle sharing was thought to be the reason of the spread of HIV among them.

The objectives and strategies of the Short-Term Plan are as indicated in Table 3.4.

The supportive strategies of the Short-Term Plan consisting of coordination with the National AIDS Programme, inter-sectoral coordination and cooperation, and expected roles of NGOs deserve further discussion because these were newly formulated strategies which emphasized cooperation among organizations in different sectors apart from the areas of blood screening and information distribution.

The inter-sectoral coordination and cooperation concerned coordination between medical schools and the Department of Medical Sciences to establish laboratories for blood screening, the coordination with other institutes both in and out of the country to exchange information about AIDS, and the promotion and encouragement of other institutions to conduct technical study and research on AIDS.

Moreover, the Department of CDC said in its Short-Term Plan that the involvement of NGOs in the prevention and control of AIDS was very beneficial especially for the detection of HIV cases and health education. In the Thai National Programme on the Prevention and Control of AIDS,

Table 3.4 Objectives and Strategies of the Short-Term Plan of the Department of CDC, 1988

Objectives:

1. Goals; To prevent the transmission of AIDS among Thai population and to reduce the infection rate and morbidity from the disease.

2. Special Objectives;
   a) To educate the general public with specific attention to those population groups most at risk of acquiring infection.
   b) To understand the overall pattern and transmission of infection in Thailand and the factors which may influence it in the future.
   c) To prevent the spread of the virus.
   d) To appropriately manage HIV infected people and people with AIDS.
   e) To educate health care workers to cope with HIV infected persons.

Main Strategies:

1. Health education programme
2. Epidemiological surveillance
3. Treatment service for AIDS patients
4. Training of health personnel
5. Medical AIDS and social counseling units

Supportive Strategies:

1. Coordination of the National AIDS Programme
2. Inter-sectoral coordination and cooperation
3. Roles of non-government organizations (NGOs)

Source: Department of Communicable Disease Control, Ministry of Public Health,April 1988:3-9.

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1988-1991, the Department of CDC described the cooperation with NGOs also but only in the area of the establishment of a committee and improvement of private hospitals laboratories for blood screening. However, in the Short-Term Plan, the Department of CDC recognized the necessity of cooperation with NGOs in the area of health education. This was to "reach a wide variety of population"(CDC,April 1988:9) following the spread of HIV among the public, particularly among IDUs. In addition, it is interesting to note as well that WHO had pushed involvement of NGOs in the AIDS prevention and control activities and had described in the Proposal for 1987 that "During 1987, SPA* proposes to assist 50 Member States with *urgent* and *short-term* support," and further said "Member States will be identified for priority action" according to: "ability and willingness of national authorities to utilize non-governmental organizations (NGOs) as well as a broad range of health, education and social service sectors as part of the AIDS prevention and control plan."(WHO,March 1987:11) WHO further said that "SPA financial requirements for 1987" would depend upon: "the availability of other (national, bilateral, NGO) support" in other words, other financial support.(WHO,March 1987:17) This policy of the Special Programme on AIDS was mentioned in March 1987, less than one year before the development of the Short-

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* Special Programme on AIDS.

Term Plan in December 1987.

Thailand's National Coordinating Committee on the Prevention and Control of AIDS was first established in August 1985 and revised in November 1987.(See Table 3.5) For the Short-Term Plan, the monthly meeting between the committee and its three sub-committees was determined to be conducted in order "to assess and update the epidemiological pattern of the disease and to discuss the progress of prevention and control programmes, as well as to give appropriate recommendations to be implemented." (CDC,April 1988:8) Furthermore, responsibilities of the Center for the Prevention and Control of AIDS, first established in October 1987 under the Department of CDC, (See Table 3.6) was clearly written and its expansion in terms of staff and functions was also decided in the Short-Term Plan.

As described above, the Short-Term Plan was the plan formulated by the Department of CDC of Thailand for the prevention and control of AIDS. However, it was greatly influenced and prompted to be developed by the policy of WHO's Special Programme on AIDS, and the technical and financial support was given by an international organization, namely, WHO.

Table 3.5 The National Coordinating Committee on the Prevention and Control of AIDS

Structure:	
Committee	
Sub-Committee	1. Sub-Committee on public relations
	2. Sub-Committee on technical aspects
	3. Sub-Committee on data and information
Working Group	1. Working Group on health education
	2. Working Group on legal aspects

Responsibilities:

To coordinate and cooperate among the institutions concerned on the prevention and control of AIDS;

1)to give advice on the research intervention for the benefits of prevention and control of AIDS

2)to appoint the ad hoc committee to work on any critical issues.

Source: Department of Communicable Disease Control, Ministry of Public Health,April 1988:7-8.

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Table 3.6 The Center for the Prevention and Control of AIDS

Responsibilities:

To implement and coordinate

1)planning and evaluation

2)epidemiology

3)health education and public relations

4)training and seminars

5)medical and social counseling

6)laboratory services

7)promotion of study and research.

Agencies the center coordinated and collaborated with;

Agencies of MoPH:	1)The Department of CDC
	2)The Office of the Permanent Secretary
	3)The Department of Medical Services
	4)The Department of Medical Science
Ministries:	1)Ministry of Interior
	2)Ministry of University Affairs
	3)Hospitals in other ministries
NGOs:	1)The Thai Red Cross Association
	2)several non-profit organizations including Social Welfare Council and the family planning societies
	3)private clinics and private hospitals.

Source: Department of Communicable Disease Control, Ministry of Public Health, April 1988:8-9.

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3.1.4 Medium-Term Plan (1989-1991)

Following the Short-Term Plan, a Medium-Term Plan, 1989-1991, was drafted by the Department of CDC in August of 1988. It was strongly linked with the guidelines of WHO's Special Programme on AIDS because the Medium-Term Plan was defined as the next step for implementing the prevention and control plan of AIDS by WHO.* Namely, the Medium-Term Plan reflected globally agreed upon policies and strategies. As the Department of CDC said, the purpose of the establishment of Medium-Term Plan reflecting the globally agreed upon plan of the WHO was not only "to provide a working framework for government, non-governmental organizations and private initiatives", but that the Medium-Term Plan "will also provide potential donors with a plan which, it is hoped, will trigger a response of solidarity from the international community in the fight against AIDS."(CDC,August 1988:1) That is, the Department of CDC's Medium-Term Plan expected to receive financial and technical support from abroad as well as to prevent the spread of HIV.

The objectives and strategies of the Medium-Term Plan which were more detailed and widened are in Table

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* In the Strategies and Structure Projected Needs, March 1987, the WHO said "To establish and strengthen national AIDS programmes, WHO/SPA must be prepared to support;" "*short-term* (first year) planning and actions", and "*medium-term* (3-5 year) planning and support", p 10.

3.7, and the budget allocations for each prevention activity for the first year of Medium-Term Plan, 1989, are described in Table 3.8.

In the Medium-Term Plan, first priority was given to the prevention of transmission of HIV among IDUs, reflecting the sharp increase in the number of HIV-infected people among IDUs.* The Department of CDC defined intravenous drug use as "the highest risk behavior in relation to HIV infection," and said "Immediate and intensive prevention is required to control and prevent the spread of HIV among IV (intravenous) drug users and their sex partners."(CDC,August 1988:15) Then, it listed the prevention measures against HIV-transmission among IDUs as the first clause of the strategies in the Medium-Term Plan, and more than 60% of the whole budget was allocated to this strategy. Compared with the Short-Term Plan, much attention was paid to IDUs.

In addition to the prevention strategies which consisted of the prevention of HIV-transmission among IDUs, sexual transmission, transmission through blood and blood products, and perinatal transmission,(See Table 3.7) three more programme elements were included in the

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* According to serosurvey among the Thai population carried out up to May 1988, 4.48% of 7,615 IDUs were infected with HIV, which was the highest positive rate among any other risk groups, such as male commercial sex workers (1.28%), prisoners (0.67%), female commercial sex workers (0.09%), and heterosexual male (0.00%).(CDC, August 1988:9)

Table 3.7 Objectives and Strategies of the Medium-Term Plan

Objectives:

1. Long-Term Objectives;
   1) Prevent HIV transmission in Thailand
   2) Reduce morbidity and mortality associated with HIV infections
   3) Reduce the social and economic impact resulting from HIV infection
2. Medium-Term Objectives;

   By the end of 1991, the National AIDS Prevention and Control Programme will have:
   1) Established a monitoring and evaluation capacity with effective epidemiological surveillance, social and behavioral change evaluation and management information system;
   2) Reduced the annual incidence of HIV infection among intravenous drug users and reduced the risk of transmission from them to other individuals;
   3) Reinforced safe sexual behavior through information, education, communication and the promotion of condoms;
   4) Achieved the prevention of transmission of HIV through blood and blood products by the establishment of a safe blood supply system and etc, etc.
   5) Reduced the impact of HIV infection and AIDS by the provision of social, psychological and medical support to HIV infected persons and the community;
   6) Provided the programme administration, through applied research, with a continuous flow of the information required to improve efficiency, effectiveness and impact.

(Continue to p.67)

(Continued from p.66)

Strategies:

1. Prevention of Transmission in intravenous drug users (IDUs)
   1) Epidemiological surveillance
   2) Medical service
   3) Social service and counseling
   4) Education
   5) Training
   6) Research
2. Prevention of Sexual Transmission
   1) Research
   2) Epidemiological surveillance
   3) Health Education
   4) Condoms
   5) Training
   6) Programme Support
3. Prevention of Transmission through Blood and Blood Products
   1) Blood Donor Practices
   2) Testing Facilities
   3) Blood Substitutes
   4) Blood Product Safety
   5) Donated Organs and Semen
   6) Training
   7) Research
4. Prevention of Perinatal Transmission
   1) Health Education and Counseling
   2) Training

Source: Ministry of Public Health, August 1988

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Table 3.8 (1) Budget Estimates for the Medium-Term Plan for 1989

(Unit: Million Baht)

Activity	<a>	<b>	<c>	<d>	%
<u>Transmission in IDUs</u>					
Surveillance among IDUs, Prisoners, Selected Communities and Sex Workers	–	–	7.7	–	6.5
Treatment of IDUs and Medical Care	–	–	21.75	–	18.2
Social Services and Counseling	–	1.05	–	–	0.9
Social Welfare	–	–	4.0	–	3.3
Health Education; Individual, Group, Mass Communication; Production of Health Educational Material	–	30.1	–	–	25.3
Training; Seminars, Workshops, and Short Courses	–	7.2	–	–	6.0
IDU Research Workshop	–	–	0.1	–	0.1
<u>Prevention of Sexual Transmission</u>					
1) KABP Surveys	–	1.125	–	–	0.9
Grants for Studies of New Intervention	–	–	0.5	–	0.4
2) Prevention Counseling	–	0.1	–	–	0.1
3) Condoms – Distribution	–	–	9.0	–	7.6
Condoms – Promotion & Research	–	1.2	–	–	1.0
Condoms – Quality Control	–	–	0.02	–	0.02
<u>Prevention of Transmission through Blood and Blood Products</u>					
1) HIV screening and Quality Control	–	–	–	30.0	25.1
2) Blood and Blood Products – Control	–	–	0.6	–	0.5
3) HIV Testing Quality Control	–	–	–	0.2	0.2
4) Health Worker Training	–	–	0.1	–	0.1
<u>Prevention of Perinatal Transmission</u>					
1) Seminar on Breast Feeding and HIV infection	–	0.06	–	–	0.05
2) Training in Management of HIV infected Pregnant Women, Mothers and Newborn	–	–	0.1	–	0.1

(Continue to p.69)

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Table 3.8 (2) Budget Estimates for the Medium-Term Plan for 1989

(Unit: Million Baht)

Activity	<a>	<b>	<c>	<d>	%
(Continued from p.68)					
Management of HIV Infection and AIDS					
1) Medical Care - Workers Protection and Provision of Drugs	-	-	1.2	-	1.0
2) Laboratory Facilities	-	-	-	1.0	0.8
3) Research Agenda	-	-	0.1	-	0.1
Management Collaboration and Coordination of the National AIDS Programme					
1) Establishment of National AIDS Committee	0.5	-	-	-	0.4
2) NACP** Manpower Requirements					
3) AIDS Reference Library including Subscription of Journals, Computer Service and other Operating Costs	1.5	-	-	-	1.3
Total(Baht)	2.0	40.835	45.17	31.2	119.205
%	1.68	34.26	37.89	26.17	100.00

<a> Management
<b> Health Education
<c> Surveillance, Control and Treatment
<d> Laboratory Support
* KABP: knowledge, attitude, behavior and practices
** NACP: National AIDS Control Programme

Source: Ministry of Public Health, August 1988:55-56.

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Medium-Term Plan. Those were 1)management of HIV infection and AIDS, 2)management collaboration and coordination of the national AIDS programme, and 3) programme monitoring and evaluation.

The objective of the first element was "to provide HIV infected persons, and AIDS and ARC cases with the highest available and affordable standards of physical, psychological and social care."(CDC,August 1988:28) The management consisted of six elements, that is, pre-post counseling, counseling of HIV-infected individuals and AIDS cases, clinical care, laboratory facilities, training, social support, and research.

One of the most interesting in terms of the involvement of NGOs with the government AIDS prevention activities was social support. The Department of CDC said "Non-governmental organizations will be encouraged to develop projects for the care and social support of HIV-infected individuals and their household or workplace contacts." It further said "These projects should aim to provide physical, moral, religious and, if necessary, material support to those concerned," and "Of particular importance will be foster care for orphans born to HIV-infected mothers."(CDC,August 1988:32)

Furthermore, the Department of CDC described in the social service and counseling clause for the prevention of transmission of HIV among IDUs that "Social welfare services including vocational training and

essential occupational equipment will be provided to drug rehabilitation centers by government agencies concerned and non-government organizations,"(CDC,August 1988:16) Also the clause supporting the prevention of sexual transmission stated that "NGO assistance will be sought to deal with the volume of activity and to ensure consistency of message and execution."(CDC,August 1988:22) Concerning private agencies, the Department of CDC said "advertisers and advertising agencies will be requested to consider providing public service support for campaign design and development. Public service advertising time will be solicited from the media."(CDC,August 1988:22)

As seen from the above, the government expectations of the NGOs and private sectors obviously increased in the Medium-Term Plan in comparison to the Short-Term Plan particularly in the field of social care. However, the roles expected of NGOs and private sectors for the Department of CDC's prevention activities were still only the supportive roles.

In the second element, management collaboration and coordination of the national AIDS programme, the advisory role of the National Coordinating Committee on the Prevention and Control of AIDS and the role of the Center for the Prevention and Control of AIDS were mentioned. Here, the Department of CDC described the necessity to establish provincial AIDS committees and AIDS prevention and control plans in the provinces to deal with

the widespread HIV prevalence.

Furthermore, intersectoral coordination and cooperation among government agencies and between the government and non-government agencies was encouraged; "Collaboration and cooperation between the NACP* and the private groups, institutions or individuals will be built around project proposals which will be evaluated and approved by the National AIDS Committee."(CDC,August 1988: 35)

In addition, the Department of CDC defined that the participation and support of NGOs was a major objective for the NACP and described the areas of involvement, that is, case detection, education, social welfare, and other activities including the reporting of AIDS-related activities and fund-raising activities. Here, social welfare had the purpose to solve the social and economic problems faced by AIDS-patients and their families, such as, providing medical care, psychological and religious support, employment and employment retraining, education, adoption service, and programmes to prevent family disruption. Also here, the areas in which the government expected NGOs to work were further expanded from those of the Short-Term Plan.

Concerning information and policy support, the Department of CDC recognized the necessity of information

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* NACP: National AIDS Control Programme

for policy makers, opinion leaders, and the media to establish and maintain a positive environment for the NACP. To support the NACP, small briefings were planned to be conducted for senior staff in the government, universities, NGOs, and the private sectors, in which information concerning basic facts about HIV infection and AIDS in Thailand, policy implications and strategies, and objectives of the NACP would be covered. Furthermore, a comprehensive media and press relations programme was planned to be instituted, which included media workshops (annually), site visits (to clinics, hospitals), news releases for print and electronic media (minimum one per month), and special events such as National AIDS Week, World AIDS day. As already mentioned, the AIDS Hot Line would also continue to operate during the Medium-Term Plan, and the issue of a biweekly AIDS Newsletter was determined. The establishment of an AIDS Reference Library at the Department of CDC, support for subscription and related costs for three years for journals, periodical reference literature and a computer-based information system were planned under close collaboration with UNESCO.

The third element, programme monitoring and evaluation, consisted of programme monitoring, epidemiological surveillance, and programme evaluation. The development of indicators for programme monitoring and evaluation was planned in order to guide programme

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decisions. For that purpose, the framework of epidemiological surveillance and programme evaluation was identified.

3.1.5 Summary of Responses of the Department of Communicable Disease Control in the First Period (From 1983 to October 1988)

Before the first national programme was started in 1988, the Department of CDC had implemented AIDS prevention measures within its ordinary budget for sexually transmitted diseases. Later, due to the need to expand existing activities because of the increasing trend of AIDS and HIV-infected cases, the Department of CDC developed the National Programme on the Prevention and Control of AIDS for the year of 1988-1991 and was allocated a 43 million baht national budget for the programme. Because almost all of the AIDS cases found at that period were male CSWs who had had homosexual intercourse with foreigners, the prevention of HIV-transmission through sexual contact was mainly focused on in the programme. Case finding, contact tracing, and case follow-up were, then, carried out in a hurry. At the same time, however, the prevention activities related to information, counseling, coordination with other agencies, support of research, and promotion of condom usage were only planned to be implemented within the ordinary budget,

funds from abroad, or with support from other programmes, and was not boosted by additional funds as were the other activities in the national programme.

Soon after the Short-Term Plan was launched in 1988 with the financial support of US$ 500,000 (about 12.5 million baht) from WHO, the first explosive spread of HIV emerged among IDUs. However, when the Short-Term Plan was drafted in December 1987, the majority of IDUs found to be infected with HIV were prison inmates. Therefore, even though 31.3% of the whole budget of approximately 30 million baht ($1,193,600) was allocated to health education, only IDUs who were prison inmates were provided with some health education by the mobile health education teams planned in the Short-Term Plan. Moreover, the National Coordinating Committee on the Prevention and Control of AIDS, originally established in August 1985, was revised in November 1987 and the monthly meetings were determined to follow the rapidly changing situation. In the Short-Term Plan, the Department of CDC clearly recognized the roles of NGOs and expected more from them than they had in the national programme. It mentioned the significant role of NGOs in health education and social services for they could reach a wider variety of population than the Department of CDC, which was an government agency.

The Medium-Term Plan was formulated in August 1988, when the sudden and sharp increase of the HIV-

infection rate among non-prison inmates IDUs became obvious. The primary priority was, therefore, given to the prevention strategy for IDUs and more than 60% of the whole budget for the first year, 1989, was allocated to it. Prevention activities of sexual transmission, on the other hand, were only allocated 10%. Nevertheless, by June 1989, 44% of the HIV-infection rate, literally the explosive spread of HIV infection, would be found among low-charge female CSWs in a northern province.

In the Medium-Term Plan, the Department of CDC paid more concrete attention to the roles of NGOs for providing health education and social services, and private sectors, and especially advertising agencies and the media, for disseminating information about AIDS. It also recognized the necessity for a AIDS prevention plan in the provinces.

3.2 Responses from Other Government Agencies

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While the Department of CDC carried out prevention and control measures against the AIDS epidemic, the other government agencies were generally keeping silent except for the Ministry of Interior which issued a Ministerial Announcement related to AIDS, and the Ministry of Education which conducted seminars for the inclusion of AIDS topics in the high school curriculum.

One of the reasons that only the Department of CDC

and a few related government agencies took action against the epidemic was that the AIDS problem at that time was considered as simply a public health issue for which the MoPH should take responsibility. Dr. Wiwat Rojanapithayakorn, former director of the AIDS Prevention and Control Center, said that the MoPH did not receive good cooperation from other government ministries in the early period but at the same time the MoPH itself did not ask for specific cooperation except from the Ministry of Interior and the University Affairs Bureau.(Personal interview,April 1995) From this personal interview, it seems that neither other government agencies nor the MoPH considered AIDS as a serious public health issue.

Another reason for the indifference of the general government agencies to the AIDS epidemic was the image problem attached to AIDS. When AIDS first spread among male homosexuals in the U.S. in the early 1980's, what kind of disease AIDS was had not yet been determined. Therefore, because AIDS was found only among gays, it was called "Gay-Related Immune Deficiency (GRID)," "Acquired Community Immune Deficiency Syndrome (ACIDS)," or "Community Acquired Immune Deficiency Syndrome (CAIDS)." (Randy,1987)* Thus, as AIDS was strongly linked to gays, that is, male homosexuals, people avoided talking about it, politicians and senior government officers included. The former Minister of Interior, General Sitthi Jirarote, whose ministry was asked by the MoPH to revise the

Immigration Act to ban foreigners with AIDS/HIV, said "he did not want to talk much about AIDS."(Bangkok Post, September 27 1985)

These people did not want to talk about it because they were afraid it could damage the image of Thailand where the tourism industry was one of the most important sources of income. When an NGO, the Intensive Development of Quality of Life Association; Phetchburi General Hospital; and Mahidol University launched a campaign against AIDS in Pattaya in September 1985, the campaign was strongly criticized by residents, especially gays, gay and regular bar owners, and even the then Minister of Public Health, Marut Bunnag, who said, "the ministry's prior consent will help make all campaigns against the disease follow a consistent line." The 'consistent line' was that "the ministry would work quietly to prevent the disease from spreading to the beach resort." He explained that "as a tourist centre, Pattaya generated a huge amount of income for Thailand," and therefore, "any campaign should be planned to take into account its possible impact on the resort's image."(Bangkok Post,September 9 1985)

In another case, the Minister of the Prime Minister's Office, Chirayu Isarangkula na Ayutthaya, tried to give a brighter picture of the AIDS situation by explaining the figures more accurately reporting a much

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* "Community" in this case means "Gay community", according to Randy Shilts.

lower number of cases, but whether intentionally or not, this resulted in the belief by the public that the AIDS problem was smaller than it was.(In detail, see footnote on page 48)

Furthermore, Dr. Praphan Phanuphak said "he could not be more precise" about the number of Westerners infected with HIV who were prison inmates and avoided to publicize the information. The Bangkok Post, the local English language daily newspaper, reported that "Public Health Officials either declined to talk or said they were forbidden to answer questions about AIDS in Thailand." (Bangkok Post,July 10 1987)

Under such circumstances in which even the Minister of Public Health wanted to deal with the AIDS issue quietly because of fear of the negative impact of AIDS on tourism, it was natural that most government agencies neither paid positive attention to nor took action to deal with the AIDS epidemic.

Finally, according to a certain senior officer of the MoPH, General Prem Tinsulanonda, the then Prime Minister, had come to MoPH in 1987 and forbidden officials to talk about AIDS publicly because of the effects it could have on the country's tourism industry.(Personal interview,December 1995) Since 1987 was "Visit Thailand Year," and also the year of the King's 60th birthday, various events were planned to be held. Therefore, the Prime Minister was afraid that tourism might have been

affected if the AIDS epidemic in the country was widely reported. In short, the implementation of the prevention and control programme on AIDS by the Department of CDC was affected by these political factors.

3.3 "End of Secrecy"

Following the general election in July 1988, the new government led by General Chatichai Choonhavan came into power in August. Under the new administration, Mr. Chuan Leekpai, the then deputy leader of the Democrat Party and the then Minister of Public Health, suddenly called for the end of secrecy about AIDS in October. He said "there was no longer any need to keep the cases secret."(Bangkok Post,October 25 1988) He himself began to move and talk actively about AIDS in front of the pubic.

He honestly admitted that "the ministry's previous policy had been to avoid publishing AIDS cases for fear that the public, which at that time knew little about the killer disease, would panic." He said "the ministry now wants the general public to know more about AIDS and how to take preventive measures."(Bangkok Post,October 25 1988) From the above quote, it could be said that under Chuan, the AIDS policy of the MoPH was changed from protecting the public from panicking, into protecting the public from being infected with HIV.

Afterwards, he actively moved to let people know

about AIDS. He visited a 13-month-old baby suffering from full-blown AIDS in November 1988 at Bamrasnaradura Hospital, where the special AIDS ward had been established. He listened to the mother's difficulties which had been featured in the local English language newspaper.(Bangkok Post,November 11 1988) In August 1989, he warned about the spread of HIV (Bangkok Post,August 18 1989) and visited brothels at Phayao, a province in the north, as part of an AIDS study tour.(Bangkok Post,August 28 1989) In September, he attended a television programme *Sonthana Panha Baan Muang* (Talk about the national problems) with Mechai Viravaidya, a famous AIDS activist, and talked about AIDS as the Minister of Public Health. (Bangkok Post,September 4 1989) Soon after this, he talked about the AIDS situation in Hat Yai, a province in the south where a lot of Malaysian tourists visited, and was strongly criticized by the local tourism association. (Details will be described in Chapter 4)

Why was the then Minister of Public Health so active against the AIDS epidemic at this time? The first reason was because the wide spread of HIV was suddenly found among IDUs outside of prisons. At Thanyarak Hospital, the 1.17% HIV-infection rate among IDUs in January 1988 increased to 4.01% in February, 10.83% in March, and 14.77% in April.(Prasert,1989:26-28) Also at a clinic of the Bangkok Metropolitan Administration, the rate of 0.8% in January increased to 24.5% in February.

(Prasert,1989:26-28) Furthermore, the detection of many people infected with HIV among residents in Klong Toey slum, the biggest in Thailand, was widely reported through the media in April by the Duang Pratheep Foundation, an NGO working for Klong Toey slum residents. Also, only four days before the Minister called for the end of secrecy about AIDS, fourteen cases of HIV-infection from blood transfusions during operations were reported. (Bangkok Post,October 21 1988) The sudden spread of HIV at that time was then widely known by the public. It was no longer feasible to keep silent about AIDS or there would have been more confusion among the public. Thus, the previous policy of the MoPH which was taken in order to avoid the people's panic, soon became a factor which could have created real panic. It was precisely the wide and sudden spread of HIV which urged the Minister of Public Health to say that "since people had became more aware of the Acquired Immune Deficiency Syndrome, there was no longer any need to keep the cases secret."(Bangkok Post,October 25 1988)

Another reason was because since the 1987 Visit Thailand Year had ended, there was no reason for the MoPH to follow the policy of the former Prime Minister, General Prem, who had ordered officials to keep quiet to prevent the loss of income from the tourism industry.

Because of these reasons, the then Minister of Public Health called for the end of secrecy on AIDS and

worked energetically on the AIDS issue. His attitude was so active that he was strongly criticized. Dr. Prayoon Kunasol, the director of the Epidemiological Division of the MoPH in 1988 and the director-general of the Department of CDC in 1992-1993, said "Mr Chuan Leekpai, as the Minister of Public Health at that time was very active to introduce AIDS prevention and control measures, but was very hurt and a loser."(Personal interview,December 1995) What Dr. Prayoon meant when he said Chuan was a loser was that he was strongly criticized by the local tourism industry.

In November 1988, the MoPH under Chuan set up the National Coordinating Committee on the Prevention and Control of AIDS chaired by the permanent secretary of the MoPH. The committee was originally established in August 1985 and had been chaired by the director-general of the Department of CDC. Since the committee was chaired by the permanent secretary of the MoPH, and the Minister and the Deputy Minister of the MoPH became advisory members of the committee, all departments and divisions in the MoPH could be mobilized to deal with the AIDS prevention and control measures, that is, the priority of the AIDS measures was raised from that of department-level to that of ministry-level. Thailand's AIDS prevention measures thus entered their next stage.

3.4 Public Responses

During the first period, from 1983 to October 1988, HIV spread slowly among an extremely limited population, almost only among male CSWs, in the first few years. It then in 1988 explosively expanded among a new population group, the IDUs. AIDS patients and people infected with HIV were mostly found in Bangkok and other tourist areas.

As a result the government generally keeping a silent attitude towards the AIDS issue in this first period, the public was left almost ignorant about the nature of AIDS. People received information about AIDS mainly through the media, such as television or news-papers which provided negative image of AIDS. Therefore, it was natural that people believed AIDS was a disease only for CSWs and IDUs, and stigmatized people with AIDS.

Under these circumstances, people were confused by rumors related to AIDS and without correct medical information, they were unnecessarily afraid of AIDS. Therefore, when the first HIV-infected case contracted from a blood transfusion was publicized, people fell into a kind of panic. The person, whose name and those of his family members were published by the media, became the victims of the social denial, fear, stigma, and discrimination against AIDS. Due to misconceptions about AIDS, people infected with HIV and AIDS patients had to

suffer from social discrimination, as well as the incurable disease.

Although some NGOs were working on the AIDS issue from early on, their number was very limited and their activities were mostly focused on cooperating with the government in the fields of blood screening, case finding, and reporting to the officials. Health education was also provided by NGOs but the target groups were limited to the high risk groups such as male and female CSWs and IDUs. Consequently, such efforts by the NGOs were of little help in making the general public feel easy, and correctly understand about AIDS.

3.4.1 Impact on Society

(1) Gays and Gay Bar Owners

A part of the public expressed their dissatisfaction with the Department of CDC's responses to AIDS.

In September 1985, when HIV infection had been found only among gays, a campaign against AIDS was conducted in Pattaya, the famous beach resort near Bangkok. As the primary purpose of this campaign was to conduct blood tests for people in Pattaya, especially gays and CSWs and to find HIV-infected people rather than to disseminate knowledge and prevention methods, this

campaign was strongly criticized by gays and owners of gay bars who said that "it unfairly labeled the resort as a centre of disease."(Bangkok Post,September 8 1985)

Gays and bar owners claimed that "The campaign was carried out as if Pattaya was full of disease and will create a false impression among tourists."(Bangkok Post, September 8 1985) They were afraid that the campaign would prevent people from coming to the resort, and were worried about the future of their business.

On the other hand, there were gays who agreed with the campaign by saying that "more publicity should be given to the disease to prevent it (AIDS) from gaining a foothold in Thailand,"(Bangkok Post,September 8 1985) As Natee Teerarojjanapongs, a well-known gay activist against AIDS, said, it was not as if all gays in Thailand were working as CSWs. In this case, therefore, there seemed to be different opinions about AIDS campaigns between gays working as CSWs and those who were not.

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(2) Rumors and the Public

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In July 1987, two rumors related to AIDS spread among the public. Both of these were concerned with the transmission of HIV.

One rumor was that mosquitoes could spread HIV. (Nittayawadee,1987:19-20,Thai) After the news was publicized, a doctor from Ramathibodi Hospital, in an

effort to calm down the uneasiness widely spreading among the people explained to the public that HIV could not live in the body of mosquitoes.

The other rumor told that a certain woman who had a cesarean operation, later died at Ramathibodi Hospital because she had been given a transfusion with AIDS-contaminated blood during her operation on 16 July 1987.(Nittayawadee,1987:16-19,Thai) This rumor stirred up fear among the public, especially recipients of blood. The hospital doctors had desperately denied the fact by suggesting that no women with AIDS had been found and that there were no AIDS cases infected from blood transfusions in Thailand. They further explained that the woman had not died of AIDS but that there were many diseases which had AIDS-like symptoms, leading to the decrease in immunity.

However, these doctors' statistical and medical explanations seemed to be less successful in making people feel at ease, and in fact these doctors were using incorrect data. In a series of denials by doctors, one of them said that there was no necessity to fear infection with AIDS from blood transfusions because all units of donated blood were checked for HIV.(Nittayawadee,1987:17, Thai) This, however, was not a fact. Since October 1987 the National Blood Center had expanded the capacity of blood screening for HIV to about 1,000 units per day. (Prasert,1989:24) However, there were about 700,000 units of donated blood a year at that time, almost 2,000 units a

day. Thus it was impossible to check all donated blood units for HIV. In fact, the first case of HIV-infection from blood transfusion in Thailand was detected only two months after the rumor was spread, in September 1987.

In dealing with these two rumors, doctors not only made every effort to make the public believe that those rumors were not true but also Dr. Nittayawadee Phromyuu, a serology specialist and the author of the book, 'Knowledge about AIDS: Enormous Danger of the 20th Century,'(Thai) also tried to ease the anxiety of the public who were so scared of the disease. In the process of explanation, the so-called high risk groups were much emphasized as the sources of the spread of HIV so as to suppress the panic. For example, Dr. Nittayawadee clearly said in her book that "groups which have been spreading HIV at present are homosexuals and intravenous drug abusers."(Nittayawadee, 1987:17,Thai) She might have been trying to assure the people by insisting that AIDS was the disease of some specific group of people. But such efforts succeeded only in making the public misunderstand that AIDS was a disease for specific groups and not for the general public. Thus, contrary to the doctors' intent, their efforts contributed to the misconception and the building of a negative image of AIDS by the public. This was proved by the following incidence.

(3) The Case of Cha-on

At that time, when the public was afraid of the spread of HIV and was worried about being infected with HIV themselves, the first case of HIV-infection by a blood transfusion became public in September 1987.

Cha-on Suasam, 48 years old, was a security guard with Pioneer International Corporation's factory in Samut Prakan Province. In November 1986, he underwent two operations for a stomachache at Taksin Hospital. In April of the next year he was visited by some officials from the Venereal Disease Control Division of Bang Rak Hospital and both his and his wife's blood were tested. After several visits, he was sent to Chulalongkorn Hospital where it was pronounced that he was HIV-positive.

After his employer learned that he was infected with HIV, the company tried to fire him. Even though Dr. Praphan Panupark, the doctor at Chulalongkorn Hospital who sent the result of the blood test to Cha-on, wrote to the company explaining that HIV could be transmitted only by blood transfusion or sexual intercourse, and thus there was no need to fear that Cha-on could spread the virus, the employer eventually fired Cha-on and also asked his wife who had been working at the same company but who had tested negative to resign. Each received six-months' severance pay. The company explained in an interview with the Bangkok Post that it "feared their presence might ruin

the firm's image and create alarm among workers who do not fully understand the disease."(Bangkok Post,September 11 1987)

Upon their dismissal, Cha-on and his family had to vacate their lodgings at the factory. They and two of their four children moved to a small wooden house near the factory. While his wife and children were allowed to enter their relatives house, Cha-on had restricted access in a small space arranged for him. His relatives expressed their fear of AIDS. His 8-year-old daughter, the youngest liked to play with her father but was often taken away from him. Because Cha-on and his wife lost their jobs and their six-months severance was used to pay for the operations, their third son had to give up his studying and find odd work.

Cha-on asked "Why must I be the one who is doomed?," and said "I am left with no strength or hope for anything," while his wife said "We prefer not to know about it (AIDS) and die right away," and "We don't know where we can turn to....We would not have regretted it if we got this disease as the result of some misconduct." (Bangkok Post,September 14 1987)

As in this case, people with HIV/AIDS who were publicly identified were almost completely shut out from society. First, by loosing their jobs, they were cut off from any means to earn their living, and lost a place to live, then they were even avoided by their own relatives

and neighbors. Such incident also affected spouses and children.

Not only that, Cha-on's case convinced people that it was possible to be infected with HIV from blood transfusions. This confirmed that the people's fear had come true.

In January 1991, Cha-on died of AIDS after he spent his last three months in Bamrasnaradura Hospital. (Bangkok Post,January 25 1991)

(4) The Case of Spun

Another case which shows how the public, especially medical personnel and the media, reacted to AIDS is that of a famous 19-year-old model, Spun Selakul.

In October 1987, one month after the case of Cha-on was published, the media reported that Spun was HIV-positive. The first news report quoted a doctor as saying that "A top model who has tested positive for AIDS is continuing to work as a call-girl." The doctor was Dr. Suraphong Amphanwong, director of Phyathai Hospital. (Bangkok Post,October 3 1987) She had reportedly defied the doctor's advice because she needed to make money through prostitution for her future.

Her name was withheld the first time, but later the initials of her name, SP, and her photograph were publicized by the Thai language press. Then, as the media

chase continued, her name was finally revealed. Spun said in an interview with the Bangkok Post that she was not aware the model was herself until she saw her picture in a Thai newspaper.(Bangkok Post,October 15 1987)

In the end, she was found to be HIV-negative, but she had been badly damaged by the publicity, and suffered a severe mental breakdown. She said all she wanted to do was to escape and get as far away as possible. She once thought of committing suicide but she gave up the idea as it was not true that she was HIV-positive. However, she said she met a group of people who "expressed obvious loathing just at the sight of" her.(Bangkok Post,October 15 1987) She continued; "it's been personally very traumatic," "It was death in life," and expressed the experience as "excruciating pain." Her boyfriend also said that "in fact, the injuries inflicted by the press are more deadly than the disease."(Bangkok Post,October 15 1987)

Spun's incidence caused controversy over the moral duty of medical personnel to keep a patient's privacy as well as over the sensationalized media coverage of AIDS-related news.

Concerning the ethics of the medical personnel, the publicity of Spun's case was due to the fact that her doctor believed that she was a call-girl and thus there would be a likelihood that she could spread HIV to others. Although Dr. Suraphong denied that he named the model, it

is clear that his mentioning of the famous model's situation at an AIDS seminar in October was done in order to warn the model to accept medical advice and stop her sexual behavior.

Concerning the attitude and ethics of the media, it is certain that the sensationalism of the Thai media regarding AIDS-related news was again confirmed and in this case, it almost drove a person alleged to be HIV-positive to her death.

As these two cases show, public responses to people infected with HIV/AIDS at that time were those of discrimination and ostracism. As a result of these responses, people with HIV/AIDS lost their normal lives and also feared physical attacks from the public. While they had to fight against the symptoms of the incurable disease, they were also forced to fight against social discrimination and loneliness.

Cha-on's case prompted the MoPH to begin universal testing of blood donations in 1988. But owing to the "delay in procuring testing equipment, nationwide coverage of this measure was not achieved until mid-1989."(Wiwat, August 1994:10) Spun's case prompted the ministry to hold a seminar on AIDS for the press. In fact, the MoPH revealed its plan to launch public AIDS campaigns and to establish an information center on AIDS at just the same

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time as the sensational reports about Spun were circulating.

(5) A Case of a Community-Based Organization

In September 1987, the first HIV-infected case among residents of Klong Toey slum, the biggest slum in Bangkok, was found.(The Duang Pratheep Foundation,July 1990,Thai) The person was one of many sent to a hospital under the Freedom of Drug Abuse Program of the Duang Pratheep Foundation, an NGO working for the people in the slum. After the foundation learned from Thanyarak Hospital that there was one HIV-infected case among the 17 drug abusers sent to the hospital for treatment, and that the hospital would not accept him because he had HIV, Nittaya Promporchuenboon, a leader of the project, said the foundation just let him return home without doing anything because there were no symptoms.(Personal Interview, September 22 1994) The foundation certainly did not know how to handle this case. In November of the same year, 25 drug abusers were sent to the Thanyarak hospital under the project and 2 more HIV-infected cases were found, but all the foundation did was to let them go home as in the first case. Nittaya admitted that the foundation at that time did not know what AIDS was and how to manage it because it did not have any knowledge about it.

However, in March 1988, 13 more drug abusers were

found to be infected with HIV, then the foundation began to realize that something was wrong. At this time, the situation was first publicized to the public through the media. At a press conference in April 1988, a senior community leader reportedly said; "we just don't know what to do. This is terribly shocking, and something totally new to us."(Bangkok Post,April 30 1988) One of the drug addicts whose wife was also an IDU and infected with HIV said "I knew nothing about AIDS before. I'd heard about it, but I never cared."(Bangkok Post,April 30 1988)

The MoPH heard the news and came to the foundation later. After a one month education course arranged by the MoPH, an AIDS project was then started by the foundation.

As this case shows, even a community-based organization which would usually be sensitive to social problems did not know what AIDS was until they had their own case at the beginning of 1988. This means that AIDS had not been understood by people or the society. The government AIDS campaigns had still not succeeded.

3.4.2 Responses of NGOs

While the government AIDS campaign focused on the so-called "high risk groups," the general public was left in fear, confusion, and frustration. Some of the NGOs working for social welfare reacted quickly to the AIDS

issue, but their numbers were extremely limited and their targets were also only the risk groups.

(1) The National Blood Center of the Thai Red Cross Society

When Cha-on's case, the first case of HIV-infection through a blood transfusion, was reported, the National Blood Center of the Thai Red Cross Society, an NGO which promoted voluntary blood donation and distributed donated blood free of charge to both government and private hospitals,(Prasert,1989:39) faced a big dilemma.

Dr. Chaivet Nujprayoon, director of the National Blood Center, explained that "the centre was in a difficult position because it was obliged to supply blood to hospitals to save lives. And then a person we helped has got AIDS."(Bangkok Post,September 12 1987)

As a preventive measure against HIV transmission through blood transfusions, the National Blood Center started partial screening for donated blood before distribution at the end of 1986.(Prasert,1989:39) It began to refuse blood donations from service girls and homosexuals at the beginning of 1987.(Bangkok Post,September 11 1987) When Cha-on's case was reported in September 1987, the Red Cross was conducting only "a random check of 40,000 out of the 700,000 blood donors each year."(Bangkok Post,September 11 1987)

There were three main reasons for this very small amount of blood being screened in 1987. The first was the concern about delays in blood supply if the screening process was increased, the second was the low awareness of hospitals about the risk of HIV infection through donated blood, and the third was the cost involved.

Dr. Chaivet said the center would screen every bottle from October 1 1987, but at the same time he expressed anxiety whether this would cause some delay in blood deliveries. The duty of the National Blood Center was and is to smoothly supply enough blood to hospitals nationwide. There was a possibility of delay in blood supply and a shortage of blood as the result of the test for HIV. Also, if all donated blood had been screened at that time, there would have been a shortage of the reagent to test HIV contamination in the blood.

In addition, the number of hospitals interested in using screened blood, let alone paying for the screening cost, was small. Some hospitals that objected to the use of screened blood argued that blood screening was "a waste of money" although the center only charged 30 baht, half the cost, per bottle.(Bangkok Post,September 12 1987) Furthermore, some hospitals had been under the impression that the risk of infection with HIV through donated blood was still very low.

Obviously screening all donated blood for HIV could have prevented the tragedy inflicted on Cha-on, but

it could also have caused delays in the blood supply which might have been critical to saving other lives. It was also a costly process, and the infection risk was still considered to be low. Therefore, little attention was paid to the issue of screening donated blood for HIV by hospitals at that time. Despite the negative attitude of hospitals, the MoPH advocated the universal testing of donated blood in 1988, but because of "a delay in procuring testing equipment," the nationwide coverage of blood testing had to wait until the middle of 1989.(Wiwat, August 1994:10)

(2) An NGO for Gays

Responses of a dance group led by a well-known Thai gay activist, Natee Teerarojjanapongs was very quick. From very early on, this group named *Sen See Khao*, 'white line' in Thai, had begun AIDS campaigns mainly for gay CSWs and bar owners at Patpong to explain the necessity of using condoms. According to Natee, bar owners had not understood the seriousness of AIDS at first and his face was injured when one bar owner threw things at him. (Personal Interview,October 31 1994). That was in the period when most AIDS patients were gays and AIDS was seen as a gay disease.

However, the gay community learned comparatively fast about AIDS and accepted the preventive attitude.

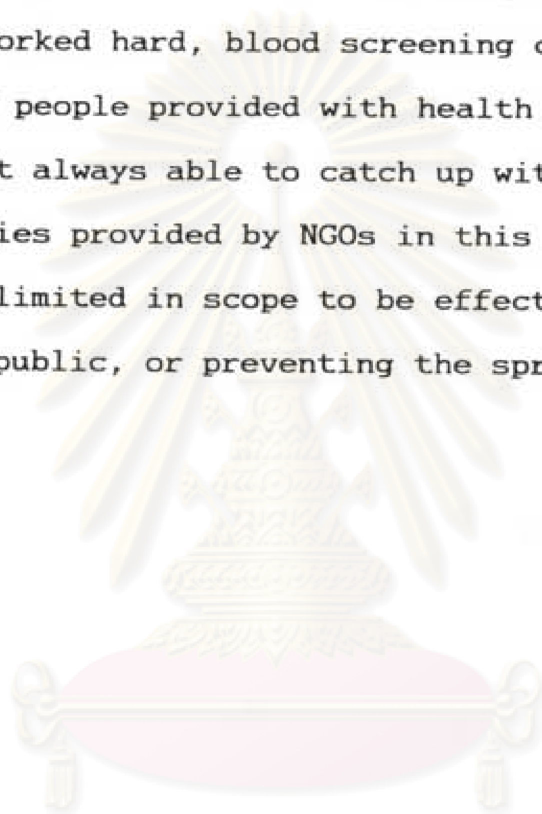
According to a research, conducted and reported in 1987 by Natee, all owners and managers except one out of 30 gay bars in Bangkok where research was done had already instructed gays to use condoms when going off with customers.(Bangkok Post,September 23 1987) In 1988 Natee said that members of an informal group of gay bar operators "are very receptive to the AIDS information campaign because they view the disease as danger at close range."(Bangkok Post,August 23 1988) However, the fact remained that when gays were forced by customers to have sexual contact without using condoms, they could not refuse in order to avoid problems with the customer and to continue to work there.

3.4.3 Summary of Public Responses during the First Period

During this first period, the fear and anxiety about AIDS was growing among the public. People were scared of being infected with HIV and were confused by rumors. Finally, the people responded to the situation in panic. Sometimes this appeared as strong criticism against the AIDS campaign, and at other times, it appeared as denial or stigmatization of people with HIV/AIDS. People were frustrated by the ambiguous AIDS situation. People were irritated that they had no knowledge about what AIDS was and how to protect themselves from being

infected or even how to handle the situation. As Nittaya, a leader of the Freedom of Drug Abuse Project of the Duang Pratheep Foundation, explained, people at that time did not know what AIDS was and how to manage it.

Although some NGOs quickly responded to the spread of HIV and worked hard, blood screening came too late, and the range of people provided with health education about AIDS were not always able to catch up with the spread of HIV. Activities provided by NGOs in this period were too few and too limited in scope to be effective in easing the fear of the public, or preventing the spread of HIV.



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