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AIDS Awareness in Rural Northeast Thailand

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Foreword

In the past ten years, AIDS has spread with a terrible impact throughout Asia, and especially in countries like Thailand. In spite of all of the good and noble efforts of many people, there is still much misunderstanding about the disease, how it spreads, who is vulnerable, how to treat it; so many questions with so little time.

In the West, much research has been already done to document how HIV moves through the population. Many people now understand how to protect themselves. However, in Thailand the epidemiology of HIV is still not completely described, and what is known is incompletely, and even in some cases, poorly communicated to the public and those at highest risk.

This monograph is an important contribution to a better and fuller understanding of how HIV specifically spreads through Thailand. It addresses some of the particular communication problems that characterize HIV's presence in the rural, northeastern part of the country. If this awful disease is to be controlled in places like Thailand, it will be studies like this one which help point the way to public policies that will inhibit its spread, and give people the information they need, in contexts they comprehend, to combat it.

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AIDS AWARENESS IN RURAL NORTHEAST THAILAND

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It is characteristic of epidemics to begin quietly and capriciously, as depicted by Albert Camus in his novel *The Plague* (1948). In its early phase of surreptitious spread, few realize their vulnerability to AIDS. In Asia the epidemic is still invisible. In Thailand, with fewer than 200 persons known to be symptomatic out of the population of 56 million, hardly anyone feels vulnerable. The Thais have an aphorism: “Mai hen long sop mai lang naamtaa”-- or “If you don't see the corpse in the coffin, you don't shed a tear.”

-- Marjorie A. Muecke

This quote reflects in large measure the sentiment of the Thai people. They know about AIDS, recounting in lurid detail the causes of AIDS and known behavioral factors associated with it, but they still do not feel vulnerable. As a result, preventive behaviors that could deter the spread of the HIV virus, such as condom use, are not generally practiced in spite of government reports to the contrary (AIDS Policy and Planning Coordination Bureau, n.d.: 5-6). AIDS is believed to be the disease of Westerners, homosexuals, intravenous drug users, and prostitutes, but not the disease of the average citizen.

While the Royal Thai Government, together with non-government organizations, e.g. Thai Red Cross, sustain an aggressive campaign to combat the spread of HIV, the effect of these interventions has not always resulted in behaviors that “promote the sexual health” of the population (Ottawa Charter for Health Promotion, 1987). These interventions do not consistently result in behavioral changes that reduce the risk of HIV. The current conundrum of national governments worldwide is: how is it possible to raise the consciousness of all persons

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in a society, heterosexual, homosexual, intravenous drug users, etc., through the provision of AIDS prevention messages that are compelling, meaningful, situationally relevant, and culturally sensitive? Culturally appropriate interventions are capable of alerting targeted groups to the risk situations that should be avoided if they are to be protected from the disease (Editorial, 1993), but these need to be complemented with supportive counseling, effective management for those who become infected, and the continuing search for a cure.

The underlying problem of how to control the spread of HIV/AIDS, however, is of a political nature. The issue still remains as to how to deal with the socio-economic factors that propel, force, or seduce vulnerable persons into situations of risk, e.g. the “risk realities” of brothels and massage parlors. What should be done with/for the so-called “formal” and “informal” female entertainment workers who are vehicles for the rapid spread of the disease (National Economic and Social Development Board, 1992:16). Sex tourism and the Thai entertainment industry generate large revenues for the government. In light of this fact, it is not surprising that the government appears to enforce a less than aggressive stance with respect to the moral and legal issues raised by the commercial sex industry. While the government denounces the practice of recruiting and employing commercial sex workers under 18 years of age, it is reluctant to report the actual prevalence of HIV/AIDS in the country (National AIDS Committee 1991:1; National Economic and Social Development Board 1992:25). As Mueke (1990: 24) reports:

The Thai government faces a dilemma of trying to meet incompatible needs: a need to maintain the stability of the economy and a need to contain the spread of HIV infection. Tourism and export labor are major components of the successful economy, yet both are major contributors to the AIDS epidemic. As in most countries, the government has responded to the AIDS threat with a variety of strategies: testing, denial, targeted prevention education, and coercion. The strategies do not add up to a comprehensive attack on the problem, and some are counterproductive.

In the debate about how to control the spread of HIV/AIDS in Thailand, both of the following strategies need attention:

- 1) A political-economic strategy (requiring both the political will and strength to counteract human inequities and suffering), and
- 2) Health care programming that advances more effective, engaging, and culturally relevant AIDS prevention messages.

HIV/AIDS in Thailand

Within only a few years, the AIDS pandemic has exploded in Asia. Recent figures have indicated that by the year 2000, Asians will comprise 42% of the world's infected people. One

of the focal points of the epidemic in Asia is Thailand, where a high rate of the spread of HIV has been well documented (Weniger, et.al., 1991). Much of this information characterizes the situation in the Northern and Central areas, where the virus is spreading among prostitutes and heterosexual males (Ibid.).

In Thailand, the first case of AIDS was reported in 1984 in a Thai male homosexual who returned from the USA. Because of this the lay people in rural areas have relegated AIDS to a position as a disease of “multiple otherness”, restricted to the homosexual, transmitted from Westerners, and solely an urban phenomenon, particular to Bangkok. Newly reported cases in 1986 supported the conceptualization of AIDS as a disease of “otherness” because IV drug users were involved. In 1987, the media reported a famous female model as HIV seropositive, and the degree of “otherness” decreased--the implication being that now the heterosexual was at risk. However, AIDS remains the disease of a nude model who had contact with Westerners and urban life. Regardless of present day AIDS campaigns targeting the heterosexual community, rural people still cling to the construction of AIDS as a disease of “otherness.” Only sexual intercourse with low-class prostitutes, sex with multiple partners compounded by the perception of a “loss of systematic control,” and substance abuse via injection are perceived as risky behaviors. Sexual intercourse with an occasional, non-professional commercial sex worker is not perceived as a risk behavior, nor is self injection with a pharmaceutical solution, or sexual intercourse with multiple partners when perceived by the individual to be carefully done, or “under control.” (see Kanato, Bokum 1989, and Kanato, Willms, 1991).

In the highly populated Northeast, rates of infection appear to be lower at present, and the rapid increases in seroprevalence observed elsewhere have not yet been observed in rural communities (Weniger et.al., 1991). A recent epidemiological survey of HIV and other sexually transmitted diseases (STDs) among the general population of Udonthani, Khon Kaen and Hamasarakham provinces has recorded a 0.5% confirmed HIV seropositivity among 15 to 29 year old males in 1991 (Elkins, personal communication). Although this figure is the lowest presently recorded in Thailand, the figures for syphilis and STDs closely associated with increased HIV transmission, are threatening. Almost 30% of males and 20% of females over 30 years of age have been found to have a history of exposure to treponema infections, like syphilis. That HIV will spread in the Northeast as much as it has in other areas of Thailand is not in question.

Research has shown that other factors which characterize the region are those which inevitably facilitate the spread of the virus once it is established. These factors include: poverty, short-term migration for seasonal labor (by a large proportion of the adult population to areas with high seroprevalence rates), a rapid push for economic development which has disrupted traditional society, efforts to promote both domestic and international tourism to the region, and the large number of establishments where prostitutes are available in both urban and rural areas. Data collected in 1992 from the Udonthani Provincial Health Office shows the prevalence of HIV seropositivity in female prostitutes and STD patients of 25-30% and 8-10%, respectively. All of these factors indicate that the Northeast is on the brink of a drastic increase in HIV infection via sexual transmission, yet the opportunity still exists to reduce and slow the spread of

AIDS with effective, far-reaching prevention programs. Effective AIDS prevention and condom promotion in the Northeast could have a tremendous impact on the region as well as on its impoverished, but rapidly developing and highly susceptible neighbors.

Unfortunately, the Northeast, has received considerably less attention than the Northern and Central regions from both government and non-government AIDS prevention efforts. Because of the rapid spread of HIV among high risk groups in these regions and limited resources, the Ministry of Public Health has had to focus most of its activities in the Northern and Central regions. Non-governmental organizations have largely worked in the North as well, leaving little for other regions which are likely to face a similar, though somewhat delayed, spread of the disease.

This study addresses the possibility of a more advanced health care strategy to control the spread of HIV/AIDS and posits the kind of research still required to further strengthen HIV/AIDS intervention.

The Thai National Program Against AIDS

The Thai government has been active in fighting the spread of AIDS and has gained considerable international recognition for its efforts. The sentinel surveillance program that has been in operation since June 1989 to monitor the spread of HIV, particularly among high risk groups, is virtually unique in the developing world. This surveillance system has provided highly accurate data for use in projections which clearly demonstrate to the government that it faces a very severe AIDS problem. These projections indicate that by the year 2000, 2 to 4 million Thais will carry HIV (National Economic and Social Development Board 1992:3). The lower estimate takes into account highly effective control campaigns and the higher estimate assumes minimal control success. If these projections are accurate, “in the year 2000, one out of three deaths will be caused by AIDS” (Ibid). As for HIV prevalence rates, the most recent sentinel surveillance rates are as follows:

<i>HIV Prevalence Rates</i>	
blood donors:	12.3% (Maehongson)
pregnant women:	7.4% (Rayong)
male patients with STDs:	45% (Payao)
intravenous drug users:	71.4% (Pattalung)
professional CSW:	67.2% (Nakornpathom)
optional commercial sex workers:	39.7% (Srisaket)

In Bangkok, the HIV prevalence for commercial sex workers is reported to be 33.3% for professional commercial sex workers (CSW) and 9.4% for optional commercial sex workers (Division of Epidemiology, June, 1992). The Ministry of Public Health predicted that the areas

most seriously affected include Bangkok, Bangkok's suburbs, and the upper northern provinces, with a large number of fisherman in the east and the south of the country (Ibid.). Another observation is that while, "hill tribes make up only about 1% of the population in Thailand, about one third of the commercial sex workers in a recent survey in Chiang Mai were members of hill tribes, and more than one quarter were ethnic Shan from Burma....many of these women return to their own ethnic group to live after leaving the industry, and thus, may be important sources of transmission to uninfected men" (Peter Kunstadter, personal communication).

The Thai government and non-governmental organizations recognize that in the absence of a vaccine or effective treatment, prevention of infection with HIV is presently the only feasible option for the control of AIDS. Most transmission is related to high risk behaviors, and attempts to change these behaviors are key objectives of the Thai Government. Recently, the government announced an accelerated national plan (National Economic and Social Development Board 1992) with particular emphasis on:

- 1) Public information
- 2) Treatment and rehabilitation
- 3) Protection of human rights and social support
- 4) Research and evaluation

The objectives of the national plan are:

- 1) To limit the spread of HIV;
- 2) To promote understanding and awareness among the population and to integrate the infected into general society without discrimination or infringement of individual rights;
- 3) To mobilize resources and manpower in domestic public and private as well as international donor agencies to join forces to support the prevention and control of AIDS;

Using the vehicle of public education via radio and television, the government's strategy has been to implement education, information and counseling programs on safer sex practices and condom use for targeted groups practicing high risk behaviors, to provide information and influence behavior choices among susceptible groups, including housewives and non-sexually active youth, and develop an orchestrated national information campaign using professional advertising techniques, and increased involvement of non-government and private organizations (The Division of AIDS, Ministry of Public Health, 1992).

These specific strategies appear to target both high risk groups, e.g. intravenous drug users, as well as vulnerable groups in the population susceptible to infection, e.g. persons involved in high risk sexual activities, whether these persons are practitioners in the commercial sex industry or consumers of this industry. For the most part, the prevention strategies are directed towards people involved in high risk sexual activities. The educational messages are communicated through: "TV and radio spots, documentaries, handbooks, appointment books, pamphlets, cartoons, video, audio tapes, posters, training manuals, slide sets, etc." (National Economic and Social Development Board 1992:9) The language used in all of these mediums is Central Thai. Unfortunately, in the Northeast, culture and language differ substantially from the

dominant Central Thai language group. The essential messages delivered are that the average citizen should learn the risk behaviors associated with HIV transmission, and if they already know what these behaviors are they should avoid them! Building on these two fundamental principles are the following messages: AIDS is an infectious disease; AIDS is an incurable disease; AIDS is caused by an individual's sexual behavior; and persons with HIV/AIDS should be permitted to live with the general public.

Sexual Behavior in the Context of the Northeast

The occurrence of premarital sexual relationships in the Northeast is not unusual. After marriage, it is generally accepted that men will engage in extra-marital sexual relationships. These relationships occur mostly with commercial sex workers. No moral implications are attached to sexual activity outside the marriage, because involvement with CSWs carries no possibilities of obligation or responsibility, thus an inherent double standard, or inequality in sexual relations, is present.

Historically, boys were, and still are, socialized from a young age to value experience and knowledge gained from the concept of *len* (visiting and courting girls). While adolescent girls are given much more responsibility, the boys are allowed much freedom and given few responsibilities. With such freedom, a boy would spend time with his friends, and indirectly learn about sex through jokes or referral among his peers. Most young men learn about sex by visiting prostitutes, or being with girls who are sexually experienced. It is their peers and older friends who help guide them through the process of sexual initialization (Kanato, 1992). Men are supposed to be sexually experienced before marriage. At times, village boys practice their sexual skills with village girls. Social values reinforce the double standard by accepting as normal a man who has sexual relationships with several women, but in contrast, a woman with multiple partners is labeled a "whore."

The Study

The objectives of this study include: exploring the state of awareness of the rural population in the Northeast of Thailand, comparing AIDS awareness among adolescents, adults, and the elderly, and understanding the factors which contribute to an awareness of HIV/AIDS.

To accomplish this we did research in two different, but typical villages in Ban Doong district, Udorthani, in the Northeast. We focused our research on one single village and one cluster village. The population of a single village usually ranges from 60-200 households, while cluster villages have 200-600 households, and most become sub-district centers. This means that cluster villages contain a number of government service stations, such as health posts, schools, etc. Therefore, these two village types differ from each other, in that cluster villages presumably tend to get more information on AIDS since they are closer to the sources of such information. While the different sizes of the two villages may affect how information is

disseminated and absorbed, one must also consider geographical factors as well. The government health officers tend to visit the closer villages rather than the villages that are far away. The distance of the cluster village to the community hospital is 24 kilometers---10 kilometers on the main asphalt surface road plus 14 kilometers on a secondary hard surface. The single village is 3 kilometers closer. Both villages have an elementary school and a temple. In addition, the cluster village has a secondary school, a health post, and a police station.

Participants

This study examines the knowledge and attitudes of 1,139 individuals from representative samples of four age groups made up of people of both sexes:

1. Adolescents currently in school, and/or living in rural villages (10-19 years)
2. Adults who are 20-44 years of age
3. Adults who are 45-59 years of age
4. Elderly who are 60 years of age and over

The study group is made up of 28.5% adolescents (aged 10-19), 8.1% elderly (60+), and 63.4% adults. Fifty four percent of the participants are female, one third (35.8%) are single. Three percent have never been in school, while 73% attended only primary education, and 5.4% are illiterate. Thirty out of the 1,139 villagers identify themselves as community leaders. Most of the participants identify themselves as possessing “middle class” socio-economic status, 9% identify themselves as having a lower socio-economic status, while 11.3% identify themselves as having higher than average socio-economic status. Almost 80% are farmers, 10% are students, and the rest are laborers and civil servants. The average income per month is about 1504 Baht---just about the poverty line--and more than three fourths (78.3%) are below the poverty line. Only 6.9% earn more than 5,000 Baht, or US \$200, a month.

AIDS Awareness and Knowledge among Villagers

This study reveals some interesting data on condoms and Thai beliefs on their effectiveness in preventing AIDS. Only 45.4% of those interviewed believe that condoms can prevent AIDS, 47% were not sure, and 7.6% believe that condoms cannot prevent AIDS. As for using condoms, 81% never use them. Among condom users, 44.6% have no objection when their partners want them to use a condom, and 30.7% were sexually satisfied when they used them.

The study reveals that when presented with seven different possible modes of transmission, there is only one category, that of HIV infection via blood transfusions, in which less than 80% of the respondents fail to identify correctly a mode of transmission appropriate to HIV. However, this data on AIDS knowledge reflects only the cognitive domain of the people. When asked how best to prevent infection with HIV, villagers did not demonstrate a clear understanding of HIV sufficient to protect themselves.

Confusion about HIV/AIDS transmission and risk can be illustrated by the following perceptions and concerns of villagers who participated in the study: 1) they do not understand how AIDS is different from other infections that they are familiar with (i.e. diarrhea, TB, colds, etc.); 2) because AIDS is a disease associated with drug addicts, many believe that one can become infected by inhaling paint thinner; 3) that injecting saline solutions or vitamins, an illegal practice in Thailand, does not pose a risk of acquiring HIV/AIDS, since this is not a practice of “drug addicts”; and 4) that a man can get AIDS through having sex with a low class prostitute, a *SoPeNee*, but not from other prostitutes or from women men label as “pickups,” *Kai*, and “minor wives,” *MiaNoi*.

Preventive practices are complicated by the fact that a woman cannot ask her husband to use a condom. This request would sever the trusting relationship required in Thai marriages, wherein a marriage sanctioned through legal registration and ritual ceremony means that the man and woman will live together forever--“until they get a gold walking stick and a diamond club.” Lastly, a condom is perceived as “dirty,” i.e. not something to be talked about. Many villagers do not know how to use a condom, where to buy them, or, for that matter, how much they cost.

Considering AIDS awareness in terms of perception, prioritization, and relevance, the study shows an interesting trend. More than 90% of the villagers feel sure that the way they behave does not put them at risk of acquiring AIDS. Implicit in this attitude is the notion that AIDS is a problem, but not for them personally. To compound this problematical perspective is the fact that, despite recognizing AIDS as a serious disease, more than half of the surveyed villagers, in both villages, believe AIDS is curable.

The individuals in this sample stated that they receive information on AIDS through television (87.7%), radio (70.3%), printed materials (38.4%), and village broadcasting (29.9%). There are slight differences between the two villages in how information is disseminated. Cluster villages get AIDS information through television, radio, and village broadcasting more often than do single villages.

Perception of personal susceptibility to AIDS tends to be low among each age group. Every age group agrees that preventive behavior would not be too hard for them to practice, but more than half saw it as unnecessary for themselves to adhere to behavior modifications since they would not have any or little benefit from them. Even though half of them considered AIDS a serious disease, very few felt any real threat to themselves.

Villagers who perceived that they are at risk in acquiring AIDS represent only 3%, 8.8%, 9%, and 3.3% of the population in adolescents, young adults, mature adults, and the elderly, respectively.

Summary

In the process of translating policy to implementation at the local level, health stations get materials from district health offices. In collaboration with the village headman, the materials are distributed among and used with the villagers. The materials include booklets, brochures, cassettes, posters, etc., as well as a script which the village headman can read on the air through a village broadcasting system, a popular mode of communication available throughout the Northeast. Villagers also took the script to the temple during merit making ceremonies. They asked for a short time to give this AIDS information to the listeners. Because these broadcasts, as well as the other AIDS materials are composed in Central Thai, often using medical jargon, villagers may not really understand the message that they are at risk for HIV/AIDS. People in the Northeast use the Isan language to communicate with each other verbally, and not through writing or texts (brochures or pamphlets). To complicate matters, many of them are illiterate and unable to read Central Thai; this language is too difficult for them to understand and introduces different, conflicting meanings. As a result of our findings we should perhaps view Central Thai as inappropriate for lay education in the Northeast.

Many of the villagers interviewed for this study, while comprehending a great deal about the primary modes of HIV transmission, failed to make the necessary connections between modes of transmission and effective means to prevent HIV infection. They harbored an enormous amount of fear about the disease, marginalized and shunned HIV+ people who lived in the community, associated the disease with a skin rash, and basically had incorrect and misguided notions about the treatment for HIV/AIDS. In one case, because one person with AIDS had swam in a reservoir used by the entire village, many people refused to take water from the reservoir and claimed that the water had changed color because the person with AIDS had swam there. Others stated that they would not allow their children to play with infected children, nor would they go to visit someone who was sick with AIDS for fear of contacting the disease.

These results of this study illustrate the problems associated with AIDS prevention policy and strategies that build on epidemiological evidence alone (e.g., the results of sentinel surveys) without the benefit of evidence predicated on an understanding of risk situations and behaviors, using data that is anthropologically and behaviorally oriented (Adrien et.al., 1991). This latter evidence is much harder to generate, and more difficult still to transpose into culturally tailored and socially appropriate AIDS prevention messages.

Our study indicates that people seem to know and remember certain things, and even believe in them, but sadly, with respect to prevention, or in their everyday confrontations with people who they believe are infected, the individuals in our study do not appear to change their behaviors to match these beliefs (e.g. socially supporting and communicating with HIV infected people). More innovative strategies are required to address the intractable problems associated with high risk sexual behavior, and more specifically, the gap between knowledge, what people say they believe about HIV risks, and behavior, what people actually do in response to a perceived threat to their personal health and well-being.

The Thai Government is, not surprisingly, limited in its ability to tailor the message of HIV/AIDS prevention to each of the many ethnic groups in the country. Based on our evaluation of the effectiveness of the government's message, an alternative strategy is needed. This study suggests that increasing effort needs to be directed to researching the socio-psychological determinants of behavior. Knowledge alone does not lead to behavioral change. Therefore, a more aggressive strategy, incorporating a deeper understanding of the socio-psychological factors which shape individual behavior, must be adopted by the government if the AIDS epidemic is to be controlled in Thailand.