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Response to AIDS at Individual, Household and Community Levels in Thailand

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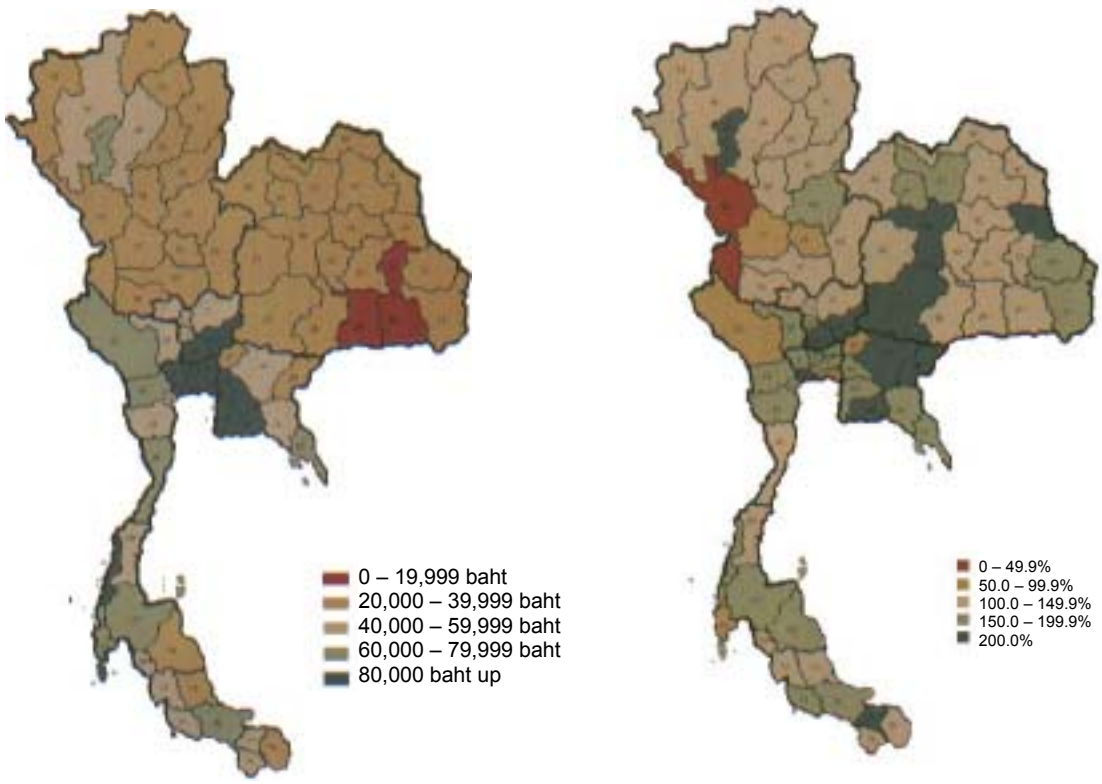
Background

Thailand's response to the HIV/AIDS epidemic, globally acknowledged for confronting the basic issues, nonetheless was slow out of the starting gate and remains uneven. Not until several years after the epidemic emerged did the government undertake a national program, including the establishment of National HIV Sentinel Surveillance surveys to monitor the progress of the epidemic and guide subsequent government policy and actions. While the national response to the epidemic is well documented (see Poocharoen, 1998 and Porapakkham, n.d.), less is known about how individuals, families and communities cope with and respond to the challenges presented by HIV/AIDS, particularly outside the much-studied Northern Region. This paper attempts to redress this gap. It begins by briefly reviewing the influence of the on-going social transformation in relation to the AIDS epidemic in Thailand. Subsequently, the paper explores the situation of AIDS by region and argues that limited information is known about Thai responses to HIV/AIDS outside the Upper North region where the epidemic is severest. The paper next explores changes in behavior undertaken by individuals to prevent infection, how people living HIV/AIDS (PHA) respond after being infected, and addresses how families adjust to infection of family member(s) with HIV/AIDS. The concluding section describes how communities react and respond to PHAs and how the communities utilize resources to support people affected by HIV/AIDS.

Social Transformation and Mobility

During the decade beginning in the mid-1980s, HIV/AIDS entered and spread in Thailand roughly in parallel with the rapid growth of foreign investment. Rapid economic growth, largely based on the emergence of peri-urban export industries, produced imbalances across provinces, with the relatively better-endowed Bangkok and Eastern Seaboard areas enjoying higher growth than other parts of Thailand (see Figure 1). High growth in turn fueled a snowballing social transformation.

Figure 1 Per capita income by province (1996) and change of per capita income (1988-1996)
Source: UNDP, 1999 (Map 1&2)



During this period, rural Thai villages experienced an intensification of connections with urban areas and with the opportunities and challenges of integration with global markets. The attraction of regular pay in jobs less physically demanding than farming, the excitement and diversity of cities, and schooling which prepares rural students for non-farm jobs are among other factors pulling youth out of villages. Indeed, migration for schooling is an important aspect of mobility. Rural children attend district and provincial schools at the secondary level, in many cases living in private dormitories near school. With the emergence of residential universities outside Bangkok over the past 35 years, dormitories have flourished, often offering little or no supervision.

The out-migration of young adults for urban employment has increased the shortage of farm labor. Traditional labor exchange has been replaced by hired labor, rationalizing the system but loosening community solidarity. Contributing to the reduction of farming during the boom years, land speculation enriched some farmers, but left fields idle. Many farmers lack their own land and have to rent land for farming (Im-em, 1996; Im-em, Phuangsaichai, 1999).

Migration, historically a cyclical phenomenon as rural men seek wage labor during the off-farming season, has become increasingly long-term. Of some 3 million people who migrated at least once over the two-year period from September 1995-September 1997, about 30 per cent contribute to families through regular remittances (National Statistical Office, 1997: Table 23), which constituted the major source of cash income for some elderly parents. Rural men from throughout the country seek jobs in construction work, as taxi drivers in Bangkok, as fishermen in the Gulf of Thailand and beyond, as guards of businesses and private homes, and increasingly during the boom years of the late 1980s and early 1990s, in industry. Rural women have joined the exodus and constitute some 80 per cent of the export industry workforce in the textiles and foods industries. Among 11-19 year-olds, twice as many females migrant to Bangkok as males (Gender and Development Research Institute, 1995). Women

and men have also migrated abroad to work in the Middle East and in wealthier Asian nations (including Taiwan, Malaysia, Brunei, and Singapore).[1]

Meanwhile, the attraction of higher wages in Thailand has led to increased migration from neighboring countries.[2] Episodic reports indicate that cross-border migration increases the likelihood of infection, due both to ignorance of risk and to physical and sexual abuse of migrants.[3] However, sero-prevalence rates in border areas are among the highest in the region. For instance, the 1997 Sentinel Surveillance survey indicated that the sero-prevalence rate for Koh Kong, along the Thailand-Cambodia border, is alarming (52 per cent of commercial sex workers [CSWs] surveyed, 21 per cent of police, 10 per cent of the military, 19.5 per cent of pregnant women). In 1999 the rates were 42 per cent for CSWs, 24 per cent police and military (combined) and 8 per cent for pregnant women attending antenatal clinics (CARE International, nd).[4]

Poverty

The proportion of people in poverty in Thailand has declined rapidly over time. In 1962-1963, 57 per cent of the people were living in poverty and twenty years later the percentage had declined by half and stabilized at this level for another 10 years. The period around 1970s-1980s was the time that increasing number of people from the rural areas sought overseas employment, often in the oil-producing countries of the Middle East, for higher income. Many migrant workers returned home rich.[5] With the stimulus of wealthy returned migrant workers and the economic boom of the 1990s, the percentage of people in poverty further declined to 11.4 per cent in 1996. In 1999, the percentage of people living in poverty increased to 15.9, a result of three years of economic crisis (Meesuk, 2000).

While mobility increases risk across different socio-economic groups, the majority of Thais reported to be infected with the HIV/AIDS virus are poor. The poor have less access to information and services which might protect them from sexually-transmitted infections; poor men are probably somewhat more likely to patronize sex workers who do not insist on condom use, and poor women are less likely to have the bargaining power to protect themselves against infection in relations with a regular partner. Poverty, the relative status and power differentials associated with being poor, and mobility interact to heighten vulnerability to infection. Being female increases risks, with some researchers indicating that women factory workers face vulnerability of two sorts: public perceptions of "sao rongngan" (factory girls) as loose and ready to experiment sexually, and power realities in the workplace, where women are largely workers, not managers, and sexual advances and rape by male supervisors are known but go underreported because of fear of job loss (Thaweesit, 2000).

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1 The reported number of Thai working overseas from 1995-2000 was about 200,000 per year, and between 14-18 per cent of them were women (Overseas Employment Administration Office, cited in Soonthorndhada, 2000; National Economic and Social Development Board (NESDB), 2001).

2 In the mid-1990s, it was estimated that one million migrant workers were in Thailand. The vast majority of them were from Burma (Archavanitkul, 1996).

3 Based on the first author's experience to evaluate the HIV/AIDS Prevention Project in Keng Tung Province located in northeast Burma or above Upper North Thailand, the AIDS situation there was devastating in 1998 and 1999. It was found that a large number of PHAs living in the villages there were young women returning from commercial sex work in Thailand. See also Duangdetaweerat (1998) and Oppenheimer (1998).

4 Even though the commercial test kits for HIV were new to Thailand, blood testing for HIV was widely carried out in the country beginning in 1986 because the receiving countries at that time required all workers to be certified AIDS-free before going there to work. Of over 172,000 overseas workers tested for HIV in 1986-1988, only 19 persons were tested positive for HIV. The laboratory service for the HIV test had been expanded dramatically beginning in 1987, largely because of the demand for blood tests among the overseas workers. More than 30 laboratories were available for the HIV test in major cities in the year 1987, only three years after the first AIDS case was reported in the country (Thongcharoen et al., 1991: 19; Weniger et al., 1991: Table 5).

5 Many returned migrant workers from the Middle-East countries in the 1980s were well recognized among Thais as 'setthi sa-u' or 'Saudi (Arabian) millionaires' who enjoyed spending money for new houses, electronics goods, drinks, and women. The number of overseas contract workers from Thailand has increased overtime and the total number reported for the year 1999 was 202,416 persons. Half of them were those going to work in Taiwan (Ministry of Labour and Welfare Report, 2000).

Transformation of Social Institutions

Both emblematic and causative of larger social transformation, migration and mobility more broadly cannot be ignored as a major element in Thailand's rapid social change. The growing significance of the nuclear family, evidenced by the mushrooming of single-family housing developments both in Bangkok and in most provincial centers, is confirmed by census data which indicates that the proportion of one to two person households increased from 11.6 per cent in 1980 to 16.4 per cent in 1990[6]. This shift in family living patterns contributes to an erosion of the extended family and the social support and constraints which it provides.

Industrialization has taken both women and men out of home-based commerce and industry (including agriculture) and into formal workplaces – offices and factories often distant from home. The rapid development of high-quality roads throughout Thailand has made commuting to work possible. Many rural teachers live in larger district towns and commute to outlying schools, a development which in itself has been criticized as isolating teachers from the smaller communities in which their schools are located and depriving the community of important resources in the broader development process. Vehicle ownership[7] nearly tripled between 1989 and 2000 (calculation based on statistics from National Statistical Office, 1990: Tables 5&80; 2000: Tables 1.1&5.7). The parallel growth in numbers of children in day care programs is indicative of the decline in family care of the very young as economic opportunities (and necessity) have absorbed increasing numbers of parents into the workforce.

Social change has touched religious institutions, as well. In a series of highly publicized cases, Buddhist monks have broken their vows of celibacy, thereby eroding the legitimacy of religious figures, and to some extent, religion itself. Buddhist strictures on contact between lay women and monks, compounded by social views of women's sexuality as both dangerous and degrading, restricts the ability of monks to address intimate matters (Thaweesit, 2000).

Economic Crisis and Its Impact on HIV/AIDS

East Asia experienced severe economic crisis, starting in Thailand in July 1997. The root cause of the Thai economic crisis was excessive, foreign debt-financed investment by the private sector together with declining demand for Thai exports in the world market. In the aftermath of the crisis, businesses closed, resulting in massive unemployment, under-employment and a 14.5 per cent increase in poverty incidence, from 6.9 million in pre-crisis in 1996 to 7.9 million in 1998. The crisis resulted in loss of employment, household income contraction, changing expenditure patterns, child abandonment, and poor mental health, furthering the difficulties of families in addressing the needs of PHAs (see Tangcharoensathien et al., 2000).

Anecdotal reports of PHAs themselves and of some health professionals indicate that the sharp fall in the value of the Thai Baht (from Baht 25:$1 pre-crisis to Baht45:$1 late in 2001) has greatly reduced the ability of PHAs to access drugs to counter opportunistic and fungal infections. While this can be hypothesized to have reduced the quality of life and accelerated death rates, no study of this aspect of health impacts of the economic downturn has yet been undertaken.

Tangcharoensathien and others (2000) reported that the crisis has had little effect on HIV/AIDS and STI prevalence. HIV prevalence rates since 1997 have further declined, consistent with stable levels of regular condom use in commercial sex, despite significant reductions in both the total national AIDS budget and free condoms distribution in brothels by the Ministry of Public Health. Total condom distribution fell from 60 and 50.2 million pieces in 1995 and 1996 to 11.2 and 14.2 million pieces in the following years (Pothisiri et al., 1998). In non-free condom distribution brothels, condoms were paid for by clients or charged inclusive with sex services. This suggests that if messages about personal responsibility for safe sex are maintained and sex workers urge clients to

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6 The census data does not give information about the family structure, i.e. nuclear versus extended families. The full results of the 2000 census data are not available to the public as of late 2001.

7 Refers to all registered vehicles.

always use condoms, a high level of consistent condom use would continue despite the lack of free condoms.

Public speculation that the number of women entering sex work may have increased during the economic crisis period appears to be supported: the annual census of commercial sex establishments shows an increase from 7208 in 1997 to 8016 in 1998, with a small increase in sex workers from 63,526 to 63,941 in the same period (Tangcharoensathien et al., 2000). Furthermore, recent sexual behavior changes, including a diversification to smaller, informal arrangements, mobile brothels, and casual sex contacts possibly obscure the real scope of the sex industry.

Return migration of those who lost jobs in the wake of the financial crisis provided a potential source of further spread of the HIV/AIDS virus. Indeed, Thailand's Northeast experienced the largest numbers of returnees, amounting to about one million workers. The Northeast is now experiencing an increase in HIV prevalence even though the level is lower than that reported in other regions (World Bank Report, 2000: Table 11).

Post-crisis job loss is credited by some with fueling the rapid spread of amphetamine sales throughout Thailand. Although increased vigilance by law enforcement authorities has no doubt contributed to increased arrests of drug offenders and drug seizures, reports from village-level informants in a number of communities indicate a major increase in drug dealing and drug use has occurred. Along with the increase in amphetamine sales, the growth of child prostitution, both boys and girls, has been evident in the main tourist destinations as recently reported by UNDP of Thailand … "UNICEF studies confirm the seriousness of the risks (for child prostitution). They have shown the correlation existing between child prostitution and such factors as dire poverty, increased family indebtedness, the growth of poor single parent families, the lack of educational and employment opportunities, and broken homes and divorced and separated parents. All of these risk indicators have undoubtedly increased in Thailand since the crisis (UNDP, 1999, pp.142-3).

Changing Conceptions of Sexuality

The rapid economic and social changes provided the medium for behavioral changes that increase vulnerability to sexually transmitted diseases. For instance, there is a prevailing social attitude that men can be sexually experienced, but women should be virgins at marriage. Thai family law historically viewed women and children as chattels, although the 1997 Constitution has changed this. The freedom associated with one's own paycheck and the absence of parental or community restraints provided young workers, both male and female, with the opportunity for radically different lifestyles than would have been the case in their rural homes. The other side of the coin, the hollowing out of family and community support capacity, partially shapes the current rural response to HIV/AIDS.

Peer influences on risk behavior have been well-documented among a number of groups (Bond, 1997). Friends who experimented with drugs, alcohol, and sex were likely to induce others in their group to follow suit. Belonging to a group whose members do not indulge, on the other hand, extends a protective influence on behavior. Group norms among males, whether local to the community or migrants, often encourage drinking and brothel-based sex.

Upon return home, infected returnees form a bridge for further transmission of HIV or other sexually transmitted diseases within rural communities. Since many of these return visits coincide with major holidays and festivals at which alcohol plays an important role, risk of sexual transmission of disease is high.

The Thai belief that it is natural (in fact, imperative) for men to achieve sexual release legitimizes the sex industry, as highlighted by public opposition to government policy to close brothels on the grounds this would lead to an increase in rape and the destruction of the lives of "good" girls and women. As AIDS risk has become better understood, men have adopted a range of behaviors to reduce risk, including fewer men patronizing sex workers and condom use becoming the norm in commercial sex (Chamratrithirong et al., 1999). While young men are less likely to engage in paid sex

than the previous generation, casual (unpaid) sex has increased. Educated youth tend to postpone sexual initiation and to have sex with a girlfriend, with a small proportion continuing to have paid sex (VanLandingham, et al., 1997; van Griensven et al., 2000). Indeed, young men now say that visiting commercial sex workers is "not modern," and is for "tao hua ngu" (literally, old snake-heads, a Thai term for dirty old men). However, there are reports of more clandestine sex workers and of an increase in (unprotected) casual sex with colleagues, schoolgirls or others assumed to be risk free.

Older men are increasingly likely to have sex with 'informal sex workers', waitresses, colleagues, or others. A recent survey of over 2,000 women found that 6 per cent of reproductive age women believed their husband paid for sex in the last 12 months. One-fifth reported their husband had ever had another wife or long term partner within their marriage (Archavanitkul et al., 2001). Nevertheless, little is known about the pattern of overlap or concurrent partnership in Thailand, which may have amplified the risk of HIV transmission as suggested in Africa (Morris and Kretzschmar, 1997).

Concepts of female sexuality are changing in Thailand, concomitant with changing views of women's place in the world. Young women are choosing the single life in increasing numbers particularly among those received tertiary education[8], as a response to concerns partly about HIV/AIDS, partly about family and career responsibilities, and reflecting a growing acceptance of same sex relationships or sexual abstinence.[9]

Among single women, whether in short-term or steady relationships, evidence abounds that prevention of infections from sexual intercourse is low on the list of priorities.[10] Despite the known risk behavior of single men involving paid sex and/or casual relations, newlywed couples rarely obtain counseling including HIV blood test prior to marriage. Hence, a number of women learn they are infected with HIV when an antenatal clinic conducts blood tests, including HIV, in their first pregnancy.

Married women reported various responses if they find that their husband were involved with paid partners. Abstinence until the husband obtained an HIV blood test is the principal method of protection. A few reported in focus group discussions that they would ask their husband to use condoms (Im-em, 1996). In reality, prevention of HIV within marriage is more difficult and the level of condom use within marriage remains low. Wives of taxi drivers and fishermen who return periodically to their rural homes in the northeastern provinces indicate a bit of desperation in addressing their concerns regarding HIV/AIDS. Requesting condom use could be turned against them as (presumed) evidence of their infidelity. A recent survey of more than 2,000 Thai women suggested that only 18 per cent of women report ever using a condom with a spouse to prevent STI, 6 per cent ever asked their partner to use a condom to prevent STI, and about half of those who ever asked said their partner refused condom use (Archavanitkul et al., 2001). The female condom has gained little public interest and has not been promoted for general use. Microbicide trials are currently being conducted in Thailand, and may provide promise of acceptable protection within long-term

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