From Family Planning To HIV/AIDS Prevention To Poverty Alleviation: A Conversation With Mechai Viravaidya

Thailand’s “Condom King” shares his views on how to improve health status by changing health behavior.

by Glenn A. Melnick

ABSTRACT: In this interview, Mechai Viravaidya shares how he harnessed the media and various other distribution channels in Thailand to launch nationwide programs aimed at changing attitudes, beliefs, and health behavior in very controversial and difficult areas, such as sexual behavior in the context of population control and HIV/AIDS. He provides insight into the leadership skills required to change cultural beliefs in order to achieve public health objectives. And finally, he describes how his thinking has evolved and broadened to include poverty alleviation and improved management and sustainability models for non-governmental organizations (NGOs) as the most effective way to improve health status in the long run. [Health Affairs 26, no. 6 (2007): w670–w677 (published online 25 September 2007; 10.1377/hlthaff.26.6.w670)]

Glenn Melnick: Senator Mechai, could you describe your role in aiding Thailand to become a model for a successful national family planning program in the 1970s?

Mechai Viravaidya: In 1972 Thailand had fifty-four million people living in an area slightly larger than California [where the population was about twenty million]. On average, a Thai family had seven children, and the population was growing at 3.3 percent per year. The Thai government recognized that to meet the people's basic needs, something had to be done about rapid population growth. The only contraceptives available then were condoms and the pill, and only 15 percent of married women used any form of contraceptive. The pill was the most effective and popular method, but Western standards required that doctors prescribe it. With only nine doctors per million people in Thailand at the time, we needed alternatives to meet the need. So we proposed having nurses, and then midwives, prescribe oral contraceptives. This strategy worked extremely well because it was women helping women, whereas most physicians were men. But it covered only the urban areas and villages in close proximity, while 80 percent of the people lived in rural villages with no access to government health workers. That's when we had to change our thinking.

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We realized that people who need family planning are not sick. In fact, they are very healthy. That's why they're having so much sex. Why do you need the doctors or nurses or midwives to prescribe contraceptives?

When the Royal College of General Practitioners of Great Britain endorsed medically supervised nonphysician distribution of contraceptives in 1974, we seized the opportunity to propose community-based distribution of contraceptives. This approach trained members of the community to distribute contraceptives in every village, with medical backup. Now we could cover every village in the entire country. There were shopkeepers, dressmakers, hairdressers—we even had golf caddies—distributing pills and condoms in villages. These were respected members of the community providing oral contraceptives at an affordable price using a checklist to screen for contraindications. That was the beginning, and Thailand's population growth rate came down and down. By 1984, the annual population growth rate fell to 1.6 percent (it is 0.5 percent today), and 65 percent of Thai couples were practicing family planning. Today Thai women have on average 1.9 children. Community-based distribution of contraceptives has been adopted by the government throughout the country. Some other countries have followed suit. Unfortunately, most countries in the world still believe that you need overworked physicians to prescribe the pill, which is really a failure of health policy.

Melnick: In this campaign where you introduced and promoted the use of condoms, did you meet any resistance? And if so, how did you overcome it?

Viravaidya: The condom was not a major contraceptive at the time. In fact, little was known about any of the conventional methods. When I talked to large audiences about the pill, the IUD [intrauterine device], and sterilization, I received blank stares. I needed something to catch their attention. One day, during a training session for a thousand teachers, I pulled out a condom and started blowing it up. The teachers roared with laughter. Maybe I'm onto something, I thought. I had to think fast, so I said, “The condom is a great friend. You can do many things with it. You can use it as a balloon. You can put Coca-Cola into it. You can use the lubrication for after-shave lotion. You can use different colors on different days—yellow for Monday, pink for Tuesday, and black when you're mourning. You can use it as a tourniquet for snake bites.” The laughter escalated, so I seized the moment. “If you've never seen a condom, why don't you take one and have a good look.” My staff, mostly women, distributed condoms to the entire audience. The teachers were laughing as they handled the condoms. So I said, “Now pull it out and blow it up.” And the audience erupted in laughter. That was the beginning of the condom blowing championships for teachers. In five years we trained 320,000 rural schoolteachers, who in turn taught their students and children. They realized that the condom is not a dirty product. It doesn't kill. It became normal.

Melnick: So it was a symbol for you?

Viravaidya: It was a potent symbol; it was the advertising program. It was the aria, and it was the overture. It desensitized the issue of contraceptives and sex. Rather than getting embarrassed, people laughed. We even had policeman distributing condoms at traffic lights. We called it our “Cops and Rubbers” program.

Melnick: And how did a condom come to be known as a “Mechai”?

Viravaidya: When I first began passing out condoms ubiquitously, not everyone was amused. A satirical article, “The Mechai Story,” appeared in the press, spoofing the movie Love Story. The author wrote, “If this guy likes condoms so much, let's call a condom a 'Mechai' and see how he likes it.” This was a public relations windfall—the opportunity to have con-
doms become synonymous with my name was too good to be true. I seized the opportunity and have used it to my advantage ever since.

**HIV/AIDS Prevention**

Melnick: I would like to move to a related topic: HIV/AIDS in Thailand. After your successful family planning efforts in Thailand, the prime minister asked for your help with the emerging HIV/AIDS problem. That campaign began with controversy in the late 1980s, when you challenged the government’s position that there wasn’t an HIV/AIDS problem in Thailand. Weren’t you afraid that you would be silenced or lose support for taking such a strong position?

Viravaidya: I have always taken strong positions. If others regard it as controversial, I don’t mind. As long as I believe that my position is honest and correct, I just keep on going. When HIV/AIDS emerged in Thailand, I knew how many lives could be at risk. We had to be open and honest and provide public education. I’ve never worried about my own welfare, because if I die, there are sixty million other Thai people who can take my place. When you think you are indispensable, your effectiveness is marginalized. So I didn’t mind if people didn’t agree. I was proven right because what I was doing was honest.

Melnick: And your previous experience with family planning had reinforced in your mind that taking unpopular positions is necessary when you’re dealing with a crisis like HIV/AIDS?

Viravaidya: In this case, I had solid evidence that something had to be done. A study in 1990 had estimated that if nothing was done about the impending HIV epidemic, by 2000 up to four million Thais could be infected, 460,000 deaths from AIDS could be expected, and the direct and indirect costs of the disease would reach $8 billion. When Prime Minister Anand Panyarachun in the interim government asked me to be the minister for tourism, public information, and mass communications, I proposed one addition to the portfolio: that I become the temporary AIDS czar and that the prime minister become the real AIDS czar, because without support from the country’s top leadership, you cannot solve the multifaceted issues surrounding HIV/AIDS. It’s more than a health problem. It’s a behavioral problem, a societal problem. It requires total war.

Melnick: What transpired after you assumed the HIV/AIDS portfolio?

Viravaidya: The key was to develop a national AIDS information program that was inclusive. It had to involve the business sector, the religious sector, and the educational sector, in addition to the government. Everyone joined. Gas stations and McDonald’s restaurants gave out condoms; banks and insurance companies distributed printed AIDS information to their customers and to the public. Cars passing through toll booths received AIDS information and condoms with their change. We made it compulsory for all radio and television stations to provide free air time for thirty-second AIDS education messages every hour. In return, each station was given a half-minute extra per hour to advertise and earn more money. And we involved movie theaters. We also gave a subsidy to TV and radio production houses if they put correct AIDS information into their regular programming.

Melnick: How do you explain the change from the Thai government’s initial reluctance to admit that there was a problem to, a short time later, its embrace of a total commitment to fighting the problem?

Viravaidya: When the HIV/AIDS crisis first materialized, Thailand had a government led by people who would not acknowledge the problem because broadcasting AIDS information on radio and television would scare away tourists, and this would be a disservice to the country. My position was the exact opposite. If we do nothing, one day the whole world will...
be scared away because Thailand will be full of AIDS. The more public education on HIV/AIDS, the more enlightened Thai people would be, and the more the tourists would appreciate it. As it turned out, a subsequent survey of Thai attitudes towards AIDS vindicated my position. Although Thai people were uneducated about AIDS, they were interested in learning. We had to give them the facts.

When a new government led by Prime Minister Panyarachun came to power in 1991, things changed completely. The new prime minister was a very enlightened person. He listened to my reasons and agreed to the “total war” on HIV/AIDS.

Melnick: What is the situation in Thailand today with regard to HIV/AIDS?

Viravaidya: Much has been achieved, but more needs to be done. The inexorable spread of HIV that was feared in the early 1990s has been checked. The number of new HIV cases annually has fallen. Most importantly, there is irrefutable evidence that the high-risk behaviors that facilitate HIV transmission have modulated. Thai men visit sex workers less often, and when they do, they are more likely to use condoms. There is a 100 percent condom policy at commercial sex establishments that is vigorously enforced. There is still a multi-sectoral HIV/AIDS committee chaired by the prime minister.

However, the battle against HIV is never won. Recent years have seen a resurgence of HIV infections among some groups, especially adolescents and pregnant women. And there are signs that the Thai government’s commitment to controlling HIV/AIDS is wavering. Since the Asian Financial Crisis of 1997, public expenditure on HIV/AIDS has fallen by 50 percent. Such myopia will have long-term consequences unless it is quickly rectified.

Poverty Reduction

Melnick: Senator Mechai, you began your work in family planning and health care and now focus more of your efforts on poverty reduction. Why this change in focus, and have you given up on health care?

Viravaidya: Many organizations in the developing world—admirable organizations—do excellent work providing health care. Some give it away free. Some sell socially marketed health products. They are all trying to solve health problems that are the consequence of
poverty, but they don’t address the root cause of poverty. Hence, they will never be sustainable. Once they stop providing free health care, the good health care stops. As for those who sell health care services or products, be it malaria bed nets, contraceptives, or oral dehydration solutions, they are basically serving the upper end of the poor, leaving the poorest unserved.

Why can’t we do two things? First, continue to provide free or low-cost health care, medications, and so on, but also have a program for those who are poor and can’t afford to buy these health products. Help them engage in business, become barefoot entrepreneurs, and earn a profit so that they can spend some of that profit on health care. This approach enables those who can’t afford it to pay for their health care, and that’s the difference. It becomes sustainable.

So, to answer your question, I have not given up on health care, but now we try to address both sides of the coin—providing health care and trying to reduce poverty by providing loan funds to poor people: train them, let them do business so they can use part of that newly earned income to pay for their health care. Eventually they can pay for some educational needs and even prevent exploitation.

**Melnick:** It seems that an important element of this approach is an expanded role for the private sector in reducing poverty. What role do you see for the private sector beyond non-governmental organizations (NGOs) in reducing poverty and improving health?

**Viravaidya:** Poverty prevents people from reaching their full potential. Unfortunately, nearly all attempts at reducing or eradicating poverty have been done mostly by government and partly by civil society or NGOs. And both have produced few positive results because they view people living in poverty in one narrow dimension. You are poor; you deserve help; we will help you with government officials or NGOs using a welfare approach. To me, that is the wrong approach, using the wrong doctor and the wrong medicine.

You need to look at the poor in another dimension and ask, “What do they do each day?” And you will find out that some pick up garbage, some raise chickens, some grow vegetables, and some sell food. What are they doing? They are engaged in business, trying to make a profit just like anybody else. Unfortunately, that doesn’t happen very often, so they remain poor. Why do they remain poor? Why can’t they move on like everybody else? Two very simple reasons: One, they lack the basic business skills required to have a successful business. Two, they lack capital and the opportunity to borrow at market interest rates. Instead, they have to borrow from usurious money lenders at interest rates that can be twenty times higher than rates paid by rich people. The principal impediments that keep people in poverty are lack of business skills and lack of credit. To address the issue of poverty, we need to solve these two problems: teach them how to do business, and help them locate sources of credit. And who can teach you how to do business? Government officials? Highly unlikely. Government doesn’t know how to make money. It only knows how to take money. NGOs? Also unlikely. NGOs have big hearts but not much acumen for business.

And who does have the skills for business? It’s the business sector. We’ve got to understand that the only road out of poverty is through business, and the only people that can teach you business are business people. In my opinion, there is no way to get the people out of poverty without the close cooperation of the business sector. It is not the UN [United Nations]. It is not universities. It is not government. It is the business sector.

**Melnick:** You have combined this approach toward poverty reduction with HIV/AIDS control through your “Positive Partnership” program. Can you tell us about that model?

**Viravaidya:** While preventing transmission of HIV is essential to a successful HIV/AIDS control program, not enough is being done for people who are already living with HIV. Many are suffering from discrimination and lack of income. Often they have lost their jobs, used up their savings, and gone back to their village communities, where they are living off the kindness and generosity of family and friends.
And before long, they're sick of it and they don't know what to do. So we have introduced a program where we lend money to HIV-positive persons who find themselves a partner who is not infected. The loan is made to the two partners for business ventures. The person who is not infected has the responsibility of changing attitudes and behavior in their community towards people living with HIV and AIDS. This program, which we call Positive Partnerships, has created new lives for these HIV-positive people. Discrimination rates are down, they're accepted in their community, their income is good, and 84 percent of the partnerships repay their loans on time. This is higher than repayment rates for regular bank borrowers. Under the Positive Partnerships program, people living with HIV are seen as an asset in their community. They are a source of capital for the community. Now they're appreciated because they are helping their community, and they are spreading understanding and tolerance. It's a truly magnificent project whereby people who were literally given up for dead and hopeless are now becoming a very key element in their communities. They speak at schools and help influence local governments. It's just turning total defeat into a wonderful victory.

**Melnick:** Are you expanding this model to other stigmatized populations?

**Viravaidya:** The Positive Partnerships program has demonstrated that when you put something strong together with something that is not so strong, it becomes like a giant venture. That's why poor countries want foreign investment—to put something strong together with something weaker. We want to expand the program to help people who are handicapped, widows, the elderly, sex workers, migrant workers who are exploited, or people who've been incarcerated. All of these disadvantaged groups can be helped with the Positive Partnerships program. Since the loans are used to start business ventures, it also enables these people to earn an income. Before long, they'll have more money, which they can use to pay for their health care. This goes back to my previous point: When you're providing health services, the “welfare” approach provides benefits in the short term only. But if you combine health with income-generating activities, it can be sustainable in the long term.

**Melnick:** Is the expansion of the Positive Partnerships model to these other vulnerable groups a function of the amount of money available, or is it that these people are difficult to find?

**Viravaidya:** These programs are very easy to expand with more money. It's just that nobody thought about it because, in the case of HIV/AIDS, these people were given up for dead. As it turns out, they're very wonderful, remarkable people. They are so resilient and so grateful because in the past no one would lend them money. Even if you don't get the return rate that we get, it's worth doing because of the tangible and intangible benefits. First, the loans turn these people into productive members of society. Second, they now have a source of funds to pay for their HIV/AIDS treatments. And third, there is the reduction of stigmatism. They're helping spread understanding, tolerance, and acceptance. That is the multiplier effect. And it's a win-win-win situation. Your beneficiaries are not only the people living with HIV/AIDS—or other vulnerable groups, if the program is expanded. It's everybody. The community wins, the local government wins, and the people in these vulnerable groups win.

**Using Media For Behavior And Lifestyle Change**

**Melnick:** Many, many people say that you're a genius in mobilizing the media to help you in getting your public health and other messages out to populations who need it most. What are some early examples of how you've used the media to your advantage?

**Viravaidya:** The reason I mobilized the media...
to do things was because I had no money. If I had the money, I could just pay them to broadcast my messages. I had no money whatsoever, so I had to come up with things that the media found interesting, that they would like to publish or publicize. For instance, we would stage condom blowing competitions on the streets, and, of course, the newspapers would come. We had a special vasectomy day on the Fourth of July to vasectomize American men, to show our appreciation for America's foreign assistance and to signify that Thailand also wanted to give foreign assistance back to America. And the press came. At one time there were many counterfeit coins in circulation, so we had a program where people could turn in counterfeit coins and we would give them condoms in return. We had a special vasectomy festival where we did so many vasectomies that it got us into the Guinness Book of World Records. The free media coverage these events received was worth millions.

**Melnick:** So it sounds like you used the media almost as a public health training device or mechanism to reach populations who might not have been reached otherwise.

**Viravaidya:** Absolutely. The media are a powerful tool to transmit information to the people. Private companies use the media to sell their products and to change behavior because the media are their conduit to the market. We must use the same methods to change behaviors for better health that the private sector uses to sell their products. We must be equally, if not more, creative because our message is more complex.

**Melnick:** Are there other lessons that colleagues in other countries even in developed countries might learn from you?

**Viravaidya:** Yes. You can use the press and the media as an ally. But keep in mind that journalistic coverage in newspapers, radio, and TV is not enough. You need soap operas, films, game shows, the Internet. Use all media that interest people. That's number one. Also, do it in a way that is entertaining as well as educational. Don't be dull. Don't stand up there and preach. Make it fun, make it interesting, make it culturally relevant, and let people participate. For instance, we introduced a new alphabet recitation for kids thirty years ago that would be the equivalent of “B” for birth control, “C” for condom, “I” for IUD. We also had a familiar song that every child knew, perhaps the equivalent of “Jingle Bells,” where we changed the words into a song with every contraceptive method. Nine- and ten-year-old kids knew every contraceptive method. You have to use the media in such a way that the media would pick it up. It forces you to be creative, thoughtful, and innovative. If you write a press release and pass it out, they wipe their bottoms with it.

**Melnick:** You were very successful in changing behavior linked to health status in Thailand. Many developed countries have health problems linked to behavior and lifestyle. For example, the obesity epidemic in the United States and other developed countries will require behavior and lifestyle changes before progress can be made in these areas. Are there some lessons for developed countries that might be adapted to help in fighting these growing health problems?

**Viravaidya:** Probably one lesson is to work with young people. That's what we did in family planning. We worked with kids in fourth and fifth grades, nine- and ten-year-old kids. We taught them about population and family planning. We gave them lessons about arithmetic, where, instead of saying, “How much is ten divided by two?” we would ask, “If a farmer has two children and owns ten acres of land, how many acres will each child get?” Then we would ask, “What if the same farmer with ten acres has five children? What if he has ten children?” In this way children learned about math and population issues simultaneously. In anticipation of impending problems with obesity, diabetes, and heart disease among Thai people, we want to start teaching
Thai children about healthy eating habits. In schools that we run, we are teaching children in the first three grades how to cook healthy foods as a way to teach them healthy eating habits. The important thing is start when the children are young.

Now, some people say that this cannot be done in America. My response is that it does not have to be done in every American school. Just begin with some that are willing to try. With children you have to use nontraditional educational approaches. There are many familiar games that children play. Incorporate positive messages into these games about healthy lifestyle and eating habits so that these become inculcated in the children from the earliest ages. Schools can give rewards, perhaps related to grades, or recognition for children with the right mix of eating and lifestyle habits. For young children, don't just concentrate on numerical and literacy skills. Do something creatively linked to their survival in the long term. If you start with young kids, by the time they have hair on their legs you won't have to worry too much.

The Importance Of Leadership

Melnick: Earlier you mentioned the importance of involving the prime minister of Thailand in your HIV/AIDS campaign. How important is the role of top leadership in any of these campaigns?

Viravaidya: They are very important, but it takes a long time for them to accept what you're doing. Otherwise, it's just a passing phase. If you have some whiz kid flying in from New York, or from the UN or the World Bank, to advocate with the prime minister, they will receive polite nods. Fifteen minutes later, he's got somebody else advocating on a different issue. And by the next day, he's forgotten completely. You have to be around the prime minister or other top leaders like a bad smell, for a long time, to change their attitudes. It's not like a vasectomy—three minutes and it's done. That's not the case.

Melnick: So you think that the strategies you used in Thailand could be used in other countries?

Viravaidya: Thailand was an interesting situation. It was an open society with a traditional but open culture. The people were religious, but there weren't religious obstacles. These factors were important, but what made the difference in Thailand was leadership, commitment, and dedication. There were people in Thailand who were willing to experiment, to push the edge of the envelope, but to be honest and fully transparent in the process. That was the difference. In countries where there are people with this level of commitment, similar results can be achieved. People who work to effect social change must say that this is my life. This is not just my occupation or my job. This is my life, this is my conscience, this is my joy, this is my addiction. Many things can be accomplished with dedicated leaders who are committed to positive social change. That's the difference. Get people who want to do it as a lifestyle rather than people who view it only as a job.

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