

# **Children Affected by HIV and AIDS in the Aftermath of the Successful Control of an HIV Epidemic: The Case of Thailand**

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## **Introduction**

The first AIDS case was detected in Thailand in 1984. A decade later, HIV had spread to the general population; a June 2000 HIV serosurveillance survey showed that the low rate of reduction of transmission via commercial sex had led to the spread of HIV to low-risk partners and children. Indeed, the prevalence of HIV in pregnant women was 1.74 per cent in 1997 and increased to 2.02 per cent in 1999. This has inevitably given rise to HIV infection among children. The Thai Working Group on HIV/AIDS Projection (March 2001) indicated that approximately 4,000 Thai children are being infected with HIV each year. The National Economic and Social Development Board (NESDB) estimated that 63,000 children would be directly infected with HIV and 47,000 would die of AIDS by the year 2000. It was also estimated that by the year 2001, over 289,000 children under the age of 15 would have lost their mothers and by 2005, this figure would have risen to 380,000 (UNAIDS, UNICEF and USAID 2002).

Thus, a growing number of children will be affected by HIV. Fewer children and their families will be able to afford education because of loss of family income due to illness or death from AIDS. Many will be unable to complete their education because of the need to work or care for their ill family members. The illness and death of family members causes trauma and often leads to social discrimination and stigmatization at school.

Faced with the growing crisis, the Thai Government, NGOs and civil society have worked together to combat the epidemic and the results have been dramatic. An epidemiological model by the Thai Working Group on HIV/AIDS Projections (March 2001) shows that the annual number of new infections peaked in the early 1990s and then declined by more than 80 per cent in 1993. It estimated that 200,000 fewer people had been infected with HIV than would have been the case

if the upward trend had continued. The Thai experience demonstrates that effective national responses are those that draw on commitment at the highest levels of political leadership, effectively employ social capital and involve civil society, use focused programmes to guide and test policy, and draw upon institutional and traditional approaches in an overall holistic, people-centred approach – empowering individuals, families and communities to protect and care for themselves.

With no cure for AIDS currently available, planning for mitigation of the epidemic must involve long-term and broad-scale commitment to prevention programmes, especially for those in high-risk groups, such as children born to infected mothers, teenagers, injecting drug users (IDU), ethnic minorities and migrants.

Thai society also needs to be ready to cope with the increasing problems of children orphaned by AIDS, by building and strengthening government, family and community capacity to provide a supportive environment for them. This will entail the provision of appropriate counselling and psychosocial support, efforts to ensure non-discrimination and full and equal enjoyment of child rights, increasing linkages between HIV interventions and development programmes, as well as more effective and expanded coordination for HIV planning at the national and provincial levels. It is important to enhance the role of local authorities and communities, and to mobilize groups of people affected by HIV, community-based organizations (CBOs) and NGOs, in order to provide better care for people living with HIV and their families.

This chapter reviews and analyses the past and expected evolution of HIV incidence and AIDS mortality in Thailand. Intervention programmes designed for the prevention, treatment and mitigation of HIV and related illnesses will be studied and analysed to reflect on whether or not they are effective responses to the impacts of the epidemic.

The chapter looks at both the demand and supply sides of the problem. In-depth interviews and focus group discussions were conducted to: (i) explore demand for, and satisfaction with, HIV prevention and control programmes; and (ii) look into the responses and needs of service providers and receivers as evidence for developing effective policy and implementation plans.

## **The evolution of Thailand's HIV epidemic**

The HIV situation in Thailand has gone through three major phases, as outlined in table 4.

### **Phase I: Health focus 1984–1990**

The first wave of HIV infection was considered a medical health problem since it had an impact on individual health similar to a chronic disease and was concentrated in specific demographic groups: homosexuals and those who had sexual relations with

foreigners. The epidemic then spread to IDUs, whose infection rate rapidly increased from below 1 per cent in late 1987 to over 40 per cent in late 1998. The epidemic later spread to heterosexuals, particularly men who visited sex workers (SWs).

From 1984 to 1990, as HIV was treated solely as a disease, it was the responsibility of the Ministry of Public Health's (MoPH) Department of Communicable Disease Control. The Government focused on the medical and health aspects of prevention and surveillance among male homosexuals and IDUs. It was believed that AIDS was an epidemic only among the identified risk groups, so the general population did not need to be given much information about it. Moreover, the Government and business were concerned about the likely impact of publicity about HIV and AIDS on the tourist industry.

**Organization structure:** The Department of Communicable Disease Control provided care and treatment under the general umbrella of the MoPH. In 1987, the AIDS Coordination Committee was appointed to coordinate an HIV control programme between public and private hospitals. As HIV infection continued to expand, in 1990 the Government established the National AIDS Prevention and Control Organization, to serve as the national body for AIDS policy with the Minister of Public Health as chairman. The Organization's major task was policymaking and setting strategies for HIV prevention and control. It was complemented by the multisectoral National AIDS Prevention and Control Committee (NAC), chaired by the Prime Minister, with the Permanent Secretary of MoPH as the Secretary. The Committee later appointed seven subcommittees to coordinate HIV activities among public and private agencies and NGOs.

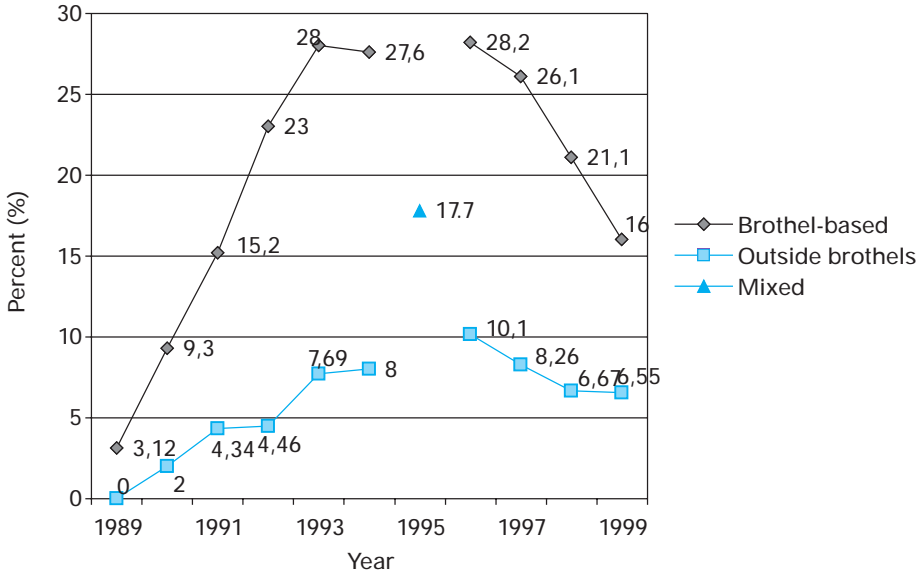
**Programmes and projects:** In 1988, a budget of 4.6 million Baht was allocated directly to HIV prevention and control programmes. The AIDS budget was then increased from 11.1 million Baht in 1989 to 66.6 million Baht in 1990. Most of the projects were short and medium term, based on WHO guidelines. Activities focused on prevention and control of HIV infection among IDUs; prevention of sexual transmission by promoting safe sex, condom use and condom distribution; prevention of transmission through blood transfusion by blood screening tests; and provision of social welfare, research, and monitoring and evaluation.

## **Phase II: Social focus 1991–1996**

**Situation:** By the early 1990s, HIV had spread to the general population. In 1994, HIV prevalence reached 31 per cent among brothel-based SWs (increasing from only 3.12 per cent in 1989). Infection in this group was high because it was the virus subtype E, which transmits more readily than virus subtype B, found among IDUs and the male homosexual group. For SWs not based in brothels, HIV prevalence increased slowly from 0 per cent in 1989 to 8 per cent in 1994. In 1995, HIV prevalence among SWs of both types was 17.8 per cent (figure 1). From 1996 to

1999, HIV prevalence then decreased, due to active HIV prevention and control activities implemented by both public and private agencies.

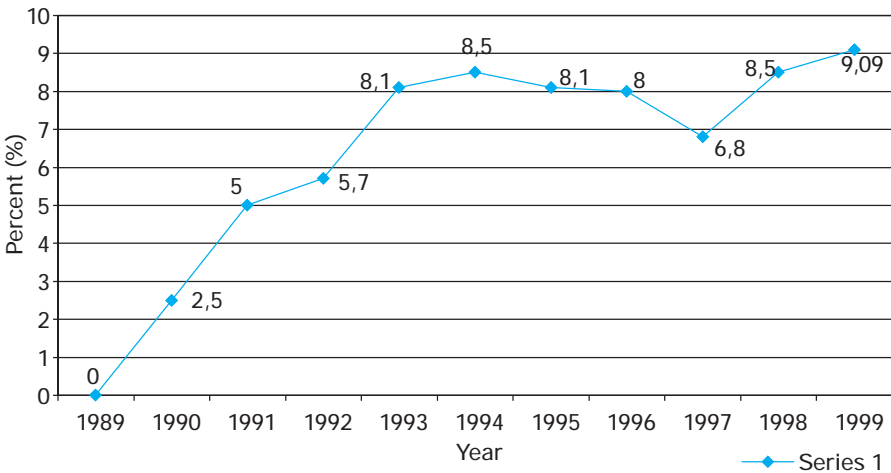
**Figure 1. HIV prevalence among sex workers in Thailand, 1989–1999**



Source: Division of Epidemiology, Ministry of Public Health.

HIV prevalence in males at STI clinics increased from 2.5 per cent in 1990 to 8.5 per cent in 1994 and dropped to 6.8 per cent in 1997, but increased again to 9 per cent in 1999 (figure 2).

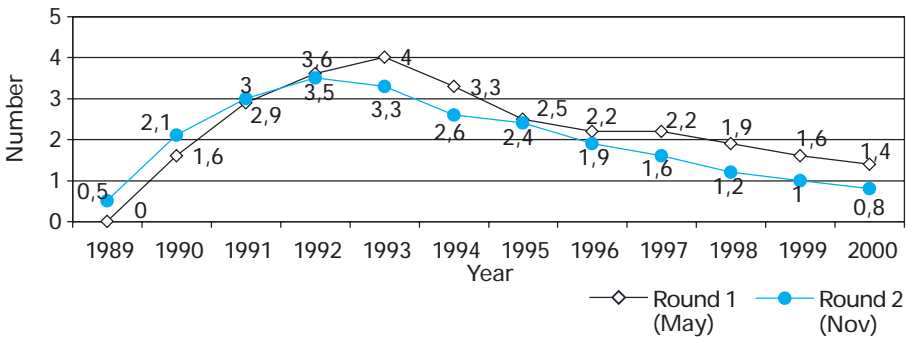
**Figure 2. HIV prevalence among male STI clients in Thailand, 1989–1999**



Source: Division of Epidemiology, Ministry of Public Health.

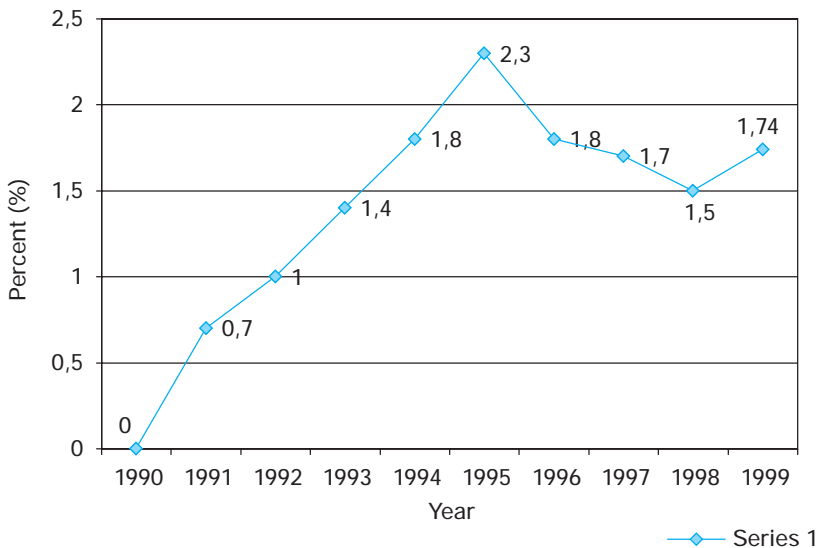
HIV prevalence in successive cohorts of 21-year-old conscripts in the Royal Thai Army (a nationally representative sample of young men and the group that comprises the prime clients of SWs) rose from 0.5 per cent in 1989 to a peak of about 4 per cent in 1993, and then decreased to 0.8 per cent in 2000 (figure 3). Since army conscripts were young, their infections could be assumed to be recent. Trends in HIV prevalence among cohorts of conscripts were often considered as a proxy for trends in HIV incidence, the number or rate of new infections annually. However, most conscripts had lower social, economic and educational status compared to other groups, and tended to have higher rates of infection than the general male population.

**Figure 3. Prevalence of HIV infection among Thai military conscripts**



Source: Division of Epidemiology, Ministry of Public Health.

**Figure 4. HIV prevalence among women attending antenatal clinics in Thailand, 1990–1999**



Source: Division of Epidemiology, Ministry of Public Health.

The infection rate of pregnant women attending antenatal clinics increased from 0.7 per cent in 1991 to 2.3 per cent in 1995, before dropping to 1.8 per cent in 1996 and 1.5 per cent in 1998, and then increasing again to 1.74 per cent in 1999 (figure 4). These women gave birth to an estimated 4,000–6,000 HIV-infected children annually.

**Policy:** A greater understanding emerged that HIV was a social problem and deserved high priority at all levels. The NAC, chaired by the Prime Minister, emphasized the need for total cooperation among all sectors of society, so that both public and private sectors could play a constructive role in minimizing the impact of the disease.

**Organization structure:** Since six provinces in the upper northern region – Chiang Mai, Chiang Rai, Lampang, Payao, Lamphun and Maehongson – had the largest number of HIV infections and patients with HIV-related illness in Thailand, the NAC established the Upper-North AIDS Administration Committee in 1994. This Committee was responsible for analysing budget disbursement, monitoring operational plans and preventing duplication among subcommittees, as well as helping the administrative committee to operate efficiently.<sup>1</sup> Importantly, the Committee provided a means for more effective disbursement of funds to the community level, which opened channels for increased community involvement in the AIDS response.

**Programmes:** The four major programmes (from the 1992–1996 National AIDS Prevention and Control Plan) were: Public Information, Treatment and Care, Human Rights, and Research and Education. Since HIV was treated as a social problem, all parties concerned were encouraged to participate according to their particular areas of responsibility. The relevant budget was increased sixfold from 1991 to 1994 to a total of 1,142.5 million Baht.

As the HIV epidemic spread and changed rapidly in mid-decade, the prevention and control programmes were adjusted to emphasize changing high-risk behaviour and involve more agencies (table 1). The Government assigned more resources to HIV prevention. Activities were adopted nationwide in 1991 to promote universal use of condoms in commercial sex (Rojanapithakorn 1991). However, although the prevention portion of the budget increased from 9.3 per cent in 1995 to 14.3 per cent in 1996, about 65 per cent was devoted to treatment, because of the high unit cost. Included in unit costs are patient care, prevention of infection in hospitals and clinics, training of relevant health personnel, construction of HIV inpatient wards, etc. The budget also covered HIV-sentinel surveillance of risk groups and the provision of breastmilk substitutes to babies 0–2 years old whose mothers were HIV-positive.

**Table 1. Policy plan/programme and budget of HIV prevention and control programme, 1995–1996**

	1995		1996	
	Million Baht	%	Million Baht	%
HIV and AIDS Behavioural and Social Prevention Programme	144.5	9.3	294.7	14.3
Health Promotion and Medical Treatment and Care Programme	1,019.3	65.4	1,350.9	65.7
Consultation Services Programme	20.0	1.3	33.0	1.6
Support and legal measures for people living with HIV	39.0	2.5	154.4	7.5
Research and Evaluation Programme	16.2	1.0	50.4	2.4
Management Development Programme	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.

### Phase III: Civil society focus 1997–2001

**Situation:** As indicated earlier, the 18th Round of HIV Serosurveillance in June 2000 showed that since the rate of transmission via commercial sex was only declining slowly, HIV infection was bound to spread to low-risk partners and children. The prevalence of HIV in pregnant women increased from the 1997 rate of 1.74 per cent to 2.02 per cent in 1999. There is now no region in Thailand where the infection rate among pregnant women is declining. The Thai Working Group on HIV/AIDS Projection (March 2001) indicated that approximately 4,000 Thai children were being infected with HIV annually. Research shows that without any medical intervention, roughly 25–35 per cent of HIV-positive pregnant women infect their newborn children during pregnancy, childbirth, or breastfeeding (Shaffer et al. 1999). However, a short course of AZT during pregnancy and labour can reduce the probability of HIV transmission from mother to child to about 8.2 per cent. Half of all children not treated would die by the age of five (Kanshana et al. 2000).

**Policy:** Government policy was reoriented to a more holistic approach. It was accepted that AIDS was not the sole responsibility of the Government, and that strengthening the role of all related actors according to their specific missions was essential for success. This included involving NGOs in public service, the private sector in prevention and control of the disease, and individual families and communities in activities such as home care programmes (National AIDS Prevention and Control Committee 1996). The National AIDS Foundation was established to campaign for funds to support the activities of NGOs, HIV infection groups and community organizations.

**Organization structure:** In 1997, two national committees were established under NAC. One was the AIDS Programme Executive Board, with four subcommittees: AIDS vaccine development; international cooperation on HIV and AIDS; problems of ARV procurement; and coordination between public and private care providers. The other national committee was the Management Committee for the Fight against HIV/AIDS in the Upper-North.

The NAC consisted of seven subcommittees: Public information on HIV control; research and education on HIV control; community involvement in HIV control; medical precautions necessary for HIV control; strengthening indigenous knowledge and wisdom and research for HIV control; and HIV prevention and control at the provincial level.

**Programmes and projects:** The National Prevention and Alleviation HIV/AIDS Plan (1997–2001) proposed eight comprehensive strategies to tackle the epidemic:

- i) Developing the potential of individuals, families and communities to prevent and alleviate the onset of HIV while promoting a spirit of mutual assistance, and preserving the community culture.
- ii) Strengthening business undertakings that are not destructive of Thai culture and traditions. This strategy included dissemination of good quality information and documentation via the mass media.
- iii) Providing psychosocial support to enable people living with HIV to lead a normal life without any discrimination.
- iv) Developing basic social services to promote a sound understanding of healthy behaviour; caring for affected people, including the elderly and children orphaned by AIDS; and improving the availability and quality of HIV counselling services by both the public and private sectors.
- v) Introducing health promotion schemes and medical care services, emphasizing the provision of appropriate medical services for patients with HIV-related illness, and encouraging home care in the family and community.
- vi) Utilizing cultural wisdom and available knowledge and promoting relevant research. This strategy emphasized the planning and conduct of further high-quality relevant research, promoting exchange of knowledge among researchers domestically and internationally, and developing industries essential for development and production of technologies necessary for HIV prevention and control.
- vii) Enhancing international cooperation in assessing and exchanging HIV-related technologies and state-of-the-art techniques for prevention and alleviation of HIV problems.
- viii) Revising and strengthening managerial processes in order to create a holistic approach to programme management from the national to the regional level.



From 1997 to 2001, the average budget for HIV and AIDS was 1.5 billion Baht per year (table 2).

Due to the financial crisis, the total funding for AIDS programmes declined by 9 per cent between 1996 and 1997 (from 2,187.5 million to 1,986.1 million Baht), and was then reduced even more dramatically, by 27.8 per cent, from 1997 to 1999. From 1997, prevention expenditure dropped by half and declined as a share of the total AIDS budget from 11 per cent to 8 per cent.

The main cut was in the budget for antiretroviral therapy, because there were doubts about the effectiveness of the therapy. Free condom distribution was also reduced, from 45 million to 12 million (1998 figure), in order to encourage cost sharing as much as to conserve the budget.

The main activities were: formulating the HIV plan and supporting NGOs and private activities; developing the potential of individuals and communities to prevent HIV and alleviate its effects; implementing the '100 per cent Condom Use Programme'; supporting care for children born of infected mothers, abandoned children and orphans; and job training and skill development for PLHIV and infected family members to allow them greater employment opportunities. Other important activities emphasized providing medical treatment to patients suffering from opportunistic HIV-related infections; safe donation and transfusion of blood; supporting antiretroviral therapy (ART); and providing free HIV testing to pregnant women. Those who were HIV-positive would receive a short regimen of AZT before and after delivery, AZT syrup for the child, and a year's supply of breastmilk substitute (powdered milk).

In 1998 the Government shifted the budget for maintaining programme coverage for maternal and child health and HIV activities by:

- i) protecting the budget for safe motherhood activities by keeping it at the FY 1997 level;
- ii) allocating additional budget (estimated at 80 million Baht) to cover the higher cost of essential imported vaccines under the Extended Programme for Immunization; and
- iii) restoring the HIV and AIDS budget to the FY 1997 level by allocating additional budget (estimated at 105 million Baht) for prevention, community development, and activities of NGOs.

During 2001 the budget allocated to support quality of life for HIV-infected persons was maintained at 2.2 per cent of the total health budget, or \$33.8 million.

**Table 2. Thai Government national AIDS programme budget 1997–2001  
(millions of Baht)**

Programme components	1997 %		1998 %		1999 %		2000 %		2001 %	
<b>HIV prevention and mitigation programmes</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>
1) Subprogramme on developing the capacity of individuals, families and communities	217.3	10.9	138.3	9.3	108.9	7.6	110.5	7.6	123.0	8.3
1.1) Strengthening community capacity to prevent and alleviate HIV	118.8	6.0	66.6	4.5	45.7	3.2	49.6	3.4	59.1	4.0
1.2) Strengthening learning processes and knowledge about preventing and alleviating HIV	98.5	5.0	71.6	4.8	63.2	4.4	60.9	4.2	63.9	4.3
2) Subprogramme 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 to mitigate the impact of HIV	76.9	3.9	91.7	6.2	83.2	5.8	82.0	5.6	82.7	5.6
2.2) Developing and strengthening the economic status 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 implementation programmes	213.8	10.8	141.6	9.6	136.5	9.5	116.7	8.0	140.0	9.4
<b>HIV prevention and control programmes</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) Subprogramme 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 prevention and control	575	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 support facilities 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 counselling services	25.2	1.3	11.6	0.8	11.8	0.8	8.9	0.6	8.9	0.6
1.5) Homes for HIV patients	381.1	19.2	73.7	5.0	-	-	-	-	-	-
2) Subprogramme 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 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.

Note: Figures for 1997–1999 are actual expenditure; figures for 2000–2001 are budgeted.

**Table 3. Thai Government national AIDS programme budget 2002–2005 (millions of Baht)**

Programme components	2002*	%	2003	%	2004	%	2005	%
HIV mitigation programmes	864.8	87.10	917.97	74.72	1,335.57	81.02	1,337.19	82.97
HIV prevention programmes	85.23	8.58	210.58	17.14	239.25	14.51	215.91	13.40
Development of the people's wisdom and researches on the HIV problem	41.24	4.15	61.04	4.97	70.98	4.31	56.29	3.49
Research and development on AIDS vaccine	1.56	0.16	3.00	0.24	2.65	0.16	2.28	0.14
Welfare project to enable HIV patients to return home			36	2.93				
<b>Total</b>	<b>992.83</b>	<b>100.00</b>	<b>1,228.59</b>	<b>100.00</b>	<b>1,648.45</b>	<b>100.00</b>	<b>1,611.67</b>	<b>100.00</b>

Note: Does not include the 480.06 million Baht health service budget.

Source: Project Planning Programme, Bureau of the Budget, fiscal year 2002–2005.

**Table 4. Summary of the evolution of HIV and AIDS in Thailand**

	1984–1990	1991–1996	1997–2001
<b>Policy</b>	Health Focus	Social Focus	Civil Society Focus
<b>Organization management</b>	Committee (National level since 1990 Minister as a chair)	National Committee (chaired by Prime Minister)	National Committee (chaired by Prime Minister)
<b>Projects and programmes (under the plans)</b>	Short-term (1998) and medium-term AIDS prevention and control programme (1989–1991)	Medium-term AIDS prevention and control programme – 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 (1997–2004)
<b>Situation</b>			
Total AIDS cases (cumulative)	268	68,419	255,237 *
Male	236 (88%)	56,060 (82%)	183,660 (71.96%)
Female	32 (12%)	12,359 (18%)	71,577 (28.04%)
Ratio male to female	7.4 : 1	4.5 : 1	2.57 : 1
Deaths (cases)	139	20,186	72,183
Children 0–14 years old infected	22	3,682	10,991
Male	14 (64%)	1,972 (54%)	5,771 (52.51%)
Female	8 (36%)	1,710 (46%)	5,220 (47.49%)
Highest risk behaviour	sexual transmission (73%)	sexual transmission (81%)	sexual transmission (83.71%) (remainder included 4.74% IDU; 4.19% MTCT)
Province with most AIDS cases	Chiang Mai	Chiang Mai	Chiang Mai

Source: Division of Epidemiology, Ministry of Public Health, October 2004.

\* From 1984 until 31 October 2004.

## **Long-term socioeconomic impacts of HIV on children**

### **Psychosocial distress**

Infected children tend to develop ‘emotional deprivation’, as they are generally depressed and live in conditions that are both physically and mentally unhealthy. Children who are not infected themselves but live with infected parents often feel lonely and develop a sense of grievance about their parents’ illnesses.

Schools play a significant role in children’s socioemotional development, but instead of experiencing positive socialization, children affected or infected by HIV feel they are in an uncaring and unsupportive environment. They are frequently stigmatized, rejected and socially isolated from their peers, which drives them to depression, withdrawal and prolonged absence from school. Little effort is made to enhance schools’ ability to provide support to children in general, and specifically to children from families affected by HIV.

There is at present no direct evidence or research to indicate precisely how many children there are or will be in such circumstances. However, there are clear implications that the long-term impact on a number of abandoned children and orphans, as well as many HIV-infected children, will be severe.

### **Impacts on pregnant women and infected mothers**

The prospect of HIV transmission from mother to child causes great physical and mental suffering for mothers. They may feel hopeless and depressed and thus fail to provide appropriate care for their children (Limrourong 1997). Additional problems for the mother include providing for the child while she herself is sick, or after she dies, the relationship with the husband and his ability or willingness to provide for the family.

### **Abandoned children and homelessness**

HIV-infected women tend to abandon their babies because they are unprepared to take care of a child with a high probability of infection, and fear being stigmatized by their families and the community if the baby is HIV-positive. Babies born to infected mothers are more than five times as likely to be abandoned as those whose mothers are not infected (table 5). A study of one hospital from 1992 to 1994 showed that an average of 3.16 per 1,000 babies born to infected mothers were left behind in the hospital, whereas the rate for uninfected mothers was 0.59 per 1,000.

**Table 5. Rate of abandonment for newborns: Comparison between HIV-infected mothers and non-infected mothers (per 1,000 births)**

Year	Abandoned by HIV-positive mother	Abandoned by non-infected mother	Ratio between newborns abandoned by mothers with and without HIV infection
1992	3.48	0.56	6.2
1993	3.39	0.64	5.3
1994	2.79	0.57	4.9
Total	3.16	0.59	5.4

Source: Tanprasertsook et al. 1997, p. 498.

As the Department of Communicable Disease Control indicates that the number of HIV-infected pregnant women has increased over time, the problem of orphans and abandoned children can be expected to worsen and the need for effective programmes to curb the spread of the HIV epidemic among those of reproductive age will be even more urgent. However, due to the economic crisis in 1997, the AIDS programme budget has been reduced (tables 2 and 3), and this has exacerbated the situation.

### Children orphaned by AIDS

Most children orphaned by AIDS are born before their parents are infected. One 1994 study showed that many children 5–12 years old with infected mothers would be orphaned within two years.

**Table 6. Estimates of numbers of Thai children likely to be orphaned by AIDS (in '000s)**

Year	Total no. of children 0–14 years	Total no. of orphans	Total no. of orphans due to AIDS
1995	16,828	904	63
2001	16,752	1,048	289
2005	16,787	1,094	380
2010	16,635	1,054	374

Source: UNAIDS, UNICEF and USAID 2002.

These orphans can have a difficult time adapting to life with relatives or in an orphanage, and with an uncertain future can easily become involved in crime, drugs or sex work.

### Changes in household and family structure

In the medium term, the HIV epidemic will change family structures. Without ARV treatment, HIV-positive adults live for five to 10 years after becoming infected, and have a two- to three-year life expectation after developing AIDS. Since more males than females are infected, many families are likely to be without their male breadwinner.

Women, as mothers and family caretakers, will have to work harder while facing greater stresses. For those women who are HIV infected, there is a high risk of their children being neglected or orphaned and having to be left in the care of the elderly, other relatives or the community.

### **Social capital and civil society**

Since 1991, campaigns to reduce fear of the infected and discriminatory attitudes against those susceptible to the disease have been carried out nationwide. Levels of acceptance vary. In some communities, there is considerable discrimination, but in others, affected and infected persons receive support, encouragement and sympathy from their neighbours and communities. Some communities establish a saving fund where part of the fund is set aside to provide welfare to the members, in such forms as cash transfers, or cremation expenses. One of the cornerstones of Thailand's response to the HIV epidemic has been the involvement of community organizations, in particular the formation of self-help groups by people living with HIV. Since the formation of the first group in 1993 there are now over 770 such groups in the country.<sup>2</sup> The self-help groups have also developed strong networks at the regional and national level, which have been a powerful force in national policy formation and have helped advocate for their rights and more effective allocation of resources. Faith leaders have also taken part in helping HIV-affected and infected persons. Some institutions, such as the Buddhist temple, Thammarak Nives, have provided hospice support for people dying of HIV-related illnesses. Through projects such as the UNICEF-supported Sangha Metta Project in Chiang Mai, monks have been trained in HIV awareness to enable them to undertake prevention and care work in their own communities.

### **The Rights of the Child**

**Education:** The Constitution of the Kingdom of Thailand recognizes that all children have the right to be protected and receive basic social services. In addition, under the National Education Act B.E. 2542 (1999), all children have the right to nine years of free education. In practice, however, HIV-affected children's right to education is violated both by the community and the schools. Communities continue to believe that if parents have HIV infection, then their children must also be infected. Non-HIV-affected parents try to prevent children whose parents are infected from attending school with their own children or dependants. Some schools, citing potential health problems, persuade, or even force, the parents or guardians of affected children to take them out of school. Moreover, there is frequently pressure to force children to take a blood test before they enrol in school.

Children from households, particularly poor ones, where someone has died of an HIV-related illness, are taken out of school to work, help with household chores, or take care of younger children and the sick person (Pitayanon, Kongsin and Janjaroen 1997; Janjaroen 1996; Brown and Sittitrai 1996).

**Right to receive standard health care:** According to the Convention on the Rights of the Child, which has been ratified by Thailand, all children have the right to health care and neither health care providers nor hospitals should refuse treatment. In the early stage of the epidemic, such discrimination did occur, but as societal understanding has increased, the situation has improved.

## Policy response to HIV in Children

### **HIV prevention programmes**

Major strategies and approaches for preventing new HIV infections include the following:

**Strengthening health education:** Promotion of health education has evolved over time; once the sole responsibility of the Government, now a wide variety of agencies have been encouraged to play their part.

**NGOs:** There are over 1,000 NGOs and more than 770 self-help groups of people living with HIV (MoPH, AIDS Division 1998a). The activities of these groups complement public sector work on HIV, especially among fishermen, migrants and minorities in remote areas. NGO activities tend to be more flexible than those of the public sector, especially among high-risk groups, which require more time and two-way communication before any effort can be expected to lead to changes in sexual behaviour.

The Government began allocating funds to support NGOs in HIV prevention activities in 1992 and from 1997 to 2001 these funds averaged an annual 80 million Baht, or approximately 5 per cent of the total AIDS budget. During 2000–2001 loans of 90 million Baht were made under the Social Investment Project (SIP) to support NGOs in AIDS prevention activities.

**Private business:** Large private businesses provide training for their employees on HIV and AIDS. In 1993, the Thailand Business Coalition on AIDS was initiated to help businesses disseminate knowledge on HIV prevention more efficiently and effectively.

**Community:** Communities network with both NGOs and public agencies. They have a high capacity to promote activities that generate close relationships and ties among their members. They can also promote appropriate values to control risky situations, i.e. child prostitution and the luring of young persons into the sex service business. Communities may encourage volunteer groups to care for people living with HIV and affected children and provide support or motivate community leaders to initiate group interactions – such as that between mothers' groups and youth groups.

**HIV-infected people:** Members of the 770 groups of people living with HIV not only provide moral support and consultation to other members, but also disseminate knowledge about the disease to those who have direct and indirect contact with

people living with HIV, thereby creating a better understanding of the disease and potentially leading to concrete changes in sexual behaviour.

### **HIV surveillance**

HIV surveillance was first implemented in Thailand in June 1989 in 14 provinces and extended to cover the whole country the following year. The major task of this project was to follow up and monitor the HIV epidemic in seven groups considered at risk: blood donors; injecting drug users; pregnant women; males visiting STI clinics; SWs, both male and female; fishermen; and foreign labourers.

During the first wave of the epidemic, HIV testing was conducted in two rounds each year in June and December. After 1995 the new infection rate in risk groups stabilized and HIV testing was conducted once a year in June.

### **Promotion of condom use**

A major method of preventing HIV transmission is use of condoms, since more than 80 per cent of HIV transmission is via sexual relations. The 100 per cent condom use programme was initiated in 1989 and aimed at males who visited SWs, and other members of high-risk groups. In August 1991, NAC broadened coverage to every province in Thailand. The Government allocated a budget for condom distribution, but because of the economic crisis, it was cut from 70 million Baht in 1996 to 29 million Baht in 1997 and then slightly increased to 40 million Baht in 2001.

Condoms were also available from independently funded STI clinics and countrywide distribution networks where the quality of the condoms was accredited by the Quality Control Law. SWs regularly received condoms free of charge, and were provided with health check-ups and sexual disease treatment every one or two weeks. Due to the general use of condoms, health personnel were usually able to trace the source of an HIV infection to failure to use a condom.

Cooperation between the public sector, the private sector and businesses has contributed to the high rate of condom use. Information retrieved from SWs by the Department of Communicable Disease Control showed that the rate of condom use increased from 25 per cent in June 1989 to 99 per cent in June 2001. This contributed to the decrease in STI disease and HIV prevalence among conscripts in May 2000, which declined to 1.4 per cent from a high of 4 per cent in 1993 (HIV Surveillance, Division of Epidemiology, MoPH).

### **Prevention and treatment of STIs**

Sexually transmitted infections increase vulnerability to HIV infection and accelerate the onset of AIDS. Prevention and treatment of STIs should reduce new HIV infection by up to 40 per cent (Grosskurth and Waweret 1998). Prevention and control programmes were adopted that emphasized safe sex. Strategies included disseminating and exchanging information on HIV and health, promoting 100 per cent



condom use, surveillance of SWs, and encouraging activities carried out by the Friend-Help-Friend group, as well as providing appropriate pre- and post-consultation to vulnerable people.

Integrated HIV work included normal health services, e.g. family planning programmes, mothers' hygiene and child programmes and extending the STI clinics to every district of the country. These measures have had a positive impact on the STI situation. There has been an improving trend, particularly after 1986, with the STI incident rate (cases per 1,000 population) dropping from 7.85 in 1986 to 0.25 in 2000 (MoPH 2001b).

### **Treatment and care for people living with HIV**

The First National HIV/AIDS Plan (1992–1996) recognized that HIV would strain the capacity of the health system. In the beginning, only a few general hospitals, and even fewer community hospitals, were ready or willing to provide the range of services needed for HIV-positive patients. Therefore, the strategy was to strengthen both institutional and non-institutional treatment and care for people living with HIV. This meant ensuring the safety of the blood supply, improving capacity for diagnosis and treatment, establishing counselling services, ensuring universal precaution practices, training health personnel, and supporting family- and community-based treatment and care. The policy also emphasized cost-effective drug procurement measures, such as bulk purchase of generic drugs and contracts with pharmaceutical companies.

As the epidemic spread geographically and the incidence rate rose, particularly in the six upper northern provinces, it was realized that additional measures were needed. The Operation Plan for 1995–1996 aimed to further increase the capacity of the health service system and facilities to provide treatment for HIV or other opportunistic diseases, as well as to strengthen the referral system among government hospitals, and between government and private hospitals. Support was given to health personnel suffering from stress and fatigue in areas of high prevalence by instituting a rotation policy and encouraging staff to move in and out of the hard-hit areas. In addition, various temporary measures were introduced, such as extra remuneration for emergencies. One of the aims of the Plan was to facilitate families' and communities' capacity to provide health care for people living with HIV by integrating care for other chronic diseases in the community, but the policy was not implemented. Strategies that did help families included the community day-care system for patients with HIV-related illness set up by some community hospitals, whereby relatives or family members could carry on with their usual work while the patients awaited appointments with doctors.

### **Antiretroviral therapy**

In 1992 the Department of Communicable Disease Control began a programme to supply ARV free of charge to 350 people living with AIDS (PWA). Though this number was approximately one fifth of the total reported number of eligible

patients, it was probably only 3 per cent of the actual total. Table 7 shows the number of PWA and people living with HIV (PWH) who received ARV each year. The number of recipients more than doubled from 1994 to 1995, although the total cost only increased by \$5.39 million, due to the use of generic substitutes at less than \$0.50 a tablet, rather than the \$2.00 per tablet for non-generic drugs.

**Table 7. Numbers of people living with HIV and AIDS and receiving antiretroviral therapy**

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
No. of PWA 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 PWA <sup>(b)</sup>	1,761	6,900	13,855	20,604	24,478	26,342	26,410	22,267	12,8391	
No. of PWA 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
PWA receiving publicly financed ARV as % of reported PWA	19.88	10.14	12.65	17.47	8.99	8.35	8.33	9.88	17.131	
PWA receiving publicly financed ARV as % of no. of PWA 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 \$ millions)	1.44	3.45	13.97	19.36	15.84	11.74	8.68	8.51	7.07	6.60
Total public spending on AIDS programme (in \$ millions)	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 PWA, as % of AIDS programme <sup>(3)</sup>	184.19	170.78	456.40	343.41	431.22	503.82	719.46	659.68	623.65	622.22

Sources: (a) The Thai Working Group on HIV/AIDS Projection, 2001, Table B11, p B-11; (b) Epidemiology Division, MoPH, Reported AIDS Situation, various years; (c) Bureau of Budget, Office of Prime Minister, Budget Document of MoPH, various years.

Notes: (1) Reported cases as of October 2000; (2) As indicated in the budget document in the corresponding year; (3) Calculation assumed the same treatment regimen as publicly funded programme.

As the 50 per cent of the national AIDS programme budget spent for procuring antiretroviral drugs and drugs to treat opportunistic infections was disproportionately larger than the amount allocated for care of other diseases, this policy had to be reconsidered in terms of equitable distribution of resources among disadvantaged groups.<sup>3</sup>

In late 1995, NAC received support from WHO to conduct a cost-effectiveness study on the use of ARV to treat HIV.<sup>4</sup> The study observed low compliance with medication regimens, due to patients' aversion to side effects and lack of follow-up by physicians. It also found that the number of programme beneficiaries was too low, that a full-scale treatment regimen was unaffordable, and that the clinical effectiveness of mono-therapy was limited as it only extended survival up to six months. Following the study, the Government modified its policy and abandoned mono-therapy in favour of combination therapy.

With recent reductions in the price of the drugs and increased external support, the possibility of providing ARV treatment to all patients with HIV-related illness has improved markedly. On World AIDS Day 2003, WHO and UNAIDS set the global target of treating 3 million PWA with ARV by 2005. Thailand has joined the initiative and the Government allocated a budget of \$7.7 million for 2003, which was almost tripled to \$20.5 million for 2004. The programme was rolled out to 914 hospitals nationwide in three years and increased at the rate of 3,000 new adult patients a month between January and August 2004. By December 2004 it was estimated that at least 45,000 PWA were being treated with ARV – some 44 per cent of the estimated 114,000 PWA 15–49 years old who actually needed the therapy (UNAIDS and WHO 2004).

### **Treatment and care for mothers and children living with HIV**

Thailand is one of the few countries that also focuses on treating children infected with HIV. Under the national programme, 200–300 children were being enrolled every month from January to August 2004. They constitute about 8 per cent of the total number of patients (UNAIDS 2004). But for children, the main emphasis is on preventing them ever being infected. Comprehensive measures were initiated to prevent vertical transmission of HIV in the late 1980s and early 1990s. Interventions included massive health and sex education campaigns among children and young people starting from grades 5 or 6, premarital counselling, and voluntary anonymous testing for HIV.

Surveillance of HIV-infected women from 1989 to 2000 showed that the infection rate of pregnant women increased from 0.8 per cent in 1990 to 1.76 per cent in 1999. Since the results of a research study conducted by a team of US physicians indicate that the HIV transmission rate from mother to child is 30 per cent without

treatment, 4,000–5,000 Thai babies are likely to be infected annually. The Thai Red Cross claimed that the transmission rate could be reduced to 8 per cent if mothers were to receive AZT before delivery and during labour, and newborns were to be given AZT for the first six weeks of life.

In 1997, the Ministry of Public Health started a programme to give AZT to infected pregnant women and supply powdered milk to children infected by their mothers for one year. In March 1998, a CDC and MoPH-supported trial in Bangkok showed that short-course AZT could reduce mother–infant HIV transmission by 50 per cent among non-breastfeeding HIV-infected women.

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

1. All service-providing institutions must organize HIV testing and high-quality confidential counselling services for couples. Only the pregnant woman and those to whom she has given permission are authorized to receive the test results.
2. All pregnant women should be offered voluntary testing for HIV antibodies 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:
4. Starting at 34 weeks of pregnancy, morning and evening, with each dose totalling 300 mg until labour pains commence.
5. During labour, the dose provided will be 300 mg every three hours until delivery.
6. For babies born to HIV-infected mothers:
7. All babies of HIV-infected mothers who have taken antiretroviral drugs for four 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 every six hours for seven days.
8. All babies of HIV-infected mothers who have taken antiretroviral drugs for less than four weeks during pregnancy and delivery will get AZT syrup, starting immediately after birth at a dose of 2 mg per 1 kg body weight every six hours for six weeks.
9. All babies born to HIV-infected mothers will receive infant formula to substitute breastfeeding until 12 months of age.
10. 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.
11. All mothers and infants who receive antiretroviral drugs will receive proper medical care and treatment.

The 1998–2000 report of the PMTCT programme 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 per cent attended antenatal clinics and 75 per cent agreed to have their blood tested for HIV; 64 per cent of the HIV-positive women who came for delivery received AZT.

Before the ACT076 treatment regime was proven effective, infant formula was provided to babies for a period of two years in order to prevent HIV transmission through breastmilk. This was later modified to a period of one year. Difficulties arose when the paediatric wards administered different feeding practices. When mothers and babies were discharged from the hospital, they were supplied with infant formula to last until their next appointment, but in most cases the mothers did not return.

Table 8 shows the number of children born to HIV-positive women who received powdered milk and AZT as well as financial assistance. However, it should be noted that this treatment was only provided during pregnancy, labour and for a short period after delivery. It was not extended to cover the whole life span of the mothers with HIV.

**Table 8. Burden of care for pregnant women and children with HIV**

	1993	1994	1995	1996	1997	1998	1999	2000	2001
No. of children 0–2 years born to HIV-positive mothers who received milk substitutes	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 to HIV-positive mothers who received ARV	-	-	-	-	-	-	7,500	7,500	9,700
No. of HIV-positive mothers who received ARV	-	-	-	-	-	2,500	7,500	7,500	9,700
Estimated public expenditure on powdered milk for children 0–2 years born to mothers with HIV (in \$ millions)	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 mothers (in \$ millions)	-	-	-	-	-	n.a.	0.70	0.69	0.90

Source: Bureau of the Budget, Office of the Prime Minister, Budget Document of MoPH, various years.  
 Note: Figures in parentheses denote numbers of children 13–24 months old.

In 2002 the Government began providing combination therapeutic treatment to about 500 HIV-positive mothers. This was only 5 per cent of those who initially received treatment to prevent HIV transmission to their newborn babies. However, the Minister of Public Health then announced that by 2005 ARV treatment would be available to all those who needed it.

### **Policy/programme measures for mitigation of the impact of HIV**

In 1999, the HIV infection rate decreased by 24.5 per cent. However, the epidemic continues to spread throughout the country, especially in the north (tables 9 and 10).

**Table 9. Comparison of reported HIV patients and HIV-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	
1984–1989	29	9.73	298
1990	92	20.81	442
1991	472	42.48	1,111
1992	1,499	48.37	3,099
1993	4,336	48.03	9,027
1994	7,496	39.63	18,916
1995	9,425	32.65	28,870
1996	9,777	28.37	34,460
1997	9,911	26.59	37,276
1998	8,896	23.67	37,581
1999	7,786	21.40	36,382
2000	6,966	19.97	34,887
2001	6,316	19.19	32,917
2002	5,174	16.33	31,693
2003	4,860	17.24	28,193
2004	3,044	22.63	13,453
Total	86,080	24.69	348,605

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

Note: Data until November 2004.

**Table 10. HIV transmission route among various groups in the upper north and whole country**

Groups of people	Upper north (region 10)	Whole country (12 regions)
Blood donation	0.82	0.57
Intravenous drug users	46.64	40.00
Pregnant women	5.00	1.68
Male patients at STI clinics	18.81	6.79
Brothel-based SWs	57.14	26.14
SWs not in brothels	13.74	8.20

Source: Division of Epidemiology, Ministry of Public Health.  
Note: Surveillance data from specific areas in June 1997.

### **Provision of social services to HIV-positive people, patients with HIV-related illness and their families**

Provision of social services commonly includes consultation, supplying milk substitutes, home visiting, financial assistance to families, career training, funds for education, friends-help-friends groups, the hotline service, and anonymous consulting units.

The Government provides free breastmilk substitutes for HIV-positive mothers, and free school lunch programmes for eligible primary school students. Both programmes have been expanded since the financial crisis of 1997. The priority target group is poor and disadvantaged children: prior to the crisis, 30 per cent of all children were eligible for the free lunch programme but currently 50 per cent are eligible. However, there is no guarantee that all infected and affected children do in fact receive the benefits available.

After the 1997 economic crisis, cash transfers for the elderly increased from 200 to 300 Baht per month/person. By 1999, the number of the elderly eligible for such transfers had also increased from 300,000 to 400,000 persons. However, there are still a large number of the elderly who are not covered by this programme.

### **Cooperation among agencies and effective management**

NGO partnerships with the Government have had a major impact on community development and mobilization (World Bank 2000b), and their links with the private sector are more flexible in approaching and helping targeted vulnerable groups that are HIV-infected and poor. There have been increasing efforts to coordinate initiatives among the NGO community and build partnerships through greater networking (e.g. NGO Coalition on AIDS and National Council for Social Welfare). Greater cooperation among the many sectors and provincial administrations is also a major goal.

During the economic crisis, the Ministry of Public Health was allocated a 90 million Baht loan from the World Bank to support HIV prevention and control programmes. The Government selected development agencies as partners for the following activities:

- i) cooperation with local agencies to support local planning activities;
- ii) development of effective prevention and care programmes;
- iii) technological and technical transfer to local organizations;
- iv) collaboration among networks of private NGOs working on HIV problems in other regions;
- v) monitoring and follow-up to support effective programmes and ensure their sustainability.

### **The role of social capital and local organizations in assisting HIV-infected persons**

After the 1997 economic crisis, the Thai Government assigned a portion of its World Bank loan to social investment through community development. The \$120-million social investment fund (SIF) was created for local and community grassroots organizations to implement their development projects.<sup>5</sup> The funds were channelled through the Social Fund Office of the Government Savings Bank. The Office granted money for projects initiated by local community organizations, municipalities and other informal groups, the general purpose being to promote civil society and strengthen good governance throughout the country at all levels of administration.

One of the five SIF classifications was 'Community welfare and safety' programmes initiated by the communities themselves, such as child development and day-care centres, community playgrounds, and shelters for the elderly and patients with HIV-related illness. Since the beginning of September 1998, SIF has supported 3,131 such projects worth 352.27 million Baht.

More recently implemented were several government policies aimed at encouraging self-reliance and strengthening local people's potential to help each other. The most well known are the '1-million-baht per village revolving fund' and the 'one village, one product scheme'. Both programmes aim to increase the local communities' capability to generate income. Income gained from the programmes' products is used to pay back the revolving fund, compensate producers and contribute to savings for the community's welfare. Such savings will augment the increase in saving groups fostered under the Community Development Department, and will play an important future role in assisting and caring for those in need, including HIV-infected people. The majority of people infected with HIV end their lives at home and are therefore cared for by family members and supported by the communities.



In many areas across the country, Buddhist and Christian clergy offer a number of community-based programmes, including counselling, outreach and hospice services. The Sangha Metta Project in Chiang Mai trains monks in community-based HIV prevention and care (World Bank 2000b). Such programmes have significant power to combat stigmatization by associating patients with revered faith-based institutions.

## **Conclusion and recommendations**

From 1984 until 31 June 2001, there were 172,760 cases of HIV, of whom 47,798 died. The percentage of males infected by using non-sterile needles greatly increased from 5 per cent in 1990 to 18 per cent in 2000 and is expected to rise to 30 per cent by 2005. Meanwhile, the percentage of females infected by their husbands or other sex partners is projected to decrease from 42 per cent in 2000 to 29 per cent in 2005.

The number of children orphaned by AIDS increased, from 63,000 in 1997 to 289,000 in 2001 and was expected to reach 374,000 by 2010 (UNAIDS, UNICEF and USAID 2002). These children, and mothers and children living with HIV, will place increasing demands on the economy for care and social support and will require policy responses in the area of prevention, treatment and mitigation.

Although Thailand has been successful in HIV-prevention efforts, there is a need to increase participation by communities, people living with HIV and other groups of people affected. In general, NGO–Government partnerships have worked best at the local level, through development of appropriate linkages between programmes and services.

### **Lessons learned**

The evolution of Thailand's AIDS policy and the impact of the programmes in reducing HIV problems suggest important lessons that may be of use for other countries in the region and the world:

- i) **For action to be effective, national leadership and political commitment at the highest levels are required:** Leadership must recognize the devastating scale of the epidemic and be willing to discuss openly the enormity of the HIV problem. In Thailand, leaders with commitment to the most progressive HIV policies established the NAC, which serves as a policy decision body and includes members of government authorities, NGOs, business, community leaders and people living with HIV. The Government also committed adequate resources in the struggle against the epidemic.
- ii) **Deployment of social capital and involvement of civil society:** In Thailand, actors include the public and private sectors, NGOs, families, communities,

and particularly civil society and faith-based groups. The Government has encouraged local people to form such groups by providing financial and technical support.

- iii) **Effective programmes ‘lead’ policy to the right outcomes:** In Thailand, good policy arose from the examples of good programmes. The pilot programmes are likely to have the largest influence on policy when the impact is well documented. Factors contributing to success included a clear policy objective, strong political commitment from the central, provincial and local levels in providing technical advice and intensive public relation campaigns. Decision-making on allocation of resources and coordination was also decentralized, thus facilitating timely and effective response to local conditions. The involvement of small groups of core actors, with clear roles and responsibilities at the provincial level, helps minimize the duplication of activities and resources.

## **Recommendations**

- i) **Continue prevention programmes** by focusing more on target groups, such as the highest risk teens, MTCT and IDUs.
- ii) **Develop a specific policy to assist boys and girls orphaned by AIDS.** Strengthen the capacity of the Government, families and communities to provide a supportive environment for affected and infected children through appropriate counselling and psychosocial support. There should also be a national policy and strategy to ensure non-discrimination and full and equal enjoyment of all human rights.
- iii) **Enhance the roles of local authorities and communities.** Strengthen the potential and promote the role of affected groups, community-based organizations and NGOs so as to provide care for people living with HIV and their families. Improve and mobilize existing local funds and social capital from all sectors to help in this effort.
- iv) **Develop counselling and mental care services** corresponding to the specific problems of the target groups. This includes providing professional counselling on a regular basis and providing counselling training to government personnel and volunteers (family and community counselling volunteers). Establish a warning system on risk factors at the community level, so that risk groups can be assisted in a timely manner.
- v) **Increase the linkages between HIV responses and development programmes** as well as more effective and expanded coordination for AIDS planning at the national and provincial levels.

- vi) **Improve mechanisms to prevent violations of the rights of people living with HIV and their families.** Procedures should be established to monitor such protection closely and regularly.
- vii) **Emphasize the following in further research and development:**
- a) Urging drug-producing countries, regional and international organizations and institutions, particularly pharmaceutical companies, to be actively involved in research and development of HIV vaccines and drugs, in order to help make HIV vaccines and HIV-related drugs more widely accessible and affordable by all those who need them in developing countries.
  - b) Development of national and international research infrastructure, laboratory capacity, improved surveillance systems, improved data collection, processing and dissemination.

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### Notes

- 1 This committee had four subcommittees on: Coordinating Information; Coordinating and Analysing Plans; Monitoring Implemented Plans; and Public Relations.
- 2 Personal communication from Thailand Network of People Living with HIV/AIDS, March 2005.
- 3 Much concern has been raised as to the inequity and appropriateness of the AIDS programmes financed by the Government, since AZT costs 45 Baht a day per PWA, while the government-financed school lunch programme costs 5 Baht per meal per student.
- 4 This unpublished study was conducted by the late Dr. Nicholas Prescott, Senior Economist at the World Bank, with the joint collaboration of MoPH, WHO and the World Bank.
- 5 There are 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.