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The Making of an AIDS Epicenter

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A nurse threads her way around the 40 beds jammed into the ward, many of which are occupied by patients whose [AIDS related] *diseases have progressed so far that their limbs are as thin as the metal tubing that frames the beds.*

—Jon Cohen, upon visiting a northern Thai hospital

Already more people are condemned to die from AIDS in Thailand than were killed by the two atomic bombs dropped on Japan at the end of World War II.

—Mechai Viravaidya, prominent crusader against AIDS

There is a wildfire burning in Thailand. In hospital beds throughout the nation lie the first wave of victims from the explosive epidemic which was introduced in the mid-1980s. And this is only the beginning. By the year 2000, it is predicted that this plague will infect 4 million Thai citizens. Thailand's HIV wildfire is sweeping across generations, sexual preference, and economic status. First felt by the homosexual population, it quickly spread to intravenous drug users, then to commercial sex workers, and now takes its grip on the heterosexual population. Thailand stands as a harbinger for the fate of humankind as we await the predicted consequences of the AIDS pandemic. Though Thailand's

efforts to quell the AIDS wildfire are bold, considerable socio-cultural difficulties provide consistent barriers to such actions.

The non-indigenous HIV pandemic had reached Thailand by 1985. In that year, a test of 301 patients of sexually transmitted disease clinics revealed the first documented case (Wasi et al in Chow 418). Various reports have posited that this individual was a homosexual who had received payment for sexual favors while on a trip to the United States. It was this path of transmission which began the first stage of the HIV explosion in Thailand. In "AIDS in Thailand: A Medical Student's Perspective," Dominic Cheung Chow states, "By 1988, the number of documented AIDS patients had risen to 10, all of whom were homosexual males having apparently contracted the virus overseas or from tourists" (418).

Thus, AIDS was initially labeled a disease of homosexuals. Categorizing the epidemic as such has had lasting effects on Thai views of homosexuality. Thailand is traditionally more tolerant of homosexuality than most nations of the Western world. Stigmatization of homosexuality is quite diffuse in Thai society, having a much less rigid structure than in the Western world (Jackson 140). But by the late 1980s, the shock of AIDS had instigated widespread homophobia. Buddhist writers fueled this stigmatization by disseminating the view that AIDS was a divinely created punishment for homosexual behavior (Jackson 140). This idea subsequently developed into a widely-held folk belief. It currently stands as a barrier to Thai AIDS educators who try to debunk this belief in the now-threatened heterosexual population.

The initial limiting of AIDS to the homosexual population had a profound effect on national and international assessment of the situation. The study performed by Wasi et al in 1985 was used by the World Health Organization as the primary determinant in categorizing Thailand's epidemic (Chow 419). The World Health Organization placed Thailand as a category three nation, signifying that HIV was a relatively minimal threat. As Chow asserts, "Funding for AIDS education and prevention was therefore minimal. Officials argued that Thailand was immune from AIDS, describing it as a foreign disease and

dismissing all proposals to improve AIDS awareness" (418). The government intentionally kept AIDS statistics confidential because of the potential threat to foreign investment and tourism (Ratanakul 25).

The second pathway of AIDS transmission came via the hypodermic needles of intravenous drug users. Northern Thailand has long been a key contributor to the Golden Triangle opium trade. Thus, opium consumption became a historically integral facet of Thai culture. With the banning of opium in 1958, heroin became the widespread drug of choice (Quinn in Roizman 90). It is hypothesized that AIDS may have been introduced into the intravenous drug addict population via heroin smuggling in Thai prisons. As Chow states,

> Rapid transmission occurred between HIV negative Thai prisoners and HIV positive imprisoned expatriates in early 1987. The annual pardon of prisoners in December 1987 was appreciably higher than in other years, and subsequently may have resulted in the release of a sufficient number of infected inmates to trigger a chain reaction of HIV spread among IVDA's [Intravenous Drug Addicts] in the community. (418)

Hence, in a study conducted by Choopanya et al which monitored IVDA's undergoing methadone therapy, the number of positive addicts rose from 1 percent in 1987 to 43 percent in 1988 (in Chow 418). Also contributing to the high rate of HIV positive IVDA's are the many so-called "shooting galleries" of Bangkok, in which a drug pusher will inject several addicts using the same hypodermic needle (The Economist 36).

Thailand's third AIDS pathway is rooted in its notorious sex industry which generates 1.5 billion dollars annually (Chow 421). Prostitution is widely accepted in Thai culture. A study conducted by Havanon et al in which 181 urban men were interviewed about their sexual activity indicates this cultural facet:

> Almost all the male respondents, married and single, felt that having sex with prostitutes is socially acceptable behavior. Having sex is seen as meeting a basic need.

> Single men, especially, believe that they need to have an outlet for their sex drive and that visiting prostitutes is the most convenient way of accomplishing this. In general, the respondents also feel it is acceptable and usual for married men to visit prostitutes as long as they do not do so too frequently. They see it as a way of adding variety to married life (that is, to relieve the boredom of sex with the same person). . . . (4)

Participation in the sex industry is considered an act of masculinity as described in the following interview with a married, white-collar worker: "Visiting prostitutes is normal for men because men have to go whoring. If you don't you might as well go into the monkhood" (Havanon et al 4).

Amongst women, the lack of stigmatization is also prevalent. A study of primary and secondary school students in northern Thailand revealed that though girls knew of the dangers of commercial sex work, they had already rationalized potential future engagement in this occupation (Sittritai et al in Berkeley S331). It is likely that much of this rationalization is poverty.

The cultural acceptance of commercial sex workers thus implies that this group has the greatest HIV impact on the general population. Thailand is estimated to have 500,000 prostitutes. As of 1994, Thailand's Ministry of Public Health estimated that 23 percent of these individuals were HIV positive (Chow 419). As Chow suggests, "If on average each prostitute [of the nation's estimated 500,000] has 3-4 clients per day, there are a total of 2 million clients. Then about 460,000 individuals are at risk for HIV daily . . ." (419).

These 460,000 individuals include the boyfriends and husbands who bridge the fourth pathway of HIV transmission. Heterosexuals are the most recent group to be hit by the AIDS explosion. The current statistics indicate that 95 percent of all new HIV cases are infected via heterosexual intercourse (Nitayapan in Chow 420). Thus, males infected by commercial sex workers are infecting their girlfriends and wives who, in turn, infect their children. Consequently, marriage can be con-

sidered a risk factor for women.

Now that HIV has completed its progression from isolated social groups to the general population (currently infecting 400,000 individuals), it becomes quite evident that Thailand's categorization as a class three nation is obsolete. The Thai government has accordingly ended its denial of the problem and is currently struggling with the control of HIV. The government cannot ignore a problem which will cost the health industry between 7.3 and 8.7 billion dollars between 1991 and 2000 (Neher 54). The health industry is also facing the expense of tackling Thailand's current rise in tuberculosis, which is making a comeback in the weakened immune systems of AIDS victims. As Thavisakdi Bamrungtrkul of the Thai National Tuberculosis Program states, "TB is like a shadow of AIDS" (*World Press Review* 37).

The tourism industry is already feeling the effects of AIDS. The labor force faces potential shortages due to AIDS-related illnesses and deaths. Such shortages will affect both blue- and white-collar workers. As Robert F. Black asserts in "Selling Sex Does Not Pay," "One thing people [employers] are going to have to realize is that they have every chance of losing a managing director as well as a factory-floor worker" (53). The recent trend for smaller families in Thailand (2.0 to 2.2 children is now considered ideal) coupled with AIDS deaths could produce a drastic drop-off in population growth, thus reducing the labor force (Backhaus et al 4). These economic and demographic consequences will likely have their greatest impact on the impoverished. This is due to their heavy reliance upon manual labor employment, and a lack of compensation (e.g. health, life, social welfare, and disability insurance) for family members stricken with AIDS (Hamilton and Ducker 20). Thus, AIDS will deepen economic inequality in Thailand.

In 1991, the government began implementing its HIV prevention strategies. AIDS education became a primary focus, disseminating awareness via the media and various clothing, button, and key chain campaigns. The AIDS awareness program was financed by 4.7 million dollars of government and private sector funding (Chow 421). This campaign implemented a free hypodermic needle and bleach program

for intravenous drug addicts. Thailand's medical establishment began applying advanced screening techniques to the donated blood supply. However, an article from the February 23, 1996 *Bangkok Post* stated that 200 units a year (of the nation's 700,000) are contaminated, and since September 1995, 38 patients were infected with HIV. As described in the December 14, 1995 *Bangkok Post*, the program has recently set up a budget for children orphaned by AIDS. The AIDS awareness program also started a massive condom education and dispensing campaign, which now gives away 60 million condoms annually (Fairclough 30).

An effort to bring condoms to the brothels was already underway. The so-called "100 Percent Condom Campaign" began in 1989 (Celentano et al 125). In "AIDS in the Developing World: An Epidemiologic Overview," Seth Berkeley states, "This policy requires all establishments to comply to ensure that those who seek sex without a condom will not be able [to] purchase services anywhere. . . . The success of this approach will have to be carefully monitored" (S332). And for obvious reasons. Such a program is quite difficult to enforce, just as attempts at mandating AIDS testing of prostitutes suggests similar problems. The government hypocritically wants to clean up the sex industry by supplying condoms but also proposes to grant "Disease-Free" certificates to HIV and STD negative commercial sex workers (Chow 421).

Implementation of the nationwide condom program has also met considerable difficulties. Havanon et al found that "only 35 percent of the men [in their sample] reporting more than 20 commercial sex episodes in the last year usually used condoms" (8). Social beliefs regarding HIV transmission stand as persistent barriers to cultural acceptance of condoms. As Havanon found,

> The greatest barrier to condom use in commercial sex encounters is the perception that condoms are not "natural": 40 percent of the men who did not use a condom [during their last commercial sex encounter] cited this as the primary reason. Nearly 30 percent of nonusers claimed they did not use a condom because the sex worker

"looked clean" (8).

It is a widely held belief that frivolous determinants such as outward appearance of a prostitute, skin temperature, body odor, price, and ambiance of the sex-act setting can be used to diagnose a prostitute. Some men believe that if a woman has few partners and is less attractive, she is less likely to have HIV. The following excerpts from Havanon's interviews illustrate this belief:

> I don't use condoms because I have a close relationship with the prostitute. She assures me that there is no risk of disease, that she has been examined. Usually I will ask her first because she is a regular partner of mine. But sometimes, when I want to try out a more attractive prostitute, I will wear a condom because she has many partners and I might get something from the guy before me. (married, blue-collar worker) (9)
>
> If the price is expensive when I have commercial sex, I won't use a condom; but if it is cheap, I will. (student) (9)

Men also hold folk beliefs about tactical prevention methods. The most popular of these is the idea that withdrawal before ejaculation prevents HIV infection. Some men take antibiotics before sex or use cleansing agents such as toothpaste or soda water following the sex act to avoid HIV infection (Havanon et al 8).

As suggested by Graham Fordham in his recent study of the effects of alcohol on condom use, "There is . . . ample evidence, both anecdotal and research based, suggesting that alcohol use is associated with failure to use condoms, the surreptitious removal of condoms, and condom failure" (156). Thai men usually make trips to brothels in groups which indulge in large amounts of alcohol consumption before the sex act. His study also showed that 38.6 percent of his sample claimed that their purchase of sex was a direct result of alcohol consumption (156).

Various studies show the difficulties that female sex workers face in requiring their clients to use condoms. They often receive higher payment if they do not require protection (Berkeley S332). Ji

Ungpakorn suggests a possible solution in "To Defeat AIDS, Stop Preaching": "Allowing sex workers to form trade unions would increase their bargaining power to demand condom use" (Ungpakorn 52). Another possible measure would be the development of a prostitute-controlled means of protection. David Celentano of Johns Hopkins University plans to test and develop a vaginal microbicide which may kill HIV and could be used when clients refuse to use condoms (Wheeler A9).

The current hope lies in the development of an AIDS vaccine. Thai researchers and several American pharmaceutical firms are conducting small-scale trial tests in Thailand. Funding is not yet available for large-scale trials which will allow scientists to put to rest the question of an AIDS vaccine, and provide for international approval of the treatment (Cohen 904).

As we near the twenty-first century, Thailand's HIV wildfire continues to burn. Though HIV prevention has faced considerable barriers, Thailand's program remains ahead of other awareness programs throughout Southeast Asia. With 4 million new cases of HIV predicted by the year 2000, we can only speculate on the immensity of AIDS consequences in Thailand, Southeast Asia's epicenter of the modern plague.

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