AMDA NEWSLETTER

THE ASSOCIATION OF MEDICAL DOCTORS FOR ASIA

VOL.3 NO.1 NOVEMBER, 1988 ISSN 0857-7412

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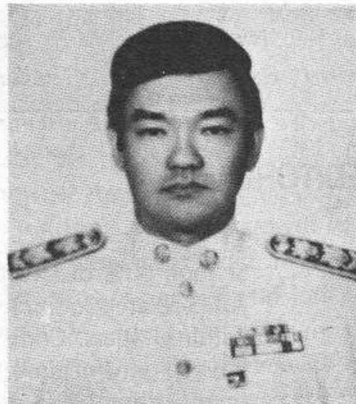
PROF. D. MUANGMAN

CURRENT AIDS SITUATION IN THAILAND



Prof. Debhanom Muangman gained his doctorate degree in public health from Harvard University in 1968. He has become dean of the Faculty of Public Health, Mahidol University since 1976. Being appointed consultant to many local and international organizations, Prof. Debhanom has been very active in the fields of public health and social development in Thailand.

At present, Thailand has about 52 million population with the growth rate of 1.6%. About 75% live in rural areas with the average per capita income of US $600 annually. Since 1985 up to the present time, Thailand had 6 confirmed AIDS patients who were all dead. Two of them were Thais. Both were homosexual. One got the disease in California, diagnosed there, and died at Ramathibodhi Hospital, Bangkok within one year after contracting AIDS. The other Thai male never went abroad but had a German boyfriend whose blood was positive for AIDS but is healthy at present. This second Thai man died last year at Chulalongkorn Hospital, Bangkok. Most physicians and nurses who treated them never used any precaution in handling the patients, needles, etc. It remains to be seen what would happen to them later on. Two other patients were homosexuals. One was a Negro hairdresser who worked and gave service to people at the U.S. Embassy in Bangkok. Both of them were sent back to USA and died within one year. Two other patients came from European countries and were sent back and at present all were dead. Now, there are no AIDS cases in Thailand. Since August 1986, the Ministry of Public Health of Thailand had passed the regulation requiring all clinics and hospitals to report AIDS cases within 24 hours. How

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AMDA NEWSLETTER

A MONTHLY PUBLICATION OF THE ASSOCIATION OF MEDICAL DOCTORS FOR ASIA

PURPOSES

1. To publish information about AMDA activities.
2. To provide a venue of communication among AMDA members.
3. To be a forum for AMDA members to express ideas and comments.
4. To publish articles about health care and community development

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EDITORIAL

Dr. Nipit Piravej

In this issue of AMDA Newsletter, we decide to bring AIDS (Acquired Immune Deficiency Syndrome) into our focus with 2 special reports from Thailand. It is not our intention to follow the vogue, nor is it our purpose to create any unnecessary sensational feeling on the topic. But it is actually because the problem of AIDS in Asia has already reached a point that we can no longer ignore. The present impact of AIDS in Asian communities is great because of the following reasons.

1. AIDS is no longer an isolated problem for western communities.

2. AIDS is no longer an isolated problem among homosexuals.

3. AIDS is a time-bomb type of problem, According to a recent report from Harvard Medical School, 80% of HIV positive patients would develop AIDS-related complex (ARC) or full blown AIDS within 8 years. Consequently, one AIDS carrier may have plenty of time to spread the virus around to many other persons before he himself succumbs.

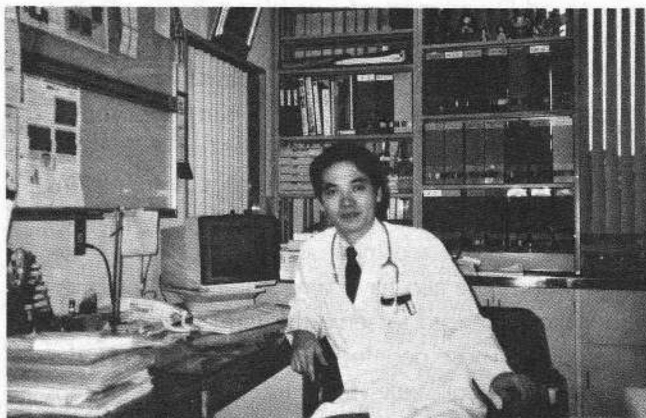
4. AIDS, even at the early phase, still lacks effective treatment. This make the high risk groups hesitate to do any screening test, let alone to cooperate in any official AIDS registration program.

5. The public health authorities in most Asian countries are still not ready to cope with this increasing precarious situation.

Moreover, another special aspect of Asian AIDS problem, at least in Thailand, is that a large proportion of the present HIV positive patients are drug addicts in low socio-economic urban slum areas. This make the problem even more difficult to be controlled.

We realize that AIDS will continue to be a problem in the ninty and only 2 articles are not enough to cover all aspects of the Asian AIDS problem. However, we hope that these will provoke some interest among the AMDA members on the topic. We do welcome your comments, data, articles or even the proposals of some projects to be implemented in the community. I am certain that a lot of grants are still available for good projects in this field.

The Editor



Message From The President

Dr. Shigeru Suganami

Dear Friends,

I am very happy to send this message in the ocassion of begining the publication of **3rd volume of AMDA - INTERNATIONAL's newsletter** from Thailand, a pride nation of Asian Continent for its great cultural heritage and growing economic importance.

It was a long felt dream for AMDA members to publish and circulate the newsletters to exchange our views and to introduce ourselves to the external world. After completing two years of AMDA activities we succeeded to bring out the first newsletter Volume 1, Number 1, in November 1986. Since then, the newsletter has gradually grown up along with the growth of Association of Medical Doctors for Asia (AMDA) Now we are proud that we have Hongkong, India, Indonesia, Japan, Malaysia, Philippines, Singapore and Thailand a total of seven countries as members who have joined hands across the limitations of race and region to realize the dreams of AMDA. There are a few more nations who will join AMDA in the near future.

Now, it is certain that the AMDA newsletter will come out with more creativity under the dynamic editorship of Dr. Nipit Piravej and his friends who have joined hands with him in the editorial board. I request to all our AMDA companions to support them in sending news, articles and special reports in large numbers than before. Let us make this AMDA newsletter as a forum to enhance friendship and mutual understanding.

As medical professionals, we have to progress and prosper ourselves and then only we would be able to nourish AMDA in every manner. AMDA companions, being most of them young & enthusiastic doctors must achieve these two goals with equal importance. Medical service, education and research are the three important areas of operation for doctors which will lead any individual of any organization in the path of development. Let us keep this in our mind and strive incessantly to realize our common dream **"BETTER MEDICINE FOR A BETTER FUTURE"**

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CURRENT AIDS SITUATION IN THAILAND

can they report AIDS cases when most doctors, nurses, and other health personnel do not know what AIDS patients look like? The laboratory centers which can test for AIDS are few and are mainly located in Bangkok. The Ministry of Interior of Thailand in 1986 also passed a regulation giving the Immigration Office the authority to deport AIDS patients from Thailand. However, they can't do anything to foreign tourists with AIDS-related complex (ARC) and those with blood positive for AIDS which have been confirmed by Western Blot tests.

This year is being promoted as the "Year of Tourism" in Thailand. Normally, about 2 million tourists from abroad visit Thailand yearly. In 1987, it was estimated that about 3 million tourists from all over the world will visit Thailand. This is a matter of great concern for health academicians and health officials because Thailand is a fertile ground for AIDS propagation. At present, we have the following:

1. Female prostitutes	600,000
2. Male homosexuals	200,000
3. Drug addicts (most of them used heroin and shared needles)	600,000
	1,400,000

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In addition, most of our blood banks do not test blood for AIDS because it is very expensive. A lot of people came to donate blood on various important occasions such as the King's birthday, New Year's Day, etc. A large number of those who committed various crimes and were put in prisons also like to donate their blood in order to increase their good conduct and merit and get an early release. In the prisons, we also have large number of foreigners who were sentenced to serve the term there because of narcotics. These people have had sexual episodes with their Thai colleagues there too. Thus, the prisons are another vulnerable spots besides the unprotected blood banks.

According to the large AIDS blood survey carried out during 1985-86 by the Communicable Disease Control Department, Ministry of Public Health, in several popular tourist places such as Patpong area in Bangkok; Pattaya; Chiengmai in the North; Korat in the Northeast; Hadyai and Phuket in the South, about 6,000 blood specimens were drawn from male homosexuals and female prostitutes. Elisa Tests were done and confirmed by Western Blot tests. They are as follows:

Total blood specimens	6,000
Blood positive for AIDS	29 (0.5%)
a. Healthy (no symptoms and signs)	17 (0.3%)
b. ARC (with lymph node enlargement, etc.)	12 (0.2%)

Most of the above blood positive for AIDS cases were male homosexuals who had frequent contacts with their foreign tourists in the past. Few were female prostitutes. These people were advised to change their profession in the bars and night clubs and were followed up quite closely every month. Although the blood positive tests are still small in percentage, however, only 0.4% of the estimated total of 1.4 million prostitutes, gays, and drug addicts were tested. Those who go to work in the Middle East countries also were required by the Arab nations to have blood tested for AIDS. Up to the present time, about 60,000 blood specimens were tested, 39 cases were found to be positive to Elisa tests and only 5 (0.008%) were confirmed by Western Blot tests. These 5 cases were male homosexuals who had sexual contacts with foreign tourists. Most of the Thai workers who go to work in the Middle East usually come from rural areas where they have almost no sexual contact with foreign tourists. It can be emphasized here with confidence that AIDS disease is not endemic in Thailand like malaria, Dengue hemorrhagic fever. This new viral disease came with the infected foreign tourists who visited Thailand on their business or pleasure trips. The average cost of an Elisa test is 40 bahts (US $1.6/test) and the Western Blood test costs 200 bahts (US $8/test). This second test is viewed to be very expensive by most Thai people.

The Ministry of Public Health has established the AIDS Prevention and Control Committee since 1985 composing of various representatives fr[illegible] both public and private health agencies. However, because of the "Year of Tourism" in Thailand in 1987, all mass health education campaigns and seminars were banned by the Thai Government. In addition, the blood surveys on more prostitutes, gays, drug addicts, convicts in prisons, blood banks were carried out at a very slow pace because of a very limited budget. The health professionals and the public were not well-informed about the cause of AIDS and how to prevent, control, and protect themselves. The Ministry of Public Health has requested some AIDS fund from WHO. I, myself, had written about AIDS in column "LONG LIKHIT" in Thai Rath newspaper, the most popular Thai newspaper, in the first week and the third week of January 1987 informing the public about the cause, signs, and symptoms of AIDS, and how to protect themselves. Two million copies went to the people so far but about 60% of Thai people read newspapers. Other mass media channels have to be utilized soon. We need assistance on AIDS test kits of both Elisa and Western Blot tests. The diagnosing centers should be established in 4 regions of Thailand, i.e., North, Central, Northeast, and Southern region, using Bangkok as the headquarters. The financial assistance on training of health personnel and the use of mass media is also very much needed in the nearest future.

Dr. Praphan Phanuphak, Associated Professor of Internal Medicine and Immunology at Chulalongkorn Hospital Bangkok graduated medicine in 1969. He gained his doctorate in Microbiology (Immunology) at University of Colorado Medical Center in Denver, and later also earned Diplomat American Board of Internal Medicine in 1977 and American Board of Allergy and Immunology in 1979. Dr. Praphan is now an authority in the study of AIDS in Thailand.

Dr. Praphan Phanuphak

AIDS Perspectives: Thailand 1989

Since the emergence of AIDS in Thailand in late 1984, AIDS has become a public health and social problem in the Kingdom as well (1). As of 15 October 1988, 1,436 cases of HIV infection have been reported to the Ministry of Health, 9 of these were full-blown AIDS cases (2). Besides these alarming figures of increasing number of infected individuals, the spread of HIV infection among intravenous drug users (IVDU) is astonishing. It was less than 1% at the end of 1987 then rose to 16% in May 1988, and is over 40% in October 1988. These figures were dervied from the examination of several thousands of IVDU who attended the drug dependence treatment centers in Bangkok metropolitan area. One has to consider that these HIV positive individuals represent only a small proportion of the total number of IVDU in Thailand.

The problem of HIV spread among drug addicts threatens the heterosexual community, since many drug adicts do have heterosexual contacts as well. Newborns are now also at risk. In fact, the first baby of an infected IVDU mother was born at Chulalongkorn Hospital in July 1988, and several more infants were born since then. Thirty to fourty percent of babies born from HIV-infected mothers will eventually show evidence of HIV infection (3). AIDS as a pediatric problem has now arrived in Thailand. Indeed, the first infant with full-blown AIDS was diagnosed at Ramathibodhi Hospital in November 1988. The mother was not an IVDU.

The tragedy of the pediatric AIDS problem is compounded by the possibility that some infected IVDU mothers may abondon or "sell" their children to others. This calls for immediate action from governmental and non-governmental organizations to provide shelter and other relief for such unwanted and potentially infected babies.

Thailand is currently spending considerable funds and resources to detect new HIV infected individuals and to monitor the epidemiologic trend on HIV infection among several high-risk groups. These include IVDU, male homosexuals as well as male and female "sex workers". However, the governmental infra-structure for pre-and post-test councelling and follow-up has not yet been fully developed and does not keep pace with the rapidly growing number of tested persons with positive HIV tests. For example, many of the prostitutes and IVDU do not know what the implications of having an HIV test are, and are often not even told then results of the test that has been performed. According to a recent survey by the Center for AIDS Research and Education (CARE) of the Thai Red Cross Society, *almost all of the female prostitutes questioned, considered having a regular AIDS test as a means that would help protect* them from the diasese (4). There was, unfortunately, still a great deal of ignorance about transmission modalities and risks discovered in this survey. Most surveys have, unfortunately, not collected adequate data concerning beavioural and other factors that might result in increase or decrease of the risk of HIV infection in Thai cultural and social setting. Such data are urgently needed to intervene and to reduce risk. According to the CARE survey, almost all female prostitutes perform some type of perineal and vaginal cleansing immediately after sexual intercourse (4). Some use antiseptic solutions and soaps as well. Whether this kind of practice is effective and might explain the continuing low prevalence of HIV infection (less than 0.5%) among Thai female prostitutes, remains an unanswered question).

One also has to understand that treatment for STDs is readily available in Thailand and that most genital ulcerations are not left without being medicated. Virtually all larger massage parlors and many bars that employ "Service Girls" have a contract with a physician and/or nurse who regularly (usually weekly) examines the girls and treats all genital lesions. This practice may also act as a retardent of infection in this community. No such retardent exists in the IVDU group.

One has to recognize that many seropositive IVDU and prostitutes in Thailand are still injecting drugs and selling sex respectively. The government authorities know about this, but are just as unable to stop this as governments elsewhere in the world have been. They do not have sufficient personnel and funds to counsel, educate and follow each infected individual. On the contrary, many HIV-infected IVDU were dismissed from inpatient drug-dependent treatment centers once they were found to be HIV seropositive. Finally, the news have just been released that in 1989 the Thai Ministry of Health will set up a drug-dependent treatment center which will house and treat only HIV-infected IVDU on a voluntary basis. Occupational and community therapies can be integrated in this treatment center. A similar approach is also needed for infected sex workers. This is even more of a problem because selling sex is the only way in which most of these individuals can earn their living.

Many high-risk individuals are afraid of participation in anti-HIV testing programs. These are often the well educated middle class. They are either afraid of discovering that they are sero positive or of being known by the public as members of HIV high-risk groups. In order to avoid such fears, alternative anonymous test sites for anti-HIV are needed in Thailand. Although testing would be anonymous, pre-and post-test counselling can still be given in leaflets followed by confidential personal interviews. Such an approach should help to prevent the further spread of HIV infection by most of these individuals.

Every expert agrees that education of the high-risk groups as well as of the general public is the best currently available tool to fight the spread of AIDS. However, the currently available educational materials in Thailand are not tailor-made to suit the need of individual high-risk groups. For example, many of the female prostitutes are illiterate and most do not have time to watch the television news. Many of the booklets about AIDS are difficult to understand or not attractive. Many bar or brothel managers do not like to have AIDS posters in their premises because they think that this will make the bar look like having an AIDS problem. Therefore, further planning among communication specialists and health educators is neededs to develop effective educational materials to suit the need of various high-risk groups. Fortunately, suppression of an anti-AIDS campaign because of fear of a negative impact on tourism is not the policy of the present Thai Government.

Let's turn to the medical aspects of AIDS in Thailand. By now, almost all Thai doctors and health-care workers have heard and know about AIDS from various sources. They know how to suspect a case of HIV infection and how to prove it, i.e., by an anti-HIV test. Begining October 1988, every provincial hospital throughout Thailand has been equipped with an ELISA machine as well as the reagents to perform anti-HIV testing. The primary purpose of this is to screen every unit of donated blood for HIV infection. Although more than one million US dollars are needed for this nationwide operation, everyone can be assured that the blood that one is getting has now been made as safe as possible. Every doctor in any part of Thailand can now request anti-HIV screening without delay and at a reasonable cost. The only problem that may still remain is the confirmatory test, especially in the groups with low prevalence rates. Only certain centers in the country are equipped and competent in performing a confirmatory test, particularly the immunoblot assay.

Making the diagnosis of full-blown AIDS is sometimes a difficult task. It requires expectise, equipment as well as the willingness of the expert to perform definitive diagnostic tests such as bronchoscopy or esophagoscopy, diagnosis of full-blown AIDS has therefore to be made on clinical grounds in most cases.

Unjustified fear among health-care workers is an expected reaction but can sometimes jeopardize the care of the patients. This is partly due to misconceptions. Therefore, extensive and continuous counselling and education of health-care workers is also needed as well provision of an adequate and safe working environment.

The only acceptable anti-HIV drug currently available in Thailand, as well as in the rest of the world is zidovudine (azidothymidine). It prolongs life but does not cure. The drug is very expensive and has many side-effects. Most Thai patients cannot afford it or cannot tolerate its full dose. Therefore, its applicability to Thai patients is rather limited.

Many other anti-HIV drugs and immunomodulators have been tried in several stages of HIV infection. Most of these trials have been carried out in USA, Europe and Africa where there are more patients with AIDS. We have urged our Ministry of Health to consult with WHO and to negotiate with pharmaceutical companies to carry out promising drug trials in Thailand as well. Such new drug trials may also attract more high-risk individuals to appear for blood tests and follow up. Even if these trials are double-blinded, some patients will benefit, provided that the drug has passed its first phase toxicity study. Vaccine trial will be most appropriate in high-risk populations where the prevalence rate of infection is still low. Thai male homosexuals and sex workers are among the most appropriate groups for any future AIDS avccine trials.

In conclusion, although prospects to prevent AIDS from spreading in Thailand look rather dim, there are still many things that one can do. We all should aim to retard the spread of this epidemic rather to eliminate it. This needs prompt and collaborative efforts from all governmental and non governmental bodies.

December 1, 1988.

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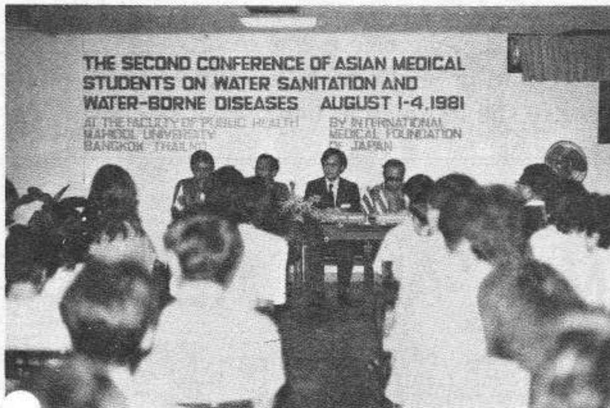


The Second Asian Medical Student Conference, 1981

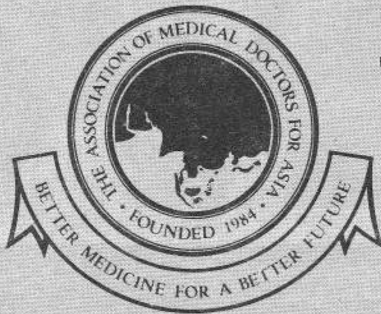
NEWS & NOTES

Dr. M. Doshi visited AMDA president, Dr.S. Suganami at the Suganami Hospital.

DR. DOSHI IN JAPAN

Dr. Minaxi Doshi, MD, DGO, DFP; Gynecologist and Obstetrician of "K.K. Maternity and General Hospital" and member of AMDA India visited Okayama from 18th to 25th September. After presenting a paper in Osaka in the 10th annual conference of Research Society for Ayurveda in Japan, Dr. Minaxi came down to Okayama and stayed in Suganami Hospital's guest house.

During her one week stay in Okayama, the young lady doctor visited a private Obstetric and Gynecology hospital and also paid a visit to Ob. & Gy. department of Okayama University Medical School. Besides the sight seeing of the places of interest in the vicinity of Okayama, nice exchange of views between the visiting doctor and AMDA President Dr. Suganami were held to promote international friendship. After completing Okayama visit, Dr. Minaxi left for Tokyo from where she returned to India.



THE 1989 AMDA-AMSA MEETING

(THE 10th ANNIVERSARY AMSA CONFERENCE)

AUGUST, 1989 - KOBE, JAPAN

TOPICS INCLUDE:

ASIAN RURAL HEALTH PROBLEMS
HEALTH PROBLEMS AMONG LABOR
HEALTH PROBLEMS AMONG REFUGEES

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