Never in a Vacuum: Learning from the Thai Fight Against HIV

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INTRODUCTION

More so than any other widespread health threat in the twentieth century, the emergence and dissemination of HIV/AIDS caught the attention of much of the world and scared it out of its wits. Initial reports, often sensational, fostered a lingering association of the virus with the homosexual and intravenous-drug-using communities. Long after this premise had lost whatever truth it may once have had, deeply ingrained stereotypes stood in the way of the kind of concerted action that such a health threat demanded. This phenomenon

1. Efforts to use frightening stories about AIDS as tools to vilify the gay community began in the early days of the virus and have often been wildly misinformed:
   Much was made in the early years of the epidemic of a so-called ‘Patient Zero’ who was the basis of a complex “transmission scenario” compiled by Dr. William Darrow and colleagues at the Centre for Disease Control in the US. This epidemiological study showed how ‘Patient O’ (mistakenly identified in the press as ‘Patient Zero’) had given HIV to multiple partners, who then in turn transmitted it to others and rapidly spread the virus to locations all over the world. A journalist, Randy Shilts, subsequently wrote an article based on Darrow’s findings, which named Patient Zero as a gay Canadian flight attendant called Gaetan Dugas. For several years, Dugas was vilified as a ‘mass spreader’ of HIV and the original source of the HIV epidemic among gay men. However, four years after the publication of Shilts’ article, Dr. Darrow repudiated his study, admitting its methods were flawed and that Shilts’ [sic] had misrepresented its conclusions.

2. In Thailand, for example, during the early and mid eighties:
   [G]ay men, sex workers, injecting drug users and tourists were more commonly affected than other groups. The government took some basic measures to deal with the issue, but an epidemic was not yet apparent. Most of these measures were aimed at high-risk groups, as the government believed that there was not yet sufficient reason to carry out prevention campaigns among the general public.

3. Dr. Harold Jaffe of the Centers for Disease Control (CDC) remembers that “[w]hen it began turning up in children and transfusion recipients, that was a turning point in terms of public perception. Up until then it was entirely a gay epidemic, and it was easy for the average person to say ‘So what?’ Now everyone could relate.”

4. “Although heterosexual sex is now the main means of transmission in most communities, stereotypes and stigma often remain attached to men who have sex with men. They are still ‘blamed’ for HIV/AIDS in many instances.”
(initial indifference, followed by panic, followed by belated action)\(^5\) was a global one and has played out in parts of the developing world much as it did in the industrialized nations.\(^6\)

Thailand’s experience with HIV/AIDS is instructive because it involves many of the topics that have been identified as central to understanding how the virus spreads.\(^7\) To understand the story of HIV in Thailand is to understand how a complex web of culturally specific ideas and practices regarding the disease have operated to create an epidemiologist’s potential nightmare scenario,\(^8\) and how a resource-poor developing nation managed to take an effective stand against what sometimes seems like an infectious juggernaut.\(^9\) The pertinence of the Thai case has, therefore, been broadly recognized.\(^10\)

5. The example of the United States’s response is instructive in this regard. CENTERS FOR DISEASE CONTROL, HIV AND AIDS — UNITED STATES, 1981-2000, June 1, 2001, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5021a2.htm. Following the identification of the first United States case in June 1981, the federal government did not implement universal distribution of HIV prevention funds to health departments until 1985. The first nationwide public awareness campaign, including school educational programs, did not take shape until 1987. Id.

6. In South Africa, for example, although the first case of HIV was documented in 1982, the government’s initial reaction was slow. AVERT, HIV & AIDS in South Africa, http://www.avert.org/aidssouthafrica.htm (last visited Feb. 28, 2007). The AIDS Advisory Committee was not created until 1985, and antenatal HIV testing did not take place until 1990. Id.


8. The high rates at which Thai men have traditionally patronized prostitutes, when combined with low rates of condom use in these encounters, made Thailand especially vulnerable for an HIV epidemic. See infra Part II for a discussion of the evolution of the sex industry in its modern form and the unique problems it presented for the anti-HIV effort.


10. See, e.g., Hamilton, supra note 7.

The global HIV/AIDS crisis has prompted foreign scholars to recognize the importance of Thai sexual practices and the prevalence of commercial sexual relations. As in Africa, the pattern of rapid spread of infection through multiple channels, notably heterosexual intercourse, has made Thailand an important site for examining the relations between cultural, social, and economic parameters implicated in the spread of the disease. Some of these are only now beginning to be understood: for example, the organization of the trade in girls, which spreads far beyond the boundaries of the country; the attitudes to commercial sex among young males in the provinces; attitudes to prostitution in the context of mother-daughter relations; responses to the anti-HIV/AIDS public education campaign; and Buddhist accounts of AIDS and attitudes towards homosexuality.

Id. at 147-48 (citations omitted).
Part I of this note examines the emergence of and early attitudes towards HIV in Thailand. Part II is devoted to the commercial sex industry in Thailand, which has played a central role in the spread of the disease and has been made the primary focus of the government’s prevention and education efforts to date. Part III charts the aggressive response of the Thai government, led by its Ministry of Health, to the HIV threat it recognized as being so immediate. The implications for the prevention program of the 1997 Southeast Asian economic crash, which originated in Thailand and spread throughout the region, are considered in Part IV. Part V explores the possibility that the government’s anti-HIV strategy no longer focuses on the right social behaviors and examines some alternate plans for updating the program. Part V also attempts to draw some useful lessons from the Thai battle against HIV and to see which elements of the program proved most successful. This section further examines whether and how these lessons can now be transplanted for use in other countries forced to contend with the spread of the disease.

I. THE EMERGENCE OF THE THREAT

The story of HIV/AIDS in Thailand began not long after the disease was first isolated and identified. In September of 1984 the country’s first case appeared: “a homosexual Thai male who had previously lived in the United States.” The Thai Ministry of Public Health took notice and mandated nationwide reporting of the disease the following year. As was common throughout the world in the 1980s, the Thai perception in the early stages of the epidemic was that HIV/AIDS was a disease largely confined to the homosexual and intravenous-drug-using populations. As will be discussed later, the vigilance and proactive approach taken by the Ministry of Public Health (especially notable in comparison with other countries in the region) had much to do with Thailand’s ability to arrest the spread of the disease to the extent that it did. See infra Part III.

13. Id. As will be discussed later, the vigilance and proactive approach taken by the Ministry of Public Health (especially notable in comparison with other countries in the region) had much to do with Thailand’s ability to arrest the spread of the disease to the extent that it did. See infra Part III.
15. David Plummer & Doug Porter, The Use and Misuse of Epidemiological Categories, in NO PLACE FOR BORDERS: THE HIV/AIDS EPIDEMIC AND DEVELOPMENT IN ASIA AND THE PACIFIC 41, 41-43 (Godfrey Linge & Doug Porter eds., 1997). The authors argue that the persistent conflation of HIV/AIDS with homosexuality (itself a concept that often defies cross-cultural analysis) slowed the response of the global scientific and political communities to the emergence of the disease. Id. Although “the risk category ‘homosexual’ is generally (but unjustifiably) taken to mean a male whose lifelong sexual pattern involves relationships with other men,” they observe, “the epidemiological term homosexual does
Ministry reported a dramatic spike in the infection rate among female sex workers (henceforth FSWs).\(^6\) Shortly thereafter, the Thai anti-AIDS effort, which had been the sole province of the Health Ministry,\(^7\) took on an entirely different character, with the Prime Minister personally overseeing a newly-formed AIDS committee.\(^8\) This National AIDS Prevention and Control Committee drew personnel from several Thai government ministries as well as from the staffs of non-governmental organizations (NGOs) working in the region.\(^9\) It was tasked with engineering a multifaceted response to the emergent crisis.\(^{10}\)

The fact that a sudden explosion in the infection rate among FSWs elicited such a dramatic official response is hardly surprising, given the size of the Thai sex industry\(^{21}\) and its thorough permeation of Thai culture.\(^{22}\) Whereas the government considered a high rate of HIV infection among homosexuals and intravenous drug-users, two numerically small and socially marginalized sectors of the Thai population,\(^{23}\) a low-grade threat to the public health at large, the state
recognized almost instantly that an epidemic among FSWs posed an immediate threat to the entire population.\textsuperscript{24} To understand the central role played by the Thai sex industry in both the initial dissemination and subsequent arrest of the virus,\textsuperscript{25} it is necessary to examine the history of the industry itself.

**II. Birth of a Vector: A Brief History of the Thai Sex Industry Since the 1960s**

Although commercialized sex had been a part of the culture for hundreds of years,\textsuperscript{26} the Thai sex industry as it exists today was created by and for the United States military in the years surrounding the Vietnam War.\textsuperscript{27} In the mid to late 1960s, as United States military involvement in Southeast Asia grew year by year,\textsuperscript{28} United States and Thai officials collaborated to forge both treaties and informal understandings that had the effect of creating an elaborate, country-wide "personal services" sector, primarily although covertly sexual in nature, catering to the United States military.\textsuperscript{29}

\textsuperscript{24} See Abdel-Monem, supra note 12, at 385 (describing the government’s appreciation of the risk to the “general population” of a high rate of HIV infection among FSWs and the urgency of its subsequent efforts).

\textsuperscript{25} For a cultural anthropologist’s take on the Thai government’s fixation on FSWs as the primary vehicle of the HIV/AIDS threat, see Graham Fordham, *Moral Panic and the Construction of National Order: HIV/AIDS Risk Groups and Moral Boundaries in the Creation of Modern Thailand*, 21 CRITIQUE OF ANTHROPOLOGY 259, 260 (2001): Thailand in the early 1990s was experiencing both rapid economic growth and, as analysts such as Ford and Kittisukkasit (1994), Fordham (1998), Cash (1993, 1995), and Chayan (1993) point out, rapidly changing social and sexual mores which gave rise to widespread concerns about controlling female sexuality. Thus, that the HIV moral panic of the early 1990s focused on prostitutes, whose unrestrained sexuality clearly marked them as contravening the behavioral rules for good women, is not surprising.

\textsuperscript{26} See Jeffrey, supra note 16, at 3-28 (charting the early development of prostitution in Thailand and Southeast Asia generally and the dramatic course of changing cultural attitudes toward the phenomenon).


\textsuperscript{29} See Rho-Ng, supra note 27, at 109-10. Seen in the light of subsequent Thai governments’ hard-line attitude toward prostitution, the degree of official Thai collusion with the United States military in this matter is astounding.

In 1966, the Thai government passed the Service Establishment Act, also referred to as the Entertainment Act, which regulated the operations of service businesses such as hotels, night-clubs, bars and massage parlors which
The United States military presence "throughout Southeast Asia in the 1950s and 60s planted the roots of militarized prostitution in Thailand," and this process has left an imprint on the institution lasting to this day. "This infusion of U.S. servicemen, and their overrunning of R & R destinations such as Bangkok contributed directly to the development of a massive prostitution market in Thailand in the late 1960s." Such was the scale and economic importance of this activity that "[i]n Bangkok and other cities designated as R&R destinations, the sale of sexual services to U.S. servicemen became the basis for the local economy." This economic boom was not only large in scope but diversified in nature, as many sectors were benefitted by the influx of men and dollars; "local establishments profited tremendously" from United States military patronage of Thai "hotels, nightclubs, video parlors, and venereal disease counseling businesses." Far from being hidden or unsanctioned by the authorities, the situation on the ground mirrored that at the highest levels of government and the military. As all parties stood to gain, the

catered to the U.S. military. Notably, during the economic revitalization phase of the late 1960s, army officers on both sides of the planning board played leading roles in formulating Thai tourism policies which legitimized prostitution. Negotiations between a general of the Thai Royal Air Force (whose wife was a co-director of the Tourist Organization of Thailand) and a U.S. Air Force officer launched what would later become part of the most lucrative R & R sex business in the world. The Thai government signed a document known as the "1967 Rest and Recreation Treaty" ("R & R Treaty") with the U.S. This codification of a U.S.-Thai alliance, [was] intended to ensure the servicing of the U.S. military during the Vietnam War... In 1967, an estimated U.S. $5 million was spent on R & R leave in Thailand by U.S. military personnel. Shortly after 1968, the U.S. canceled Hong Kong and Sydney, Australia as alternate R & R destinations, thereby placing greater emphasis on Thailand's main attraction. In 1970, the amount spent on R & R leave in Thailand exploded to U.S. $20 million, as much as one-fourth of the total value of rice exports for that year.

Id. (citations omitted).
30. Id. at 105 (citations omitted).
31. Id.
32. Id.
33. Id. Although the "R&R" services provided to United States Servicemen in Thailand kept local economies afloat, some authors have argued the sexual services provided were equally as crucial for the United States Servicemen: "[w]ithout a standardized 'rest and recreation' period, would the U.S. military commanders be able to send young men off on long, often tedious, sea voyages and ground maneuvers?" Id.
34. Id. at 106.
35. Rho-Ng, supra note 27, at 106.
36. Id. at 109-10.
37. All the male parties, that is. It is necessary to remember that however tremendous the profits may have been, and however beneficial the industry may have been to the Thai economy, this form of commerce had very real human costs, born by the Thai FSWs. "With its rampant consumerism, the U.S. military assisted [t]he owners of brothels and
enterprise was fostered by both sides. "A cooperative yet often corrupt relationship among the U.S. military, the local Thai government and local bar owners long sustained Bangkok's sexual services industry."

That prostitution was illegal in Thailand at this time, having been banned by the Suppression of Prostitution Act of 1960, demonstrates the perceived centrality of the sex industry to the Thai economy. This deliberate sexualization of the Thai tourism industry became a self-fulfilling prophecy, and civilian sex tourists began to visit the country in rapidly growing numbers. As the American military presence in Southeast Asia diminished in the 1970s, Thailand plowed even more resources into its foreign tourism industry to make up for the shortfall. "Prostitution services — sold, for instance, through joint venture links between hotels, travel agencies, and airlines to sex-tour groups — became a lucrative way to fill the empty hotel rooms left by American servicemen. . . . Thus the structural basis of prostitution became well entrenched during the 1970s."

The departure of the United States military did not sound the death knell for the Thai sex trade. If anything, it has flourished, becoming the centerpiece of Thailand's already formidable tourism industry. A quick glance at the demographic data on the industry reveals the lingering influence of the four-decades-old agreement between the United States military and the Thai government to make Thailand a prime destination for commercial sex:

bars — almost all male — in profiting from the sexual services industry by systematically controlling and exploiting Thai women." Id. at 106 (citations omitted).

38. Id.


40. See Rho-Ng, supra note 27, at 109-10 (describing official toleration of military-oriented prostitution, typically conducted under the “special services” designation, and thereby technically avoiding classification as commercial sex).

41. Id. at 112-13. The United States Servicemen left a bustling “R&R” industry that was easily adaptable to create “sex package tours” for foreign businessmen. Id. at 111. Although the precise number of men who travel specifically for sexual services is unknown, in 1986 seventy-three percent of the total number of tourists were male, and in 1988 the number of tourists rose from 1.8 million to 4.3 million. Id. at 111-13.

42. See Kane, supra note 28. From a high of over five hundred thousand troops in 1968, "the total number of U.S. troops in Vietnam declined dramatically in every year thereafter, until the complete pullout in 1975." Id.

43. Rho-Ng, supra note 27, at 111.

44. JEFFREY, supra note 16, at 40.

45. Rho-Ng, supra note 27, at 111.

46. Id.
In 1988, the number of tourists rose to 4.3 million. Of this figure, three-fourths were unaccompanied males. By 1995, it was estimated that there were more than five million tourists visiting Thailand every year, many of whom were sex tourists. The visitors—mostly men from the U.S., Europe, Australia and the Middle East—find their respite in areas like Patpong and Soi Cowboy where they are sexually and emotionally serviced, much like their predecessors, U.S. servicemen during the Vietnam War.

The end result of this historical process (a large population of FSWs, a massive volume of foreign sex tourism, and a national economy heavily reliant on the sex trade), taken in combination with a high rate of domestic patronage of FSWs, created fertile ground for an HIV/AIDS catastrophe. By the mid-1980s, Thailand was in a position not only to see its own population ravaged by the disease, but to export it through human trafficking, a tragic side effect of its burgeoning sex sector.

However one chooses to define human trafficking, the practice centers on a coercive relationship whereby a person is transported for the economic benefit of another. FSWs in Thailand have often been trafficked there from other countries in Southeast Asia, due to...
Thailand's longstanding reputation in the region as a place where there is serious money to be made selling sex.\(^\text{55}\) Thailand is also a source country, meaning that Thai women are regularly trafficked out of the country to work as FSWs.\(^\text{56}\) The scale upon which this practice is carried out is tremendous, and it involves individuals from all strata of Thai society, as

the huge amount of easy money draws in international crime syndicates as well as corrupt government officials who hope to augment their often paltry salaries. National and international press and human rights reports all emphasize that the sex sector is supported by politicians, police, armed forces, and civil servants, who receive bribes, demand sexual favors, and are themselves customers and often partial owners of the establishments. For example, Burmese children often speak of how policemen or border guards were involved in their trafficking into Thailand and how they had to entertain policemen.\(^\text{57}\)

Thailand, because of its sex industry and human trafficking, has from an epidemiological standpoint come to both threaten and be threatened by its neighbors in the region.\(^\text{58}\)

III. FIGHTING TIME, IGNORANCE, AND APATHY ALL AT ONCE: THE THAI GOVERNMENT TAKES ON HIV/AIDS

The uniquely widespread and entrenched character of the Thai sex industry and the increasing porosity of national boundaries meant that when the HIV menace became evident the Thai government was not the only interested party.\(^\text{59}\) In the late 1980s the Ministry of Public Health received support and financial backing from the UN World

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\(^55\) Rho-Ng, supra note 27, at 112.

\(^56\) Schwartz, supra note 51, at 389.

\(^57\) Id. at 389-90 (citations omitted); see also Anchalee Singhanetra-Renard, Population Movement and the AIDS Epidemic in Thailand, in SEXUAL CULTURES AND MIGRATION IN THE ERA OF AIDS: ANTHROPOLOGICAL AND DEMOGRAPHIC PERSPECTIVES 70, 79 (Gilbert Herdt ed., 1997) (examining the rural-urban migration in Thailand and noting that the widespread practice, traditionally one of rural Thais' few opportunities for upward social and economic mobility, is now, given its linkage with the sex industry, a major conduit for the dissemination of HIV in Thailand).

\(^58\) Schwartz, supra note 51, at 389-90.

\(^59\) See Abdel-Monem, supra note 12, at 383-84.
Health Organization (WHO),60 and the two bodies launched a joint HIV education and prevention scheme.61 Limited in resources and scope,62 this assortment of programs was no match for the problem once the virus spread to the FSW population.63 In 1991, the Prime Minister assumed the chairmanship of the newly created National AIDS Prevention and Control Committee,64 which quickly generated an intensified, multifaceted response.65 Recognizing the need to reach as many Thais as possible with its prevention message, the Committee’s strategy included a major advertising blitz focused on encouraging condom use in all commercial sex encounters.66 The uncompromising nature of the government’s effort to tackle the HIV problem by focusing on making commercial sex safer is especially admirable in light of its then thirty-year-old prohibition of prostitution.67 That the 1960 law was widely flouted was, of course, a well known fact in Thailand,68 but the government’s willingness to set this aspect of its social policy aside and deal with the implications of HIV for

60. Id.
61. Id. These efforts “focused on strengthening programs within the formal healthcare and education systems, such as increased training among healthcare professionals, condom distribution, and stronger surveillance programs.” Id. at 384. Although commendable, the Ministry of Health/WHO program was not particularly well funded and had a narrow focus, due to the perceived source of the HIV/AIDS risk at the time: high risk groups and foreigners. AVERT, supra note 2 (citations omitted).
62. The HIV prevention budget for 1988 was the equivalent of one hundred eighty thousand dollars. AVERT, supra note 2.
63. See Abdel-Monem, supra note 12, at 384.
64. Id.
65. Id.
66. See Robert Hanenberg, Impact of Thailand’s HIV-Control Programme as Indicated by the Decline of Sexually Transmitted Diseases, 344 LANCET 243, 243 (1994) (summarizing the Thai government response as “the following parts: the government bought and distributed sufficient condoms to protect much of the commercial sex in the country; sanctions were brought against commercial sex establishments where condoms were not used consistently; and a media campaign bluntly advised men to use condoms with prostitutes”). Id.; see also Beyrer, supra note 9 (calling the response an “exception” to the regional problem of “Asian governments [being] slow to respond to the threats of AIDS.” Furthermore, Beyrer notes “[a] vigorous ‘100 percent’ condom campaign, aggressive treatment of STDs, reform of blood-banking practices, widespread public education campaigns, significant domestic funding for prevention and care, and considerable political pressure are the elements of Thailand’s successful campaign.” Id. at 221.
67. See Rho-Ng, supra note 27, at 117-18. As a result of pressure applied by the United Nations’ passage in 1950 of the International Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, Thailand scrapped its 1908 Venereal Disease Control Act, under which prostitution had enjoyed full legal status. Id. at 118. Nevertheless, “any deference paid to these international human rights mandates has been superficial at best.” Id. at 118.
68. Id.
commercial sex as a simple fact\textsuperscript{69} shows the pragmatic attitude it took toward its HIV/AIDS work. This pragmatism bore fruit, as the epidemiological data suggest.\textsuperscript{70} By almost all accounts,\textsuperscript{71} the Thai government's strenuous push to arrest the rate at which HIV spread through its population was a straightforward success.\textsuperscript{72} Chris Beyrer observes\textsuperscript{73} that, in the wake of the government's anti-HIV campaign,

[rates among military conscripts have decreased from the high of 12.5 percent of all recruits in northern Thailand in 1991 to less than 4 percent in 1999. General population prevalence is estimated to have decreased from 2.7 percent of all adults to 2.3 percent over the last five years—the first example of population-level declines in a severe epidemic in Asia.\textsuperscript{74}

\textsuperscript{69} In the Asian context, HIV/AIDS policies deemed “progressive” are often so only in relative terms. The fact that Thailand has even officially recognized its HIV problem puts it far ahead of some other countries in the region. Neighboring Myanmar (formerly Burma), for example, has shown a lasting refusal to acknowledge its HIV epidemic. See Anna Johansson, Comment, A Silent Emergency Persists: The Limited Efficacy of U.S. Investment Sanctions on Burma, 9 Pac. Rim L. & Pol'y J. 317, 327 (2000).

While the World Health Organization estimates approximately 500,000 of Burma’s forty-seven million people are HIV positive, the regime acknowledges only 21,503 confirmed HIV cases and 2,854 AIDS cases. In April 1999, Dr. Peter Piot, executive director of the United Nations AIDS program UNAIDS said, “Burma has the second worst AIDS epidemic in Asia.... But the big problem is the recognition of the problem by the government.” Id. (citations omitted); see also Jeremy Sarkin & Marek Pietschmann, Legitimate Humanitarian Intervention under International Law in the Context of the Current Human Rights and Humanitarian Crisis in Burma (Myanmar), 33 H.K.L.J. 371, 384 (2003) (citing a World Bank estimate for Myanmar of “over 1 million cases of HIV/AIDS in 2000. Other sources speak of 4 per cent to 5 per cent of the population being HIV-positive, more even than in Thailand”) (citations omitted).

\textsuperscript{70} Beyrer, supra note 9, at 220-21.

\textsuperscript{71} Note that “[d]espite an increase in contraceptive use and decrease in the incidence of sexually transmitted diseases credited to public health education campaigns, the HIV/AIDS epidemic continued to spread among the population.” Abdel-Monem, supra note 12, at 386. The government’s program did not entirely stop the spread of the virus, but most observers agree that it decreased the transmission rate. See Hanenberg, supra note 66.

\textsuperscript{72} The Thai initiative has “saved millions of lives, reducing the number of new HIV infections from 143,000 in 1991 to 19,000 in 2003.” AVERT, supra note 2 (citations omitted).

\textsuperscript{73} Beyrer, supra note 9, at 220-21.

\textsuperscript{74} Id. (citations omitted); see also Hanenberg, supra note 66, at 243, citing even more dramatic results:

Between 1989 and 1993 the use of condoms in commercial sex in Thailand increased from 14 to 94%, according to surveys of prostitutes, and the number of cases of the five major sexually transmitted diseases declined by 79% in men. We estimate that sex acts with prostitutes where there was a risk of HIV transmission declined from about 26% in June, 1989, to about 16% in June, 1993.

\textit{Id.}
By treating HIV/AIDS as the mortal threat it was and is and by heed-
ing the sometimes difficult-to-follow advice of both outside experts and its own domestic public health officials, the Thai government managed not only to slow the spread of a deadly disease among its population but to set an example for future efforts.

Thailand is a developing nation and cannot bring financial re-
ources to bear on a health problem in the way the United States or another first world industrialized nation could. Given this back-
ground, Thailand's ability to make such significant progress against HIV/AIDS potentially meant all the more for other developing coun-
tries' prospects, should they face an epidemic of such proportions.

This success, however, was not cheaply bought, and it accounted for a relatively large portion of Thai domestic expenditures. The eco-
monic setback suffered by Thailand (and Southeast Asia generally) in 1997 had serious negative consequences for the HIV/AIDS effort in that country.

IV. THE WHEELS FALL OFF: THE ECONOMIC CRISIS OF 1997 AND ITS IMPACT ON THAI HIV/AIDS POLICY

For a variety of reasons, the Thai economy, which had been growing at a rapid pace, hit a brick wall in 1997. The crash, which was severe enough to necessitate an International Monetary Fund emergency loan, "[h]ad major social implications for unemploy-
ment, under employment, household income contraction, changing

75. See AVERT, supra note 2.
76. The extent to which the Thai model can be transplanted to other countries facing HIV epidemics is an open question. Thailand had many factors working in its favor in 1991: a government willing to accept the existence and severity of the problem, a sub-
stantial NGO presence with major resources to contribute, and, critically, a communica-
tions network capable of reaching the vast bulk of the population. See Abdel-Monem, supra note 12, at 384. The importance of this last factor in the Thai effort makes the pros-
psects for success of such a project in other developing countries seem questionable. Id.
78. Id.
80. See id. at 789.
81. Id. at 797.
82. Id. at 790. The authors attribute the collapse to, among other things, "high-risk and low-return economic activities in the non-tradable sector," which led to a high deficit. Id. "The decline in regional demand for Thai exports exacerbated the problem, leading to a sharp fall in exports and a slowdown in economic growth in 1996." Id.
83. Id.
84. Id.
expenditure patterns, and child abandonment. The crisis increased poverty incidence by 1 million, of whom 54% were the ultra-poor.\textsuperscript{85}

Naturally, this economic setback had an impact on the government’s ability to maintain its cost-intensive HIV/AIDS program.

The 1998 national AIDS programme budget was cut by 25\% in nominal and 33\% in real terms. . . . The first three programme activities consuming the highest proportions of the [reduced] budget involved medical interventions; the use of antiretroviral drugs (ARV), opportunistic infection drugs and donor blood screening. Despite the high budget allocation, these medical interventions could not effectively match the potential demand for curative services. In addition, cost inflation of opportunistic infection drugs and other imported medical goods further aggravated the problems of limited resources in 1998.\textsuperscript{86}

The prognosis from many expert observers was grim: with its funding slashed, how could the HIV/AIDS program hope to continue stemming the tide?\textsuperscript{87}

Writing in March of 1998 about previous projections of HIV incidence in Thailand into the twenty-first century, one commentator warned of a fundamental problem that could potentially undo the program’s success: if the Health Ministry stopped distributing condoms, would 100\% use become a memory?\textsuperscript{88} The supply of condoms from the Health Ministry did not, in fact, dry up entirely, but it was sharply reduced from 1995 through 1997.\textsuperscript{89}

\begin{itemize}
\item \textsuperscript{86} Tangcharoensathien et al., supra note 79, at 797.
\item \textsuperscript{87} \textit{Id.} at 806.
\item \textsuperscript{88} See Kenrad E. Nelson, Editorial Comment, \textit{The Demographic Impact of the HIV Epidemic in Thailand}, 12 AIDS 813, 814 (1998):
\begin{quote}
Studies of military conscripts have shown that high levels of compliance with the 100\% condom program have been achieved in Northern Thailand, partially because of the Ministry of Public Health program of distributing free condoms to women in commercial sex establishments and monitoring their use. If the provision of free condoms, monitoring and education programs were to falter because of economic constraints, it seems likely that the risks of HIV transmission from commercial sex would increase. Few men who visit brothels report bringing their own condoms; most rely on the availability of free condoms at the establishment and the social pressure supporting their use.
\end{quote}
\textit{Id.} (citations omitted).
\item \textsuperscript{89} See Tangcharoensathien et al., supra note 79, at 800-01 (noting that the “budget for free condom distribution in brothels was significantly cut by 16\% and 72\% in 1995-96
To date, a full picture of the economic crash’s ramifications for the HIV/AIDS program has yet to emerge; there is contradictory evidence with regard to overall HIV prevalence and discouraging anecdotal evidence regarding rates of condom use in commercial sex, which is itself changing shape as a result of the economic slump. An increasing number of FSWs are working independently, outside the structure of the brothel system and thus outside direct government oversight. Many of these independent operators are not Thai and have moved onto the less prestigious rungs of the sex industry ladder to fill the void left by the Thai women no longer willing to work in such conditions. This informalization of commercial sex is an unfortunate development from an epidemiological as well as a human

90. Id. at 806.
91. Although targeted “risk” groups saw their HIV rates decline throughout the 1990s, the virus spread widely throughout the general population. Abdel-Monem, supra note 12, at 387. One should guard against complacency in the Thai case, as slowing infection rates do not cure the infected; “[s]ince the outbreak of the epidemic in the late 1980s, an estimated 300-350,000 people have died of AIDS in Thailand, with 66,000 dying in 1999 alone.” Id. at 388 (citations omitted). But cf. Tangcharoensathien et al., supra note 79, at 799-800 (“The STD incidence per 1000 population followed the pre-crisis downward trend, from 0.494 in 1996 to 0.379 and 0.305 in 1997 and 1998 respectively. It is a sustained result of the pre-crisis campaign for 100% condom coverage preventing HIV/AIDS among commercial sex workers.”).
92. See Beyrer, supra note 9, at 221 (arguing a serious lack of interest in prevention efforts among drug users and describing “the changing nature of the sex industry, which now involves many more women and girls trafficked from Burma and tribal areas” of Thailand itself. Because they lead such secluded lives, “[t]hese vulnerable women have proven more difficult to reach and to support than the Thai women who preceded them in the trade. In addition, the large, gay-male commercial sex industry has continued to see high rates of infection”).
93. Id.
94. Sukhontha Kongsin, Economic Impact of HIV/AIDS Mortality on Households in Rural Thailand, in NO PLACE FOR BORDERS: THE HIV/AIDS EPIDEMIC AND DEVELOPMENT IN ASIA AND THE PACIFIC, supra note 15, at 89. With improving economic conditions in Thailand came an increasing unwillingness on the part of Thai women to work in what were perceived as less desirable sex industry roles. Id. “Thai women are becoming less willing to prostitute themselves at home or in low-paid positions; they will work in Bangkok bath houses or brothels but not so much now at truck stops or in cheap rural establishments,” where FSWs are less empowered to assert themselves regarding the use of condoms. Id. “Increasingly, it is Burmese, Hill-tribe and Chinese women who work in these wretched village brothels and then return to their home countries without, in many cases, realising that they have contracted HIV.” Id.
95. The World Bank’s Global HIV/AIDS Program of Action, WORLD BANK, Dec. 2005, at 2, http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf. “It is more difficult to target individuals with risky behaviours when they are subject to social taboos, or are marginalised, or not clearly identified — for example, widely dispersed informal and part time sex workers who do not work in establishments or ‘red-light’ districts.” Id. at 14.
perspective (many of these non-brothel FSWs are trafficked women),

as “when commercial sex workers diversify services from a brothel base to a more informal and casual arrangement not using a condom with casual partners has a high risk for HIV infections. . . . Sero-surveillance cannot detect these informal sex services and the true picture is therefore masked.”

It is possible to overstate the HIV/AIDS-related damage done by the economic crash and the subsequent budget cuts, at least as far as condom distribution and its direct effects are concerned. Also, the anecdotal observation that much of the commercial sex trade has moved out of the brothels and into the informal sector may mean that a top-down governmental effort such as the 100% target cannot be regarded as a permanent solution to a problem with such protean characteristics.

96. Beyrer, supra note 9, at 222.
97. Tangcharoensathien et al., supra note 79, at 800, 805. The authors’ concern is that the government’s message has been understood almost exclusively in the context of brothel-based commercial sex, with the result that men associate the safe-sex message with brothel visits and nothing else. Id. “There is a need for effective health messages on ‘using condoms with any non-regular partners’ by the national HIV/AIDS control programme.” Id. at 800.
98. See id. for a measured analysis of the condom drought’s impact on HIV transmission (pressure applied to clients by FSWs appears to have been at least as important as the provision of the condoms themselves) and the growing importance of non-commercial sex as a vector for HIV. Id.

Analysis indicates that resource reduction in the AIDS programme and free condom distribution did not jeopardize the programme outcome, if FSWs urged their clients to use condoms and if the message on condom use among clients was sustained. Moreover, there is no channel to distribute free condoms among casual sex partners outside brothels or other indirect establishments — which is increasingly important — so messages about personal responsibility on safe sex may be more important than free condom distribution in brothels.

Id. at 801. But see Nelson, supra note 88, at 814, for a prescient take on the (then) prospective effects of the economic crisis on the HIV program’s success: Studies of military conscripts have shown that high levels of compliance with the 100% condom program have been achieved in Northern Thailand, partially because of the Ministry of Public Health program of distributing free condoms to women in commercial sex establishments and monitoring their use. If the provision of free condoms, monitoring and education programs were to falter because of economic constraints, it seems likely that the risks of HIV transmission from commercial sex would increase.

Id. Nelson takes a position unlike Tangcharoensathien’s on the issue of male FSW clients’ motivations in using condoms: he thinks that the success of the 100% condom program was inextricably tied to the combination of government-provided condoms and pressure by FSWs to use them. If free condoms are not made readily available, they are much less likely to be used in commercial sex, as “[f]ew men who visit brothels report bringing their own condoms; most rely on the availability of free condoms at the establishment.” Id.

99. See Beyrer, supra note 9, at 221.
V. TAKING STOCK: THE NEW DEMOGRAPHICS OF THE HIV/AIDS THREAT AND SOME POSSIBLE WAYS FORWARD

One lesson from the post-crash analysis of the state of the Thai HIV/AIDS prevention program is that the target has likely shifted in the years since the program's inception. 100 In 1998, the major transmission risk has become sexual transmission among married couples and mother-to-infant transmission. Prevention of HIV transmission among married couples is a very difficult public health challenge. Regular condom use among married couples is unusual unless both partners are aware that one is infected with HIV. Diagnosis of HIV infection in married men or women prior to transmission to their regular partner is the public health challenge of the future for the control of the HIV/AIDS epidemic in Thailand. 101

Essentially, the passage of fifteen years and the expenditure of mountains of government and outside funds have seen off the HIV threat in its initial form and has succeeded in preventing many thousands of people from being infected. 102 Naturally, though, it did not get into gear before any transmissions took place, and the majority of these were likely FSW-to-client (and vice versa). These clients, often married men not accustomed to using condoms with their wives 103 (and indeed, never instructed to do so by the government public-awareness campaign), 104 are the new face of the HIV threat. 105 The women they came home to and infected years ago are now beginning to show symptoms of HIV, 106 and the consequences for the Thai HIV strategy promise to be dire. 107

100. The World Bank's Global HIV/AIDS Program of Action, supra note 95 (noting that changing social factors, among other causes, have made women more susceptible to infection, "resulting in an increasing feminization of the epidemic, particularly in Sub-Saharan Africa and South Asia").
102. AVERT, supra note 2.
103. The fact that the 100% condom program has made little progress in stopping transmission within marriages is evidence that condom use in these situations is rare. Rev. Leonardo Legaspi, O.P., D.D., Archbishop of Caceres, Naga City, Evangelium Vitae and the Churches in Asia (Dec. 5, 2005), available at http://webservice.mnl.ust.edu.ph/bioethics/absComment.asp?RecNo=5.
104. The 100% condom program could be more accurately described as "100% condom use for all commercial sex." Id.
105. "Now half of the newly identified infections [in Thailand] are occurring among the wives and sexual partners of men who got infected several years ago." Id.
106. See Abdel-Monem, supra note 12, at 387 (citing a ten-year average incubation period for the AIDS virus).
107. Id. Unless a cure or more effective treatments are discovered in the very near future, Abdel-Monem postulates a grim future for AIDS sufferers in Thailand and for Thai
In determining how to cope with this mutated threat, worth noting is that the sexual practices of married couples may be more difficult to change (from unprotected to protected sex) than those of FSWs and their clients. One unintended consequence of the 100% condom program's success may be that Thai men associate condom use with commercial sex, to the exclusion of everything else. Rather than attempt to change the way men conceive of marital sex, it will probably make more sense to focus on widespread testing, followed by antiretroviral treatment as the primary mode of preventing further transmission.

Not only is Thailand dealing with a new primary mode of HIV transmission, but it is now facing a drain on its financial and public-health-dedicated resources that was not yet present in the program's 1990s heyday: providing treatment to the huge number of Thais living with the disease and its devastating effects. As of 2001, the Thai health service was providing antiretroviral drugs for a tiny fraction of the number in need of them, and even this token effort placed the government's financial resources under heavy pressure. As costly and logistically difficult as the government found its 100% condom campaign to be, it is beginning to look very cheap indeed next to the costs involved in keeping a large number of HIV-positive citizens alive and healthy.

The fact that Thailand, which is economically well-off in comparison with other countries in Southeast Asia,
is able to medicate so few of its ailing citizens\textsuperscript{117} bodes ill for neighboring countries' ability to do so, should they attempt to launch HIV initiatives of their own.\textsuperscript{118}

Skyrocketing pharmaceutical costs are facts of life in the developing world just as they are in the rich world,\textsuperscript{119} but people living in the developing world have far scantier resources with which to meet them.\textsuperscript{120} For countries like Thailand that have a significant population already suffering from AIDS-related illnesses, simple prevention can no longer be the primary goal. In addition to holding back the rate of new infections, the challenge now involves keeping those already infected alive long enough to avoid a demographic disaster,\textsuperscript{121} an impossible task without the help of antiretroviral drugs.\textsuperscript{122}

Putting Thailand's 100% condom campaign into practice was a massive undertaking,\textsuperscript{123} and one for which the government had a great deal of outside counsel and logistical support.\textsuperscript{124} Although the

\begin{itemize}
\item \textsuperscript{118} "Although wealthier states with fewer patients can probably afford antivirals (Japan, South Korea, Singapore, perhaps even Malaysia), most heavily affected states in Asia are poorer than Thailand (Cambodia, Burma, much of India) and will be hard pressed to provide any of these drugs." Beyrer, supra note 9, at 221. That Thailand, despite having suffered such a massive financial crisis in the past decade, looks so robust economically in comparison with its neighbors is indicative of the substantial structural obstacles facing those nations in any attempts to tackle HIV. \textit{Id.}
\item \textsuperscript{120} More than one in five South Africans are living with HIV/AIDS, and one in two live below the poverty line. \textsc{CIA World Factbook, South Africa}, http://www.cia.gov/cia/publications/factbook/geos/sf.html (last visited Feb. 28, 2007).
\item \textsuperscript{121} See Abdel-Monem, \textit{supra} note 12, at 387-88 (noting "[d]eath rates due to AIDS may be so high that the overall population rate may actually decline by 0.7% annually instead of increase"). Although 0.7% does not sound catastrophic, it is a huge setback in demographic terms, with profound consequences for Thai "economic productivity, loss of income from declining tourism (one of Thailand's strongest domestic industries), problems related to social stigmatization and discrimination, rising crime rates, and so on." \textit{Id.} at 388.
\item \textsuperscript{122} In referring to the case of a female patient recently started on ARVs in Haiti, Dr. Paul Farmer describes himself as "militant about these drugs because we keep seeing these startling responses to therapy. For people like them it's either antiretrovirals, or, you know, as she'd probably tell you, or a coffin." \textsc{The Global Fund to Fight AIDS, Tuberculosis, and Malaria, Haiti Video Transcript}, http://www.theglobalfund.org/en/in_action/stories/haitivideotranscript/ (last visited Feb. 28, 2007).
\item \textsuperscript{123} The AIDS program's budget "increased almost 20-fold to $44 million in 1993." \textsc{Avert, supra} note 2.
\end{itemize}
scale of the initiative \(^{125}\) made for daunting costs, which would have been well beyond the Thai government's ability to underwrite on its own, condoms were and are very inexpensive when compared with antiretroviral drugs. \(^{126}\) Current AIDS treatment calls for a number of different drugs to be used in tandem; \(^{127}\) a patient is to take several pills with complementary effects at fixed times during the day. \(^{128}\) The necessity of adhering to a strict dosage regimen \(^{129}\) has bred considerable skepticism about ARV therapy's potential in settings where patients cannot be monitored during the course of treatment. \(^{130}\) Pioneering researchers like Dr. Paul Farmer, \(^{131}\) however, along with a growing consensus among the international public health community that ARV therapy can be as effective in the developing world as it has been in the rich world, \(^{132}\) are working to change these notions. \(^{133}\)

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\(^{125}\) See AVERT, supra note 2.

\(^{126}\) The World Bank estimates the average cost of a year of triple-combination antiretroviral therapy to be from $8,776 to $13,902. Total Cost Implications of Providing Anti-Retroviral Therapy, WORLD BANK, http://www.worldbank.org/aids-econ/arv/floyd/whoarv-webp4.htm (last visited Feb. 28, 2007). This does not allow for therapy with ritonavir, a newer and more expensive ARV drug. Id.; Keith Alcorn, 400 Percent Ritonavir Price Hike, INT'L ASS'N OF PHYSICIANS IN AIDS CARE, available at http://www.thebodypro.com/inpac/jan04/rtv_price.html (last visited Feb. 28, 2007). See Kongsin, supra note 94, at 90-94, for a discussion of the crushing financial burden placed on rural households by caring for a family member who has AIDS. In many cases, direct health care costs (hospital visits, etc.) can account for nearly half of a rural family's average income. Id. at 92-93. More sobering still is that this figure does not account for the lost earnings of the patient or those who have to take time off to provide care. Id. at 93-94.


\(^{129}\) The World Bank's Global HIV/AIDS Program of Action, supra note 95, at 21.

\(^{130}\) Dr. Farmer has stated:

One of the biggest set of myths we're dealing with are about therapy for HIV. HIV, it can't be done in a placed [sic] like this. You know, people don't have other rights, they don't have a concept of time, they don't have wrist-watches, the medications have to be refrigerated. It's not cost effective. You know, it's not anything you would ever initiate in a really poor country.


Lack of access to antiretroviral (ARV) treatment has perpetuated HIV/AIDS-related stigma and discrimination in many countries. The cost of medicines, poor infrastructure and the lack of skilled healthcare workers are frequently cited as obstacles to scaling up ARV treatment in resource-limited settings.
Not only is ARV therapy the best option to date for maintaining the health and continued functionality of those already infected, but it is also crucial in arresting the spread of the virus to others. An outbreak of HIV/AIDS among a population of FSWs in Haiti raised a unique set of difficulties. The nature of their work puts these women at much greater risk of infection than the general population, and its illegal nature makes them more likely to live off the radar of national health services (assuming such exist); FSWs are potential vectors almost without parallel elsewhere in society. In Haiti, "[s]topping exploitative prostitution would require addressing poverty, gender inequality, and racism, but in the absence of serious societal programs with such aims, public health authorities can make a priority of protecting, rather than punishing, sex workers." This statement seems to reflect the attitude the Thai government has been so willing to take with regard to HIV and its sex industry: rather than tilt at windmills trying to eradicate prostitution itself, focus on making prostitution less dangerous for everyone involved and less likely to spread HIV into the general population.

The HIV issue in Haiti is as fraught with problematic social and cultural implications as it is in Thailand. Without the time and resources, to say nothing of a workable theory or method, to solve the social problems implicated in the Thai sex industry, an AIDS-treatment-based approach, using ARV therapy, is the only practical
course of action in Haiti.141 Finding a way to pay for such an initiative is an altogether more complicated proposition.

One way to reduce drug costs dramatically is to opt for generic versions.142 Bowing to the time-sensitive nature of the AIDS threat and the impossibility of meeting the costs that would be involved in attempting to medicate the country's entire population of AIDS patients143 with costly ARVs, Brazil in 2001 announced that it was going to violate the Swiss drug company Roche's patent on a vital AIDS medicine144 and produce a generic version on its own.145 Needless to say, pharmaceutical companies, which invest heavily in the research processes undergirding new drug development,146 have been less than receptive to the idea of developing nations exercising this option.147

In response to the growing crisis prompted by developing countries' inability to purchase sufficient supplies of ARVs at market

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141. See CLINTON FOUNDATION, supra note 133.
142. For example, a generic Brazilian version of the AIDS drug AZT can be obtained for ninety-four percent less than its main-brand counterpart. Brazilian Generic ARV Drugs in South Africa — The Background, MEDECINS SANS FRONTIERES, Jan. 29, 2002, http://www.accessmed-msf.org.
143. At the time of the announcement, Brazil had an estimated 200,000 people living with AIDS, the highest rate in Latin America. Brazil to Break Aids Patent, BBC NEWS, Aug. 23, 2001, http://news.bbc.co.uk/2/hi/business/1505163.stm. Of these, roughly a quarter used the drug in question. Id.
145. BBC NEWS, supra note 143. This move came under the aegis of a Brazilian law that allowed the government to break Roche's patent on the grounds that Roche was a foreign company, selling its product in Brazil and had failed to begin producing the product in Brazil within three years. Id. The United States had challenged the legality of this provision at the World Trade Organization but abandoned its protest just before the WTO set out limited conditions under which drug patent infringement by developing nations is acceptable. See Press Release, World Trade Organization, Decision Removes Final Patent Obstacle to Cheap Drug Imports, Aug. 30, 2003, http://www.wto.org/english/news_e/pres03 _e/pr350_e.htm.
prices, the World Trade Organization in 2003 established conditions under which compulsory licensing, a euphemism for patent infringement, is tolerated. This compromise represents Thailand’s best hope for medicating as many of its infected citizens as possible. Taking advantage of this patent infringement exception and obtaining compulsorily licensed ARVs must be the next step in Thailand’s AIDS-fighting strategy.

An important, and heartening, lesson to be drawn from the Thai case is that HIV/AIDS is not the unstoppable juggernaut the world once feared. The United States and other wealthy nations have had a considerable degree of success in retarding the spread of the virus, but the Thai example proves that with careful planning, adequate resources, and a high level of official commitment and oversight, the

148. See Press Release, World Trade Organization, supra note 145. These conditions are intended in part to provide a modicum of protection for the patentee’s intellectual property rights, and the main points can be summarized as follows: (1) the country in need is to produce only as much of the drug as it actually needs to confront its emergency, (2) the patentee must be timely notified and given an opportunity to negotiate a new price or make donations, (3) the patentee must be compensated at some level, and, importantly for countries like Thailand, (4) the country can import a generic version of the drug if it lacks facilities for domestic production. Elizabeth Durham, Holding Patents Hostage?: The Need for HIV/AIDS Drugs in Poor Countries Threatens the Health of International Patent Protection, BAKER BOTS INTELL. PROP. REP. httpJ/www.bakerbotts.com/file_upload/ DuhamArticle2.htm (last visited Feb. 28, 2007).

149. Although drug companies cannot be expected to suffer patent infringements gladly, the WTO result is closely tailored to the specifics of the global AIDS crisis and poses little threat to drug companies’ profit margins, as developing nations were buying few of their products in the first place. Id.

150. Drugs that prevent the mother-to-child transmission of the virus (notably the ARV Nevirapine) will be especially important in halting its spread from one generation to the next. AVERT, Preventing Mother-to-Child Transmission of HIV, http://www.avert.org/motherchild.htm (last visited Feb. 28, 2007).

151. Paradoxically, the success of the 1991 strategy may be harming Thailand’s ability to question its assumptions about the best way to fight the disease. See generally Tangcharoensathien et al., supra note 79, at 305-06. As celebrated and effective as its 100% condom efforts were, Thailand has been perhaps understandably slow to update its methods. See generally id. (discussing the need for additional AIDS/HIV prevention strategies).

152. AVERT, supra note 2 (noting the major successes of Thailand’s HIV/AIDS programs).

153. Although there have been disquieting signs of complacency/backsliding due in part to knowledge of ARVs’ ability to extend patients’ periods of good health. Warning Over AIDS Complacency, BBC NEWS, June 25, 2001, available at http://news.bbc.co.uk/2/health/1406793.stm.

154. As important as the monitoring element of the 100% condom campaign proved to be, such a task would be much more difficult and cost-intensive in a large-scale ARV treatment program. Ensuring that patients comply with necessarily strict ARV treatment regimens is a formidable task even in the near-ideal conditions present in rich world clinical trials. See The World Bank’s Global HIV/AIDS Program of Action, supra note 95, at 21. Doing so in the conditions present in a developing nation, especially in the rural settings increasingly at risk for exposure from returning FSWs, seems likely to prove considerably more difficult.
developing world need be no different.\textsuperscript{155} It is thus worthwhile to consider which elements of the Thai program were most effective and which could potentially be used with success in other settings.

The linchpin of the Thai strategy was its unrelenting focus on public educational efforts and a simple, effective message: use condoms.\textsuperscript{156} In dealing with a preventable disease like AIDS, the broad dissemination of accurate and practically useful information is crucial. The case of the virus in sub-Saharan Africa provides a tragic example\textsuperscript{157} of how quickly and thoroughly AIDS can take hold of a population when there is a widespread lack of awareness about the disease and how it spreads.\textsuperscript{158} Because its spread is preventable given a properly informed population, HIV requires an information vacuum in which to thrive.\textsuperscript{159} Media blitzes like that initiated by the Thai government\textsuperscript{160} are a highly effective way of preventing such a vacuum.

In 1991, Thailand had an infrastructure and communications network in place that allowed it to put its message on general release with confidence that it would reach most of the people it needed to reach.\textsuperscript{161} Such will not necessarily be the case in other parts of the world, where mass media have achieved limited penetration.\textsuperscript{162} In the absence of effective means of mass communication, the prevention and treatment message will have to be carried around developing counties on foot by NGO-affiliated and other public health workers. Most of the funding for these activities will come from the World

\textsuperscript{155} Of course, getting all of these factors to align as they did in Thailand is more easily said than done.

\textsuperscript{156} See Hanenberg, supra note 66.

\textsuperscript{157} In 2005, an estimated 13.3\% of all South African women were HIV-positive; in a troubling sign of worse rates to come, 29.5\% of all South African women who visited antenatal clinics also tested positive. AVERT, South African HIV/AIDS Statistics, http://www.avert.org/safricastats.htm (last visited Feb. 28, 2007).


\textsuperscript{159} If people understand nothing more than the fact that having protected sex and avoiding intravenous drugs will more than likely keep them safe from the virus, they can alter their behavior accordingly and deny the virus room to spread. See generally id.

\textsuperscript{160} Among other measures, the Thai government saw to it that “[a]nti-AIDS messages aired every hour on the country’s 488 [state-owned] radio stations and six television networks, and every school was required to teach AIDS education classes.” AVERT, supra note 2.

\textsuperscript{161} See id.


Across Africa, the radio is the primary communication medium for reaching to the largest segment of the population. The radio is a constant presence on the streets, in homes, market places and workplaces. Radio is also cross-cutting in its penetration, serving divergent populations.

\textit{Id.}
That being the case, an examination of the World Bank's plan to combat the spread of AIDS should provide a good indication of what global prevention and treatment efforts will look like. In its 2005 Program of Action, the World Bank declared that "preventing new infections should still remain the highest priority for all countries — at all prevalence levels." While acknowledging the value and effectiveness of ARV therapy, the program points out the myriad obstacles to its widespread implementation in the near future and reasons that aggressive prevention strategies are the most practical long-term option. Keeping people from becoming patients in the first place is certainly a worthy goal, and it is the appropriate AIDS policy centerpiece in situations where the virus has yet to take a firm hold. With AIDS as entrenched as it is, however, it seems that just as much attention ought to be paid to treating those living with the disease, to both prolong individuals' lives and to ensure that hard-hit countries do not see their working-age populations wiped out.

This is not to say that the Bank's proposal ignores treatment options, or dismisses treatment of existing cases as of secondary importance. Indeed, the opposite is true: in light of the remarkable results from their use in Brazil, the Program announces the Bank's intention to provide ARVs to developing nations at the greatly reduced prices bargained for by the William J. Clinton Foundation. Just

163. "By June 2004, the World Bank had committed US $2.46 billion in credits, grants and loans to 62 low- and middle-income countries for 106 projects to prevent, treat and reduce the impact of HIV and AIDS. About US $1 billion of this sum had already been disbursed." AVERT, Funding the Fight Against AIDS, at http://www.avert.org/aidsmoney.htm (last visited Feb. 28, 2007) (citations omitted). This level of financial commitment makes the World Bank the largest source of funding for prevention work in developing nations. Id.
164. See id. (discussing the work done by the World Bank).
166. Id.
167. Id. at 3, 20-21.
168. "The more successful countries are at preventing new infections, the more feasible they will find it to provide treatment and care to those who are infected." Id. at 3.
169. Thailand's experience is particularly on point, as World Bank President Paul Wolfowitz acknowledges in his Foreword, calling Thailand's case a "significant victory... in turning back the disease." Id. at v.
170. The World Bank estimates that forty million people are currently living with AIDS, and that twenty million have died from AIDS-related causes. The World Bank's Global HIV/AIDS Program of Action, supra note 95, at 8.
171. "Universal access to ART [anti-retroviral therapy] in Brazil has, since 1996, enabled the country to avert more than 60,000 new cases of AIDS and 90,000 HIV-related deaths." Id. at 20. This policy was made possible by Brazil's willingness to take an uncompromising stance in a series of high-profile patent-related clashes with pharmaceutical companies. See supra notes 142-48.
172. The World Bank's Global HIV/AIDS Program of Action, supra note 95, at 21. For details of the Clinton Foundation's work in negotiating the pricing structures of ARV
seems that recognition of the fact that forty million people are already infected\textsuperscript{173} would lead to treatment plans being given a more prominent role in the scheme.

The Bank makes clear its intention to remain one of the main global financiers of AIDS-related work\textsuperscript{174} and to use "its flexibility to fund countries and activities that others cannot or will not finance."\textsuperscript{175} This professed willingness to step into the breach gives the impression that the Bank seeks to transcend political considerations and allocate funds where they will be most effective, irrespective of those considerations. The Bank's status as a multilateral organization frees it to some extent from the policy objectives of its contributors,\textsuperscript{176} but the Program cites, as an example of the challenges the Bank faces, a "social, political and legal climate [that in developing countries] is often inimical to effective AIDS programming."\textsuperscript{177} Examples of this climate are official hostility to proposed needle exchange programs and to the promotion of condom use among FSWs and men who have sex

\footnotesize{therapy for developing nations, see Partnership with International Dispensary Association To Expand AIDS Care and Treatment, July 14, 2004, http://www.clintonfoundation.org/071404-nr-cf-hs-ai-pr-clinton-foundation-partners-with-international-dispensary-association.htm. Under the agreement, one line of common AIDS medications "will cost $140/person/year, one-third to one-half of the lowest price otherwise available in most settings." Id.\textsuperscript{173} \textsuperscript{174} The World Bank's Global HIV/AIDS Program of Action, supra note 95, at 8. \textsuperscript{175} Id. at 5. \textsuperscript{176} Id. \textsuperscript{177} AVERT, Funding the Fight Against AIDS, supra note 163. After naming the World Bank as one of the multilateral institutions responsible for the provision of AIDS funding, the author notes:

These large organisations are able to make their decisions — some more than others — fairly independently of the countries who provide their funds. This means that they can direct funding to countries and projects that might otherwise be ignored by national government or private funders for political reasons or other prejudices. For example, PEPFAR is reluctant to direct AIDS funding to any government that the USA sees as connected to terrorism — although some countries that are so labelled would benefit from HIV-specific donations.

\textit{Id.} The World Bank explains its fund-raising activities in a way that makes the organization sound like a mutual fund:

We raise money in several different ways to support the low interest and no interest loans (credits) and grants that the World Bank (IBRD and IDA) offers to developing and poor countries. IBRD lending to developing countries is primarily financed by selling AAA-rated bonds in the world's financial markets. IBRD bonds are purchased by a wide range of private and institutional investors in North America, Europe and Asia.

with men.\textsuperscript{178} Although the direct reference here is to the developing countries in which the Bank carries out its work, the fact that hostility to such initiatives is described as an obstacle can be read as a subtle critique of the United States’s funding practices.\textsuperscript{179} If the Bank were to air this criticism in a more public forum and in more explicit terms, pressure might begin to build on the United States to base its AIDS funding decisions on effectiveness rather than ideology.\textsuperscript{180} As the organization best placed to analyze need and make projections of programs’ effectiveness in the absence of political accountability to an electorate,\textsuperscript{181} the World Bank should call on the major donor nations to pool their financial resources and allow the Bank to allocate the funds. As the Thai example demonstrated, only by setting political considerations aside can HIV/AIDS be fought effectively.\textsuperscript{182}

CONCLUSION

In 1990 an observer would have had every reason to think that Thailand, with its massive and well-patronized commercial sex industry, would shortly become the global nerve center for the transmission of HIV.\textsuperscript{183} The Thai government’s response, however, was as effective as it was radical: by subordinating domestic policy (specifically enforcement of the ban on prostitution)\textsuperscript{184} to the pressing public health need to educate its citizens and help them prevent HIV transmission, the strategy achieved surprising results.\textsuperscript{185} As effective as

\begin{itemize}
  \item \textsuperscript{178} Id. at 2-3.
  \item \textsuperscript{179} Under the President’s Emergency Plan for AIDS Relief (PEPFAR), thirty-three percent of United States AIDS prevention funds are allocated to programs taking an abstinence-only approach. AVERT, supra note 161. Moreover, PEPFAR also refuses to fund projects and organisations that do not oppose the legalisation of prostitution, and allows faith-based organisations to refuse to provide information about proven methods of protection against HIV/AIDS (condoms) or to refuse to make referrals to clinics or organisations that offer critical prevention services and information.
  \item \textsuperscript{180} The benefits of abstinence-only programs remain speculative at best. See Doctors Denounce Abstinence-Only Education, MSNBC, July 5, 2005, http://www.msnbc.msn.com/id/8470845/.
  \item \textsuperscript{182} The Thai government’s decision to temporarily ignore the illegality of prostitution in favor of educating FSWs and encouraging them to use condoms was a critical element in the program’s effectiveness. See supra text accompanying note 66.
  \item \textsuperscript{183} See Rho-Ng, supra note 27, at 112-13. The menacing spike in HIV infection rates among FSWs in 1989 lent credence to this forecast. Abdel-Monem, supra note 12, at 384.
  \item \textsuperscript{184} See Rho-Ng, supra note 27, at 119; Hanenberg, supra note 66.
  \item \textsuperscript{185} Hanenberg, supra note 66.
\end{itemize}
the program proved to be, however, there is reason to think it is no longer having the impact it once did.\textsuperscript{186} The Thai anti-HIV strategy is in need of modification not because of some fundamental flaw but because of the changing nature of the threat to which it is meant to respond.\textsuperscript{187} Focusing prevention efforts on a discrete segment of the population is unfortunately no longer an option: the disease has spread beyond "high risk" groups and into the general population. Finding a way to reach these people with a coherent and persuasive prevention message, as well as effective treatments, is the next challenge facing the Thai government and multilateral organizations like the World Bank.

As an indication of what the global anti-HIV community has learned and where its future efforts will be directed, the World Bank's Global HIV/AIDS Program of Action\textsuperscript{188} demonstrates that the strategic and logistical components of prevention and treatment are much better understood than they have been in the past.\textsuperscript{189} The Thai triumph of the 1990s was the product of an especially fortuitous combination of factors,\textsuperscript{190} and to expect comparable results elsewhere is likely to result in disappointment.

As the scientific community works toward developing a cure, there are a few important lessons to keep in mind from the Thai fight against HIV. The first is that condoms are an indispensable component of an effective prevention and containment strategy.\textsuperscript{191} As a corollary, abstinence-only sexual education is not a viable substitute and should be phased out wherever possible.\textsuperscript{192} The second main point, drawn from more recent developments in Thailand, is that members of "high risk" populations often have sex with members of otherwise "low risk" populations,\textsuperscript{193} and prevention messages must be targeted beyond the traditional high-risk groups.\textsuperscript{194} The final point, and perhaps the most problematic given the financial and

\textsuperscript{186} Beyrer, supra note 9, at 218.
\textsuperscript{187} See Kongsin in LINGE AND PORTER, supra note 94.
\textsuperscript{188} The World Bank's Global HIV/AIDS Program of Action, supra note 95.
\textsuperscript{189} See id. at 49 (charting the Bank's goals and specific actions needed to carry them out). The document's focus is on prevention, but its recognition of the effectiveness of and expanding need for ARV treatment is worth noting. See supra text accompanying note 168.
\textsuperscript{190} The Thai success was the product of a well-financed multimedia public-education campaign, undertaken in tandem with an extravagantly-funded condom distribution and brothel monitoring scheme (brothels were still the primary locus of commercial sex activity, which no longer appears to be the case). See supra text accompanying notes 92-94.
\textsuperscript{191} Nelson, supra note 88, at 814.
\textsuperscript{192} See MSNBC, supra note 180.
\textsuperscript{193} Nelson, supra note 88, at 814. See AVERT, supra note 2.
\textsuperscript{194} Id.
intellectual property issues implicated, is that ARV therapy must play an increasingly prominent role if the effect of AIDS on society is to be contained. Scientific research will hopefully yield a cure for AIDS in the foreseeable future. Until then, the disease will continue to kill on a fearsome scale and threaten the fabric of society in the places hardest hit. The world cannot afford to ignore valuable lessons like those provided by the Thai case.

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195. The World Bank’s Global HIV/AIDS Program of Action, supra note 100, at 21. Of special importance in stopping the intergenerational spread of AIDS will be drugs like nevirapine, which help prevent transmission from mother to child. See AVERT, Preventing Mother-to-Child Transmission of HIV, supra note 150.

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