UNGASS COUNTRY PROGRESS REPORT

THAILAND

Reporting Period
January 2008- December 2009

National AIDS Prevention and Alleviation Committee

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Abbreviation

AEM	Asian Epidemic Model
AFRIMS	Armed Forces Research Institute of Medical Sciences
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
ART	Anti Retroviral Therapy
ARV	Anti Retroviral Drug
ASO	AIDS- Response Standard Organization
BMA	Bangkok Metropolitan Administration
BOE	Bureau of Epidemiology
BSS	Behavioral surveillance survey
CCM	Country Coordinating Mechanism
CICT	Client Initiated Counseling and Testing
CIDA	Canadian International Development Agency
CSE	Comprehensive Sexual Education
DDC	Department of Disease Control
DiC	Drop-in centers
DLPW	Department of Labour Protection and Welfare
DMS	Department of Medical Services
DMSc	Department of Medical Sciences
DOC	Department of Corrections
DOH	Department of Health
EQA	External Quality Assessment
FAR	Foundation for AIDS Rights
FHI	Family Health International
FSW	Female sex workers
GDP	Gross Domestic Products
GFATM	Global Fund to fight AIDS Tuberculosis and Malaria
HAART	Highly Active Anti Retroviral Therapy
HBV	Hepatitis B Viruses
HCV	Hepatitis C Viruses
HITAP	Health Intervention and Technology Assessment Program
HIV	Human Immunodeficiency Virus
HIV-NAT	HIV Netherlands Australia Thailand Research
HSRI	Health Service System Research Institute
HSS	HIV Sero-surveillance system
IBBS	Integrated Biological and Behavioral Sentinel Surveillance
IDU	Injecting Drug Users
IEC	Information Education and Communication
ILO	International Labour Organization
IOM	International Organization on Migration
LAOs	Local administrative organizations

M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MCH	Maternal and Child Health
meth	Methamphetamines
MHV	Migrant health volunteers
MHW	Migrant health worker
MMT	Methadone Maintenance Therapy
MOE	Ministry of Education
MOL	Ministry of Labour
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MSDHS	Ministry of Social Development and Human Security
MSM	Men who have Sex with Men
MSW	Male Sex Workers
MTCT	Mother to Child HIV Transmission
NAMc	National AIDS Management Center
NAP	National AIDS Program Software
NAPAC	National AIDS Prevention and Alleviation Committee
NAPHA	National Access to Antiretroviral Program for PHA
NASA	National AIDS Spending Assessments
NASP	National AIDS Strategic Plan
NCA	Norwegian Church Aid
NGO	Non-Government Organization
NHSO	National Health Security Office
NHSP	National Health Security Program
NNRI	Non-nucleoside Reverse Transcriptase Inhibitors
NSC	Office of the National Security Council
NSU	Non-specific Urethritis
OI	Opportunistic Infections
ONCB	Office of the Narcotics Control Board
PATH	Program for Appropriate Technology in Health
PCM	Provincial Coordinating Mechanism
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PHIMS	Perinatal HIV Intervention Monitoring Surveillance System
PHOM	Perinatal HIV Outcome Monitoring Surveillance System
PICT	Provider Initiated Counseling and Testing
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother – To – Child HIV Transmission
PPAT	Planned Parenthood Association of Thailand
PR	Principal Recipient
QI	Quality Improvement
RDS	Respondent Driven Sampling
RH	Reproductive Health
RHIS	Routine Health Information System

RTF	Raks Thai Foundation
RSAT	Rainbow Sky Association of Thailand
SD NVP	Single-dose of Nevirapine
SSO	Social Security Office
STI	Sexually Transmitted Infection
SW	Sex Workers
SWING	Service Workers in Group
TAO	Tambon Administrative Organizations
TB	Tuberculosis
TBCA	Thailand Business Coalition on AIDS
TDN	Thai Drug Users Network
THE	Total Health Expenditure
TNCA	Thai NGO Coalition on AIDS
TNP+	Thai Network of People Living with HIV/AIDS
TRC	Thai Red Cross
TUC	Thai MOPH - US CDC Collaboration
TWG	Technical Working Groups
UA	Universal Access
UIC	Unique Identifier Code
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services

Preface

After the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) was convened in June 2001, 189 representatives of countries around the world signed the accompanying declaration on HIV/AIDS, showing consensus of the world toward the conceptual framework and the Millennium Development Goal (MDG) to never allow the return of the HIV pandemic.

The UNGASS Declaration emphasized the importance of collaboration of the various sectors including the government, business, civil society, labor organizations, and PLHIV organizations in implementing the programs to confront the HIV/AIDS challenges at every level of society, including prevention of new infection, expanding access to care and treatment, and mitigating the impact of HIV/AIDS.

In order to monitor implementation in support of the Declaration goals, UNAIDS and partners developed a framework of indicators to assess progress of related programs, and requested the signatory countries to report on these indicators every two years.

As part of the 60th United Nations General Assembly on June 2, 2006, progress and successes in implementing programs in support of the UNGASS Declaration were reviewed (ref: Agenda Item 45).

◘ Acknowledge and recognize the significance of the facts that:

⊡ AIDS is a global catastrophe that threatens development and security of nations.

⊡ There has been progress in mobilizing global resources to combat HIV/AIDS.

⊡ One-third of this funding in 2005 came from governments of middle and lower-income countries.

◘ Issues of concern:

⊡ The spread of HIV in women.

⊡ That half of new infections are among those under age 25 years.

- That there are approximately 2.3 pediatric cases of HIV/AIDS; many countries do not have adequate Anti Retro Viral (ARV) drugs to treat these pediatric HIV infections.

Reaffirm that:

- It is alarming that the spread of HIV/AIDS has impacted every region of the world.
- There is a need for concern for protection of human rights and basic freedoms.
- Eradication of stigma and aversion toward PLHIV is the foundation for effective solutions to HIV/AIDS.
- Access to ARV drugs is an important and fundamental principle.

Recognize that:

- HIV/AIDS is both a cause and consequence of poverty.
- There is unnecessary spread of HIV/AIDS deaths.
- Every sector needs to work together in an effective way.
- Ways must be found to eliminate problems and obstacles in the body of laws, regulations, and measures that block access to prevention, treatment, care and support.

Convinced that the important elements of resolving the HIV/AIDS crisis consist of:

- Policy improvement
- Strong leadership
- Being steadfast in the commitment to the Declaration
- Full participation of all sectors
- Adequate resources for effective implementation

Reaffirm our commitment to implement fully the Declaration of Commitment on HIV/AIDS, entitled "Global Crisis – Global Action". Adopted by the General Assembly at its twenty-sixth special session, in 2001.

Thailand has previously prepared and submitted three reports on national progress as measured by the UNGASS indicators in the years 2004, 2006, and 2008. Each time, the objective was not merely to send the report to UNAIDS but to use the report preparation process as a means to strengthen the monitoring and evaluation of the national response on a continuous basis.

Preparation of this progress report was accomplished by the efforts of the Working Group, comprised of representatives from the government, NGOs, civil society, technical experts and international organizations who

collaborated together to produce a comprehensive summary of progress. It is hoped that this reporting process will serve as one tool to advance the AIDS program to reach its targets for access to prevention, care and treatment, universally and equally, and in accordance with the National AIDS Strategic Plan (NASP) for the prevention and control of HIV/AIDS for the period 2007-2011.

I. Status at a Glance

1. Inclusiveness of the Stakeholders in the Report Writing Process

Preparation of the Thailand progress report for 2010 according to the UNGASS declaration on HIV/AIDS was successfully completed only through the collaboration of all the program partners from the public sector, civil society, technical specialists, and international organizations. They were involved in every major step of the report writing process beginning from the first participatory consultative meeting to determine the timeline, assembly of data for the indicators, writing the report, analyzing problems and limitations of the indicators in the 2008 progress report, and summary of lessons learned and recommendations to be applied to improving the report preparation process for 2010.

The current report was engineered by the National Monitoring and Evaluation (M&E) Working Groups including the Advisory, the Executive and Monitoring and Evaluation Working Groups and sub-groups comprising 16 teams in all. The composition of the working groups included representatives of the government, civil society, technical specialists and multi/bilateral development organizations. The members had the task of assembling the relevant data for the indicators, tabulation and analyzing the values and trends of the indicators, and preparing reports for each indicator area. The final step of the report preparation process was the convening of a seminar to solicit a wide range of opinions from various sectors and levels on the output of the 16 working groups and sub-groups. These opinions were fed into the analysis of the progress, problems, obstacles and implementation to meet the targets for access to equitable prevention, care and treatment, and targets as specified in the National AIDS Strategic Plan (NASP) for the period of 2007-2011. Next, the National M&E working groups incorporated the results of the seminar into revisions of the draft progress report, and presented this to the National Subcommittee for Program, Budget, M&E for HIV/AIDS Prevention and Alleviation Coordination for consideration. Finally, the report was submitted to the

National AIDS Prevention and Alleviation Committee (NAPAC) for their approval.

In assembling the data for these indicators this was the first time that data from the provincial level was used for indicators that still have some limitations, such as Indicator 11 concerning the integration of HIV/AIDS in the life skills school curriculum, Indicators 10 and 12 concerning the support for schooling and related assistance for AIDS orphans and other affected children, and data on AIDS-related expenditures in the field from various sources, especially those supported by the local administrative organizations which are not yet able to numerically summarize this expenditure or the proportion of the budget spent on AIDS. The data from this review of the situation can be applied to the baseline data set to help fill gaps in the portion of the report on national expenditures on prevention and control of HIV/AIDS to achieve a higher level of completeness.

2. Status of the Epidemics

Thailand has set the target to reduce the number of new cases of HIV by at least half of those projected for 2011 despite the fact that the epidemiological and behavioral surveillance over the past 3 to 4 years indicates that the number of new HIV cases has not declined in all groups, especially in adolescents, among whom there was an increase in HIV and sexually transmitted infections (STIs). In addition, the HIV surveillance data show an increase in the level of infection among pregnant women and military recruits aged 20 to 24 years. This increase is consistent with risk behavior data in youth which reported an increase in sex-partner mixing without condom use, which could be contributing to the increased risk for STIs and unwanted pregnancy. This can be seen from the age distribution of STI patients in which the highest number of cases was in the 15-24 year age group, and from the data that one in five women who delivered a child in 2008 was under age 20 years.

In the general population the national trend in prevalence of HIV infection is one of continuous decline since 1996. At the time of this report, the prevalence of HIV in pregnant women was under 1%, and under 0.5 percent in new military recruits. In any event, the spread of HIV in some provinces of Thailand is still severe, especially those which receive a large number of tourists, and provinces bordering on the eastern seaboard and Gulf of Thailand. These provinces include Phuket, Chonburi, Trad, and Samut Songkram, and in which HIV among pregnant women is nearly 2%. The Upper North region of the country, which experienced the highest levels of HIV

prevalence in the early part of the epidemic still report higher prevalence of HIV among pregnant women.

Among the higher risk groups, when compared with 2005, the number of new infections among indirect and street sex workers nearly doubled by 2008. Approximately five times as many indirect and street sex workers experienced new HIV and STI infections as brothel workers. This is especially worrisome since proportionally more of the indirect sex workers are outside of the formal HIV prevention program than the direct sex workers, and may not be receiving the same level of care and information about prevention of HIV and STIs.

HIV infection among men who have sex with men (MSM) remains higher and does not show any indication of declining. HIV among MSM is higher in large urban centers and important tourist locations. Nevertheless, the intensified prevention activities among this population over the past two years, especially in Bangkok, are starting to show results in terms of reduced HIV prevalence, from 30.7% in 2007 to 24.7% in 2009.

Prevalence of HIV among injecting drug users (IDU) attending detoxification centers is still high, at levels of 30% to 40%. Nevertheless, results from the latest (2009) survey round using the respondent driven sampling (RDS) method found that the prevalence of HIV in Bangkok and Chiang Mai was lower than the national prevalence for this group (i.e., 24% and 11% respectively).

In general, HIV infection among the population of international labor migrants is higher for those working in the fisheries industry than other occupations. This differential is possibly because of the nature of the work and higher sex risk behavior of fishing boat crew. Sex workers in Thailand who are foreign migrants have higher levels of HIV than their Thai counterparts. Limitations of education and Thai illiteracy are barriers to accessing information and services for prevention of HIV and STIs.

In sum, the epidemiological and behavioral data indicate that the number of new HIV infections in Thailand has not decreased. A trend of increasing spread of HIV is noted in the population of adolescents, and HIV prevalence remains high in the traditionally higher-risk populations and shows no indications of declining any time soon. These patterns of spread of HIV present a challenge for reducing the incidence of HIV by half in 2010 as targeted in the multi-national agreement on Universal Access, and according to the targets specified in the NASP for 2007-2011.

3. Policy and Program Response

Thailand has experienced three decades of the HIV/AIDS epidemics. To this day, AIDS is still having an adverse effect on Thai daily life, the health system, and socio-economic well-being of the country. The country has learned how multisectoral collaboration would enhance the fight against HIV/AIDS. Even though the political situation has not been favorable during last 3-4 years, the strength of the partnerships among sectors still keeps partners moving the AIDS responses in the country.

However, at the NAPAC meeting on 24 July 2009, the prime minister expressed his views in committing to the country response to HIV/AIDS and showed strong leadership by serving as the NAPAC chair and has the policy of accelerating the reduction of new infections by half by 2011 as stated in the current NASP which cover the year 2007-2011.

The measures to achieve this consist of public media campaigns, condom promotion, prevention in youth and most-at-risk population groups, including use of joint KPI indicators to promote participation of all sectors, strengthen networks, and galvanize the local administrative organizations, and the province to take ownership and leadership in advancing the AIDS program goals in the months and years ahead.

During 2008-2009, the subcommittee for advancing the prevention program effort, managed by the Coordination Center for Development of HIV Prevention Approach and Mechanism; has supported various agencies, government and civil society organizations to implement HIV prevention through 3 strategies including (1) public information campaigns; (2) strengthening the HIV prevention networks; and (3) finding ways to ensure sustainability at the provincial and local administrative organization levels to accelerate and take ownership of the HIV/AIDS prevention agenda.

The Director General of the Department of Disease Control (DDC), as the secretary of the NAPAC has restructured and equipped the National AIDS Management Center (NAMc) with more people and resources to be more capable for coordination the planning and implementation as well as monitoring and evaluation and propose the needed policy. During the 4th quarter of the year 2009, the NAMc has coordinated with the Center for Development of HIV Prevention Approach and Mechanism organizing multi stake holder workshops to develop accelerated HIV prevention plan to halve the incidence of HIV by 2011, as assigned by the decision of the NAPAC in the meeting on 24 July 2009.

Prevention

As target populations are identified in the NASP for 2007-2011, the HIV prevention programs in Thailand are mostly targeting specific population groups.

Most-at-risk population groups are very important and have received greater attention. This can be seen from policy and plan to reduce new infections by half by 2011 in IDU, MSM, female sex workers (FSW), prisoners and migrants in Thailand. The national program is working intensively with all these groups using both domestic and international funding. It is well recognized that to increase access to HIV prevention among these population groups needs outreach services by civil society organizations and linkage with services of hospital, of which health service providers have to understand sex/gender/sexuality issue in order to make their services friendly to the target populations.

Prevention of Mother to Child HIV Transmission (PMTCT) is being implemented efficiently in Thailand. Triple therapy is now being used. Therapy is tailored to the client's CD4 cell count, and Thailand has launched the "staying negative" strategy in Ante-natal Care (ANC) Clinics through promotion of couple ANC attendance. Thus, it can be seen that the program is giving increased importance to the health of the mother. In any case, implementation of PMTCT is still seen as overly focused on the infant at the expense of the infected mother. This is particularly sensitive in the area of planning a pregnancy, carrying a pregnancy to term, or having an abortion based on fully informed consent and self-determination.

In addition, HIV testing at the ANC clinics not wholly voluntary but is more like provider-initiated counseling and testing, which is more focused on case finding. This results in less attention to voluntary decision making and respect for the preference of the woman. Thus, there should be support for rights protection in reproductive health care settings together with development of health services that are more user-friendly, and promotion of couple ANC to help the woman communicate her prevention priorities with her partner.

Youth is an important target group under the NASP for 2007-2011, including the target of reducing new infections by half by 2011. Most of this portion of the national program is supported by the Global Fund to Fight AIDS, TB and Malaria (GFATM). Nevertheless, the strategy for youth behavior change has not had optimal effect since Thai youth are increasingly diverse in terms of attitudes, beliefs, and lifestyles. It is still an important challenge for the

program to tailor strategies for youth to the various different lifestyles that are currently in fashion.

Promotion of comprehensive sexuality education is still a weak point of the program. The challenge here is to find a way to institutionalize comprehensive sexuality education in the school system through policy improvements at the national and ministerial level. There is no core curriculum at the national level that is acceptable to the Ministry of Education (MOE). The attitude of the MOE administrators and teachers still is not accepting of the need for comprehensive sexuality education. In any case, comprehensive sexuality education alone probably is insufficient to change attitudes and behaviors over the long-term since youth have different ways of learning as they mature into adolescence and adulthood. In addition, there are many variables to consider such as increased ease of access to sinful (risky) temptations and peer pressure.

Care, support and treatment

Thailand has the policy to provide full coverage of care and treatment for PLHIV throughout the country as part of the Universal Coverage. The goal is for every Thai to have health insurance under one system or another to expand coverage of Anti-Retro Viral Therapy (ART). In any event, by viewing AIDS as just another chronic condition that requires life-long treatment could lead to the new challenge of preventing HIV among the increased number of PLHIV who survive for decades because of ART.

Pregnancy among PLHIV is one area in which PLHIV is confronting competing prevention priorities as, in one study, 60% of infected pregnant women knew of their sero status before becoming pregnant.[1] Thus, there is the need for counseling of all PLHIVs from the health provider and peer PLHIV, and group activities to help the PLHIV understand and make an informed decision for safe sex and practice contraception that is appropriate. This will lead to a more satisfactory physical, psycho-emotional and social life of the PLHIV.

Another challenge is the fact that new clients for ART are diagnosed when their immune system is already quite damaged (CD4 counts are under 100). There is a need to develop and promote outreach counseling services for the general population through mass media campaigns to raise concern about HIV prevention, prevention of risk, and the benefit of knowing one's

[1] Report of the committee to monitor policy and implementation of PMTCT by civil society in 2009. The full report is part of the comparative study of policy and implementation of reproductive health in 9 countries Argentina, Belize, Brazil, Indonesia, Kenya, Peru, South Africa, Thailand, Uganda implemented by GESTOS, Brazil supported by the Ford Foundation.

serostatus. The 5-year plan to develop system and improve quality of counseling services are being developed by multi stakeholders and expected to get funding from the National Health Security Office (NHSO).

It is recognized that support for the promotion of quality of life of PLHIV in the community should be increased by strengthening the role of the comprehensive continuum of care, rather than just conducting group activities and home visits. This would include developing models of guidelines for collaborative action at the community level by each sector to build the quality of life of the PLHIV in the community. Parallel with this is the need to promote community attitudes that are favorable and inclusive of the PLHIV. This will help reduce the stigma and prejudice suffered by the PLHIV, and improves their quality of life as a result.

AIDS and human rights

A provision of the Thai Constitution (2007) provides for the protection of rights and freedoms of the population broadly, including the prohibition of discrimination or unfair treatment of individuals. In addition, there are laws about health security, national health laws, laws for labor protection, and child rights protection. There are guidelines for HIV/AIDS prevention in the workplace which were formalized on August 21, 2009. The plan for human rights, V. 2 for 2009-2013 received Cabinet approval on October 20, 2009. In addition, the NASP for 2007-11 specified the protection of AIDS rights in strategy 3, and is supported in various measures including dissemination of information on human rights. All of this reflects Thailand's legal and policy strategy to create an environment that respects rights, especially those of PLHIV.

PLHIV rights protection is implemented by the government and civil society. The government strategy is implemented through the Department for the Protection of Rights and Liberties of the Ministry of Justice and who participate as part of the rights protection network, and consider complaints of rights violations in collaboration with PLHIV representatives. Civil society emphasizes their role in campaigning and promoting understanding of rights, and recommending policy action to improve protections such as the Foundation for AIDS Rights (FAR) which produced a report of a study reviewing laws and policies on human rights and AIDS rights, and the report of the situation of human rights related to HIV/AIDS in Thailand (2007 and 2008). The Thai Network of PLHIV (TNP+) conducted a study of stigma and discrimination toward PLHIV in 2009, while the Thai NGO Coalition on AIDS (TNCA) with coordination by Raks Thai Foundation

produced a report analyzing policy as a response to AIDS seen through the lens of sexual and reproductive health rights.

Even though Thailand has rather good policies in place, these are not always implemented in practice. Human rights related to AIDS still do not receive optimal priority, and implementation at the peripheral level is often not consistent with national policy. There is still ignorance about the rights policies and their relationship to AIDS.

Orphans and children affected by HIV/AIDS

Policy and measures to help orphans and children affected by HIV/AIDS are still not as clear as they could be. This is because of a lack of strategic information to understand the full situation and problems of orphans and children affected by HIV/AIDS. Most of the assistance is still in the form of rehabilitation such as health care and ART for children infected through their mothers. But this is only for those children and families that are open about their serostatus. Social and psycho-emotional support is still not adequate, and is mostly conducted by NGOs. Some projects are good-practice models and can be expanded, such as the ECAT project and the Art Therapy Project.

Although the Ministry of Social Development and Human Security (MSDHS) has the policy to encourage the family and community to support children affected by HIV, the orphanages are still needed for some children. It is also recognized the needs to standardize the quality of both public and private orphanages.

The cases of HIV+ children who are becoming adolescents are another challenge that needs solutions. This is because some PLHIVs are encountering difficulty in adjusting to the changes of adolescence and leading a quality life. There are issues related to ART compliance and issues of sex behavior, since society may feel that PLHIVs are spreaders of disease and therefore should not have sexual relationships or be limited to PLHIV partners. There needs to be greater support for communities to look after orphans and other children affected by HIV/AIDS, and reduced community stigma, and a greater array of youth-friendly services.

Resources

A strength of the Thai program in its AIDS prevention and control program is that most of the budget (80 to 90%) is domestic. This reflects the importance that Thailand gives to AIDS, and its ability to be self-reliant. At the same time, a weakness is that the allocation of resources is not always balanced because so much has to go for treatment (69-76%). By contrast,

the budget for prevention was only 14% of the total in 2009, and most was from external sources. About one-third was for behavior change while 3% was for condoms.

Dependence on external sources of budget is a concern of civil society which sees that there is too much dependence on the GFATM source. There is a need to begin to explore alternatives for a post-GFATM program so that localities can generate their own sources of support to continue essential HIV/AIDS program activities. It can also be seen that there should be some consideration of increasing the proportion of resources for prevention, since prevention of a single new infection confers tremendous future savings in the cost of treatment and care.

4. UNGASS Indicator Data in an Overview Table

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
NATIONAL COMMITMENT AND ACTION					
1.Domestic and international AIDS spending by categories and financing sources			6,728 million Baht (2007)	7,208 million Baht (2009)	Compile secondary data on actual expenditure on HIV/AIDS from financing agents. In case of non available data, the imputation based on PQ approaches (P refers to price/unit cost, Q refers to services rendered)
NATIONAL PROGRAMS					
3. Percentage of donated blood units screened for HIV in a quality assured manner	99.9 (2003)	100.0 (2005)	99.79 (2007)	100.0 (2009)	Data from National Blood Center and Regional Blood Centers of Thai Red Cross Society including 371 blood banks of 942 government and private hospitals Donated blood was 100% screened
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy		41.0 (2006)	52.9 (2007)	77.76 Adult 75.43 Pediatric 85.46 (2009) 67.14 Adult 66.49 Pediatric 86.06 (2008)	According to the national protocol, ART will be provided to either symptomatic or asymptomatic PLHIV with CD4 lower than 200 cell/cu. mm. Thus, denominator also included asymptomatic PLHIV with CD4 lower than 200 cell/cu.mm. Denominators Adult:- using Asian Epidemic Model and Pediatric: using spectrum

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission		89.77 (2005)	95.90 (2007) 90.10 (2006)	94.71 (2009) 93.31 (2008)	
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV			32.60 (2007)	25.82 (2009)	Numerator: TB patients with HIV positive from Tuberculosis Patients Register Denominator: the estimated number HIV/TB patients in Thailand which was calculated by using WHO estimates on TB incidence (142/100000) HIV infection rate in TB patient (17%), yielding to the estimated number of 16, 077 new TB/HIV patients in 2009. Total population in 2009 was 66.598 million
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results			19.12 (2006)	19.12 (2006)	Data from the National Sexual Behavior Survey of Thailand 2006. Sample are male/female aged 18-49
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results			FSW 52.60 MSM 34.9 IDU NA (2007)	SW 35.81 FSW 36.03 MSW 35.20 MSM 21.33 (2007) IDU 59.7 (2008)	BSS among FSW using venue based sampling in 8 provinces IBBS for MSW, MSM conducted in 3 provinces (Bangkok, Chiangmai and Phuket) IBBS among IDU using RDS in Bangkok, 2008 (presented in this table). But data in Chiang Mai was 18.2%.
9. Percentage of most-at-risk populations reached with HIV prevention programs.				NA	Data is not available. Thailand will applied standard definition for measuring prevention coverage in IBBS 2010.

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child			Not Applicable	Not applicable	HIV Prevalence among pregnant women in Thailand less than 5% (0.72% in 2008 and 0.74% in 2009). Thailand does not require reporting this indicator. Multiple Indicators Cluster survey (MICS) conducted in 2006 revealed 21.4% of all orphaned and vulnerable children aged 0-17 receiving at least one type of basic external support.
11. Percentage of schools that provided life skills-based HIV education in the last academic year			NA (2007)	0 (2009)	Life skill-based HIV education in schools in Thailand has been implemented by 3 approaches under the Ministry of Education: 1. Integrated into technical subjects at least 5 hours / academic year in primary schools 2. Life skills and sexual education at least 10-16 hours/academic year in secondary and vocational schools 3. Intensive sexual education at least 16 hours/academic year mainly in vocational schools with 68% coverage for only vocational schools AIDS and sex -related campaigns/ activities are conducted biannually.
KNOWLEDGE AND BEHAVIOUR					
12. Current school attendance among orphans and among non-orphans aged 10–14			95.50 OVC 96.4 Non-OVC (2006)	95.50 OVC 96.4 Non-OVC (2006)	MICS collected between December 2005 –February 2006

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	18.67 (2003)	31.15 (2005)	37.42 (2006)	37.42 (2006)	2008, 2010 UNGASS report used data from the National Sexual Behavior Survey of Thailand 2006. Sample group: male/female, aged 18-24 2004, 2006 UNGASS report used data from the survey on vocational students
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			FSW 28.4 MSM 25.3 IDU 49.10 (2007)	SW 38.26 FSW 41.33 MSW 29.33 MSM 25.53 IDU NA (2009)	BSS among FSW using venue based sampling in 8 provinces IBBS for MSW, MSM in 3 provinces (Bangkok, Chiangmai and Phuket) BSS among IDU conducted in 2007 in 3 provinces.
15. Percentage of young women and men aged 15–24 who have had sexual intercourse effort the age of 15	6.39 (2003)	12.10 (2005)	4.82 (2006)	4.82 (2006)	2008, 2010 UNGASS report used data from the National Sexual Behavior Survey of Thailand 2006. Sample group: male/female, aged 18-24 2004, 2006 UNGASS report used data from the survey on vocational students.
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months			9.39 (2006)	9.39 (2006)	Data from the National Sexual Behavior Survey of Thailand 2006. Sample group is male and female youths, aged 18-49
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse			50.88 (2006)	50.88 (2006)	Data from the National Sexual Behavior Survey of Thailand 2006. Sample group is male and female youths, aged 18-49
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client			FSW 96.2 (2007)	FSW 92.2 (2009)	BSS among FSW used data frograde 114 provinces Data among MSW is not reported since questions

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
				MSW NA	used to construct this indicator are difference from standard definition suggested in the UNGASS guide. But this indicator will be available starting frograde 8010 onward.
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			NA	NA	Data in 2007, 2009 IBBS among MSM is not reported since questions used to construct this indicator are difference from standard definition suggested in the UNGASS guide. But this indicator will be available starting frograde 8010 onward.
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse			35.00 (2007)	41.98 (2008)	2007 data from program monitoring from Bangkok IBBS using RDS conducted in Bangkok in 2008
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected			NA	63.16 (2008)	IBBS using RDS conducted in Bangkok in 2008
IMPACT					
22. Percentage of young women and men aged 15–24 who are HIV infected	0.95 (2003)	0.45 (2005)	0.64 (2007)	0.58 (2009)	2003-2009 data used HIV Prevalence among ANC clients aged 15-24 from sentinel sero surveillance In 2009, HIV prevalence among military conscripts was 0.50
23. Percentage of most-at-risk populations who are HIV infected	FSW 6.70 MSM NA IDU 46.8 (2003)	FSW 5.15 MSM N/A IDU 37.64 (2005)	FSW 5.00 MSM 24.6 IDU 28.78 (2007)	SW 3.17 FSW 2.79 MSW 14.17 MSM 13.53 IDU	Data on FSW used HSS conducted in venues based sentinel sites. However IBBS in Bangkok revealed 19% and 10% Chiang Rai using RDS. MSW and MSM (MSM and TG) used IBBS, data from 3 tourist provinces; Bangkok, Chiang Mai and Phuket IDU used HSS conducted in methadone clinics.

Core indicators	Reporting period				Remarks
	2004	2006	2008	2010	
				38.67 (2009)	However Thailand has IBBS using RDS that showed HIV prevalence among IDU as follow; Total 23.3% in Bangkok and 10% Chiang Mai
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			84.9 (2007)	85.14 Adult 84.89 Pediatric 90.02 (2008)	
25. Percentage of infants born to HIV-infected mothers who are infection				NA	Data from spectrum is not available Evaluation conducted by MOPH in 2007 found level of transmission of HIV from mother to infant was 2.9% based on laboratory diagnostic. If dead infants are included in the analysis transmission rate was 5.6%.

II. Overview of the AIDS Epidemics in Thailand

A. AIDS epidemics

The spread of HIV in Thailand continues after the first outbreak more than 20 years ago. From the first AIDS case report in 1984, the main driving force of the epidemic has been unsafe sex, and this has disproportionately affected women and men of reproductive age. Even though Thailand has had a NASP since 1997 which helped the country succeed in rapidly slowing the spread of the virus during the decade that followed, HIV continued to spread during the first decade of the new millennium among the general population, with troubling trends in the highest risk and/or hard-to-reach groups.

Changes in Thai society in the midst of socio-economic challenges combined with advances in communications technology in accordance with the trends of globalization means that the traditional methods of behavior change communication and HIV control might not work as effectively as in the past. Indeed, some of these modernizing trends may actually increase HIV risk for some of the youth and adolescents populations. Data on the current status of the epidemic is giving a warning signal that the HIV "fire" could re-ignite in Thailand unless prevention activities are intensified and aggressively rolled-out to achieve sustainable coverage.

In brief, the following have given rise to the concern regarding the current status of HIV/AIDS:

- Data from the HIV surveillance system show that HIV is not declining in some sentinel populations.
- The emergence of factors which increase vulnerability of youth due to rapid socio-cultural change and changing lifestyles.
- Trends from the analysis of the situation of the epidemic for the purpose of prioritizing locations and populations for intensified prevention.

1. Absence of a sustained decline in HIV and warning signs that an increasing trend may return

The epidemiological data combined with data from ad hoc serosurveys indicate a trend toward sustained spread of HIV with the possibility of a reverse to an increasing trend in some most-at-risk groups such as sex workers, MSM, and IDU. These developments pose a threat to Thailand's ability to achieve its targets for reduction of new infections as specified in

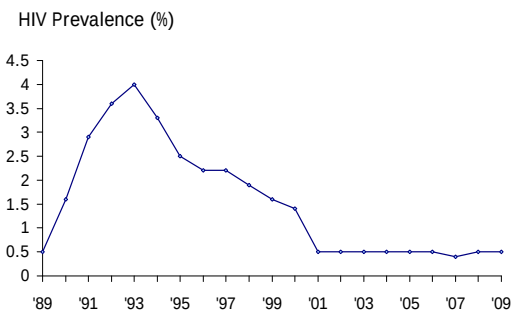
the NASP for 2007-2011. The NAPAC had set a target of halving the number of new HIV infections from the projected total; reduce the prevalence of HIV among pregnant women and Thai military recruits by at least 0.05 percentage points per year.

1.1 HIV trends in the general population

HIV prevalence has declined in the general population as indicated by HIV surveillance among military recruits and pregnant women appearing for ANC. The combined efforts of all sectors under the NASP have resulted in these successful declines. However, the decline of HIV has reached a plateau in the past 4 to 6 years.

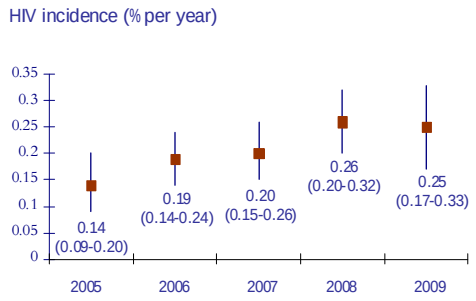
Among military recruits, who can be considered to be approximately representative of Thai male youth age 18-24 (average age of 21 years), HIV prevalence initially increased rapidly from 0.5% in 1989 to 4.0% in 1993, and then declined until it reached a plateau. During the period from 2005 to 2009, the HIV prevalence among this population had remained constant at 0.5%, and is not declining in accordance with the targets specified in the NAP (Figure 1). In addition, HIV incidence during the same period showed a slight increasing trend, from 1.4 per 1,000 per year in 2005 to 2.5 per 1,000 per year in 2009 (Figure 2). These trends are consistent across regions.

Figure 1: HIV prevalence among military recruits: 1989-2009



Sources: AFRIMS

Figure 2: Incidence of HIV: military recruits: 2005-2009

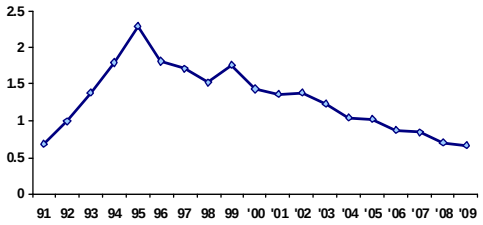


Sources: AFRIMS, BOE, and TUC

Results from HIV surveillance among ANC clients in government hospitals throughout the country show that the provincial median prevalence of HIV initially increased rapidly from 0.68% in 1991 to 2.3% in 1995. Effective prevention activities from 1993 started to show results by the reversal of this increasing trend after 1995.However, the decline in prevalence reached a plateau in 2005 and has remained there to the present (0.70% and 0.65% for 2008 and 2009 respectively (Figure 3). When looking at one-year incidence of infection among pregnant women, HIV actually increased from

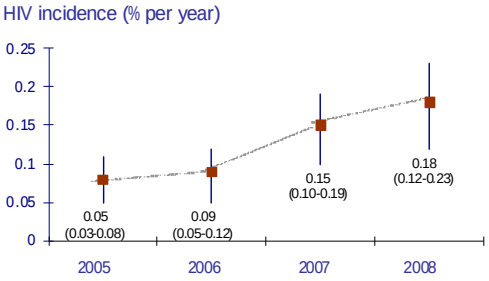
approximately 0.5 to 1.8 per 1,000 per year between 2005 and 2008 (Figure 4).

Figure 3: HIV prevalence in ANC clients: 1991-2009



Source: HIV surveillance, BOE

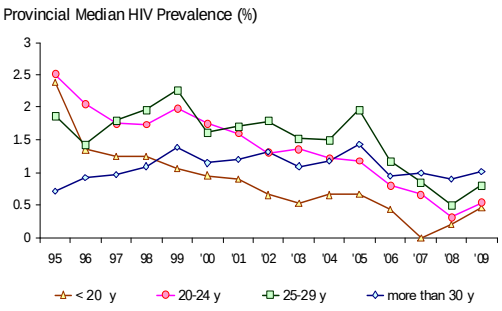
Figure 4: HIV incidence among ANC clients: 2005-2009



Sources: HIV surveillance, BOE, Medical Sciences Department, and the TUC

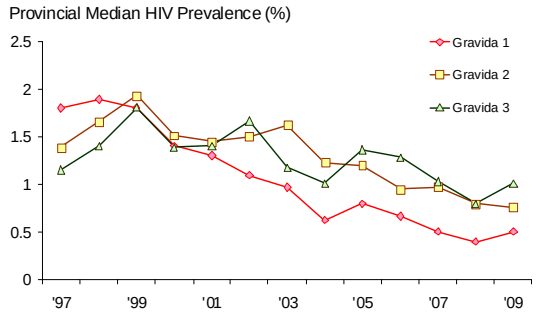
When examining prevalence among ANC clients by age group in 2009, HIV is highest in the group age over 30 (1.02%). However, HIV prevalence among the group under 30 years increased since 2008, especially among those under age 20, whose prevalence increased steadily since 2007 and at an accelerating rate (from 0 in 2007 to 0.20 and 0.46 per year respectively). HIV prevalence among pregnant women age over 30 has remained constant since 2006 at a level of 1.0% (Figure 5). When looking at HIV prevalence by gravida, HIV is highest at gravida 3, which reflects the higher prevalence of HIV among women over 30 years. Trends in HIV among women of gravida 1 and 2 are generally constant from 2007 to 2009 (Figure 6).

Figure 5: HIV prevalence among ANC clients by age group: 2005-2009



Source: HIV surveillance, BOE

Figure 6: HIV prevalence among ANC clients by gravida: 1995 - 2009



Source: HIV surveillance, BOE

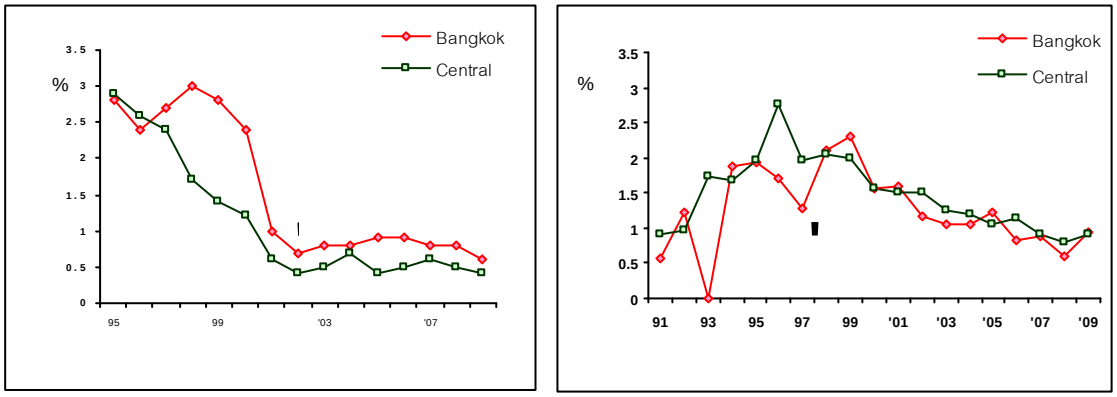
When examining HIV trends among military recruits and ANC clients by region, it can be seen that, starting in 2001, there were sustained declines of HIV in each region, especially in the upper north and central regions. However, it is noteworthy that, in the past five years, that these declines

have reached a plateau with a slight increasing trend since 2007 both in the recruits and pregnant women. In 2009, the prevalence of HIV among the recruits was highest in Bangkok (0.6%); in the other regions HIV increased from 0.4 to 0.5 in 2008 and 2009 respectively. For pregnant women, HIV prevalence was highest in the upper north (1.01%) followed by 0.93% in the central, 0.90% in Bangkok, 0.80% in the northeast, and 0.7% in the south (Figure 7). There were 20 provinces with ANC HIV above 1.0% and six provinces with a level of over 1.5%.

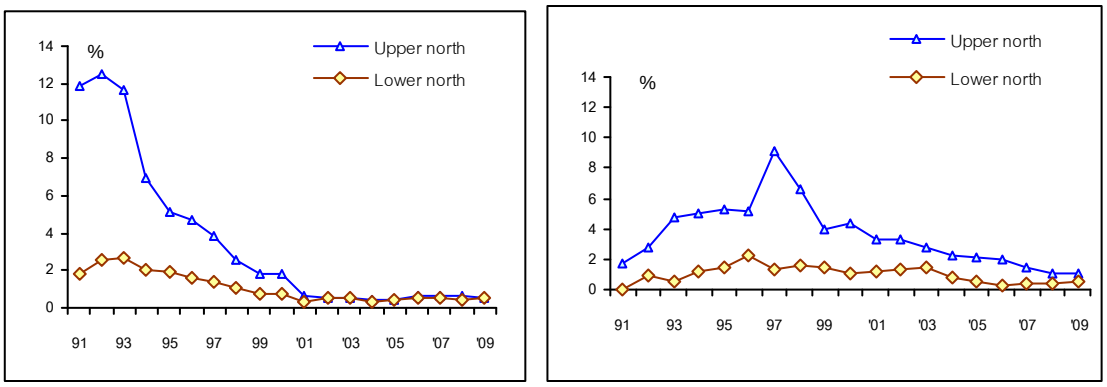
Data which confirm the worrisome levels and trends of HIV come from STI data in military recruits in the second round of the draft in 2008 (November). At that time, the prevalence of non-specific urethritis (NSU) was 6.86%, gonorrhea 0.86% and syphilis 0.09%. The level of infection was highest in the upper north and east (part of the central region) in which the rates were 13.1% and 12.5% respectively. [2]

Figure 7: HIV prevalence among military recruits and ANC clients by region

1. Bangkok and central

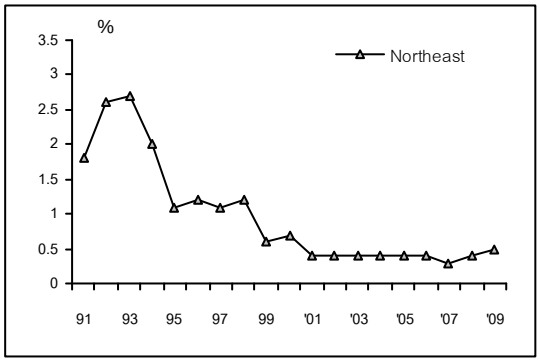


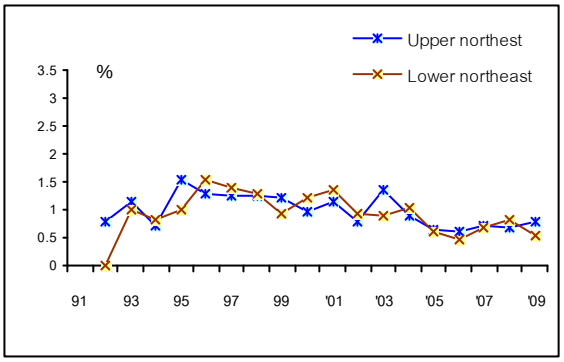
2. North



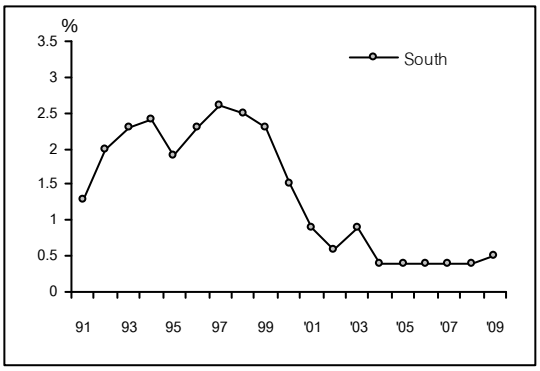
[2] Faculty of Medicine, Phramongkutklao, Bureau of AIDS, TB, and STIs, Department of Disease Control, and the TUC

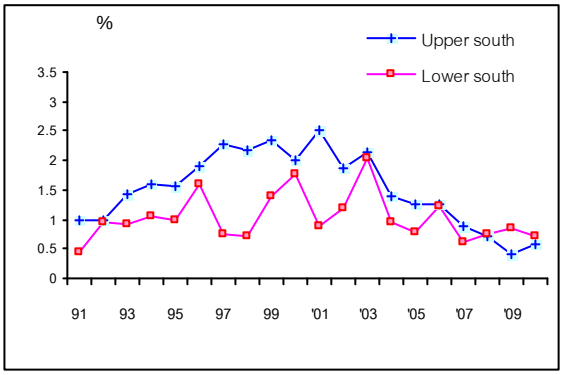
3. Northeast (Isan)





4. South





Military recruits

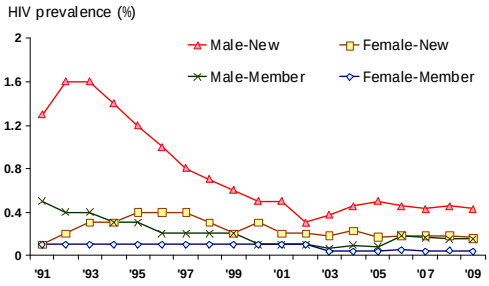
ANC clients

Sources: HIV surveillance data from BOE and the Armed Forces Research Institute of Medical Science (AFRIMS),

The population of blood donors at the Red Cross central blood bank are somewhat representative of the general population who feel they have no risk for HIV (because of the self-deferral screening process before blood is given). Overall, starting in 1993, HIV prevalence among blood donors decreased sharply though, from 2004 to the present there is differentials between sex and whether the donor is new or returning. HIV prevalence among new male donors was initially quite higher than the other sub-groups and declined from 1.60% in 1993 to 0.33% in 2002 (Figure 8). However, after that year, HIV started to climb again, and reached a plateau at about 0.45% -- a level similar to that for military recruits. The level of HIV among the new male donors exceeded the level for returning (or "member") donors by 2.5 to 6-fold. For female donors, even though the HIV prevalence is generally lower than the males, HIV prevalence among new donors exceeded member donors by 2 to 7.7-fold.

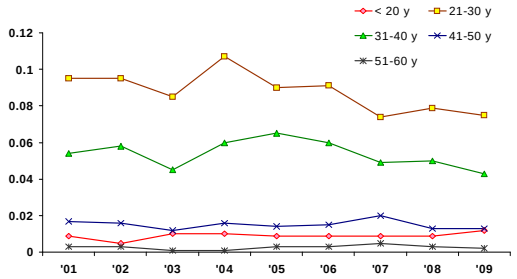
When analyzing these trends and patterns it is noteworthy that there are both males and females who believe they are at low/no risk for HIV when, in fact they still have risk. Whether they perceive that risk accurately depends on the situations they find themselves in.

Figure 8 HIV prevalence among blood donors classified by sex and type of donors, 1991-2009



Source: National Blood Bank, Thai Red Cross

Figure 9: HIV prevalence among blood donors at the national blood bank by age group. 2001-2009



Source: National Blood Bank. Thai Red Cross

Analysis of blood donor HIV prevalence by age group is shown in Figure 9. HIV is highest in the 21-30 year age group, followed by age 31-40 years. There is a slight declining trend in both groups starting in 2004. Among those under 20, the level of HIV is quite low – but is not declining, with a slight turn upward in 2009. These data suggest that more HIV can be expected among the youth and adolescents if more effective intervention is not implemented.

1.2 Trends in HIV among most-at-risk/hard-to-reach populations

Persons with most-at-risk of HIV those are included in the Ministry of Public Health (MOPH) HIV sentinel surveillance (HSS) include female sex workers in brothels and entertainment establishments, IDU, male STI patients, and documented migrant workers. The HSS has been in operation since 1989. Because of social changes, the HSS has expanded the sentinel populations to include hard-to-reach populations of MSM and free-lance sex workers (street walkers). Data from the HSS and serosurveys shows that HIV among the traditionally most-at-risk and the hard-to-reach is still at very high levels. These data emphasize the importance of achieving greater coverage of these groups with prevention services to more effectively control the spread of HIV.

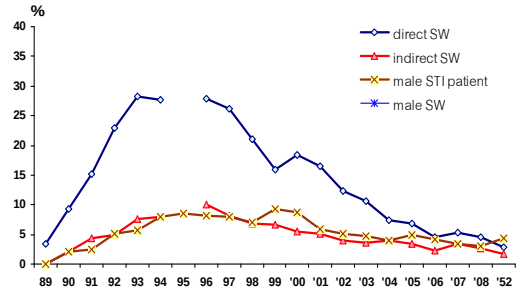
1.2.1 Situation of HIV among sex workers

Female, brothel-based FSWs are assumed to be one of the highest risk populations for HIV. In 1993, the prevalence of HIV in this group had reached 28% (Figure 10). Following massive efforts by multiple sectors and partners in the NASP, through mass communication, individual outreach, and condom promotion, the prevalence of HIV started to decline in both brothel-based (direct establishment FSWs – D-FSW) and FSWs who worked out of entertainment establishments (indirect FSWs or I-FSW). Nevertheless,

it is noteworthy that after 2004, the declined of HIV prevalence slowed to nearly a plateau as of 2009 at levels of 2.76% and 1.66% for D-FSW and I-FSW respectively. When comparing by region, the HSS shows declines in all regions, with the latest level for D-FSW in the central region, including Bangkok at 5.26%, followed by the north (3.70%), south (2.76%), and northeast (1.60). Nevertheless, it is noteworthy that the decline among I-FSW in the south was negligible and with the highest prevalence for ISW among regions (2.23%) followed by the central, including Bangkok, (1.98%), the northeast (1.75%), and the north (1.00%).

For male sex workers, the level of HIV are still high and not yet declining from a level of 11.2% in 2009 (Figure 10).

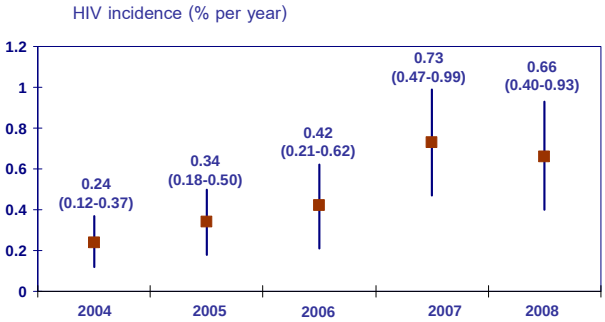
Figure 10: HIV prevalence among female and male SWs, and male STI patients. 1989-2009



Source: HSS of the BOE, DDC

As Thai society has increased in complexity, so have the various formats for indirect commercial sex. Even though HIV among I-FSW has declined, HIV incidence (among those infected less than one year) between 2004 and 2008 increased from 2.4 per 1,000 per year to 7.3 and 6.6 per 1,000 per year in 2007 and 2008 respectively (Figure 11).

Figure 11 HIV incidence per year: Indirect SW. 2004-2008



Sources: HSS of the BOE, DDC and the TUC

In addition, the formats of commercial sex are expanded including street walkers, FSWs soliciting in public areas, through networks of phone contacts, the internet, etc. From a research study in 2008 in Bangkok and Chiang Rai among I-FSWs, it was found that HIV prevalence was 20% and 10% respectively. Prevalence of NSU was 9% in both provincial samples, and gonorrhea was 2% and 1% respectively (Table 1). The network of I-FSW is expanding rapidly at present and is a group that is hard to reach. Unless effective prevention is implemented with this group, then HIV could spread further into the general population of men and women.

Table 1: Results of prevalence survey of HIV and STIs among I-FSW (non-venue-based FSW) in Bangkok and Chiang Rai in 2007

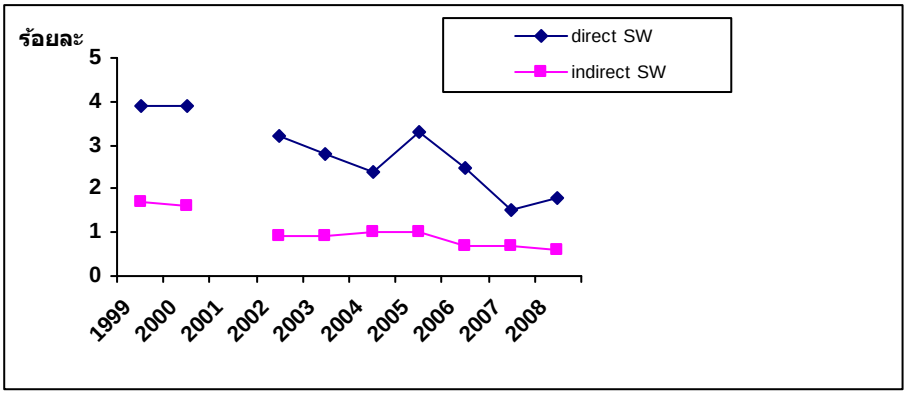
Infection type	Bangkok (N=707)		Chiang Rai (N=366)	
	Venue-based FSWs (N=164)	Non-venue-based FSWs (N=519)	Venue-based FSWs (N=267)	Non-venue-based FSWs (N=87)
HIV	2.5%	20 %	2.6%	10%
Gonorrhea	-	1%	-	2%
NSU	-	9%	-	9%

Source: Bureau of Epidemiology, DDC, MOPH and TUC

As a consequence of government reform and public health re-structuring in 2002, STI case management was integrated with the general health services of hospitals. This had the effect of reducing utilization of STI services by FSWs and the resulting closure of many STI clinics in many provinces. Despite the health reform innovations in the past 2-3 years, services have not yet reached optimal levels of coverage, and there are staff limitations in providing diagnosis, treatment and counseling outside the clinic setting, and this further reduces access to prevention services.

STI surveillance among FSWs during 1999-2008 found that HIV prevalence did not decline, and slightly increased in I-FSW (from 1.5% in 2007 to 1.8% in 2008 (Figure 12). Results from the Integrated Biological and Behavioral Surveillance (IBBS) in five provinces in 2006 among FSWs found that 10.1% of FSWs were infected with NSU, especially among the FSWs age 15-19 years (19.2%), those age 20-24 (13%); and those age 24+ years (7.2%). In a subsequent round of the IBBS in 11 provinces in 2007 found that the prevalence of NSU increased slightly to 11.3% with a similar age group differential. However, the increases were sharpest for FSWs age 15-19 and 20-24, whose NSU prevalence increased from 19.2 to 21.3 and 13.0 t 16.1 respectively (Table 2). The prevalence of gonorrhea was very low but stable at 1.6% and 1.2% in 2006 and 2007 respectively.

Figure 12: Syphilis surveillance among D-FSW and I-FSW during 1999-2008



Source: HSS, BOE, DDC

Table 2: Prevalence of NSU in FSWs by age group from the IBBS during 2006-7

Age group (years)	2006 (5 provinces)	2007 (11 provinces)
15-19	19.2%	21.3%
20-24	13.0%	16.4%
> 24	7.2%	7.3%
Total	**10.1%**	**11.3%**

Sources: BOE, DDC, MOPH; and the TUC

Results from behavioral surveillance surveys (BSS) among D-FSW found that most used condoms for all sex episodes with clients, but use declines with other types of partners. Use is lowest with husband or co-habiting partner. During 2006-8 the level of "always" condom use was 93.7%, 89.8%, and 40.8% for clients, other partners, and husband/co-hab respectively. Coverage of Voluntary Counseling and Testing (VCT) in the prior six months was under 50%. The BSS found levels of use of injection drugs to be increasing from 0% in 2004 to 1.2% and 0.8% in 2007 and 2008 respectively. Regular partners or husbands who inject are at similar levels as for the SWs. This presents a dual risk for FSWs to contract/transmit HIV (Table 3). In addition it was found that, from five knowledge/attitude questions according to UNGASS standards; during 2004 to 2008 correct response was low and not increasing at a level of 39% in 2008. The data thus far show the urgent need to increased coverage of this population with effective prevention, knowledge, and understanding in order to reduce risk behavior for HIV.

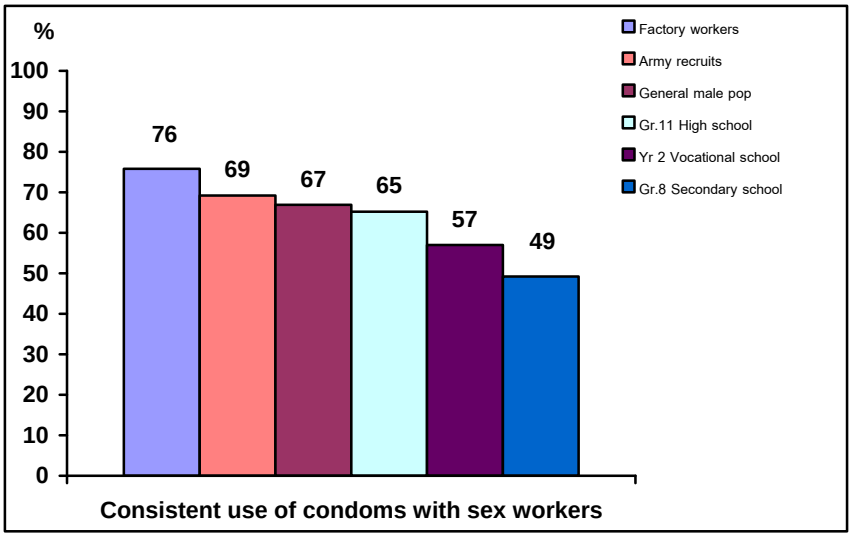
Table 3: Selected behaviors of FSWs in Thailand: 2004-2008

Behavior	2004	2005	2006	2007	2008
Use of condom every time with different types of partners in the past month					
Client	93.4	91.5	86.2	94.0	93.7
Husband or co-habiting partner	35.8	32.3	27.5	30.4	40.8
Other sex partner	82.4	83.3	83.3	80.4	89.8
Use of injection drugs in the past month					
Used injection drugs	0.0	0.6	0.7	1.2	0.8
Husband/co-habiting partner used injection drugs	0.3	0.7	2.1	1.2	0.7
Received an HIV test in past 6 months					
Ever had an HIV test	60.6	48.9	47.0	52.8	48.0
Know the results	48.5	44.8	NA	53.8	NA

Source: Surveillance of HIV risk behavior. BOE, DDC, MOPH

It is noteworthy that the results of the 2008 round of the BSS with FSWs, "always" condom use (all partners) was only 75.8% among D-FSW, 69.2% among military recruits, and 66.95 among general population males. Among school students, "always" condom use with a FSW ranged from 65.2%, 57.0% and 49.2% for grade 11 high school, 2nd year vocational school, and grade 8 secondary school students (Figure 13). These results may suggest deficiencies in knowledge and concern about the need to use condoms for all commercial sex.

Figure 13: Percent condom use with FSWs in 2008



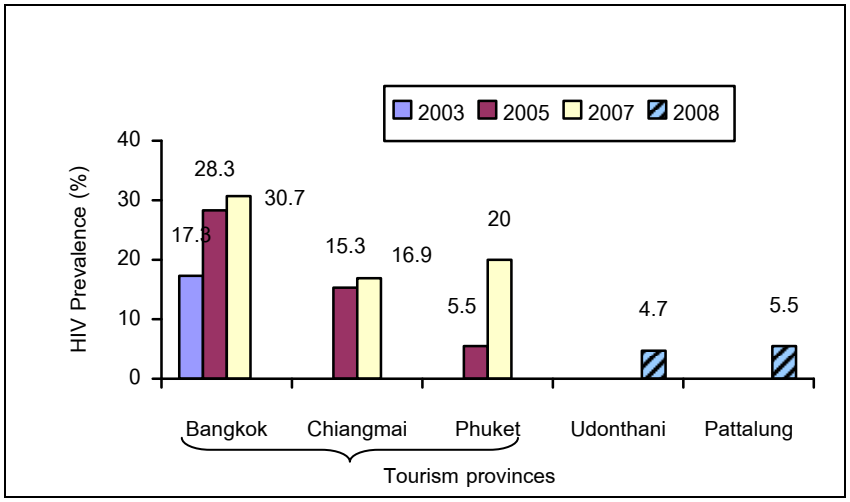
Source: HIV BSS conducted by the BOE, DDC, MOPH

1.2.2 Situation of HIV among men MSM

The spread of HIV among MSM occurred rapidly in the past and shows indications of increasing. At present, it is found that prevalence of MSM behavior is increasing or that MSM are becoming more open about their sexual orientation. The increase is greater as age increases. From surveys of young men in 24 provinces it was found that MSM behavior was 0.3 among upper high schools students, 2 to 3% among vocational school students and 4.7% among military recruits.

HIV prevalence among MSM is higher in large urban areas with higher economic status, more tourism and entertainment establishments (e.g., Bangkok, Chiang Mai, and Phuket). MSM HIV in 2007 ranged from 17% to 31% in these provinces compared to 5% in the smaller, less cosmopolitan provinces of Udon Thani and Pattalung in 2008 (Figure 14).

Figure 14: HIV prevalence from the survey of MSM in sentinel provinces during 2003-2008



Sources: BOE, DDC; and the TUC

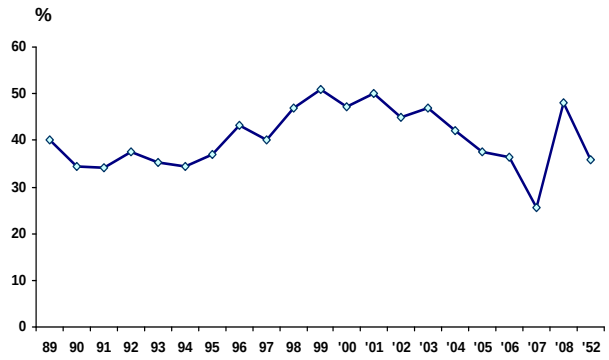
The trend in HIV infection among MSM is increasing for all years and age groups. MSM age 29+ years have the highest prevalence. From the HSS, the sentinel population in Bangkok had a level of HIV of 17.3% in 2003 and 30.7% in 2007. In Chiang Mai, the comparable rates were 15.3% in 2005 and 16.9% in 2007. In Phuket, the rates were 5.5% in 2005 and 20.0% in 2007.

MSM condom use for prevention of HIV is rather low as measured by the survey in 2007 which found that "always" use in the three months prior to the interview was 66% for Bangkok MSM, 44% for Phuket MSM, and 36% for Chiang Mai MSM. In addition, in 2008 surveys of MSM in Udon Thani and Pattalung, "always" condom use in the past three months was 56.3% and 57.0% respectively.

1.2.3 HIV situation among IDU

The level of HIV among IDU remains high and shows no sign of decline. In addition, there is increasing drug addiction including methamphetamines in youth and adolescents. From the HSS of the Bureau of Epidemiology (BOE), the prevalence of HIV among IDU attending detoxification clinics throughout Thailand is within a range of 30 to 40% (Figure 15). In a survey using respondent driven sampling in two provinces (Chiang Mai and Bangkok) it was found that the HIV prevalence was 10.8% ad 23.3% respectively among IDU, among whom only 13.8% and 70.2% had ever attended a detoxification center.

Figure 15: HIV prevalence among IDU: 1989-2009



Source: HSS, BOE, DDC

Risk behavior surveys of IDU in Chiang Mai, Songkla and Samut Prakan, most of whom were clients at the local detoxification clinic, or outreach contacts found that age at first drug use was approximately 16 years, the most common drug used was heroin following by Dormicum, and methamphetamines (meth). The percent injecting drugs with a used needle and letting someone else use one's own needle in the past month were 53.2% and 38.7% respectively in Songkla, 36.1% and 24.2% in Chiang Mai, and 26.1% and 18.0% in Samut Prakan.

In addition to the risk from needle sharing, the survey found that many IDU have unsafe sex: only 35% reported using a condom at last sex. Spread of drug use can increase spread of HIV in multiple ways. The influence of a rapidly changing society has caused many youth and adolescents to turn to drugs such as heroin, meth, Ecstasy, marijuana, alcohol, etc. The BSS found that both male and female high school and vocational students in all grades have used addictive drugs in the past. The most common drug used was marijuana, following by meth (Table 4).

Table 4: Drug use in youth and adolescents: 2008

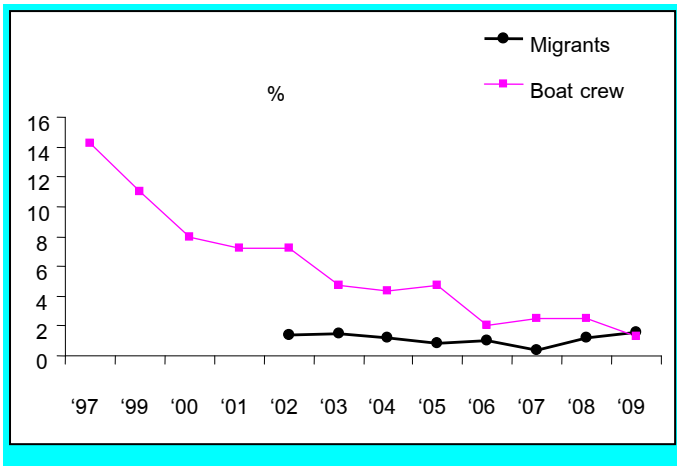
Drug used	Gr.8 secondary school		Gr.11 high school		vocational school	
	male	female	male	female	male	female
Heroin	0.6	0.1	0.5	0.5	1.0	0.1
meth	1.7	0.4	5.3	0.1	12.8	2.3
Marijuana	4.1	0.4	12.3	1.0	24.0	2.9
K	0.4	0.1	0.3	0.1	0.6	0.1
ecstasy	0.6	0.1	0.6	0.7	1.1	0.2

Source: BSS through hand-held computer data-entry. 2008. BOE, DDC

1.2.4 HIV situation among migrant workers and fishing boat crew

From the results of the HSS, migrant workers show increasing HIV infection from 0.84% in 2007 to 1.20% in 2008. For fishing boat crew, the prevalence levels are 1.25% and 2.50% respectively, following declines during 1997 to 2006.

Figure 16: Prevalence of HIV among migrant workers and fishing boat crew Thailand: 1997 - 2008



Source: HSS, BOE, DDC, MOPH

2. Factors facilitating the spread of HIV among children and youth as a result of changes in society, culture and lifestyles

The spread of HIV in Thailand has been going on for over 20 years. The principal driving force of spread has been unsafe sexual behavior, thus disproportionately affected women and men of reproductive age. Despite major advances and success in prevention, the Thai NASP has not yet been able to eradicate new infection. Indeed, rapid changes in society, culture and lifestyles could lead to increased risk of HIV among youth and adolescents in the years ahead. The advancing technology in

communications may be facilitating risk as well. New and effective prevention interventions are needed to address these trends.

Youth sexual norms

Past surveys have found similar results regarding adolescent values and increasing acceptance of pre-marital sex. From a survey in 2007 in 11 provinces among youth age 15 to 22 years it was found that 48.8% find the idea of sex among unmarried adolescents as acceptable. In addition, 67.2% of respondents felt that the decision to have sex was the individuals' choice. Fully 39.1% having multiple sex partners during adolescence was not unusual. These findings are consistent with a national study of in-school children and youth in 2006-7 conducted by the Ramajitti Institute which found that 30% of vocational students and 56% of college students thought the living together before marriage is acceptable.

Rounds of the BSS among male and female students in 24 provinces conducted by the BOE of the DDC, found that a high proportion of respondents reported a history of sex, and the trend is increasing. The 2008 BSS round found that 3% of lower secondary school students (average age of 13 years), 15% to 24% of upper secondary school students (average age of 16), and 37% to 43% of vocational school students (average age of 17 years) had ever had sex.

Sexual debut under age 15 is rising. Studies of vocational students and military recruits from 2005 to 2007 showed an increase from 0.3% to 0.8% in males and 0.2% to 0.6% in females in vocational school, and from 9% to 14% among military recruits.

Other data which substantiate the level of youth sex include an increase in teen pregnancy during 2005 to 2008.In 2008 it was estimated that there were 77,092 teen pregnancies or 211 per day; and increase from 68,385 in 2007.Early-age pregnancy leads to couples being parents before they are ready to, causing economic hardship and, in some cases, to commercial sex. [3]

The survey of youth under the Child Watch project found that 18% to 20% in Bangkok, the central and north regions had had sex; it was lowest in the south at 11.6% (Figure 17).

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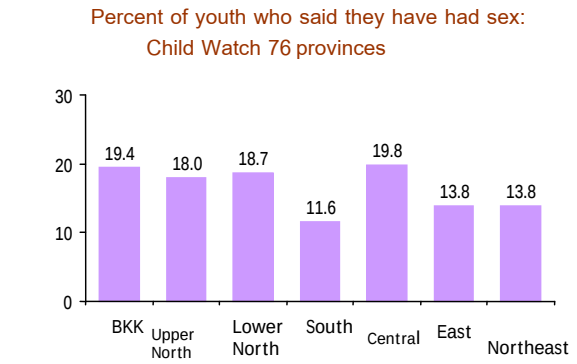
[3]Source: Dr. Amornwich Narkathap. Director of Ramajitti Institute; and Child Watch. Reported in The Nation 12/26/08.

Figure 17: History of sex of youth in high school and college in 2008



Source: Survey of behavior of in-school children and youth. Child Watch. Ramajitti Institute

2.2 Copying others' behavior and effect on promiscuity in youth

A certain segment of youth still lack knowledge and correct understanding about safe sex. In addition, some of their risk may come from copying the behavior of others, such as tendency toward promiscuity. In the 2008 round of the HIV BSS among school-based youth age 16 to 18 years by the BOE, it was found that over 50% of males had ever had sex while 20% of females had more than one sex partner in the past year.

2.3 Sex for money or in-kind payment among youth is increasing

A segment of youth has sex for some sort of material compensation which could be an outgrowth of economic difficulty or the materialistic values of the socio-cultural environment at present. The HIV BSS by the BOE of the DDC among school-based youth from 2005 to 2008 found that sex for money/material was increasing and increases with age. In 2008, 0.6%, 1.3%, and 3.2% of male grade 8 secondary school students, grade 11 students and vocational students respectively reported having sex for money/material compared with 0.1%, 0.5%, and 1.7% of females respectively.

2.4 Same-sex male risk behavior

At present, there are increasing diverse sex lifestyles, and greater openness and acceptance of these. This has rapidly increased the social network of those with different sex preferences. Men who prefer to have sex with men have been studied in surveillance surveys among general population males, male factory workers, military recruits, grade 8 and grade 11 high school students and vocational school students. Same-sex male sex increases with

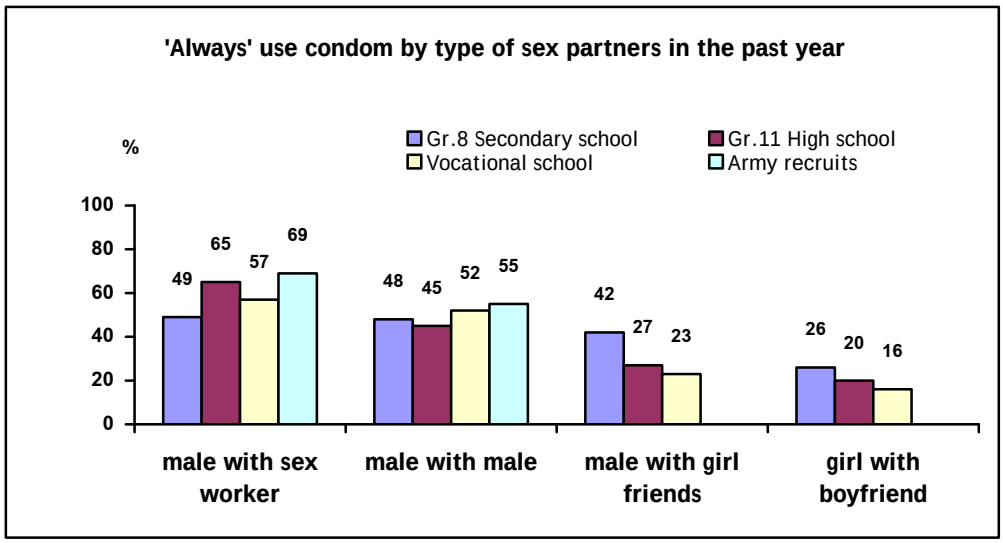
age. In 2008 0.4% of male students age 12 to 13 had had sex with another male in the past year; 2.1% to 3.0% among those age 16 to 18, and 4.7% among military recruits. Approximately 3.8% of general population males and male factory workers reported having sex with another man.

2.5 Lack of skills, knowledge and motivation for use of condoms to prevent HIV

Even though knowledge surveys show high levels of awareness of safe sex, and the effectiveness of condoms to prevent HIV and STI, there is still a lack of proper concern and skill in condom use, or in negotiating condom use when appropriate. This could be part of the explanation for non-condom use during commercial sex or with other non-marital partners. Only 50% to 70% of male students, military recruits, and male factory workers reported using a condom every time they had sex with a sex worker. Only one in four or 20% to 40% of male and female students used a condom every time they had sex with their girlfriend or boyfriend respectively (Figure 18).

In an environment where HIV is increasing among MSM, combined with increased openness about sexual orientation, the survey data show persistently low levels of condom use since 2004, with only slight increases to 50% use as of 2008.

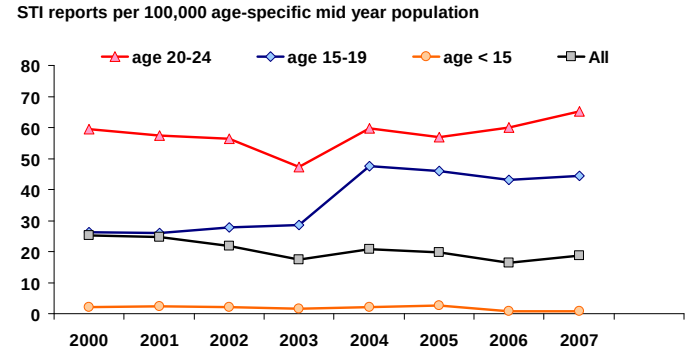
Figure 18: Condom use among youth: 2008



Source: HIV BSS in youth. 2008. BOE, DDC.

Secondary evidence for increasing unsafe sex comes from trends in STI data from the network of STI clinics through the STI Group of the DDC of the MOPH. STI cases are most numerous in the 20 to 24 years age group, followed by 15 to 19 years, with increasing trends during 2000 to 2007 (Figure 19).

Figure 19: Trends in STI among the population under 25 years during 2000-2008



Source: STI Group, Bureau of AIDS, DDC

2.6 Children and youth drink more, and this creates potential risk for unsafe sex

Male students have more pre-marital sex than females and are less aware of their HIV serostatus. Also, they are less interested in receiving information about STIs and AIDS, perhaps because they do not want to admit that they are sexually active our of fear of social rejection. Also, many studies have shown that unsafe sex is more likely when one is drunk. Also, youth who drink also use the Internet to view pornography because of easy access and lack of external controls.

From surveys conducted by the WHO in 2001, it can be seen that the proportion of youth whose age at first consumption of alcohol is under 15 years is increasing. There is a greater chance of alcohol addiction and unsafe sex. In a survey of 2nd year high school students (mean age of 12) it was found that 34% to 36% of males and 18% to 25% of females had ever consumed alcoholic beverages, with a constant trend over time (2005-2008). More in-depth surveys are needed to study the context of the drinking, the type of alcohol consumed, and access of youth to alcohol in order to develop appropriate and effective control and prevention measures.

2.7 Children and youth lack knowledge and concern about protecting oneself from HIV

From the HIV BSS among male and female students at the grade 8, 11 and 2nd year vocational school level in 2008, the knowledge score based on UNGASS indicators was low (both sexes). The percent who could answer all five knowledge questions correctly was under 50%; grade 8 students had

lower correct knowledge than grade 11 students, and 2nd year vocational students (Table 5). The questions with the least correct response were "Sharing meals with a PLHIV can transmit HIV" and "HIV can be spread by mosquitoes."

Table 5: Percentage of Thai students who could correctly answer UNGASS AIDS knowledge questions by grade of student, sex and year: 2005 - 2008

Students	2005	2006	2007	2008
Male				
Secondary school Gr.8	13.5	16.05	12.6	16.6
High school Gr.11	31.0	30.3	22.6	32.2
Vocational year 2	22.7	22.7	21.7	24.7
Female				
Secondary school Gr.8	15.60	12.7	13.7	19.1
High school Gr.11	31.3	32.1	28.3	35.3
Vocational year 2	24.1	25.7	24.6	25.9

Source: HIV BSS, BOE, DDC

Note: The five UNGASS knowledge questions include: condoms prevent AIDS; having an HIV-negative sex partner prevents AIDS; mosquitoes spread HIV; eating with a PLHIV spreads HIV; someone who looks health can be HIV+.

3. Analysis of the epidemiological situation to prioritize sites and populations for prevention activities

3.1 Guidelines for use of data to prioritize locations for confronting the epidemic

Appropriate measures need to be taken to effectively allocate HIV-prevention resources so that there is a cost-effective impact on the overall epidemic. Analyzing the available epidemiological data combined with an understanding of the dynamics of transmission can help programs make the best resource-allocation decisions.

HIV spread in Thailand has the following characteristics: (1) At present, most transmission is heterosexual; (2) There are groups with higher prevalence and incidence than others including MSM and IDU; (3) Youth have high risk behavior (condom use with SWs is low). Thus, important measures for prevention of HIV include increased condom use in various groups and reduced needle sharing among IDU.

For IDU, the priority area should be Bangkok because, in other areas, more IDU have switched to amphetamines. For MSM, there is a limited geographic range of data; however priority can be given to provinces with large tourist populations. For youth and other populations, each needs to be assessed according to its HIV prevalence level, combined with consideration of the following:

- Even though some youth have increasing risk, such as younger age at first sex, more teen sex, the important factor to consider is whether the youth's sex partner is high-risk or not (i.e., D-FSW or I-FSW).
- Whether pregnant women have high or low HIV levels derives at least in part as to their partners' behavior for HIV, and whether the man frequently purchases sex.
- The prevalence of HIV in the various sentinel groups has more or less implication for incidence needs to be taken into consideration as well (i.e., the amplifier effect).

Thus, the priority sites for HIV-prevention emphasis include provinces with at least one of the following characteristics:

- Prevalence of HIV among D-FSW is among the top 15 provinces, or
- Prevalence of HIV among I-FSW is among the top 15 provinces, and has one of the following characteristics:
- Prevalence of HIV of military recruits is among the top 15 provinces
- Prevalence of HIV of ANC clients is among the top 15 provinces

After applying the latest HIV prevalence data (2009, except for military recruits) the following priority areas are derived as shown in Table 6.

It can be seen that 25 provinces meet the initial screening criteria. After applying all criteria, there remain 15 provinces as follows:

1. Central region: 7 provinces including Bangkok, Nakorn Sawan, Samut Songkram, Saraburi, Singburi, and Suphanburi
2. Eastern region: 2 provinces including Trad and Prachinburi
3. Southern region: 3 provinces including Prachuap Kirikhan, Nakorn Sri Thammarat and Phuket
4. North region: 2 provinces including Pitsanuloke and Lampang
5. Northeast region: 1 province: Udon Thani

In any event, this review of the data is preliminary. The readiness and feasibility of implementing intensive prevention in the location, along with the size of the risk population, and integration of the target population should be taken into consideration before final selection is made.

Table 6: Distribution of HIV prevalence among sentinel populations; rank of 15 provinces with highest prevalence

Province	Direct FSW		Indirect FSW		ANC client		Army recruit ('08)		Meets criteria
	rank	%	rank	%	rank	%	rank	%	

1	Samut Songkram	**1**	**21.21%**	1	7.29%	**4**	**1.78%**	64	0.00%	**X**
2	Lampang	**2**	**16.00%**	11	3.39%	**6**	**1.66%**	63	0.10%	**X**
3	Sukothai	**3**	**10.81%**			61	0.17%	38	0.35%	
4	Phanga	**4**	**9.83%**	2	5.33%	62	0.00%	19	0.60%	
5	Trad	**5**	**9.46%**	6	4.42%	**5**	**1.77%**	64	0.00%	**X**
6	Singburi	**6**	**6.74%**			**9**	**1.42%**	64	0.00%	**X**
7	Pathum Thani	**7**	**6.67%**	38	1.05%	41	0.59%	23	0.50%	
8	Lopburi	**8**	**6.00%**	10	3.60%	28	0.85%	**3**	**1.35%**	**X**
9	Prachuap Kirikhan	**9**	**5.26%**	25	1.81%	**11**	**1.40%**	38	0.35%	**X**
10	Nakorn Sawan	**10**	**5.03%**	41	0.75%	46	0.53%	**4**	**1.20%**	**X**
11	Chumporn	**11**	**4.88%**			42	0.58%	47	0.25%	
12	Bangkok	**12**	**4.47%**	43	0.34%	23	0.93%	**5**	**1.10%**	**X**
13	Pitsanuloke	**13**	**3.70%**	32	1.43%	**12**	**1.32%**	28	0.45%	**X**
14	Phuket	**14**	**3.51%**	33	1.42%	**10**	**1.40%**	**2**	**1.50%**	**X**
15	Suphanburi	**15**	**3.26%**	18	2.41%	**8**	**1.56%**	33	0.40%	**X**
16	Yaosthorn			**3**	**5.15%**	62	0.00%	23	0.50%	
17	Prachinburi			**4**	**4.74%**	**2**	**2.84%**	**10**	**0.80%**	**X**
18	Ayuthaya			**5**	**4.64%**	51	0.41%	28	0.45%	
19	Nakorn Nayok			**7**	**4.17%**	62	0.00%	64	0.00%	
20	Nong Bua Lamphu			**8**	**4.03%**	38	0.61%	33	0.40%	
21	Saraburi	30	0.00%	**9**	**3.64%**	19	1.04%	**1**	**1.55%**	**X**
22	Roi Et			**12**	**3.33%**	22	0.95%	23	0.50%	
23	Phichit			**13**	**2.90%**	62	0.00%	33	0.40%	
24	Udon Thani	19	2.76%	**14**	**2.82%**	58	0.24%	**13**	**0.70%**	**X**
25	Nakorn Sri Thammarat	22	2.63%	**15**	**2.80%**	18	1.08%	**13**	**0.70%**	**X**

Source: HIV sentinel surveillance, BOE, DDC

B. Estimates of HIV and AIDS during 2007 to 2011

1. Estimating the number of new infections

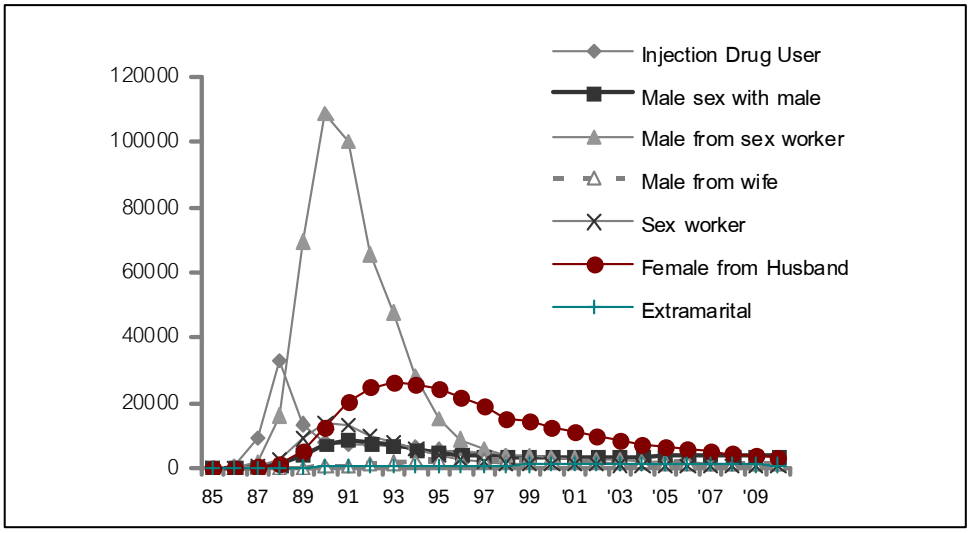
The computer program Asian Epidemic Model (AEM) informs the discussion of the projected AIDS situation and used data from the MOPH HSS and BSS among other sources and was first applied in 2000. The AEM program and baseline data has been improved and up-dated through the integrated analysis and advocacy to improve responses *(A^2)*, (a collaboration of the East-West Center, AIDS Research Unit of the Thai Red Cross, the DDC, Family Health International (FHI), and the U.S. Agency for International Development (USAID).

The results of the projection which looked at past, present and future spread of HIV found that at the beginning of the epidemic, IDUs were the first to experience an outbreak with very rapid growth of new infections, followed by a slowing down of spread due largely to a saturation of the relatively small population of susceptibles (Figure 20).

Not long after the IDU epidemic began, HIV began to spread rapidly among SW and their male clients. Because the men represented a large and mobile population, HIV spread widely throughout the country, both in urban and rural areas. HIV among these populations peaked during 1990 to 1995. Commercial sex generated more HIV infections other routes of transmission and led to a third epidemic among women married to men infected through commercial sex and bi-sexual men infected by sex wit other men.

An important factor affecting reduced trends in HIV spread include the campaigns to increase AIDS awareness and the 100% Condom Use Program implemented in commercial sex establishments beginning in 1992. Thai behavior started to change on a mass scale at this point, leading to reduced incidence (Figure 21). In any event, efforts to change behavior in other populations were sporadic, and there was less impact on reduced incidence in these groups when compared to FSWs and clients.

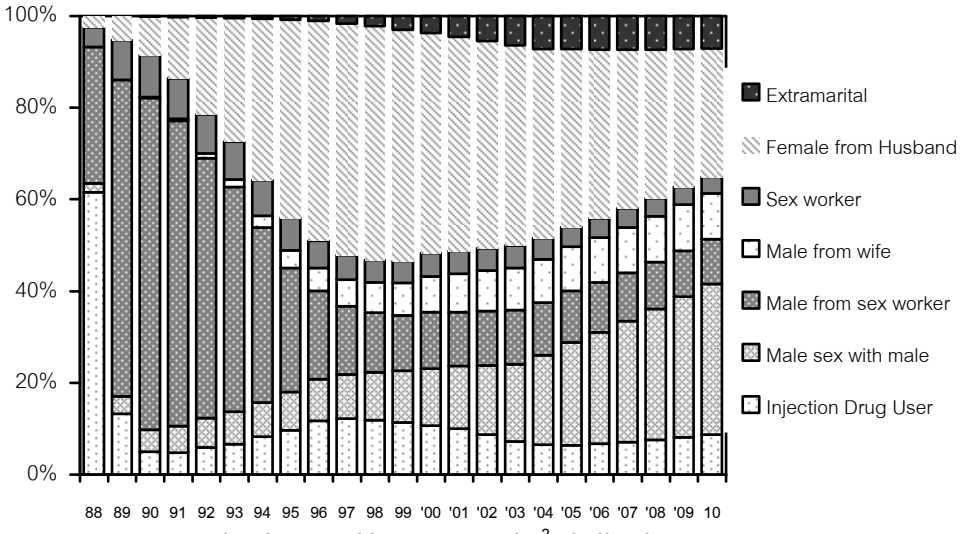
Figure 20: Estimates of the number of new cases of HIV by population and risk factor: 1985-2010



Source: AIDS Projections Working Group and A^2 Thailand

In the initial results of the projections it is noteworthy that during 2007-2011 the proportion of new cases by risk factor, women infected by a husband or steady partner and men infected sexually by another man account for more new infections than other groups (Figure 21). These data clearly show the critical and vulnerable aspects that need prevention attention at present and in the near future.

Figure 21: Projected new infections by population and risk factor: 1988 – 2010



Source: AIDS Projections Working Group and A^2 Thailand

2. Projection of AIDS patients, ART clients and AIDS deaths

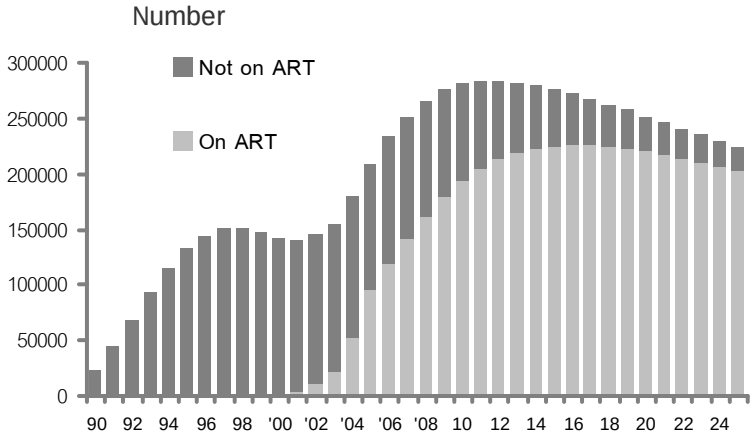
Thailand's ART program, with support from the NHSO and the GFATM, has greatly improved access to ARV so that at least 200,000 PLHIVs are being treated. Nevertheless, by looking at the projections data for surviving PLHIV plus the newly infected, holding trends constant from 2005, it is projected that there were a half million PLHIVs in Thailand in 2009, with 281,139 progressing to a stage requiring ART. Over time, the numbers of PLHIV plateau and decrease in accordance with the effectiveness of the control program (Table 7 and Figure 22).

Table 7: Number of PLHIV and AIDS patients as projected from the AEM

Estimation	Year						
	2005	2006	2007	2008	2009	2010	2011
New HIV infections	16,513	15,174	13,936	12,787	11,753	10,853	10,097
Cumulative new infections	1,073,518	1,088,692	1,102,628	1,115,415	1,127,168	1,138,020	1,148,117
Number of new AIDS cases	50,254	50,814	51,091	50,657	49,049	46,272	42,992
Number of new AIDS deaths	18,843	20,797	24,830	26,935	27,680	28,123	27,557
Number of cumulative AIDS deaths	513,268	534,065	558,895	585,830	613,510	641,633	669,191
Total number living with HIV/AIDS	562,243	556,848	546,578	532,522	516,632	499,324	481,770
Number eligible to receive ART*	207,544	233,035	252,388	266,369	275,821	281,139	283,612

* Estimates from the treatment standards issued in 2006-7 which specify initiating ART when CD4 count is under 200

Figure 22: Estimated number of PLHIV eligible to receive ART and number receiving ART according to the AIDS treatment policy of Thailand



Source: AIDS Projections Working Group and A^2 Thailand

From the projections data it can be seen that Thailand still has a large number of persons with HIV and AIDS that will need on-going care. If one also takes into consideration the families the elderly and children who are impacted by AIDS, there is even a greater need for material and human resources, budget, medical supplies, and drugs, in sufficient quantity to meet the growing need.

There is also a need to accelerate coordination among government agencies and NGOs, civil society, and the community to achieve the maximum effectiveness of the overall program.

Summary

In sum, the data from the HSS and other sources show pattern of spread of HIV and that spread of new infections continues in certain subgroups of the general population. Incidence has not declined in all groups and is still high in the most-at-risk populations and/or is hard-to-reach. These populations include IDU, MSM, and indirect sex workers. In addition, HIV survey and BSS data in youth show that rapid changes in society, the economy, and culture encourage some youth to engage in risk behavior for HIV. As stated at the outset, this provides an alarm warning for Thailand to be alert for, and try to prevent, repeated outbreaks of HIV.

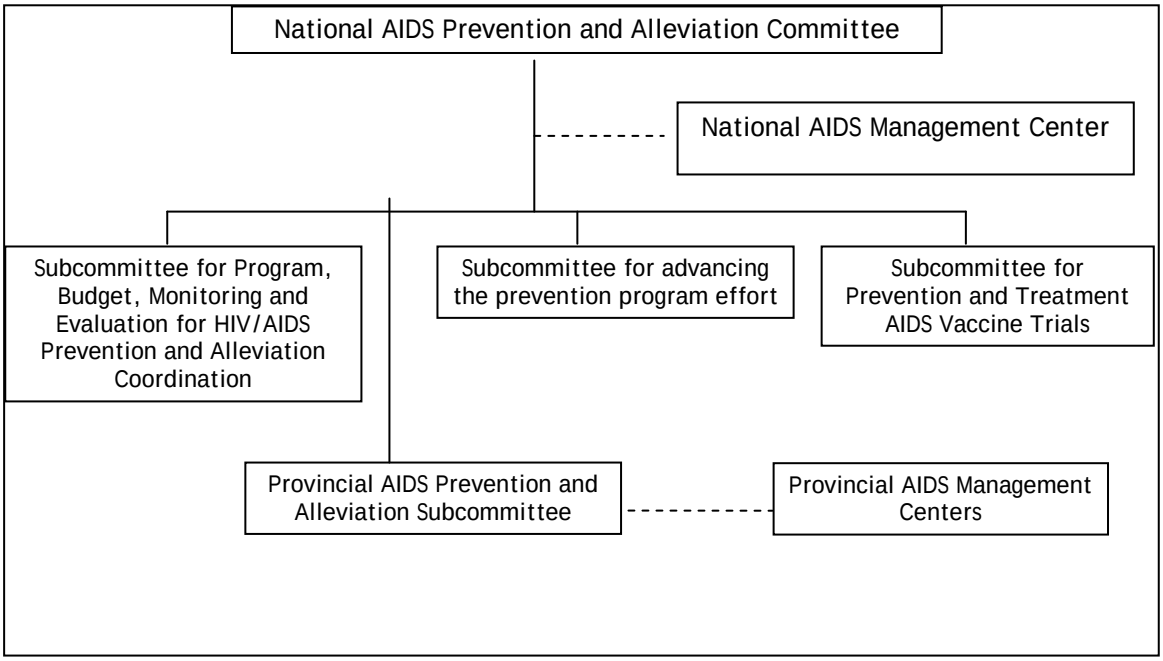
III. National Response to the AIDS Epidemics

1. National AIDS Authority

The National AIDS Prevention and Alleviation Committee (NAPAC), comprising of the representation of various sectors from the government to civil society, has been responsible for policy making for the national HIV/AIDS prevention and alleviation plan from 1997 onward. NAPAC is chaired by the Prime Minister. The Director General of the Department of Disease Control is the secretariat, of which the National AIDS Management Center is responsible as the secretariat office of the NAPAC.

At the country level, it comprises of 3 Subcommittee i.e. Subcommittee for Program, Budget, Monitoring and Evaluation for HIV/AIDS Prevention and Alleviation Coordination, Subcommittee for Advancing the HIV/AIDS Prevention Program Effort and Subcommittee for Prevention and Treatment AIDS Vaccine Trial. At the provincial level, there is a Provincial AIDS Prevention and Alleviation Sub-Committee for each province. (Figure 23)

Figure 23: Structure of National AIDS Authorities



2. National Integrated HIV/AIDS Strategic Plan

Thailand's current National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation (NASP) for 2007-2011 was developed through broad multi sector collaboration and approved by the NAPAC.

Targets set by the end of the current NASP in 2011 are: 1) reducing new HIV infections by at least half; 2) universal access to ART for those in need and 3) at least 80% of PLHIVs, families and those affected by AIDS access to social support. Its objective is to integrate HIV prevention and alleviation strategies at all levels and to promote multi sector collaboration and to provide integrated services for identified population groups. The NASP identifies four strategies: 1) improved management to integrate HIV/AIDS responses in all sectors, 2) integration of prevention, care, treatment and impact mitigation for each population group, 3) HIV/AIDS related rights protection and 4) monitoring and evaluation coupled with research on HIV prevention and alleviation and emphasizes the importance of supportive public policy and the empowerment of people to protect themselves.

3. Progress of National Response to HIV/AIDS

Thailand has experienced three decades of the HIV/AIDS epidemic. To this day, AIDS is still having an adverse effect on Thai daily life, the health system, and socio-economic well-being of the country. Even though Thailand has demonstrated strong efforts in the battle against AIDS, and has many achievements, that does not mean that Thailand is complacent about the challenges ahead and the need to continue to intensively fight the epidemic.

The report of the country response to the HIV epidemic is divided into two sections.

- The first part is a review and examination of progress of implementation in accordance with the Declaration of Commitment on HIV/AIDS to which Thailand and 188 countries were signatories in July 2001. Then there is an examination and an analysis of gaps with consideration from the viewpoint of the government and civil society.
- The second part is a discussion of progress of implementation of HIV/AIDS prevention and control over the past two years, which the M&E working teams have assembled, synthesized and summarized the relevant information on performance toward the UNGASS indicators.

Part 1

Progress towards the Declaration of Commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS, 27 June 2001

Leadership

"Strong leadership at all levels of society is essential for an effective response to the epidemic.

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.

Leadership involves personal commitment and concrete actions."

Declaration Item 37-38

- Thailand launched national AIDS strategic plans since 1995. The current plan period is 2007-2011. The plan was developed with full participation of all sectors, with integrated prevention and control. The plan specifies priority target groups and has made assurances for rights protection. Most of the budget for implementation is domestic.
- Despite the political turmoil of the past 3-4 years, Thailand has still made progress in AIDS because of its strong implementation team comprised of government and civil society working together with PLHIV. With the current prime minister (Abhisit Vejjajiva) chairing the NAPAC since July 2009, the program has been given added strength and motivation, and given the goal of accelerating prevention to halve new infections by 2011.
- With decentralization giving the local administrative organizations (LAOs) more authority, the role of local leadership is critical for the success of the NASP. In this report period, there has been a significant increase in the attempts to engage and build capacity of the LAOs in priority areas for AIDS prevention and control.
- The Thailand Business Coalition on AIDS (TBCA) has coordinated with the business sector so that businesses take more responsibility for HIV/AIDS prevention and control not only for their personnel but also for the public. Many businesses have joined the effort including Kasikorn Bank, Standard and Charters Bank, and Chevron.

Prevention

"Prevention must be the mainstay of our response"

Declaration Item 47, 48

- The current NASP calls for the halving of new infections by the end of the plan period, and has set behavior targets for the priority groups.

Declaration Item 49, 50

- In 2009, the NAPAC proclaimed that there are AIDS in the workplace programs for all worksites, public and private, throughout the country.
- Despite the fact the most of the budget for prevention work with migrants and displaced persons comes from external sources, the MOPH has arranged health insurance for documented migrant workers and has submitted policy recommendations to the NAPAC on extending HIV/AIDS prevention and control services to these vulnerable populations.

Declaration Item 51

- The MOPH has issued guidelines for universal precautions for all its health facilities.
- The national blood bank of the Thai Red Cross screens every unit of donated blood, and the MOPH has a policy of ensuring that all laboratories under its jurisdiction perform to standard – international or domestic.

Declaration Item 52, 53

- The current NASP has specified clear targets for all priority groups. However, due to decentralization of budget and implementation to the province and LAO level, the amount of coordinated prevention activity has declined.
- The Thai program has received budget for prevention with youth, MSM, sex workers, IDU, migrants, and prison inmates. In addition to increasing coverage of services for these groups, Thailand is encouraging provinces and LAOs to mobilize local sources of funds to sustain interventions in a cost-effective way.

Declaration Item 54

- PMTCT is being implemented efficiently in Thailand. Triple therapy is now being used. Therapy is tailored to the client's CD4 cell count, and Thailand has launched the "staying negative" strategy in ANC clinics through promotion of couple ANC attendance. Thus, it can be seen that

the program is giving increased importance to the health of the mother. In any case, implementation of PMTCT is still seen as overly focused on the infant at the expense of the infected mother. This is particularly sensitive in the area of planning for pregnancy, carrying a pregnancy to term, or having an abortion based on fully informed consent and self-determination.

Care, support and treatment

"Care, support and treatment are fundamental elements of an effective response"

Declaration Item 55, 56, 57

- All Thais have right of access to ART through the Universal Coverage, social security and civil servant medical benefit schemes.
- There is a network for managing pediatric AIDS treatment, with referral links among the different levels of hospitals.
- TNP+ together with NGOs has established comprehensive continuum care centers in collaboration with district hospitals to provide services to PLHIVs.
- ART still does not fully cover migrants in Thailand who are HIV+. The GFATM is providing support for ART for a portion of these migrants.
- Another challenge is that new clients for ART are coming too late in the course of their infection, when their immune system has already suffered severe damage.

HIV/AIDS and human rights

"Realization of human rights and fundamental freedoms for All is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response"

Declaration Item 58, 59

- Thailand has laws, policies, orders, and directives for human rights protections, and these extend to PLHIV in most cases.
- The Foundation for AIDS Rights (FAR) produced the report of a study reviewing laws and policies on human rights and AIDS rights, and the report of the situation of human rights related to HIV/AIDS in Thailand (2007 and 2008). The TPN+ conducted a study of stigma and discrimination toward PLHIV in 2009, while the Thai NGO Coalition on AIDS (TNCA) produced a report analyzing policy as a response to AIDS

seen through the lens of sexual and reproductive health rights. Even though Thailand has rather good policies in place, these are not always implemented in practice. Human rights related to AIDS still don't receive optimal priority, and implementation at the peripheral level is often not consistent with the national policy

Declaration Item 60, 61

- From the view of civil society, support and provision of health services that are consistent with a rights perspective interact with many different dimensions of the program and which can infringe on human and reproductive health rights. For example, the providers of the PMTCT service, HIV VCT, and user-friendly services for youth, women and vulnerable populations, need improved awareness of the need to respect client rights including an understanding the diversity of sex lifestyles, gender and sexuality.

Reducing vulnerability

"The vulnerable must be given priority in the response

Empowering women is essential for reducing vulnerability"

Declaration Item 62, 63, 64

- During 2008-2009 the Subcommittee for advancing the prevention program effort reviewed the support for different agencies in the public and private sectors.
- Prevention activities for youth and most-at-risk groups, as supported by the GFATM, use the strategy of raising AIDS awareness and skills building to providers for a better understanding of sex, gender and sexuality. Other services include condom and lubricant distribution.
- To reduce vulnerability of the family, the NASP is trying couple ANC to increase male participation to address the feminization of the epidemics.

Children orphaned and made vulnerable by HIV/AIDS

"Children orphaned and affected by HIV/AIDS need special assistance"

Declaration Item 65, 66

- Orphans and non-orphans have equal access to education.
- Thailand lacks strategic information about orphans and children affected by HIV/AIDS. Most of the assistance is in the form of welfare, when children also need psycho-social support.

- Another challenge is when pediatric PLHIV age into adolescence. There is a need for service providers to understand their needs relating to reproductive health.

Alleviating social and economic impact

"To address HIV/AIDS is to invest in sustainable development"

Declaration Item 68

- In the national socio-economic development plan for 2007-2011, there is discussion of the impact on the economy and society. There should be a review of this impact conducted in 2010 to serve as background data for planning in the next phase.

Declaration Item 69

- The guidelines for AIDS prevention and management in the workplace (2009) have an important section on rights protection of workers.

Research and development

"With no cure for HIV/AIDS yet found,
further research and development is crucial"

Declaration Item 70, 71, 72, 73, 74

- Thailand has completed a Phase 3 study of an AIDS vaccine.
- There are research studies in the clinical, behavioral, and development areas being implemented by many agencies. However, there is no overall summary or review of these results in order to serve as a database to guide future research.

HIV/AIDS in conflict and disaster-affected regions

"Conflicts and disasters contribute to the spread of HIV/AIDS"

Declaration Item 77, 78

- The military and policy have on-going AIDS prevention and control plans and programs.

Resources

"The HIV/AIDS challenge cannot be met without new, additional and sustained resources"

Declaration Item 82, 85

- Fully 80-90% of the AIDS budget is supported from domestic sources; but the proportion that goes for prevention is relatively small.

- The challenge is how to mobilize enough resources for continuing the prevention and control activities through the LAOs.

Follow-up

"Maintaining the momentum and monitoring progress are essential"

Declaration Item 94, 95, 96

- The NAPAC has set up 16 working groups with representatives from the government, civil society, experts and international organizations. These groups collaborated to produce this report, as well as producing a framework for monitoring and evaluation of the program going forward.

Part 2:

1. National Commitment and Action

1.1 National AIDS Spending Assessment (NASA)

Thai national AIDS expenditures in 2008 totaled 6.928 billion baht or 110 baht per capita, or 14,275 baht per single PLHIV (from an estimate of 485,325 PLHIVs). This represented 0.08% of the GDP in 2008 or 1.9% of all health expenditure. In 2009 AIDS expenditure increased slightly to 114 baht per capita or 14,417 baht per single PLHIV (Table 4, Annex 2).

Table 8: Thai AIDS expenditure (in baht) by type of expenditure in 2008 and 2009

Type of expenditure	2008		2009	
	million baht	%	million baht	%
Prevention	1,500	21.7	987	13.7
Care and treatment	4,560	65.8	5,483	76.1
Assistance for orphans and vulnerable children affected by AIDS	50	0.7	52	0.7
Management and strengthening planning	397	5.7	250	3.5
Compensation for staff and personnel	44	0.6	208	2.9
Rights protections and social services not including support for children/orphans affected by AIDS	219	3.2	171	2.4
Improving the environment for implementation and community development	2	0.0	8	0.1
Research not including operational research	156	2.3	49	0.7
Total	**6,928**	**100.0**	**7,208**	**100.0**

From Table 8 most Thai AIDS expenditure was for care and treatment (66% in 2008 and 76% in 2009). Prevention expenditure was 22% in 2008 and declined to 14% in 2009. The other components consume only small portions of the overall budget.

The sources of funding for AIDS are almost all domestic (85% in 2008 and 93% in 2009) and are in the form of care and treatment (71% in 2008 and 80% in 2003). Funds from external sources are declining, from 17% in 2007, 15% in 2008 and 7% in 2009. Approximately one-third of external in budget in 2009 was to support personnel, followed by 29% for prevention activities, 17% for management, and 15% for care and treatment.

The National Health Security Program (NHSP) is the largest domestic source of funds as it accounts for half of all expenditures. The government civil service and social welfare program accounted for 12% to 15% each. Almost all of this support was for care and treatment of PLHIV.

When analyzing per capita expenditure per single PLHIV in 2009 with 2007 it can be seen that per capita expenditure increased markedly from $333 in 2007 to $415 in 2009. This increase is explained by the reduced number of new infections combined with an increase of PLHIV on ART or who switched from first-line to second-line regimens due to viral resistance.

Table 9: Details of care and treatment expenditures during 2008-2009

Expenditure component	2008		2009	
	million baht	%	million baht	%
Total	**4,560**	**100**	**5,483**	**100**
1 ARV drugs	2,031	45	3,125	57
2 In-patient care	942	21	1,042	19
3 Out-patient care	420	9	491	9
4 Monitoring the effect of treatment through lab tests	697	15	373	7
5 OI prophylaxis	190	4	215	4
6 Nutritional supplements	141	3	139	3
7 Maintenance care	67	1	75	1
8 Home-based care	50	1	11	0
9 Other, non-specific	20	1	7	0
10 Psycho-emotional care	4	0	5	0

Source: Modified from Table 10 in Annex 2

Table 9 shows detail of expenditures by care and treatment component. It can be seen that expenditure in 2009 increased to 5.483 billion baht, more than half (57%) of which was for ARV drugs; 28% was for OI treatment (both in- and out-patient); 7% was for laboratory monitoring, 4% was for OI prophylaxis; and 4% for other care and treatment.

Expenditure for ARVs increased from 2.031 billion baht in 2008 to 3.125 billion baht in 2009, or 54% in a single year. This was due to an increase of PLHIV starting first-line treatment (from 96,119 to 108,924 respectively) and an increase of PLHIV taking second-line regimen ARVs from 2,998 to 5,572 in 2008 and 2009, representing an 86% increase in one year. This had the effect of increasing the cost of ARV drugs per PLHIV from 10,728 baht to 16,162 in 2008 and 2009.

Table 10 shows details on prevention component expenditures. It can be seen that prevention expenditures decreased from 1.5 billion baht in 2008 to 0.987 billion baht in 2009, for a 34% decline in one year. Approximately one-third of expenditures for prevention were for protecting the blood bank supply, and one-fifth was for ARVs for prevention such as for PMTCT and Post Exposure Prophylaxis (PEP). Prevention of risk behavior consumed about one-fourth of the budget in 2008 and increased to 38% in 2009. Expenditure for condoms was only 3% of the total prevention costs.

In sum, Thai AIDS expenditures drew primarily on domestic sources of funds and most of it was for care and treatment of PLHIV. Expenditures for prevention were small by comparison and these were mostly supported by external sources, especially that for prevention of risk behavior in priority populations. Expenditure for condoms was very small, and was probably less than is needed to achieve the target of halving the number of new infections by 2011.

Table 10: Details of AIDS Prevention Expenditure during 2008-2009

Components of Expenditure	2008		2009	
	million baht	%	million baht	%
Total Prevention Expenditure	**1,500**	**100**	**987**	**100**
1 Safe blood supply	404	27	343	35
2 PMTCT	136	9	131	13
3 Post-exposure prophylaxis (PEP)	6	0	105	11
4 Prevention in schools	118	8	78	8
5 Mass media	30	2	48	5
6 HIV VCT	23	2	37	4
7 Harm reduction for IDU	2	0	36	4
8 AIDS in the workplace	48	3	34	3
9 Condom distribution and marketing	51	3	23	2
10 Out-of-school youth prevention	100	7	22	2
11 Prevention for vulnerable populations and other special groups	26	2	20	2
12 Improved STI case management	7	0	19	2
13 Prevention for MSM	7	0	8	1
14 Working with communities	2	0	7	1
15 Prevention for positives	5	0	5	1
16 Prevention for sex workers and clients	10	1	4	0
17 Female condoms	0	0	1	0
18 Other, unspecified	525	35	65	7

Source of data: Modified from Table 11 in Annex 2

The increasing cost of treatment (especially ART) increased 54% in one year, and is attributable to new cases initiating ART and an increase of PLHIV switching from first- to second-line regimens due to viral resistance. The ARVs in the second-line regimens are 1.5 times more expensive than those in the first-line regimens. Thus, more emphasis needs to be given to prevention to help reduce the number of new cases of infection which will reduce the overall treatment costs in the future.

1.2 National Composite Policy Index

1.2.1 Viewpoints of governmental officials

Strategic Plan

Thailand has established the NASP which integrated collaboration from key government partners for 12 years. Presently, the 4th NASP 2007-2011 has been established which employed 4 strategies and clearly specified target population for HIV prevention. The plan did not assign to allocate budget in supporting AIDS programs for key government partners. However, the

government partners utilized the plan in designing AIDS programs framework and seeking supportive funds for their own. Source of their funding included the National Health Security Office, international agencies and local funds including sub-district health funds, local administrative government and budget of provincial strategic plan.

In addition, country initiated a significant plan under the NASP framework during 2008- 2009. This included the plan on HIV prevention among youths and most-at-risk populations which was supported by the GFATM and the accelerated plan in halving HIV incidence among youths and most-at-risk populations by 2011.

Although Thailand has favourable policies that promote AIDS program efforts, there still are unclear in sex education in school, harm reduction policy and health care scheme for migrants. However, a new policy was initiated to promote AIDS prevention and management in workplace both government and private sectors in August 2009.

Political supports

During 2008-2009, it was clear that AIDS prevention and management received political supports. The Prime Minister chaired the NAPAC meeting by himself and to be presenter on AIDS campaign in public media. It brought about a more attention on AIDS among key government partners. The accelerated plan in halving HIV incidence among youths and most-at-risk population by 2011 was endorsed. Key measures of this plan included public communication, condom promotion and HIV prevention among youths and most-at-risk population. Joint Key Performance Indicators (KPI) to promote collaboration of all sectors was also specified. Work strategies focused on building competent networks, encouraging local administrative government and provincial government to mobilize AIDS works continuously and sustainably.

Prevention

Although the NASP specified covering target population, strategies and measures in HIV prevention, support funds to implement AIDS programs from government agency was limited. Obstacles were either budget decreased by limitation of country financial status, law and policy not supporting AIDS works with specific target population or lack of government agency and civil society working on HIV prevention program. However, progress reflecting AIDS efforts at this round was seen. The work plan on HIV prevention among youths and most-at-risk populations supported by the GFATM has increased

HIV interventions coverage and established mechanism called provincial coordinating mechanism (PCM) to mobilize AIDS activities in provincial level.

Treatment, care and support

Thailand has provided universal and equal access to ART for PLHIV under the health care scheme through effective collaboration between government sectors and civil society including PLHIV networks.

In terms of support and care for people affected by HIV/AIDS, there still are concerning issues that need to be addressed. Old people affected by HIV/AIDS that are not yet come to attention for policy making. Increase standard for both government and private orphanages remains challenging. In addition, lack of database to identify magnitude of problem and situation of orphans and children affected by HIV/AIDS causes to deficient systematic and effective national plan.

Monitoring and Evaluation

Thailand calls for developing an unified M&E system on AIDS prevention and management by specifying clearly M&E structure, establishing 16 national working groups, and strengthening provincial M&E system.

In 2009, National M&E plan on specific target populations and program area have been developed. However, a costed M&E work plan is still main challenge. In total of 17 government agencies participated in the survey, it found only 3 organizations had M&E plan with budget. While 5 of them had M&E plan but lack of resource available, and the rest had no plan. Furthermore, the majority of government agencies had no action plan to strengthen M&E system. Integrated supervision is an M&E process in order to encourage the provincial AIDS sub-committee to effectively implement AIDS activities and mobilize leverage local resources.

1.2.2 Viewpoints of civil society

A. Human rights: support for rights and respect for humanity

From the 2009 review by the Foundation for AIDS Rights, it can be said that Thailand has favorable laws that promote the prevention program efforts including the Thai Constitution (as revised in 2007), criminal, civil and commercial laws, the NHSP, National Health Law, Patent Law, Labor Law, and Child Protection Law. There are also national guidelines for prevention and control of AIDS in various types of work sites, as announced on August 21, 2009. All of this shows that Thailand has legal strategies and policies that are favorable for AIDS control work.

Even though Thailand has favorable policies in many areas, there still are obstacles that are not being addressed. The human rights strategy is still not very influential in the area of AIDS and, at the implementation level, it has not advanced in a way that is consistent with the changing circumstances. The rights monitoring strategy needs to be strengthened in the area of AIDS, including system strengthening for rights protection at the structural and implementation levels so that they are harmonized.

In the process of presenting the report of policy analysis of the response to AIDS by the NAPAC in 2009, there was reference to the challenge of supporting the respect for humanity and elimination of stigma and discrimination by no longer viewing or using the term "risk group" or "highest risk group". This stigmatizes those individuals as spreaders of HIV and a social enemy. This results in their being viewed unequally, and causes them to suffer discrimination in a way that prevents them from exercising free will in making their life decisions in a safe and constructive way.

B. Implementation of health services

Thailand has a clear policy and increased support for prevention. This includes the creation of a subcommittee to accelerate HIV prevention and the policy to reduce incidence by half by 2011, and the additional funding to make this happen from the GFATM Round 8 to continue activities started under previous rounds and provide greater emphasis to the vulnerable populations of IDU, MSM, SWs, and migrant laborers.

Representatives from the beneficiary populations played a greater role in strategic planning or policy formulation and implementation at the national and provincial level.

In the area of PMTCT, the ART regimen was improved to include triple therapy with expansion from pilot to national coverage starting in October 2010. The Staying Negative Project was launched in MCH clinics which advocated couple counseling. These developments reflect a greater attention to the mother/wife in the family. Quality of life promotion was also featured along with sex and reproductive health rights for PLHIV, starting with those initiating ART and women appearing for ANC who learn that they are infected. This effort is being expanded to national coverage.

Harm reduction involves many sectors and players, including the legal and justice system. National level committees were formed and learned more about the actual situation of vulnerable populations, and this increased concern for the need for services. Methadone maintenance therapy (MMT) was added to the benefits offered by the NHSP starting in October 1, 2008.

The NAPHA extension project improved treatment access for 2,000 migrants, ethnic minorities and undocumented persons. HIV VCT, condoms re-supply and harm reduction was introduced into prison populations on a pilot basis and the service model is being refined. For children, there is a committee that monitors the rights of the child under the MSDHS. The focus is on children affected by AIDS – both infected and uninfected. In addition, there has been model development by the We Understand group in collaboration with clinical and technical medical services to build the capacity of children and youth with HIV so that they can actively participate in AIDS work.

One area of challenges is that the PMTCT program still overly emphasizes the health of the infant. It does not consider the woman's body, her decision options, and pregnancy planning, carrying the pregnancy, or choosing abortion. These decisions need to be based on comprehensive information for the pregnant woman and her partner. VCT services in health promotion centers for pregnant women are not yet totally voluntary.

There is a need for greater respect for the reproductive health rights of the woman based on user-friendly sexual health services, with promotion of more couple-based services for ANC clients to help women communicate their feelings and wishes to their partner.

Promoting rights of access to services for undocumented migrant is lacking supportive policy, and this is an obstacle to access to services such as lack of a comprehensive harm reduction policy. Use of the law on prostitution to harass and arrest prostitutes or MSM who carry condoms as evidence of crime is counterproductive. Migrants or ethnic minorities or others who are in Thailand illegally are also hard to reach and can't access treatment since they are not eligible for the ART program under the NHSO, or because the NAPHA extension quota of 2,000 was already filled. Ethnic minorities, or hill people, both documented and undocumented, can't often exercise their rights to service under the NHSO, or they receive disrespectful service.

Concerning services in prisons it is found that most prisoners don't understand their rights, and authorities usually overlook these gaps and don't want the prisoners to know what they are entitled to. Treatment is slow to arrive and prisoners without the 13-digit ID card are not eligible for subsidized care.

Care for children affected by AIDS in orphanages (public and private) is under standard in some cases and can be considered a rights violation. These include segregation of sleeping quarters, and inappropriately using

children for fund-raising. There should be training and information dissemination for the relevant staff with the MSDHS as the responsible agency.

C. Promoting knowledge and education

The DOH of the MOPH has studied the content of sex education and improved this so that it is more comprehensive, and submitted this to the Ministry of Education for integration into the formal school health education curriculum over a period of time starting in 2002. The Teenpath project has taken sex education further to create a Comprehensive Sex Education (CSE) curriculum, however, the curriculum is still mostly used as guidance, and it is up to the discretion of the teacher whether and how to apply it. The MOE has still not adopted the CSE approach into the formal curriculum.

Civil society recommends that there be support for CSE on a continuous basis with greater coverage in the formal and non-formal educational systems. The teachers' capacity and attitudes need strengthening. The subcommittee for accelerated HIV prevention has to consider measures to advance this as part of the human rights approach, as an adolescent's right to accurate and practical information about sex through CSE.

D. Structure and strategies for policy development, planning and implementation

There was progress in reforming the structure to increase strategies for accelerated action of the NAPAC on April 4, 2007 to create the subcommittee for control and acceleration of AIDS prevention which has the authority to monitor consistency of implementation with the guidelines such as more integrated and transparent implementation to increase cost-effectiveness. At the same time there were modifications to the strategy for accelerated action at the provincial level through the PCM which can be considered a new element of the provincial structure to manage national budget and local resources for AIDS prevention and control.

There is a need, at the national and provincial AIDS committee levels, for independent decision-making and local participation from various sectors in accordance with decentralization of authority to more aggressively address the problems of AIDS in a more participatory and cost-effective way.

Civil society recognizes that the GFATM assistance has galvanized prevention interventions at the community level with more grassroots agencies involved, however there is inadequate sharing of experience across these agencies. This is partly due to the style of management of grants by the Principal Recipient which does not encourage sharing among the sub-recipients.

Another area of concern is that the Thai program (including civil society) is now too dependent on the GFATM assistance. Therefore, the government and civil society need to brainstorm together on how to proceed in a post-GFATM world and how that will affect interventions, and devise an appropriate strategy for mobilizing funds to continue the success and cost-effective implementation that has occurred so far.

In addition, there needs to be adequate surveillance and monitoring of the problems and impact of stigmatization and discrimination regarding sex and AIDS. A subcommittee to monitor and eradicate stigma and discrimination of PLHIV and affected persons and their families would be another strategy to help the accelerated program to respond to the AIDS problem in Thailand.

2. HIV/AIDS Prevention

2.1 Blood Safety

A. Blood screening

About one-third of donated blood in Thailand comes from Red Cross donation centers. Every unit of donated blood is screened through quality procedures at every step, starting from the stage of risk assessment of the donor (who is excluded if she/he has risk for HIV).

Most of blood donation centers in Thailand use Chemiluminescence's Immuno Assay (CMIA) to screen HIV. In screening donated blood for HIV and hepatitis virus (HV), the national blood bank started using Nucleic Acid Testing (NAT) to screen for HIV, HCV, and HBV in 2000 since this method is more sensitive to detecting early infection than are routine diagnostics. Initially, NAT was applied in Bangkok and was being expanded to the four regions in 2010 at regional blood centers in Phuket, Khon Kaen, Nakorn Rachasima, and Chiang Mai. On February 2, 2010, the Cabinet approved in principle the national blood service policy of 2010 as developed by the Thai Red Cross (TRC), and instructed the TRC to consider recommendations from the Bureau of the Budget and the National Economic and Social Development Board regarding the expansion of NAT to total coverage of the country, and establishing a national blood committee.

In addition, there are quality controls for the laboratory to ensure high standards of accuracy of lab work and diagnostic conclusions. At present, the MOPH has the policy for laboratories under its oversight to comply with standards of excellence, whether these standards are international, such as

ISO 15189, or are national standards, such as the medical techniques standards (LA) as overseen by the Technical Medicine Council. Any lab that is certified as practicing either the ISO or LA standards ensures that this is a quality lab. The number of certified labs is an indicator of success of quality assurance of the laboratory sector. The WHO and the US Center for AIDS Prevention and Control have encouraged all countries to certify their labs for standards of excellence in order to guarantee that whatever diagnostic is performed, the result will be accurate and of high quality.

B. Results

A survey of 371 blood donation centers throughout Thailand out of 942 hospitals conducted by the TRC found that every unit of blood was screened for HIV through a quality control method. The number of donated units was 1,784,579 in 2008 and 1,942,333 in 2009.

Concerning prevalence of HIV among blood donors, the data from 2008-2009 show that HIV among first-time donors was higher than that for returning or "member" donors (0.28% versus 0.05% respectively). First-time male donors had higher HIV prevalence than females (0.43% versus 0.16% respectively).

C. Problems and challenges for 2008-2009

- Some have objected to the screening question that asks if the person has had sex with a same-sex partner, which is an exclusion criterion. It is felt that this question reinforces the stigma of gays as being spreaders of HIV. The blood donation centers defend the screening question by saying it is not a violation of rights because it is a reasonable method to screen for higher risk of HIV. In any event, a meeting of experts was called to review the screening questionnaire. The wording was modified to reduce stigmatization of a particular group.
- There is no single or coordinated database on blood safety program at the national level, which would be useful to monitor the program and also the HIV prevalence among frequent blood donors, considered as low risk population.

D. Plan for addressing the problems and challenges

- The national monitoring and evaluation technical working group on blood safety is expected to establish the national routine health information system for blood safety program.

E. Best practice

E.1 Evidence based proposal for blood screening policy

TRC has initiated the study on using Nucleic Acid Testing (NAT) to screen donated blood since 2004. One reactive case was found after 40,000 blood unit were screened, which can prevent 4 blood recipients to get HIV infection. TRC continues using NAT for blood screening based on the recommendation of the U.S. authority; that NAT should be used where one reactive case is found in 1,000,000 blood units.

In 2009, out of 539,093 blood units, there were 6 reactive cases by NAT, which were negative by serology test. The calculation for NAT in 1,800,000 blood units will detect 20 reactive cases, which means 80 blood recipients will be prevented from HIV infection.

Based on this evidence, the cabinet has approved the principle to use NAT for routine blood screening of the country.

E.2 Mobile database to screen HIV and HBV positive blood donors

Before 1997, there were many HIV or HBV positive people repeated blood donation. One HIV positive person donated blood for 7 times. There were 6 HBV positive persons donated 8 times.

Since 1998, TRC has tried entering and updating data on screening donated blood before and after mobile blood donation activities to be used to detect those who are HIV or HBV positive by using barcode system installed in notebooks.

In 2008-2009, after using this method, there were only 2 HBV positive persons donate blood for the second time, which was because there were many blood donors that they are not screened.

2.2 Prevention of Mother-to-Child HIV Transmission

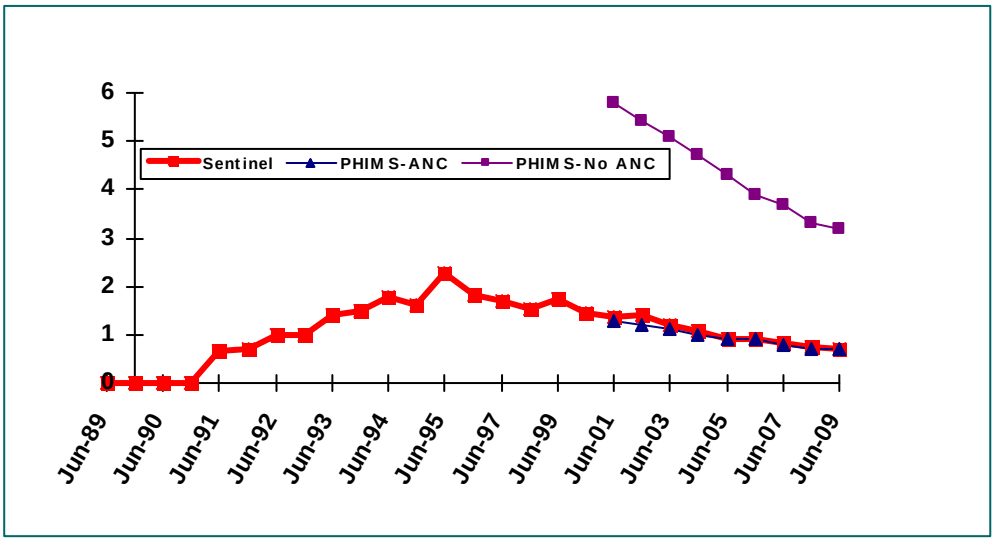
A. Situation of the HIV epidemic among pregnant women and prevention of transmission to the infant

Transmission of HIV from mother to child is a principal cause of pediatric infection. If no prevention interventions are taken, then approximately 25% to 40% of infants would acquire HIV from their mothers. Thailand began to track HIV among pregnant women in 1989 from the HIV sentinel surveillance system implemented by the BOE. It was found that the median prevalence of HIV peaked in 1995 and has shown a declining trend since then. In 2008

and 2009 the prevalence of HIV among pregnant women was 0.74 and 0.72[4] respectively.

As of 2001, the DOH was implementing its provincial hospital information monitoring system in 900 government hospitals (PHIMS); it found levels of HIV infection among pregnant women that were consistent with those of the BOE sentinel surveillance (Figure 24). But it is noteworthy that the 5% of pregnant women who did not receive ante-natal care (ANC) had significantly higher HIV prevalence than those who received ANC, namely 5.8% in 2001 and 3.3% in 2009.

Figure 24: Prevalence of HIV among pregnant women during 1989-2008



Source: Sentinel surveillance BOE; PHIMS from the DOH

Evaluation of PMTCT at the national level by the MOPH[5] during 2007 found that the level of transmission of HIV from mother to infant was 2.9% based on all lab diagnostics. However, if dead infants are included in the analysis, the transmission rate climbs to 5.6%. The reason for the persistently high rate of MTCT is that 56% of pregnant women are not receiving CD4 cell counts. Thus, these women are not receiving a proper regimen of ART as recommended by the MOPH. In addition, only 54% of infants received HIV diagnostic exams.

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[4] Results of HIV Sero-surveillance, Thailand 1989-2009. Source: AIDS Group, BOE, Department of Disease Control. Available at http://epid.moph.go.th/

[5] Naiwatanakul T, Punsuwan N, Kullerk N, et al. Reduction in HIV transmission risk following recommendations for CD_4 testing to guide selection of prevention of mother-to-child (PMTCT) regimens, Thailand, 2006-2007. In: 5th IAS Conference on HIV Pathogenesis and Treatment. Capetown, South Africa

The DOH has reported that the coverage of ANC has reached 95%,[6] but only 39%[7] had their first ANC visit before 12 weeks of gestation. Also, HIV-positive women have a lower rate of receiving ANC (87%[8]) than pregnant women in general. The median gestational age of HIV+ women was 19 weeks with nearly one in four having their first ANC visit after 28 weeks of pregnancy.[9] Those HIV+ pregnant women who received ANC had a CD4 count of over 350 cells/cubic mm.[10] Most of the infected pregnant women received ART in accordance with the guidelines. In 2007, these women came for delivery according to appointment and had a median gestational age at delivery of 39 weeks.[11]

B. Implementation of PMTCT

The most effective way to achieve PMTCT is by providing comprehensive services from the time of first ANC visit, administering an effective regimen of ARV which is appropriate to the immunological profile of the mother, and the use of infant formula instead of breast milk for nursing the infant.

Thailand has delivered HIV VCT for pregnant women since 1993. In 2000, the MOPH announced the policy to reduce MTCT for the first time. Over time, as new regimens were developed, the policy and implementation guidelines were modified. At present the 2006 policy and guidelines are in force and include the following:

- All pregnant women will receive HIV VCT
- HIV+ pregnant women will receive ARV during pregnancy and delivery to reduce MTCT of HIV.
- HIV+ pregnant women will receive CD4 counts during pregnancy, and receive triple-therapy ART as appropriate.
- HIV+ pregnant women will receive ART to reduce resistance to Nevirapine.
- Infants of HIV+ mothers will receive ART, and will receive infant formula, as well as monitoring of immunity against HIV.
- The mother and child and the HIV+ father will receive on-going monitoring and care as appropriate.

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[6] Report of the evaluation of health promotion activities in the 9th National Economic and Social Development Plan (February 2006); Published by the Veterans Printing Organization.

[7] Ad hoc report of the SaiYai Rak Haeng Khrawp Khrua Project, DOH Available at http://www.saiyairakhospital. com/newdemo/admin/user_report.html. (Last accessed Dec 23, 09).

[8] Ibid 3

[9] Bureau of Health Promotion, DOH, BOE, DDC, TUC. Paper presented at the meeting on results of evaluation of PMTCT on February 2, 2009 at the Rama Gardens Hotel, Bangkok. Ref-PATCG 076.

[10] Ibid 7

[11] Ibid 7

B.1 Policy and plan/program in response to the problem of MTCT

1) Preventing the married couple from acquiring HIV

Past policy and practices have emphasized screening of pregnant women for HIV, and then providing ART for PMTCT. This is a somewhat secondary approach to prevention. During 2008-2009 the DOH initiated a new program that is a more pro-active prevention strategy by emphasizing the prevention of HIV among the negative married couple, and preventing unwanted pregnancy among HIV+ women. The DOH collaborated with UNFPA in a project to increase participation of the husband in reproductive health (RH), care of his pregnant wife, and actions to keep both husband and wife free of HIV. The DOH also collaborated with the Thailand MOPH - US CDC Collaboration (TUC) to develop a model of couple counseling for pregnant women and their partners, and projects to increase knowledge among service providers who work with the PLHIV in areas of reproductive health (RH), family planning, appropriate contraceptive choices for the PLHIV to reduce unwanted or high-risk-of-transmission pregnancy.(see section IV: Best practices)

2) Use of HAART

The WHO has specified the target that there be no MTCT as of 2015[12] by expanding coverage of PMTCT. To achieve this, Thailand has instituted guidelines that health facilities must use the most effective ART regimens to reduce MTCT, and which are safe to both mother and child with minimal chance of resistance to non-nucleoside reverse transcriptase inhibitors (NNRTI). The regimen should be accessible, simple to apply, and feasible.

The PMTCT guidelines used in Thailand during 2004-2009 recommend AZT+ a single-dose of Nevirapine (SD NVP) for pregnant women with CD4 counts above 200.[13] After delivery, the women receive AZT + 3TC for seven days to prevent resistance to NNRTI. Nevertheless, this regimen is not able to eliminate the problem of resistance to NNRTI in both post-partum mothers and infected infants. In addition, the effectiveness in PMTCT from this regimen is still not the best one available. Using AZT+SD NVP yields a MTCT

[12] Guidance on global scale-up of the prevention of mother-to-child transmission of HIV. Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. Inter-Agency Task Team on Prevention of HIV Infection in Pregnant women, mothers and their children. WHO 2007

[13] DOH. Guidelines for PMTCT and care for mothers, infants, and the family living with HIV. MOPH. 2007.

rate of 1.9%[14] whereas the HAART regimens used in other countries have reduced MTCT to below 1%.[15]

Thus, to achieve the preliminary targets, the MOPH has collaborated with the Thailand AIDS Association and Health Intervention and Technology Assessment Program (HITAP) with budget from the NHSO to implement a pilot HAART program among all pregnant women in four provinces to assess the feasibility of a national HAART program for pregnant women. These four provinces include Srisaket, Nakorn Sawan, Sra Kaew, and Satun. In addition, there has been an economic analysis to determine the most cost-effective regimen in the context of Thailand for pregnant women with CD4 counts above 250.

The results of the analysis found the use of HAART was more cost-effective than using AZT+SD NVP in pregnant women with CD4 counts above 250 and is feasible for implementation in the field setting.[16] Based on these findings, the NHSO will support the budget and drugs for HAART in coordination with the DOH to plan for the roll-out of this service for all HIV+ pregnant women as of Fiscal Year 2011.[17]

B.2 Involvement of civil society

Over 1,000 groups of PLHIV volunteers throughout the country have modified their role from being service recipients to become service providers. They have re-grouped into implementation units under the principle of friendly rehabilitation.

The structure of activities is in the form of a foundation comprised of a steering committee at the regional and national levels. There are coordinators and field staff who are selected as representatives from the various provinces. There are seven regional committees. At the national level the committee is comprised of representatives from each region and has the following targets:

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[14] Lallemant M, Jourdain G, Le Coeur S, et al. Single-dose perinatal nevirapine plus standard zidovudine to prevent mother-to-child transmission of HIV-1 in Thailand. The New England journal of medicine 2004;351(3):217-28.

[15] Palombi L, Marazzi MC, Voetberg A, Magid NA. Treatment acceleration program and the experience of the DREAM program in prevention of mother-to-child transmission of HIV. AIDS (London, England) 2007;21 Suppl 4:S65-71.

[16] Project to evaluate the cost-effectiveness and feasibility of using HAART as a standard protocol for PMTCT in Thailand. Presented to the Committee to Develop Services for People Living with HIV/AIDS (PLHA) on November 6, 2009 by the Health Intervention and Technology Assessment Program (HITAP).

[17] Summary of the meeting of the Subcommittee on Developing the System of Services for PLHA, No. 7/2009 on November 6, 2009 at 13:30-16:30 in the 5th Floor meeting room of the Office of the Permanent Secretary, MOPH.

- Every PLHIV, child and adult, receives standard care and treatment, equitably and continuously in a sustainable way.
- PLHIV and those affected are able to live harmoniously in the community, and in communities which have knowledge about self-prevention and accept living with PLHIV and working together to address AIDS problems.
- The members of the PLHIV groups understand about their rights and strategies for the protection of rights related to AIDS.
- The members of the PLHIV groups and networks at all levels are strong, and have the potential to implement the tasks to address problems together, in the same direction, strategy of implementation, coordination, and transparency which can be externally verified.

C. Results of implementation

The Bureau for Health Promotion, DOH, in collaboration with the BOE and TUC conducted a study to evaluate the implementation of these activities. In summary, the study found that PMTCT services are achieving the requisite coverage in terms of counseling, client satisfaction toward the counseling, and provision of ART for PMTCT. However the ARV drugs being provided are not entirely in accordance with the policy. Also, HIV diagnosis in infants of HIV+ mothers is still low, and the level of MTCT is still too high, especially in those whose CD4 level is not known.

From a study of 911 cases, of whom 187 were HIV+ pregnant women who delivered during October 2006 and December 2007 in 27 hospitals of 12 provinces from each region, it was found that 96% were Thai nationals with average age of 28 years. Fully 89% were currently married, 45% had been married more than once, had an average of two children, and most were eligible for benefits under the NHSP or through the government civil service. Fully 19% were not eligible for any subsidized health service.

C.1 HIV counseling and testing, PMTCT and continuum of care after birth delivery

A total of 66% of the sample were not aware of their serostatus before. Fully 81% did not know their serostatus before receiving pre-test counseling and 93% received post-test counseling. Fully 88% were satisfied with the counseling service, 78% were satisfied with the level of confidentiality of the client's serostatus, and had rather high HIV/AIDS knowledge scores. A total of 90% received counseling on PMTCT and on-going care. However, only 51% of the husbands received an HIV test and 61% of husbands who did have a test were found to be HIV+. The reason for the low test rate among

husbands was that many of the women had not yet revealed their serostatus to their partner.

C.2 Use of infant formula to replace breast milk

All infected mothers who were interviewed used infant formula instead of breast milk. The only problem with obtaining the infant formula is the cost of transportation. From reviewing the history of 911 cases, 10% had diarrhea. A total of 17% of the mothers said that they had problems of finding a clean source of water to mix with the infant formula powder, but almost all boiled the water before mixing.

C.3 Coverage of PMTCT

CD4 counts:

From a review of records of the 911 HIV+ mothers it was found that only 10%, 43%, and 35% had CD4 counts taken before pregnancy, during pregnancy and after delivery respectively. Most of the women who had tests had CD4 counts over 200.

Receiving ART:

Most of the HIV+ mothers received ART, and almost all the newborns received a complete dose of ARV. Nevertheless, only 36% received ART that was appropriate to their CD4 level or in accordance with the guidelines. Most mothers and infants received AZT+NVP without knowing the level of CD4. Giving the tail regimen to reduce viral resistance to NVP was conducted for 51%.

Diagnosis of the status of HIV infection among infants of HIV+ mothers: Fully 56% of the children were tested to determine their status of infection, most using PCR.

Rate of MTCT:

Overall, of the mothers who received triple therapy, the rate of MTCT was 1.9%; for those receiving AZT+ SD NVP the MTCT rate was 3.5%; and for those who knew their CD4 level and received ART in accordance with the policy the MTCT rate was 1.7%.

C.4 Knowledge and practice of service providers according PMTCT policy

The PMTCT service providers worked in multi-disciplinary teams. Almost all the service providers in hospitals were able to describe the policy and guidelines correctly. Nevertheless, the PMTCT service involves many different units. The links between the service units and points of referral for data sharing is not yet systematic, especially in the larger hospitals.

D. Problems and challenges for 2008-2009

- An important trend that has received more attention in Thailand these two years includes couple prevention and reduction of unwanted pregnancy among HIV+ women. This is being done through greater involvement of the male partner in the couple's reproductive health, in care for the pregnant wife, and staying negative as a couple. Couple counseling has been expanded in ANC clinics and the challenge now is to achieve maximum coverage at a time when routine ANC services are already a heavy load for the staff.
- Even though coverage with ART for PMTCT is rather high, the challenge is to increase CD4 cell count screening to inform treatment decisions, especially the decision to provide HAART to all eligible in Fiscal Year 2011.
- There are still challenges of providing on-going care – including diagnosing serostatus among the infant which currently is less than optimal – and services for the mothers who have CD4 counts over 200, and counseling and HIV tests for HIV+ partners of pregnant women.
- Evaluation by the DOH and partners showed that there is still a need to develop the quality of counseling and diagnosis of serostatus in the ANC clinic setting. There are still pregnant women who are not receiving pre-test or post-test counseling, and there is less than optimal satisfaction with confidentiality of test results.
- Another issue for consideration is locating pregnant women who are not coming for ANC. Even though this number is low (less than 5% of delivering women) these women have higher-than-average HIV (3.3% in 2009). So there is a need to understand who these women are in order to provide appropriate prevention services.

E. Plan for addressing the problems and challenges

- Review the VCT system for pregnant women, and apply improvements to build staff capacity in hospitals in terms of both ANC and family planning services. Improve the linkages and collaborative work with the civil society sector, and develop the capacity of NGOs to deliver community interventions in the area of integrated reproductive health and PMTCT.
- Improve services in the hospital, especially large hospitals, so that there are links between services and referral of information among the relevant service units. Maximize the coverage of CD4 cell screening during pregnancy, use of HAART, and diagnosing serostatus of infants of HIV+ mothers using quality PCR diagnostics.

- Study the characteristics of HIV+ women who do not receive ANC and the factors behind this, and why they have higher infection levels. Apply this knowledge to new measures to improve prevention services for this group of the population.

F. Best practices

F.1 Services and lab quality under the project: Use of the Multiplex Nested DNA-PCR method for diagnosing serostatus among infants of HIV+ mothers

As the reference laboratory of the MOPH, the Department of Medical Sciences (DMSc) has implemented and refined a network of labs with PCR capability, starting in 1994. This network has examined over 25,000 specimens. The locally-produced reagents are 5 to 10 times less expensive than those from abroad and have passed quality assurance tests among Thai subjects, including children born to HIV+ mothers. All regions of the country now have access to this service through the DMS network of 14 laboratories which have a target capacity of 8,000 to 12,000 specimens examined per year. Members of this network have been trained and re-trained through annual re-fresher courses and all have extensive laboratory experience in diagnostics.

The quality assurance system involves controls for the quality of reagents for the Minibatch HIV-1 DNA-PCR, balancing demand and supply for diagnosis. There are two lab groups that do pediatric HIV-1 diagnosis: One is the network of 14 labs in the MSD network, which use the HIV-1 diagnosis using the Multiplex Nested DNA-PCR (In-house) method; and the Faculty of Technical Medicine of Chiang Mai University which uses the on-site or dried blood spots (DBS) method.

F.2 Development of a model of HIV prevention for pregnant women in the Health-promoting Hospital 6, Khon Kaen Province

During 2005-6 the Health-promoting Hospital 6 joined a research project of the DOH in collaboration with other health-promoting hospitals (1, 4, 7, 8, and 10). The "HIV Prevention for HIV-Negative Pregnant Women in MCH Hospitals in Thailand" project was implemented under cooperation between the DOH and UNFPA.

The purpose of the project was to define the model for minimum essential quality services at the hospital level. The study involved participatory learning, development, evaluation, integration, and modification at various stages during implementation. There was continuous coordination between the various clinics including the counselors, the ANC clinic, the delivery

room, the post-partum clinic, the well-baby clinic, and the family planning clinic. The research developed a number of innovations in counseling services related to couple counseling, disclosure of serostatus among discordant couples, and the following:

New Ideas, beliefs and values:
Service providers were able to create interest and motivation in husbands to join the hospital activities. After participating, these men had a greater appreciation for their role in providing care for the wife and infant.

Behavioral innovations:
The service providers acquired new skills and techniques in communication to help service recipients to persuade their husbands to join the ANC visits with them, resulting in more couple attendance.

Service innovations:
Couple ANC and post-test group counseling for HIV-negative couples.

Innovations in counseling:
Couple counseling and disclosure of discordant serostatus.

2.3 HIV Prevention among Reproductive Age Group

A. Situation of HIV among the population of reproductive age

The population of reproductive age in this report refers to the population between ages 15 to 49. The AIDS Epidemic Model has projected that more than one-third (38%) of new HIV infections in 2010 will occur among married couples or lovers, and 7% will be from promiscuous sex. [18]

B. Implementation of HIV prevention among population of reproductive age group

B.1 Policy and plans/programs to address the problem of AIDS in population of reproductive age group

1) The NASP for 2007-2011

Married couples and lovers are an important target population that needs to reduce its incidence of HIV by half by 2011. Recommended measures to achieve this include couple HIV VCT, counseling for disclosure of one's serostatus, increase concern, promote constructive attitudes, and reduce

[18] Thai Working Group and A^2 Thailand, The Asian Epidemic Model (AEM) Projections for HIV/AIDS in Thailand: 2005- 2025

sex-related problems by campaigns through various channels which the population of reproductive age access.

In addition, these measures include promotion of HIV prevention behavior and condom use through integrated services for ANC and other health services. Another measure includes promoting non-discrimination of women with HIV infection. For the general population who do not know their serostatus but come for other services in the health system, they need to be helped to assess their risk for HIV and get tested if appropriate, and should be encouraged to use condoms, while always trying to de-stigmatize and eliminate a sense of discrimination.

2) HIV prevention and management in the workplace

The Ministry of Labor (MOL) through the Department for Labor Welfare and Protection (DLWP) proclaimed their position on AIDS in the workplace in 2005 to increase the role of the worksite in prevention and management of AIDS activities in accordance with the ILO Code of Practice on HIV/AIDS in the World of Work through the development and application of standards (ASO Thailand: AIDS - response Standard Organization). This was seen as a tool to advance, evaluate, and control AIDS activities and to certify work sites that implement according to the standards.

With support from the GFATM, the DLWP and the TBCA developed a plan to have all worksites implement the ASO Thailand standards, and include this as a target for employers in the National AIDS Plan for 2007-2011. At the same time, the standards concept was expanded to include tuberculosis as the AIDS and TB –response Standard Organization or ASO-T.

To turn this into concrete steps, the NAPAC, in its meeting on September 28, 2005 directed the MOL to draft implementation guidelines for AIDS prevention and management in the workplace based on the MOL proclamation. The NAPAC then established order 1/2549 to set up a working group consisting of representatives from the government and civil society to revise and draft these guidelines which were approved by the NAPAC on July 24, 2009, and issued publicly on August 21, 2009 with the following key points:

- These are guidelines for all public and private worksites
- The worksite must establish standards for prevention and AIDS management in the workplace which are consistent with the national standards at least in two dimensions: (1) AIDS in the workplace; (2) implementation plan.

- Specify the role of the employer, working group and labor union, and the role of government agencies for implementation, monitoring and evaluation, oversight and correction of problems, and review results of implementation.

B.2 Progress during 2008-9

1) Prevention of HIV in married couples or other intimate relationships

The DOH in collaboration with the TUC has developed a system of couple HIV VCT as part of the routine ANC service as follows:

- Development of a model and guidelines for couple counseling for HIV VCT, and develop a training curriculum, produce video media to demonstrate the model and counseling method, and conduct training for nurses and counseling staff in five pilot provinces.
- Deliver couple counseling services for HIV VCT for new ANC clients and their husbands in 17 hospitals of five pilot provinces, and evaluate the outcome in preparation for expansion.

2) Prevention of HIV in government civil servants

Air Force: There are committee and subcommittees for prevention and control of AIDS in the Air Force with a plan of action consistent with the National AIDS plan and comprehensive for continuous provision of prevention and curative services, including knowledge campaigns, condom promotion, medical supplies for Air Force clinical staff to prevent transmission from contact with toxic fluids, and HIV screening of blood donors.

National Police Force: Support health and prevention of HIV for police, their families and other populations under their jurisdiction. There is a policy and plan for prevention and control of AIDS with support from the National *Police Headquarters:* Implementation of the plan includes HIV VCT, comprehensive treatment for AIDS, training and knowledge promotion on AIDS by training police resource persons so that they can provide training on a continuous basis to the police force.

3) Prevention of HIV in the workplace

Since 2005, the MOL through the DLWP announced the position of the MOL to support AIDS prevention and control plans in the workplace. The TBCA worked with the DLWP and the DDC to develop standards for managing AIDS programs in the workplace (ASO-Thailand) and supported the development of a network of working groups at the provincial level to implement the standards in all worksites, and conduct monitoring to ensure compliance. Complying worksites are to be acknowledged and certified, as stated in the NAPAC proclamation of August, 2009.

4) Prevention of HIV among non-formal worksites

In 2008-2009 the Bureau of AIDS, DLWP, provincial health office, LOAs, communities, and other related organizations established a network of working groups for HIV/AIDS prevention and control with an emphasis on sustainability by creating volunteer peer leaders among the migrant labor force to serve as resource persons to deliver knowledge, counseling, and support for healthy behavior. They conduct activities to expand successful components such as the traditional artist's initiative which integrates prevention messages through lifestyle interventions, as piloted in Chiang Rai and Khon Kaen.

C. Results of implementation

C.1 HIV prevention in the workplace

Knowledge, attitudes and behaviors of the employees have been impacted as a result of the activities. Workplace policies have also been positively influenced. Data from worksite surveys and reports of the TBCA found that 11,208 worksites had participated in the program, benefiting 2,866,508 employees with positive improvements in policy, behaviors for prevention, and better attitudes as shown in the table below.

Table 11: Attitudes of workers toward PLHIV friends who were trained

Degree of contact with PLHIV that is acceptable	Baseline (n=10,000)	Year 2 (n=16,861)	Year 3 (n=31,896)	Year 4 (n= 27,578)	Year 5 (n= 12,242)
Can share a work room with	84%	99 %	99 %	99 %	99 %
Can share a phone with	69%	98 %	98 %	98 %	99 %
Can share a bathroom with	62%	97 %	97 %	97 %	96 %
Can share the same set of food	59%	94 %	93 %	95 %	97 %
Can have physical contact with	59%	93 %	93 %	95 %	97 %
Can care for a close friend with HIV	58%	92 %	94 %	96 %	98 %

Table 12: Trends in behavior change of workers after completion of the training

Issues	Pre test	Post test	Difference
Concern that HIV/AIDS could enter my life	76 %	92 %	16 %
Concern that I may have risk	27 %	73 %	46 %
Concern that someone close to me is at risk	37 %	80 %	43 %

Table 13: Results of condom promotion

Condom promotion	Target	Result
Install condom vending machines	3,050	2,151
Number of condoms distributed	300,000	400,011
Number of free condoms distributed	8,550,000	6,861,550

Table 14: Condom use rate of workers increased every year

Percent who used a condom for every sex with lover			
TBCA Baseline Survey 2003 (n=9,760)	**Population Council Survey 2004**	**Population Council Survey 2005**	**TBCA Survey 2008 (n=9,088)**
16.0%	34.0%	48.6%	65.5 %

Table 15: AIDS activities in the workplace

Activities	Pre-program	Post-program
Policy to help PLHIV	14.7 %	98.7 %
Promote condoms among the workforce	15.1 %	97.2 %
Conduct campaigns in the worksite	9.0 %	96.4 %
Collaborate with others on AIDS activities	5.9 %	94.0 %
Peer leaders of the company conduct AIDS activities	1.9 %	89.6 %
Peer leaders can conduct training without help from NGOs	No data	29.4 %

Table 16: Changes in policy of the worksite

Policy	Baseline (N=2,169)	Year (N=2,045)	Year2 (N=1,703)	Year3 (N=2,013)	Year4 (N=1,884)
Do not require HIV screening of new employees	89 %	94 %	96 %	96 %	98 %
Do not require existing staff to have an HIV check	89 %	95 %	97 %	98 %	99 %
Do not fire persons because of HIV infection	47 %	72 %	81 %	76 %	90 %
Terminate employment of PLHIV	5 %	3 %	0.7 %	0.7%	0.6%
Not sure whether terminate or not	47 %	25 %	18 %	23 %	9 %
Give education to the employees	34 %	91 %	96 %	93 %	90 %

Table 17: Number of worksites certified as complying with ASO Thailand standards

Certified for	Year 1	Year 2	Year 3	Year 4	Total
ASO THAILAND Gold Level	478	746	535	549	2,308
ASO THAILAND Silver Level	793	709	851	1,004	3,357
Total	1,271	1,455	1,386	1,553	5,665

C.2 HIV prevention implementation among the police force

Training for resource persons in HIV prevention, drug addiction, and tobacco was conducted for 153 persons in 2008, and 494 in 2009. The results of a pre-post assessment showed that knowledge increased (to 91%), there was satisfaction with the training content and trainer (92% and 97%) and 87% to 94% thought the training for useful for current work.

D. Problems and challenges

D.1 Challenges among general reproductive age group

Thai society still thinks that HIV infection is limited to risk groups, and condom use in a love relationship is lower rate. They view that use of condoms means lack of trust.

D.2 Challenges for workers in the informal workforce

Application of the national guidelines for prevention and management of AIDS in the workplace needs to fully cover all workers in both public and private worksites.

E. Plan for addressing the problems and challenges

- Support public media campaigns to raise concern about the problem of AIDS and prevention of HIV in the general population, and modify attitudes of society about condoms so that they are seen as promoting sexual health rather than preventing disease.
- Support the general population to seek HIV VCT and promote couple counseling.
- Develop standards for managing AIDS programs in worksites (ASO Thailand) that are consistent with the context of the small-scale worksites and non-formal worksites.
- Advance the development of tools for evaluating and monitoring programs, and acceptance of these tools, at the regional level (ASEAN and APEC) as a strategy to accelerate implementation of Guidelines on Essential Workplace Action for Enterprises on the prevention and Management of HIV and AIDS in ASEAN member States and the APEC Guidelines for Creating an Enabling Environment for Employer to implement effective workplace practice for People living with HIV/AIDS. This will help encourage worksites with regional operations to invest in Thailand to help achieve ASO-Thailand standards as a socially-responsible action that diffuses down through the chain of sub-contractors.
- Develop strategies to accelerate national action for AIDS in the workplace programs.

F. Best practices

F.1 Preventing HIV among pregnant women through male participation: Couple ANC

This project is implemented by the Reproductive Health Division of the DOH in collaboration with various partners and the Faculty of Nursing of Burapha University. (See details in section IV: Best practices)

F.2 Continuity and extension of implementation by using ASO- Thailand standards

In 2005, the MOL, through the DLWP proclaimed the position to prevent and manage AIDS in the workplace to encourage worksites to play a role in prevention of AIDS in accordance with the ILO Code of Practice on HIV/AIDS in the World of Work by using AIDS - response Standard Organization standards as a tool for accelerating the work and evaluating outcomes and certifying the worksite as compliant.

Activities were implemented concretely and, at the same time, the standards were expanded to include tuberculosis control and management as the AIDS and TB – response Standard Organization, or ASO-T Thailand. The accomplishments of implementing these standards are attributable to the *development process* according to the following two principles:
1) Applying the concept of health behavior called the BASNEF Model to modify beliefs and behavior as follows:

- Modify beliefs and attitudes (BA) through a process of participatory learning for employers and employees.
- Access influential persons who can influence behavioral subjective norms (SN) by building awareness and understanding of the employer, cadres of peer leader resource persons, associations of employers, labor unions, worksite managers, and DLWP.
- Create a supportive environment for behavior change (EF – enabling factors) which consist of spreading a movement of mobilization on AIDS activities led by the ILO, announcements by the MOL on AIDS, create a social movement for increased responsibility for AIDS, create tools on concrete implementation of the standards (ASO Thailand and ASO-T) as a strategy to assess compliance with the policy, build motivation by publicly recognizing star performers and best practices, provide services that are convenient and adequate by building local NGOs with responsibility for providing services, conduct outreach education and use flexibility in working with target groups, including having the employer install condom vending machines to increase employee access to affordable condoms.

2) Promoting the work concept of being a stakeholder in a partnership between the government, the DDC, the TBCA, the Network of 36 Development NGOs, the AIDS Rights Foundation, the Association of Employers, labor organization, including integrated networking with the government, local administrative organizations in mobilizing funding and local resources to accelerate implementation in a networking fashion, with full coordination with the community in a way that is sustainable.

2.4 HIV Prevention among Youth

A. Situation of HIV in Youth

Thailand does not include a "youth" category as one of its sentinel populations in HIV surveillance. However, the percent of HIV among ANC clients age 15 to 24 years, and among military recruits can be used as proxy populations to track the trends. Also, the recent outbreaks among MSM show that HIV has the potential to erupt suddenly.

In addition, screening of STI among army recruits in November 2008 found that the prevalence of NSU was 6.9%, gonorrhea was 0.9%, and syphilis was 0.1%. Also, data from the BSS warn that there is the potential for epidemics among youth unless effective prevention measures are implemented to address the following:

A.1 Youth norms and sex behavior

Increasingly, youth view sex before marriage as normal.

A survey among the Thai AIDS Youth Network in 2007 in eleven provinces found that, among youth age 15-22 years, 48.8% find non-marital sex acceptable. In addition, 67.2% view sex as a person's right, and 39.1% felt that having sex with different partners during adolescence was normal. These findings are consistent with Ramajitti Institute data from 2006-7 among school and university youth that 30% of vocational school youth and 56% of college-based youth accept the idea of pre-marital cohabitation.

- **More youth are having sex**

A survey of high school students in 24 provinces conducted by the BOE of the DDC in 2008 found that the proportion of the sample that was sexually active was 3.0%, 15.2%, and 37%-43% for lower high school students (mean age 13), upper high school students (mean age 16), and vocational school students (mean age 17) respectively.

- **Youth and sex with multiple partners**

Data from the 2008 survey found that more than half of male students had had sex, and one in five female students had more than one sex partner in the previous year. A study of first-offenders in juvenile detention homes in 2009 found that, among youth age 15-18 years, 64.1% had had sex with more than one partner, and condom use for every sex episode was very low at 15.9%.

A.2 Knowledge and concern regarding condom use

- **Condom use levels among adolescents is still low.**

From 20%-40% of students use a condom every time they have sex with their lover. "Always" condom use in the past year among male students and army recruits who had sex with another man shows an increasing trend from 28% in 2005 to 50% in 2008, but this level is still considered to be very low.

- **AIDS Knowledge is low.**

The national survey of sex behavior in 2006 found that, among youth age 18-24 years, only 28.4% were able to answer all knowledge questions correctly. The 2008 round of the BSS among grade 8 secondary school students found that 15.6% and 9.1% were able to answer the 5 UNGASS indicators correctly by males and females respectively. For grade 11 students the corresponding rate was 35.3%, and for vocational school students was 25%.

A.3 Children and youth can access pornographic material easily.

The 2008 survey by the Ramajitti Institute found that children are using media more – or nearly half their waking day (6 to 7 hours). The survey of general high school and vocational students aged 16-17 years found that 69.3% of male grade 8 students had looked at porn on the Internet, while 82.4% had looked at porn books, or porn video. Fully 27.3% of female grade 11 students had logged onto a porn web page, and 54.3% had seen a porn book or video.

A.4 More children and youth are consuming alcoholic beverages

Among youth with an STI, 43% of cases occur among youth who drink. In addition, those youth with a history of alcohol consumption also report logging onto porn websites and watch porn video.

B. HIV prevention among youth

B.1 Policy and plans/programs on AIDS in youth

1) The NASP for 2007-2011

Youth are one of the target populations in the NASP, and are an NAPAC priority group included in the resolution of July 2009 to reduce HIV incidence by half by 2011.

The implementation of measures to respond to the policy and plans include AIDS and sex education and life skills in AIDS prevention, support for a social environment with positive information about sex and AIDS prevention, support for access to health services and prevention supplies, increased youth participation in decision making and implementation of AIDS prevention, and supportive collaboration of various sectors including the LAOs.

2) Policy and strategy on reproductive health (RH)

In addition to the NASP, the national RH strategic plan for 2010-2014 by the DOH also supports many of the same goals in addition to prevention of teen pregnancy. The strategy also aims to prevent and reduce the problem of disadvantaged children by focusing on youth and adolescents through coordination and collaboration among agencies at the national, zonal, provincial, and community levels with concrete directives for public and private agencies including the LAOs, and including targets on STIs, HIV and teen pregnancy, through youth-friendly services in various settings, especially hospitals.

The provincial RH plan to reduce STI/HIV and teen pregnancy included a pilot program in three provinces in 2009, expansion to 10 provinces in 2010, and plans to expand to all provinces by 2014.

B.2 Implementation

1) Capacity development for youth peer leaders

Youth in school: A collaborative activity was conducted between the MOPH, the MOE and PATH. Bureau of AIDS and the MOE developed a system of peer leaders for AIDS prevention in schools by integrating AIDS, STIs, tobacco and alcohol into the training of peers so that they can advise their fellow students through direct communication and activities. This activity began in 2006 and continued until 2009. A total of 98 educational institutions participated in 35 provinces, including 45 high schools, 23 vocational schools, and 30 colleges. In addition, youth participation was advocated by holding

web page design contests, contests to compose an AIDS campaign songs and slogans, production of guidelines for communicating about AIDS and sex for parents to get them more involved in guiding their children, and e-learning programs for youth and the general population.

In addition, allies and networks, such as the system of colleges and the MSDHS have conducted activities to support HIV/AIDS knowledge and prevention.

Youth in the community: Bureau of AIDS collaborated with NGOs, offices of disease prevention and control, and the provincial health offices, to develop a system of youth peer leaders for HIV prevention at the community level in 30 provinces beginning in 2004 and expanding into 43 provinces by 2009. The peers participate in local planning and implementation of community AIDS prevention activities.

There are links among school-based networks and the community by joint AIDS prevention activities, and support for children and youth to conduct "friends-help-friends" activities, development of adult and youth peer leaders so that they can serve as resource persons in AIDS awareness raising, sex education and RH, and as advocate for budget for child and youth facilities such as a "user-friendly center for health services in the village."

Child and youth councils: There has been support for the involvement of child and youth councils by building capacity of members at the provincial level. The DOH has implemented a program among council members to raise concern, knowledge, understanding and motivation which are in accordance with RH goals and increase youth participation in RH, both in and out-of-school. At present, 53 provinces have been covered.

2) Teaching and learning AIDS and sex education in the schools

High schools and vocational schools: In 2009, there was a modification to the implementation strategy for youth in view of the fact that the evaluation of outcomes of the GFATM support during 2003-2008 found only knowledge gains among youth in target areas, but prevention skills for safe behavior were not yet optimal. Thus, the new strategy emphasizes skills building for youth which are consistent with attitudes, beliefs and lifestyles of the youth. The new target is to cover 2.4 million youth between 12 and 24 years in 43 provinces.

The PATH organization plays a role in promoting sex and AIDS education in high schools and vocational schools through development of a curriculum, educational media, training for teachers, managers, and educational

supervisors. So far 68% of vocational colleges have been covered by this program.

University level: The DOH supports RH instruction at the college level through the network of Rachapat teachers' colleges by supporting the schools to implement an RH curriculum through the relevant course programs. This is to ensure that college students have access to information on RH, and can apply this in their work with adolescents. So far 13 branches of Rachapat University are participating, and there are plans to expand to all branches.

3) Support for Youth Friendly Health Services

The MOPH has set the target for 2014 that 80% of its hospitals will have Youth Friendly Health Services (YFHS) based on YFHS standards. At the end of 2009, about 10% of MOPH hospitals at all levels were participating. MOPH is also collaborating with partners to support YFHS in a variety of service sites in 43 provinces using the GFATM budget.

At the same time, PATH is applying the model 'Love care' approach for adolescents in private clinics and health centers in Bangkok. It is planned that there will be expansion of this model to 43 provinces which includes counseling, HIV VCT, diagnosis and treatment of STIs, contraception, condom distribution, screening for cervical cancer, and referral.

In addition, there are networks of government and NGO agencies implementing YFHS such as the services at Ramathibodi, Siriraj, Phramongkutklao Hospitals, and integration of these concepts with children's clinics in the provinces.

C. Problems and challenges

Some of the challenges cited in the previous report period still apply to the current report period. These include societal attitudes about sex education in which most adults still cannot accept sex education for youth, and this is a barrier to formalizing AIDS and sex life skills teaching for youth in school. This also impacts on limiting access of youth to condoms. Another challenge is coordination among the various agencies which means that issues are still being addressed in separate, isolated piece-meal fashion. Also, mobilizing resources in the peripheral areas, especially among LAOs, still needs consideration to improve understanding and appreciation of the importance of HIV prevention in youth.

Legal challenges: During this report period, there has been an increased focus on YFHS, to help youth accurately assess their HIV risk, to make

choices about getting tested, and deciding to diagnose and treat STIs. A limitation is that youth under 18 years must have parental consent for services, and youth do not want to reveal their need for this to the parents or guardians.

A difficulty in working with youth is dealing with social factors which increase risk. Also, knowledge and information campaigns in the past were not planned well and were short-term, not strong enough, did not impress the adolescents, lacked continuity and did not link with activities being implemented in the locality.

D. Plan to address the problems and challenges

- An urgent need is to have the responsible agencies at the central level to align the strategic plans for standards and programs to mobilize resources, so that there are clear technical directions for cost-effective and concrete implementation.
- There is a need for policy at the national and ministerial level for AIDS and life skills education, and development of a core curriculum that is implemented in schools throughout the country in the amount of 30 hours per academic year. There is a need to develop standards for this implementation so that each school has assigned and trained teachers to deliver the instruction. There should be policy support from educational administrators at the zonal level and school levels, and in the area of technical support from the network of public, education, health, NGO and international agency sectors.
- There should be a systematic and continuous plan for campaigns by developing content that is appropriate for youth at various ages. This should include the use of multiple communication channels to maximize coverage cost-effectively, and collaborate with mass media to promote attitudes which facilitate the implementation on a continuous basis.

E. Best practices

E.1 Innovation in the area of youth friendly services by PATH

PATH has implemented the 'Love care' Project which provides YFHS for youth age 12 to 25 years so that youth can access support services, prevention, and treatment for sexual and RH problems. The project is supported by the NHSP, UNFPA and the Bureau of Health Promotion. In its first year of implementation, the project was successful in setting up clinical services, conducting public awareness raising about the project, outreach and two-way communication to increase concern of the target group of the need to assess their risk and seek clinical services.

During July 2008 to July 2009 a total of 16,832 persons received services through outreach, mobile, call center and project website interaction. A total of 9,702 youth sought services at the network of 14 clinics in the project. Over half requested STI diagnosis. A total of 5,544 received HIV VCT with 3.0% testing positive. The HIV+ rate among those under 25 years was 1.6%, or about 2.5 times higher than that for the general population in that age group. Those testing positive were counseled and referred to the appropriate health outlet for follow-up care.

This innovative project is a good example of public-private collaboration. It also has pioneered a chat room service on the Internet which acts like an on-line clinic and is a good channel for reaching youth. Although it is labor-intensive, the project has recruited and trained youth volunteers from schools to help provide the YFHS.

There are four principal services of 'Love care' clinics: HIV, STI and cervical cancer diagnosis, and contraception. Of the 14 'Love care' clinics, 5,160 clients were seen during July 2, 2008 to June 30, 2009, including 2,255 under 25 years, and 2,905 age 25 years or over.

A challenge for implementation is the creation of a monitoring system for following up treatment and referral. This is especially important for those testing HIV+ to ensure they get treatment for both physical and psycho-emotional needs. There is a need to continually monitor client satisfaction and in-service training needs of staff to maintain service quality so that all youth have access to a strong network of YFHS.

2.5 HIV Prevention among Sex workers (SW)

A. Number of sex workers

The 2009 annual survey of commercial sex establishments and sex workers (SW) conducted by the Bureau of AIDS found 16,270 and 73,917 respectively, with 6,746 male sex workers (MSWs) 67,171 FSWs. This represents a decline from 2007. The top five most common commercial sex establishments were karaoke salons, beer bars, and traditional massage parlors, saunas, and coyote bars. The actual number of SWs is probably two to three times higher than those enumerated from the Bureau of AIDS survey, or approximately 150,000 to 250,000 persons.

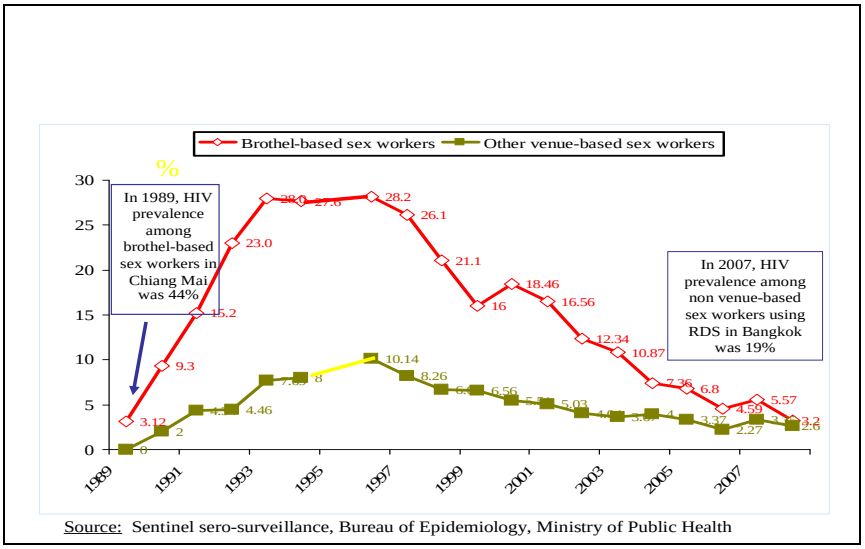
B. HIV situation among SWs

B.1 HIV infection

HIV prevalence among FSWs in commercial sex establishments is still in decline, from 4.3% in 2007 to 2.8% in 2009. There was also a decline for MSWs, from 20.7% to 14.2% respectively.

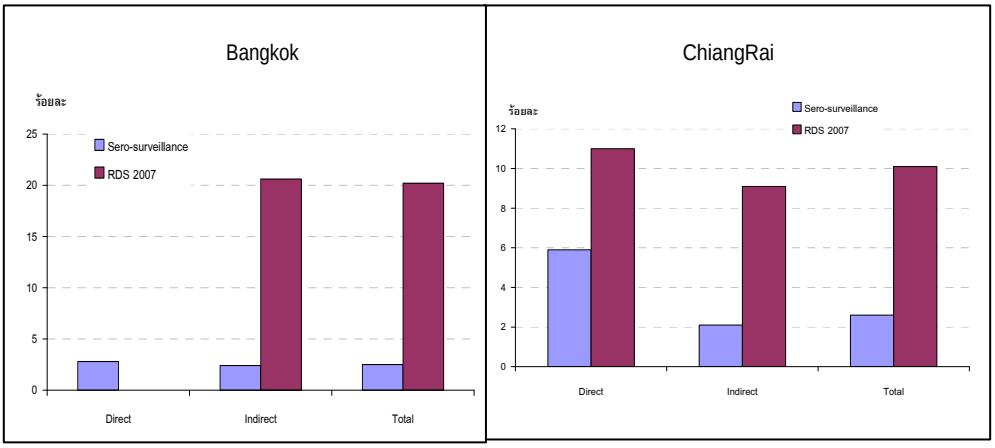
The trend of HIV among brothel-based and non-brothel-based SWs in other commercial sex establishments is declining; however the prevalence of HIV among free-lance SWs or other SWs outside the routine surveillance system is high and not necessarily decreasing. A study in 2007 by the TUC using the respondent-drive sampling method in Bangkok and Chiang Rai found HIV prevalence as high as 20% among FSWs.

Figure 25: Prevalence of HIV among FSWs in Thailand: 1989-2008



Source: Sentinel sero-surveillance, Bureau of Epidemiology, Ministry of Public Health

Figure 26: HIV prevalence among a sample of FSWs using RDS in 2007, Bangkok and Chiang Rai



In addition, surveillance of recent HIV infection using the BED captured ELISA technique of the BOE found that the prevalence of new infection among FSWs in non-brothel based commercial sex establishments increased between 2004 and 2007. Data for 2008 shows no statistically significant decline for this indicator. For MSWs, data from the national surveillance and time-location sampling found that HIV is still high and not declining for the most recent years of data.

B.2 STI situation

The situation and trends for STIs after the implementation of health reform of 2002, shows signs of increasing, with corresponding declines in SW attendance at STI clinics, especially since 2003. In 2008, the prevalence of STIs among SWs was 1.8% in females and 15.2% in males.

Improved diagnostics have allowed earlier detection of gonorrhea and Chlamydia infection. Between 0 and 2.2% of FSWs had gonorrhea, and 5% to 16% had Chlamydia. These findings are consistent with data from two private clinics in Bangkok and Pattaya which found that incidence of gonorrhea was 18.7% in 2007 and 19.2% in 2009.

In addition, the BOE has found that prevalence of syphilis among SWs is also increasing.

B.3 Knowledge and behaviour

The behavioral surveillance survey (BSS) of the BOE in 2008 assessed AIDS knowledge across the five UNGASS indicators. Both FSWs and MSWs had improved percentages answering all five questions correctly compared to 2007: 41.3% for females and 29.3% for males. Sex workers over 25 years of age had more correct response than those under 25 years.

The BSS in 2008 found 96.1%, 97.1% and 88.8% of FSWs reported that they use condoms with regular, general and other types of clients respectively. However, only 45.4% said they used condoms with their lover or partner. Condom use with last customer declined from 96.2% to 92.2% between 2007 and 2009.

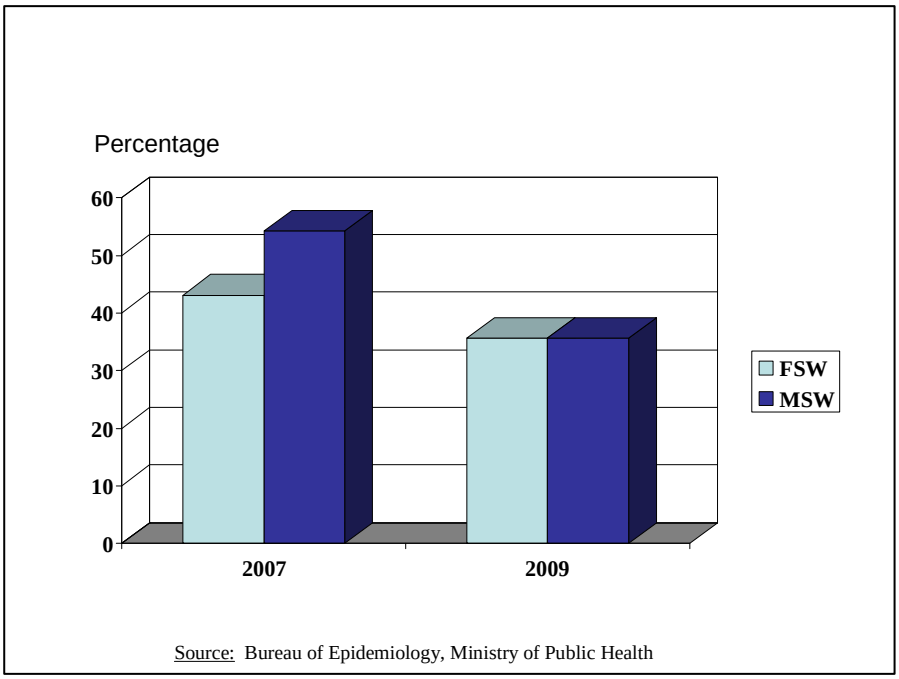
B.4 Access to health services

A survey of reproductive health access in FSWs in four cities (Bangkok, Pattaya, Chiang Mai and Songkla) in 2007 found that 68% were eligible for NHSP benefits, 8% had social welfare cards, and 22.5% had no health insurance coverage.

Service statistics from the STI control program clinics in 76 provinces found that the proportion of clients attending the clinic has declined continuously.

BOE surveillance data show that the proportion of SWs who had an HIV test in the past 12 months and knew the results declined in FSWs from 43.1% to 35.6% between 2007 and 2009, and from 54.2% to 35.6% in MSWs respectively.

Figure 27: Proportion of sex workers having an HIV test and knowing the result in 2007 and 2009 by sex



Source: Bureau of Epidemiology, Ministry of Public Health

C. Implementation of HIV prevention among sex workers

C.1 Knowledge education

The annual survey of commercial sex establishments and SWs by the provincial health office and partners, simultaneously throughout the country involves visits to the commercial sex establishments and presentations on STI/AIDS prevention for the SWs, condom promotion, raising awareness of the services for SWs in the province, and motivation for the SWs to come for STI/HIV screening.

There is continual development of media, and tools to present these, to increase knowledge and motivation, and for use by outreach teams of the government and NGOs. There are peer volunteers to help reach SWs that work outside of commercial sex establishments. NGOs play an important

role in condom promotion and distribution. NGOs such as EMPOWER conduct education in the commercial sex establishment itself, others, such as SWING, reach free-lancers in Sanam Luang, Khlong Lawd and Wong Wien 22 Korakada areas. The SWs Friends Foundation provides AIDS education for male and FSWs and transgenders.

C.2 Promotion and access to condoms

The 100% condom use program is an important strategy for prevention of HIV spread for SWs. There was 15.6 million baht allocated for this activity including the procurement of 16 million 49-mm condoms and 11 million 52-mm condoms. Activities of NGOs such as SWING have set up condom revolving funds to reduce the cost of quality condoms for SWs in Bangkok and Pattaya.

In addition, UNFPA supports the establishment of a national condom committee and draft strategy for comprehensive condom programming, and supports the trial introduction of the female condom for use by SWs and the general population.

C.3 Service clinic development

National policy stipulates that each province needs to have at least one STI clinic to increase access to diagnosis, screening and treatment of STIs, and HIV VCT. In 2009, there were a total 160 STI clinics in 76 provinces operating out of hospitals, disease control centers, the STI Cluster, and health centers of the Bangkok Metropolitan Administration (BMA).

C.4 Capacity building of government and NGO staff

With funding from the GFATM Round 8, the PPAT and network members conducted a training of NGO staff so that they could conduct better outreach education for SW peer educators to increase knowledge and distribute condoms to others SWs. The training also included relevant others such as the police, taxi drivers, commercial sex establishment managers and staff, and covered topics on AIDS, STIS, and RH.

In addition, the UNFPA supported capacity building for staff conducting outreach by synthesizing the lessons from a variety of outreach programs, and included training on estimating the population of hard-to-reach SWs, among other topics.

C.5 Increased participation of SWs and other groups

Civil society supports SW participation through volunteer activity such as those of EMPOWER and SWING which emphasize capacity building of SWs so

that they can take care of and improve themselves, and help peers gain knowledge and find referral services.

C.6 Mobilizing financial resources

During 2008-9, resources for implementation increased, from the domestic budget and from the GFATM, Health Service Research Institute (HSRI), TUC and UNFPA. Both the UN and TUC provided technical assistance.

C.7 Building a network for an alliance of workers

The DDC collaborated with the UNFPA to convene an annual, national seminar to exchange experience and lessons learned, and to build an alliance of service providers for STI/HIV and sex services with representation in all 76 provinces and civil society. The first seminar was in 2007.

In addition, EMPOWER still maintains a network of NGOs who work with SWs under the support of the HSRI.

D. Problems and challenges

D.1 Development of the data system for evaluating the situation

Data from implementation under the Global AIDS Program (GAP) found that only 60% of those eligible for treatment are receiving it, and this is only in the public sector.

D.2 Access to knowledge and prevention

There is inadequate coverage of SWs who work on the street, in parks, or other public spaces. There is very limited data on this sub-group. There is also limited data and outreach to the SWs who are foreign migrants since commercial sex establishment managers do not want it known that they have illegal migrants working for them.

D.3 Attitudes of service providers toward the SWs

Some service providers do not fully understand the principles of universal human rights and AIDS rights. They tend to view SWs as spreaders of disease, who are breaking the law, and are sinful. This leads to services that are not user-friendly.

D.4 Laws and regulations which impede prevention work

These include the law on human trafficking and the law on prostitution. A clear example of how these can be counter-productive is when the owner/manager of a commercial sex establishment does not cooperate with health service providers who want to conduct outreach in the commercial

sex establishment out of fear of legal consequences, especially if they have illegal immigrant SWs or persons under age 18.

E. Plans to address the problems and challenges

The GFATM Round 8 is supporting outreach and integrated network strengthening for the period of 2009 to 2014 in 43 provinces including Bangkok. There are clear plans, targets and an M&E plan which should be useful for other provinces to consider following.

F. Best practices

F.1 Can Do Bar

Problem, concept, objective

Sex work is an occupation that is not protected or supported by Thai labor law. The strong profit-motive of the commercial sex establishments ensures that there is unfair treatment, pressure on and exploitation of SWs. This includes lack of normal work rights such as a limited number of hours of work, salary and compensation, arbitrary fines and fees, and fewer leave days for illness or vacation than in accordance with labor laws. Often, the supplies and equipment in the commercial sex establishments are sub-standard such as soap, massage oil, dance floor, massage room, chairs, or inappropriate mandatory uniforms. When dancing in a coyote bar SWs have to wear high heel shoes, or sit in front of the commercial sex establishments in skimpy clothes even when the weather is cold. There are inadequate hazard protections in the commercial sex establishments regarding fire, sound, or cigarette smoke.

Society in general views commercial sex establishments as places where illegal and immoral activities occur, where disease is spread and drugs are used, where organized crime is active, where young women are abused, where sinful and drunk people go, where it is dangerous and disgusting. These social attitudes stigmatize the SWs and de-value them. Thus, safety and rights of these SWs are not considered as important as that for others.

Conceptual model

From meetings of the network of SW peer leaders, from reports of deaths of SWs due to unsafe working conditions, and exploitation of SWs, and lack of occupational health, it was decided to open a bar with a favorable environment for SWs. It is called the "**Can Do Bar**" and is located in Chiang Mai.

The network collected donations from members and SWs in the amount of no less than 1,000 baht per person until 1 million baht was accumulated. A space was found, made clean, fresh, well-lit, with appropriate sound system, all according to occupational health standards. A circuit breaker was installed along with fire extinguisher, private bathrooms, and a room for worker relaxation.

The Can Do Bar in Chiang Mai opened on September 15, 2006 with three full-time staff who are paid a salary. There are no fines or salary deductions. There is social insurance, and everyone has the responsibility of serving drinks, talking with customers, cleaning the premises, managing finances, and managing the stock supply. An additional 40 persons work at the bar on a free-lance basis – which means they do not receive a salary but are allowed to come and go at will. The salaried staff work under standards of the Thai labor law, and the bar is registered with the Ministry of Labor. Its hours of operation are from 6 p.m. to midnight every day of the week. The bar income comes from sales of drinks, not from bar fines for sex. The policy of the bar is that sex is a private negotiation between two adults, and the bar takes no part or interest in that.

The Can Do Bar distributes condoms for free. Staff is trained in counseling and can give guidance on safe sex. Staff is also trained in first aid, use of bar equipment, safe ways of lifting and moving heavy objects, and other life skills.

Achievements

The Can Do Bar is a model establishment that is safe and fair, that complies with labor law and social welfare guidelines.

- Staff is employed. They receive compensation at a fixed rate or a wage which is higher than the minimum wage.
- Staff work 8 hours per day and have one day off per week.
- Staff has 10 days of paid vacation per year and 13 paid holidays.
- Overtime work is available on a voluntary basis and is compensated according to labor law. There are no special conditions in which a staff person's salary can be reduced or withheld, without exception.
- Staff is encouraged to form a labor organization or unionize.
- Staff is not fine when taking sick leave; and receives social welfare.
- If there is a labor dispute, these must be settled in labor court.
- The Can Do Bar has created a space for staff to relax which is separate from the bar. Staff can take breaks outside the bar where it is convenient to do so.

- Staff is given refreshments for free that are available for staff throughout the work shift.
- There is a separate staff bathroom without any rules for how long a staff person can spend in the bathroom.

The Can Do Bar is a model space for exchange of knowledge, campaigns, changing social attitudes, public media dissemination, demonstration of SW participation, collaborative network building with other bar owners, cooperation with relevant government authorities, and production of supplies, tools and curricula for safer sex and condom use.

F.2 Mobile outreach by Issarachon

The NGO Issarachon has been delivering AIDS and sex education in various locations for street sex workers for six years. Issarachon first gets familiar with a location and builds trust before sending in the mobile unit. The SWs need to know what Issarachon is and why they are there. First, Issarachon shoulder-bag workers go into public areas such as Snam Luang and Khlong Lawd in the evening. SWs see them and ask that they are doing and how often they come, whether they have free condoms, etc. After building rapport they work on building trust so that SWs are willing to discuss their health problems and basic needs.

In 2007, a mobile unit was donated to the project which parks at the Sanam Luang and Khlong Lawd area. The unit also goes to nearby provinces such as Samut Sakorn in collaboration with other projects. The mobile van visits an area 1 or 2 times per week to give counseling on various topics such as prevention of STI/HIV. The service hours are from 3:00 p.m. to 11:00 p.m. It was found that virtually all male and FSWs said they were able to access the project services in their locality. All are aware of the need to use condoms and practice self-care. The HIV prevalence among SWs in the project area declined from 30% to 15%.

The service statistics for the mobile unit service at Sanam Luang and Khlong Lawd during August 15, 2008 to August 11, 2009 are as follows:

- 6,230 female SW visits, or an average of 83 person-contacts per day
- 2,373 male SW visits, or an average of 32 person-contacts per day
- 463 transgender SW visits, or an average of 6 person-contacts per day

The operating budget is shared with other organizations which have special skills, such as the EMPOWER under the AIDS Service Organizations Network Project, in order to help diffuse the knowledge and services, and to devise new methods of accessing clients in need, and to provide alternatives to

services if the location and hours of operation of government service outlets is not convenient. Another goal of the project is to reduce social stigma against SWs by encouraging members of the general population to help with the project activities on a volunteer basis.

2.6 HIV Prevention among MSM

A. Situation of HIV among MSM

In Thailand, the HIV epidemic among MSM can be considered severe. Many MSM continue to have high-risk behavior. Starting from the serosurvey of MSM in Bangkok in 2003 which found a prevalence rate of 17.3%, HIV continued to make inroads in this population. In Chiang Mai in 2005 and 2007 the level of HIV was 15.3% and 16.9% respectively. In Phuket, HIV was at a level of 5.5% in 2005 and increased to 20.0% two years later. [19]

The estimation of new HIV cases from the Asian Epidemic Model computer program forecast that the epidemic of HIV in MSM will be a driver of the national epidemic in the future. If the current trends continue, then MSM will comprise half of all new HIV infections by the year 2025.[20]

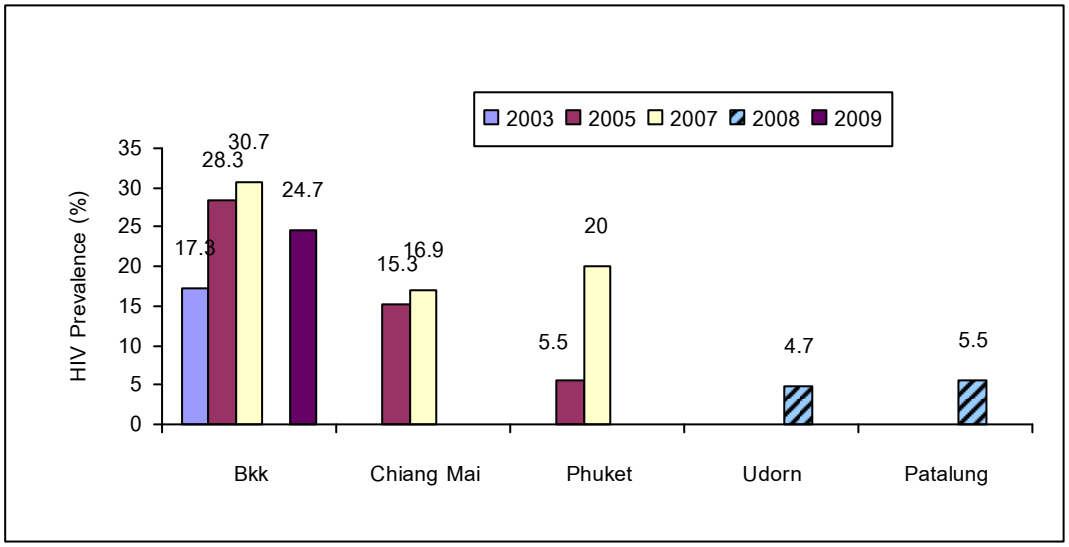
It is estimated that 5% to 10% of males between 15-49 years will have sex with other men during 2010 or, approximately 1.3 to 2.5 million persons. The results of the latest round of sentinel surveillance found that HIV declined in Bangkok from 30.7% in 2007 to 24.7% in 2009 (Figure 28), and prevalence in the population age 15-22 years declined from 22.3% in 2007 to 12.5% in 2009. [21] As seen in Figure 3, the sample sero-prevalence was 13.9%.

Figure 28: Prevalence of HIV among MSM by province: HIV sentinel surveillance during 2003-2009

[19]Prevention and control of HIV in MSM: Annual technical seminar of the NAP 2008 during February 11-13, 2008, at the Bi-Tec national convention center, Bang Na, Bangkok

[20] The Asian Epidemic Model (AEM) Projections for HIV?AIDS in Thailand 2005-2025, A2 Analysis and Advocacy, 2008, Family Health International and Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health, Thailand

[21] Keratikarn K., et al., (2010) Trends in HIV prevalence and risk behavior among men who have sex with men (MSM) in Bangkok, Thailand, 2003 to 2009, submitted to XVIII International AIDS Conference, July 18-23, 2010, Vienna, Austria



Source: Bureau of Epidemiology, Department for Disease Control and the TUC

Even though HIV prevalence has declined in Bangkok, the situation is still of concern. Prospective studies of a sample of 1,292 persons in Bangkok over three years from April 2006 to January 2008, with quarterly screening for HIV, found that the incidence of HIV was 6.0% (CI 4.5-7.9%) in the first year, 6.3% (CI 4.3-7.9%) in the second year, and 5.7% (CI 3.8-9.3%) in the third year.[22]

In Bangkok during 2003 to 2009, it was found that reports of consistent condom use in the previous three months showed no signs of increase.[23]

In provinces not considered to be popular tourist sites, it was found that HIV prevalence in the MSM population is also high, despite being lower than in the primary tourist locations. For example, surveys in Patalung and Udorn in 2008 found levels of HIV among MSM as high as 5.5% and 4.7% respectively.

B. Activities to prevent HIV among MSM

B.1 Policy and plans/programs addressing the problem of HIV/AIDS in MSM

1) The NASP for 2007-2011

The group of MSM is the highest priority target group in the NASP for 2007-2011. The plan specifies a target of reducing new cases of HIV by half of those projected to occur. The plan also specifies targets for increasing

[22] van Griensven F, et al. (2010) Three years of follow-up in the Bangkok MSM Cohort Study: Evidence of an explosive epidemic of HIV infection, submitted to XVIII International AIDS Conference, July 18-23, 2010, Vienna, Austria

[23] Ibid 3

access to and coverage of ART, along with social services for those adversely impacted.

In the NASP for 2007-11, four measures are specified for addressing HIV among MSM:

- Establishing centers for management, funding and re-supply of condoms and lubricant for MSM.
- Increase coverage of information and HIV/STI VCT diagnosis and treatment.
- Build capacity and participation of MSM in implementing HIV/STI prevention activities, and VCT.
- Establish and publicize a "friend's center" and build a network of friends centers to mobilize group effort of MSM throughout the country.

B.2 Activities by the government

The Bureau of AIDS convened a working meeting to develop guidelines to advocate for HIV prevention policy improvements concerning MSM. The result was that the DDC provided budget for strengthening and accelerating HIV/STI prevention among MSM for 2010, with an emphasis on policies to facilitate working with entertainment and service establishments, and increase concern for the need to intensify prevention activities in this population.

In addition, the Bureau of AIDS carried out numerous projects such as the "Healthy service establishments" which emphasized distribution of condoms and lubricant to ensure adequate supplies; the project to select the best entertainment establishment according to prevention standards; the project to create cadres of MSM peer leaders in colleges and universities, including the drafting of a curriculum for high school teachers on life skills for MSM youth; the project for HIV prevention through a model of friends-to-friends outreach and user-friendly services for HIV/STI diagnosis as supported by the TUC and USAID; the project to continue intensive activities in high-prevalence provinces (Bangkok, Phuket, Chiang Mai, Udon Thani, Khon Kaen, and Chonburi).

B.3 Activities by civil society (NGOs)

During 2008-9 the HIV prevention project for MSM and others with diverse sex lifestyles was implemented with support from the NHSO through the Institute for Health Services Research, and approved by the subcommittee for accelerated AIDS prevention under the NAPAC. This project was the first and largest to implement through the network of 20 MSM organizations in ten provinces. It recruited and trained 1,100 peer leaders and reached

16,800 MSM. This project was the first successful collaboration among such a large and diverse network. The project included a formal evaluation component to document experience and participation of the network members as a basis for receiving funds from the GFATM. In 2010, the project will be expanded to four more provinces.

B.4 Integrated HIV prevention for most-at-risk populations by conducting outreach and creating a linked service network

MSM are a priority target population for this project which delivers integrated HIV prevention for most-at-risk populations, and is funded by the GFATM Round 8 over five years from July 2009 to June 2014.

The principal strategy for this project is to expand coverage and access to prevention for high-risk populations by increasing participation of NGOs and the target beneficiaries. The project supports activities to improve services in the public sector so that they are more user-friendly for the target groups, and are linked with the outreach program component implemented by NGOs. The project strengthens government and NGO service providers by building knowledge and understanding about sex, sex lifestyles, and rights protections, while implementing in accordance within the prevailing policy framework.

The Rainbow Sky Association is a principal group which implements activities in the civil society sector. They conduct community outreach and manage drop-in centers, provide condoms and lubricant to improve coverage of the target population.

The DDC, through the STI cluster of Bureau of AIDS implements user-friendly services for HIV VCT and treatment of STIs in 14 provinces, including Bangkok in 2009, and 31 provinces in 2010.

C. Knowledge and behaviour

Due to limitations of the coverage of behavioral surveillance, the data in this section rely on a variety of ad hoc studies to present a more complete picture of the knowledge and behavior of MSM under different conditions.

Surveys by the Bureau of Epidemiology (BOE)

In Bangkok, Phuket and Chiang Mai in 2007 it was found that proportion of MSM who reported having “always used” condoms in the three months prior to the survey was 66%, 44%, and 36% respectively. In 2008, the survey in the rather small provinces of Udon Thani and Pattalung found that “always used” condoms by MSM in the prior three months were also rather low at 56.3% and 57.0% respectively.

In 2009, a survey of condom use found that MSM condom use during last episode of anal sex was only 21.7%, which represented a sharp decrease from the level found in the previous year's survey. It must be noted that the latest round of this survey modified the questionnaire slightly from previous rounds by asking about condom use with last male partner and did not distinguish among types of partner. Thus, the decline may be an artifact of the change in methodology rather than a behavioral trend toward unsafe sex. In any event, MSM and transgender sex workers reported condom use with customers over the prior three months at a rather high level of 87.6% and 79.5% respectively.

Regarding blood tests for HIV and knowledge of one's serostatus, the survey in Phuket, Chiang Mai and Bangkok found that only 21.7% of MSM and 20.8% of transgenders said they had been tested for HIV and received the results in the past 12 months. The data from this survey that knowledge of one's serostatus in this group is low even though the knowledge score (based on five test items) increased from 21.4% in 2008 to 25.5% in 2009.

Data from the outreach project for MSM in three provinces: Phuket, Udon Thani, Khon Kaen

In 2009 it was found that the proportion using condoms with casual partners when compared to data from 2008 increased in some provinces: from 56% to 64% in Khon Kaen; and from 71% to 82% in Phuket. However, in Udon Thani the proportion declined from 68% to 64%. The proportion using a condom at last sex regardless of partner type during October 2008 to September 2009 was 68.3% among those under age 25 years (N=1,899) and 71.7% for those age 25 years or old (N=717).

Data on MSM clinic services

The population of MSM attending clinics at Bang Rak Hospital in Bangkok, the Sabai Dee Clinic in Phuket, the Plai Fah Clinic in Khon Kaen, and the Napa Clinic in Udon Thani, increased from 345 clients in 2008 to 825 clients in 2009. Referral from outreach project staff increased from 38 cases in 2008 to 265 cases in 2009. The number of HIV VCT clients who received test results increased from 242 clients in 2008 to 513 clients. Among the four clinics, 19% of clients who were tested did not return for their results.

Data from the Male Health Clinic, Clinical Research Group, Bang Rak Hospital

It was found that MSM who are not sex workers had increased incidence of syphilis from 2.4% in 2004 to 3.4%, 4.2%, and 5.6% in 2006, 2008, and 2009 respectively. The comparable rates for male sex workers were 1.8%, 0.8%,

2.5%, and 1.4% over the same period. Regarding HIV prevalence, MSM in both groups had similar levels of infections, 18.0% among non-sex worker MSM, and 18.1% among male sex workers.

Overall, 60.1% of service recipients reported a history of ever having an HIV blood test, and 55.3% know their serostatus. Regarding condom use in the prior three months, 41.7% "always used" a condom with all sex partners (excluding commercial sex clients); 20.8% "sometimes used" a condom, and 37.5% "never used" a condom. Fully 60.8% reported using a condom at last sex; 2.4% said that the condom broke.

D. Problems and challenges

There are a number of important challenges for projects receiving the GFATM Round 8 funding to achieve their targets:

- There is a need for capacity development of government and NGO service providers and volunteers in the target communities to increase knowledge and skills in reaching the target population, providing efficient services, and achieving real prevention results. The expansion of activities to 14 provinces in the first year and 31 provinces in the second year requires that attention be paid to quality assurance along with the building of implementer capacity.
- The referral network from the outreach by NGOs to the services providing diagnosis and treatment for STIs and HIV VCT is not functioning optimally.
- Reaching the large and dispersed number MSM, bi-sexual men, transgenders, and katoeys is a challenge, particularly given the fact that most are not publicly open about their sexual orientation. Thus, new methods of outreach are needed. In addition to person-to-person outreach, there is a need to increase the number of volunteers and field staff for adequate coverage of the target.
- There is a need to improve understanding and build capacity at the provincial and local administrative organization level so that these staff can develop projects and support policy, measures and budget for the target population of MSM. This will help promote sustainability of HIV prevention for MSM by integrating this component into the routine policy, strategy, plan and budget for the province and the local areas.

E. Plan for addressing the problems and challenges

The budget from the GFATM Round 8 award will be used to address these challenges efficiently and effectively for better prevention results among MSM as follows:

- Capacity building for clinic staff including training in sexual diversity, sexual health, and MSM counseling.
- Development of the Provincial Coordinating Mechanism (PCM) which has the provincial chief medical office as the principal organization responsible for coordination among the various sectors including the local administrative organizations. The focus will be on increased contact, monitoring, coordination, and planning among relevant players in prevention, with participation of the target populations in a collaborative fashion. Especially, efforts will be made to support the system of referral between the outreach with the clinical service outlets, including training for staff of the local administrative organizations to improve understanding about the issues and problems in working on AIDS with higher-risk populations.
- Development of NGO staff through training on various topics that are necessary for effective implementation in accordance with the strategy for behavior change communication. These include skills in field work, HIV knowledge-sharing, standards for services in friend centers, collection of data for monitoring and improving the quality of services, building referral networks, and development of educational media for specific target groups.
- Strengthening of the national MSM network to support MSM groups at the provincial and district levels so that they can unite and improve their capacity to implement the prevention activities for MSM in peripheral areas.

F. Best practices

F.1 Strengthening MSM networks to implement HIV prevention among MSM

Twenty MSM organizations in ten provinces joined forces to create a national MSM network with the Rainbow Sky Association as the coordination focal point. They are implementing activities under the national strategy and to strengthen the network. The MSM network implemented two large programs to increase coverage of prevention services for MSM. These included the project supported by the Health Services Research Institute and the GFATM. They were able to improve the methods and effectiveness of access and coverage of MSM through a system of field staff and peer volunteers. In the past, these efforts were only sub-projects with independent, uncoordinated implementation without systematic reporting or evaluation.

F.2 MSM-friendly services and linkages with outreach and care and treatment for HIV illness

The system of services for STI diagnosis and treatment and HIV VCT in the Udorn Provincial Hospital is a model by virtue of its careful planning of appropriate and MSM-friendly services.They are mindful of the need to manage services so that there is an adequate number of staff, there is clearly advertised days and times of service for the specific target populations, including an after-hours clinic which is located in a convenient part of the community. The service providers have been trained in providing client-friendly services. They plan and coordinate closely with project outreach staff which creates a strong link between the field activities and the clinical services. In addition, the STI clinic is located at the same site as the ARV clinic. This facilitates links for the target population to receive HIV tests promptly and rapidly access treatment as needed.

Three other model program sites include the Male Health Clinic of Bang Rak Hospital of the DDC, the Silom Community Clinic, and the Male Health Clinic of the AIDS Center of the Thai Red Cross.

2.7 HIV Prevention among Injecting Drug Users (IDU)

A. Status of HIV infection among IDU

The HIV surveillance system of the BOE monitors the level of HIV infection among IDU in government drug rehabilitation centers. The prevalence of HIV among this population of IDU is still high, between 30% and 40%, with an increasing trend in the latest year. Using median value, HIV prevalence increased from a range of 26% to 33% in 2006-2007 to a range of 48% to 52% during 2008-2009[24].

The projected number of new infections (all causes) derived from the Asian Epidemic Model computer program is 10,853 for 2010. Of this total, 8.7% is estimated to be among IDU. The prevalence of needle/syringe-sharing among IDU was 36% in 2008 and, when applied to 2010 IDU, yields an estimated number of new HIV infections from sharing equipment of 941 IDU.[25]

Because injection of illicit drugs is a secretive behavior, it is difficult to estimate the number of drug addicts, whether by field surveys or counting those admitted to rehabilitation centers. Nevertheless, a conservative

[24] Bureau of Epidemiology, HIV Sentinel Sero surveillance
[25] Thai Working Group and A^2 Thailand, The Asian Epidemic Model (AEM) Projections for HIV/AIDS in Thailand: 2005- 2025

estimate of the number of IDU in Thailand at the time of this report is 30,000.

The latest ad hoc survey of IDU in 2009 (746 in Bangkok and 309 in Chiang Mai) found HIV prevalence levels of 24% and 11% respectively. There is wide variation of injection practices. In Bangkok, the following different drugs were injected: heroin (34%), methamphetamines (63%), Dormicum/ Midazolam (42%), and methadone (13%). In Chiang Mai the drugs that IDU injected included heroin (34%), methamphetamine (32%), Dormicum (4%), methadone (6%), and opium (14%).[26]

B. HIV prevention among IDU

B.1 Policy and plan/program addressing the problem of AIDS in IDU

1) The NASP for 2007-2011

IDU are one of the populations with a target reduction of HIV incidence by half during the plan period. This target includes both general IDU and those in jails, prisons, rehabilitation centers and juvenile detention centers. The prevention strategy is through reduced stigma and discrimination of IDU and use of appropriate policies and measures, studies to develop data and information and lessons learned, including methods of reaching IDU in the community, and detention facilities.

2) Integrated program to prevent HIV among most-at-risk populations through pro-active measures and creating a network of integrated services

IDU are a priority population in the NASP, and pro-active measures are being applied, along with the creation of a network of integrated services with funding from the GFATM Round 8 over a period of five years from July 2009 to June 2014.

A key strategy in this effort includes expanding the limits to accessing the IDUs and maximizing the coverage of HIV prevention services by increasing participation of civil society and the IDUs themselves. In addition, efforts are being made to make government services more user-friendly with links to outreach services provided by NGOs. A companion strategy is the effort to increase service providers' knowledge and understanding of different contexts of sex, and sex lifestyles, and the protection of individual rights, all within the framework of the overarching policy.

[26] Respondent-driven sampling survey of HIV-related risk behavior and HIV prevalence in injection drug users in Bangkok and Chiang Mai, Thailand, 2009 (unpublished data)

The PSI Foundation of Thailand is a principal recipient (PR) among NGOs to work with IDU. They are delivering outreach and condom supplies, clean needles and syringes to IDUs in the community. They are working with the Community Pharmacists Association Thailand to make clean needles and syringes available through community-based drug stores.

The DDC is the PR on the government side. The implementing partners include the Thanyarak Institute, Office of the Office of Narcotics Control Board (ONCB), and the Bangkok Metropolitan Administration (BMA). These agencies are also responsible for policy development, creating awareness and understanding among service providers, and applying the law to facilitate implementation.

The area of implementation during the first two years includes 15 provinces and Bangkok.

C. Progress of implementation during 2008-2009

C.1 Expansion of benefit packages under the UC program to include methadone maintenance therapy (MMT)

NGOs have long advocated for MMT to be covered by the UC program. On October 26, 2006, Ms. Supatra Nakapiew, Chairperson of the Thai NGO Coalition on AIDS (TNCA), which is a subcommittee member of the NHSO committee on benefit packages, proposed to the committee that they should consider adding MMT to the benefits for eligible persons. A working group was assigned to examine the necessity and feasibility of this proposal. The working group met with relevant organizations in the public, NGO, and IDU network to formalize a set of recommendations for the sub-committee. However, despite four rounds of proposal, no action was taken before the term of the subcommittee expired.

On November 7, 2007, representatives of the NGOs, include members of the Thai Network of People Living with HIV/AIDS (TNP+), the Thai Drug User Network (TDN), Thai Treatment Action Group (TTAG), ACCESS, Foundation for AIDS Rights (FAR), Thai Treatment Action Center (TTAG), MSF (Belgium) and the TNCA jointly submitted a letter to Dr. Suwit Wibulpolprasert, Chairperson of the subcommittee for development of benefit packages, to consider adding MMT to the NHSP. The Office of Policy and Planning coordinated with the Program for Drug Knowledge Management and related government and non government organizations via a number of meetings until the NHSO committee passed a resolution to add MMT to the benefits package on October 1, 2008.

C.2 Development of harm reduction of injection drug policy

During 2008-2009 the ONCB and the MOPH – represented by the DDC and Thanyarak Institute – coordinated with other government agencies, NGOs, experts, and international organizations to advance harm reduction policy by incorporating input from specialists and participation by all sectors.

The ONCB convened many seminars, both for staff of the ONCB at the central and field levels. In December 2008, ONCB and the MOPH convened a working meeting to produce recommendations for policy and implementation guidelines for harm reduction for IDUs with participants from the public sector, NGOs, and international organizations. The meeting produced Order 8/2009, signed on January 8, 2009 to create a working group to prepare policy recommendations and guidelines for implementation of reduction of harm and impact from the use of addictive drugs.

The Harm Reduction 2009 meeting during April 20-23, 2009, managed by the International Harm Reduction Association in Bangkok was another milestone which helped to advance the cause of harm reduction for IDUs in Thailand, and promote strategies for the coming period.

On June 25, 2009, the Minister of Health presided over the signing ceremony for the memorandum of understanding (MOU) for cooperation on harm reduction for IDU among the Office of the Permanent Secretary for Health, the Department of Medical Services (DMS), the DDC, the NHSO, and the ONCB, the UNODC office for East Asia and the Pacific, and WHO served as witnesses.

The MOU was an expression of intent to work together to advance policy for equal treatment of IDUs as for other patients, and to enable universal access and coverage. All the participating agencies agreed to work together to implement harm reduction for IDUs to reduce the spread of HIV and other diseases. The parties also agreed to pursue more effective treatment and rehabilitation for drug addicts to reduce drug-related harm by providing methadone maintenance.

In April 2009, the Senate Health Committee invited representatives from the government, NGOs, and international organizations to testify to the committee. In 2008-2009, it can be said that development of policy on harm reduction for IDU showed considerable progress. Support for study tours to countries with successful programs was implemented through the AHRN for politicians, high-level managers of relevant organizations, and NGOs. They traveled to Taiwan and, with support from WHO, the other group traveled to Malaysia. These tours helped to create a network among government agencies from multiple sectors and the NGOs. In coordination with the ONCB,

this network drafted harm reduction policy guidelines for IDU, and prepared recommendations for the NAPAC and the Narcotic Control Board

C.3 Implementation guidelines for harm reduction for IDU

During 2009, the Bureau of AIDS with support from WHO, developed implementation guidelines for health workers in delivering harm reduction for IDU, in coordination with NGOs, other government agencies, experts, and international organizations.

The resulting materials included guidelines for an outreach program, motivational interview, basic health awareness for IDU, HIV VCT, and counseling for screening and treatment, MMT, detoxification, and guidelines for needle/syringe exchange projects for consideration.

D. Harm reduction services for IDU

D.1 Government programs

1) *The Bangkok Metropolitan Administration (BMA)* has 20 methadone clinics under its Medical Department, two hospitals and 18 health centers. Each clinic has a resident physician who provides physical examination and prescribes rehabilitation action. Registered nurses administer the methadone. The types of services include the following:

- The methadone clinics provide out-patient service.
- Detoxification involves substituting methadone to ease withdrawal. New clients undergo 45 days of detoxification. However, since heroin addicts have declined (due to increased cost of drug) most of the clients at the detox clinics are not new addicts but returning IDU. The BMA's Department of Health thus extended the detoxification period to 90 days and to MMT.
- HIV VCT is offered in 68 BMA health centers and drop-in centers of NGOs
- Community-based outreach is conducted through a system of peer workers assigned to five areas. They try to access IDU in the community to provide HIV risk reduction information and referral to health centers as needed. The GFATM provides budget support along with TUC.
- In a pilot effort, a harm reduction clinic was opened on Saturdays during October to December 2009. These included group education on AIDS and harm reduction, and included occupational training with support from the Institute for Health Services Research.

2) *Agencies under the MOPH*: These include Thanyarak Institute and seven drug rehabilitation centers. These sites provide health services for all types

of drug addicts including harm reduction, HIV VCT, condoms, MMT, community outreach, screening for STIs, hepatitis, and TB.

D.2 NGO implementation

Civil society implemented activities through the IDU network and NGOs including the PSI Foundation/Ozone House, Raks Thai Foundation, AIDS Campaign Foundation, by providing peer outreach in coordination with field staff and drop-in centers (DiCs).

The DiC services are convenient for the IDU to access. They have recreational activities, experience-exchange groups, and small-group discussions on harm reduction, quitting injection drugs, avoiding needle-sharing, current drug use, knowledge about STIs, needle distribution and exchange, condoms and also referral for MMT, HVI VCT, STI treatment and other health problems.

D.3 Occupational development for IDU

Occupational development includes preparing IDU to return to mainstream society, and involves promoting self-esteem, training in self-restraint, concentration, self-confidence, and constructive use of free time. Both government and NGOs have been involved in this effort.

By government: The BMA and Thanyarak Institute implemented three activities including occupational therapy, training on applying for jobs, and job seeking.

By NGOs: Ozone House of the PSI Foundation supports occupational development by organizing interest groups based on the preferences of the IDU including a group for female IDU which makes decorative items and silk screening t-shirts. For male IDUs the groups include team activities for income-generation, revolving loan funds, etc. Over the long term, these efforts may confront obstacles of lack of market for their products or lack of replenishing the revolving loan fund.

E. Civil society and advancing harm reduction for IDUs

E.1 Thai Drug Users Network (TDN)

The negative consequences of discrimination prevent better access to treatment for HIV-positive IDU. For example, in trying to get ART, there is the condition that the IDU must quit drugs before starting ART. Mr. Paisal Suwannawongse, who helped set up the TDN, began the precursor for the network in 2000 with the goal of equal access of drug users to health care and treatment.

Process of establishing the drug user network of Thailand

On December 10, 2003, 2 to 3 drug users from the north, south and central regions met to form the TDN. With support from the UN and Bureau of AIDS, the TDN created a forum for exchanging experience among peers, and locating budget for constructive activities.

In 2004, the TDN, with support from the TUC convened a working meeting on "Reflections from drug users and the AIDS challenge" in collaboration with partners from each region. The purpose of the meeting was to brainstorm on solutions to the problems in each location and strengthen and expand the network, so that members can share information on the situation of drug users at regional, national and international forums.

In 2006, the TDN was formally established as a network with collaboration from the Project to prevent HIV among IDU in Bangkok.

Implementation by the TDN

The TDN develop models of implementation and outreach through a friends-help-friends approach using active and ex-drug users who were trained. These peer outreach workers then shared knowledge and information concerning the severity of the problem of drug use and AIDS. The peers located and integrated with drug users in the community to reduce risk behavior and the negative impact of HIV, distribute condoms, and clean supplies for the drug users who still weren't able to quit the drugs. At the same time, there was a system of referral to improve access to treatment and care, such as HIV VCT, STI diagnosis and treatment, and MMT, including comprehensive care through DiCs in the network.

Challenges voiced out from the TDN

Accessing drug users is difficult. They are secretive and fearful of being arrested. From talking with their fellow drugs users, the peers reported that, in the past, the information they got on HIV/AIDS was only from booklets and pamphlets distributed by the MMT clinic, or from the information board at these clinics. They never had a chance to get in-depth information from the government or NGOs which led to ignorance about HIV/AIDS. They misunderstood that HIV infection was asymptomatic at first. Also, the government's War on Drugs actually increased IDU risk of infection because the IDU were not able carry personal needles, therefore increasing the frequency of needle-sharing.

E.2 Network of people working on drugs (12D)

12D is a working group comprised of representatives from 12 agencies working on drugs including (1) Center for AIDS Rights; (2) TDN; (3) Asian Harm Reduction Network; (4) Raks Thai Foundation; (5) Thai PLHIV Network; (6) Foundation for Access to AIDS Treatment; (7) ACCESS Foundation; (8) PSI Foundation/Ozone House; (9) NGO Coalition on AIDS; (10) Alden House; (11) Friends Harm Reduction House of Bangkok; and (12) Independent workers with drug users.

The 12D began to be formed at the end of 2008 to improve understanding among people who worked with drug users, and examining the feasibility of MMT being included in the NHSP benefit package starting in Fiscal Year 2009.

The 12D network was not limited to only these 12 groups and had the objective to reflect the challenges of drug addicts from a broader perspective. 12D established forums for exchange of ideas, experience and advice as a way to modify the way of thinking and implementation so that it is more coordinated, focused, and united. Initially, Mr. Weraphan Ngammi who, at the time, was a free-lance worker, was chosen to coordinate among the members on behalf of 12D by communicating via the Internet regularly, and still does so up to the present.

F. Problems and challenges

- Even though MMT is now included in the NHSP, there are few users, and use is irregular.
- Harm reduction for drug users, despite the policy attention and material support it has received from the GFATM for the public and private sector, is still having problems obtaining the understanding and goodwill of local health providers and police officials in the areas of implementation, and the need for better coordination within the province.
- At the policy level, even though it is clear that harm reduction has to be integrated and comprehensive, there is difference of opinion concerning provision of clean needles and syringes for IDU.

G. Plan for addressing the problems and challenges

- There is an urgent need to develop the quality of MMT and establishment of national standards for harm reduction for IDUs. There is an urgent need to review, develop and improve harm reduction services, and prepare a handbook for service providers in the government and NGO sectors at different levels, including specifications for linkages among the various services in a comprehensive way.

- Establish strategies and communicate policy and build understanding and constructive attitudes of implementers both in the central area and the target implementation areas.
- Evaluate the lessons learned from other countries, and from within Thailand, to clarify needs and methods of implementing services for IDUs, and clean injecting equipment. This includes support for research on the results of harm reduction efforts in the area of prevention of addiction, rehabilitation, prevention of HIV, prevention of crime, and promotion of quality of life of IDU in various dimensions including finding routine work.

H. Best practices

H.1 Ozone House of Bangkok

The Ozone House is a center of information on AIDS and drug use implemented by the PSI Foundation (Thailand) with initial funding from USAID. It is implemented in three provinces including Chiang Mai, Chiang Rai and Bangkok.

The services of Ozone House in Bangkok were launched in 2005 with a target to lower the new infections among IDU. Ozone House supports participation of the IDU in addressing problems related to AIDS and drug use, and supports IDU access to health services. The activities of Ozone House emphasize creating a "home" atmosphere with user-friendly services which are suited to the problems and needs of the IDU. The activities emphasize participation of the IDU in implementation. The services consist of House-based services as a DiC and outreach in the community.

Selection of sites to be DiCs

Ozone House selects sites that are convenient and safe for accessing services by the IDU. It should be a central location relative to the five health centers of the DOH of the BMA which offer MMT. Before opening for services, there has to be a period of coordination to explain the target, objectives and implementation plan of the house. The organizers need to seek advice and request cooperation from representatives of the relevant agencies such as the police, health workers, local leaders, NGO development workers, and IDU peer educators. Formal meetings are held to explain the targets, objectives and methods of implementation of Ozone House with the representatives of these agencies and interest groups in the government, civil society, the local community and peer groups.

IDU participation in service provision

Activities and duration of operations of Ozone House are determined in consultation with a team comprised of Ozone House staff and IDU. This is done to ensure that implementation of the activities are consistent with the nature of the problems and needs of the IDU so that utilization of Ozone House will be maximized. The team develops house rules. The nature of the services emphasizes development of the IDU more than providing hand-outs or welfare. The following is a sample of the house rules for an Ozone House:

- No drug use of any kind in the house
- No purchase or selling of any kind of drug in the house
- No fighting or arguing in the house
- No theft in the house

The IDUs don't have to pay any fee for using the services of Ozone House. The house does not support transportation costs for IDUs to travel to the house. Instead it relies on providing incentives to people who do visit the house as in-kind compensation such as:

- Participate in 15 house activities = 1 T-shirt
- Participate in 25 house activities = 1 hat
- Participate in 35 house activities = 1 tote bag
- Participate in 40 house activities = the right to participate in the annual Ozone camp

Coordination with other organizations

Coordination with other organizations includes such activities as MSF sending staff to help with counseling and nursing, and medical specialists to provide health care on-site at Ozone House. This is done every Monday. The #3 BMA Health Center at Bang Sir continued these on-site clinical visits after the MSF discontinued their support. It was found that many IDU did not have their NHSP card or even their national ID card. Thus, at Ozone House they at least are able to get primary care and later could be referred into the regular system after helping them get the necessary documentation. There are house staffs or volunteers ready to help IDU with this process on a continuous basis.

Outreach Services

IDU who are interested in joining the activity for information sharing or extending help to those in the community who cannot come to Ozone House are trained in peer outreach. They provide information on AIDS and drug use to IDUs in the community. They also help link IDU who have health problems with the appropriate service providers. The outreach is a way to build

capacity of the IDU and increase IDU access to services. Ozone House staff work closely with the peer outreach volunteers to provide oversight and support as needed.

Important factors behind the success of Ozone House

- Participation from relevant agencies to help create a network of partners in the various areas that affect the daily life of IDUs. This includes a referral network of care for IDU or other networks for coordination of implementation.
- Participation of the IDU themselves in designing services through a learner-centered approach. Project staff did not attempt to think for the IDU or be judgmental. That way the IDU develop a sense of ownership of the activities so they want them to succeed. Otherwise, results could go in a negative direction.
- Uninterrupted schedule of activities and services to build trust and confidence among IDU.
- Support for IDU to help solve problems in their community in a sustainable way using a development approach that enables the IDU to be a constructive member of society instead of a welfare recipient, who just survives day-to-day.

2.8 HIV Prevention among Migrants and Mobile Population

A. Definition of migrants

The task force for monitoring and evaluation of HIV prevention among migrants has offered operational definitions of migrants and mobile populations for the purpose of reporting coverage of these populations as follows:

- Documented and non-documented migrant workers mostly refers to Burmese, Cambodian and Lao laborers
- Refugees or asylum seekers
- Ethnic minorities
- Thai laborers working abroad
- This report does not cover foreign tourists, foreigners residing permanently in Thailand, and foreigners coming to Thailand to pursue their studies. Also not included are certain groups of displaced persons such as the Rohingya, North Koreans, and others.

A.1 Number of migrants and mobile populations

At present, the number of cross-border migrants in Thailand is uncertain, but the Office of National Security Council estimates that there are about

2.5 million documented and undocumented migrant workers in Thailand. (2009 publication from the Office of the National Security Council).

The different groups of migrants are enumerated as follows: 1,475,317 migrants from Myanmar, Lao PDR, and Cambodia, registered to work in Thailand (Officer of Foreign Labor, 2010) with sub-divided totals as follows:

1. 1,314,382 migrant workers who are economic refugees who have been granted temporary permission to remain until repatriation, and who can be subdivided as follows:
   - 382,541 migrant workers working in Thailand continuously since 2004 (370,711 Burmese, 5,700 Lao, and 6,130 Cambodians).
   - 931,841 migrant workers registered to work in 2009 (708,056 Burmese, 105,154 Lao, and 118,631 Cambodians).
2. 133,488 migrant workers whose nationality documentation is pending verification but are registered to work legally including 15,784 Burmese, 58430 Lao, and 59238 Cambodians.
3. 27,447 migrant workers legally entering Thailand for work under the tri-partite MOU including 10,212 Lao and 17,235 Cambodians.

The UNHCR estimated that there are 103,566 displaced persons in nine camps in Thailand in its report dated December 31, 2009. There are equal numbers of males and females, and two-thirds are age 12 years or older. The number of displaced persons at the end of 2009 was less than at the end of 2008.

There are about 1.9 million ethnic minorities in 2009 of whom 19,775 were registered foreign migrant laborers.

Approximately 6,500 Thais are registered as migrant laborers in other countries in 2009.

B. Situation of HIV

B.1 Situation of HIV among migrants

The BOE, in collaboration with the provincial health offices of 7 provinces conducted HIV serosurveillance among fishing boat crew including Thais and migrants since 1997. The trends of HIV prevalence show continuous declines among this population, but the task force cautions that the data need to be interpreted carefully since there are questions of the quality of the data in some sites due to the small size of the sample, especially for rounds prior to 2007. Some provinces with adequate sample sizes show an increasing trend, for example, in Samutsakorn, Prachuap Kirikhan, Pattani, and Kanchanaburi.

HIV prevalence is higher among migrants than Thais in many locations

HIV prevalence among foreign migrant laborers is higher than that for the general Thai population (under 1% in 2009) in many locations. The International Organization on Migration (IOM) reported that, in 2006, for most provinces with data, the HIV prevalence for migrants was higher than that for Thai military recruits and pregnant women. Pregnant migrant women had higher HIV prevalence than Thai pregnant women in Trad, Ranong and Tak Provinces[27] (Figure 29).

HIV prevalence among migrant FSW is higher than for Thai FSW

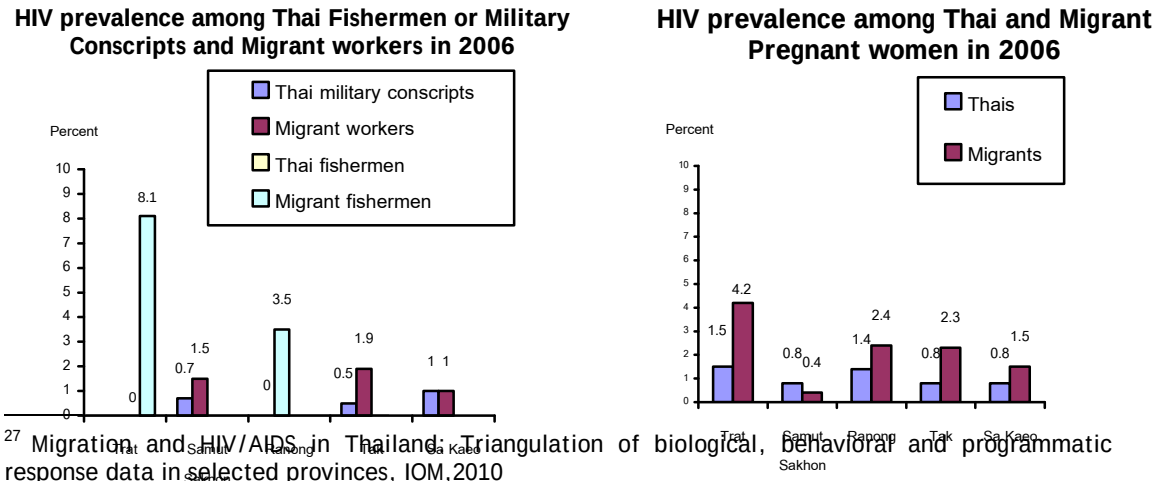
In the same way, data from Ranong and Tak show that migrant FSW have considerably higher levels of HIV than Thai FSW, despite declining trends frograde 8003 to 2006 in both provinces[28] (Figure 30).

Knowledge of AIDS and sexual behaviour of migrants

The data in this section come from the PHAMIT Project implemented by the Raks Thai Foundation. The Project found that migrants in the implementation area had increasing AIDS knowledge levels (from under 20% correct of 5 knowledge indicators in 2004 to over 27% in 2008) – with the exception of female migrants in provinces bordering on Cambodia. [29]

Male migrants reported high and increasing levels of buying sex and sex with multiple non-regular partners. The evaluation of the PHAMIT Project in 17 provinces in 2008 found that an increasing proportion of migrants were buying sex, especially in Thai-Cambodia border provinces (from 34% to 47%). However, condom use during last commercial sex episode was 97%.[30]

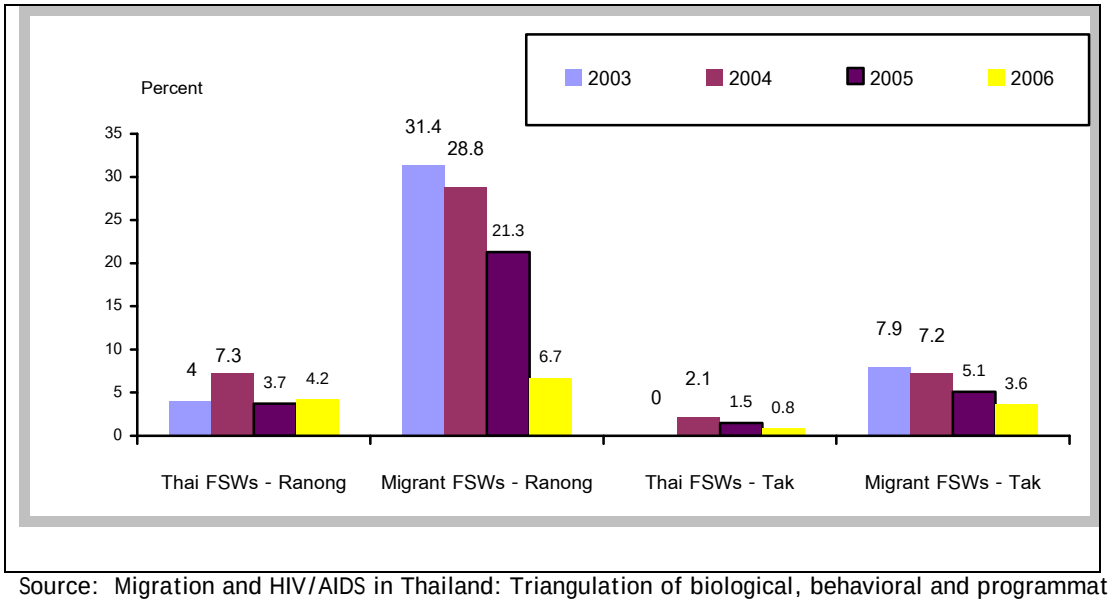
Figure 29: Prevalence of HIV among Thai fishing boat crew, army recruits, migrant workers, Thai and migrant pregnant women in 4 provinces in 2006



[27] Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioral and programmatic response data in selected provinces, IOM,2010
[28] Ibid 1
[29] Prevention of HIV/AIDS Among Migrant Workers in Thailand: The impact survey 2008, IPSR page 40
[30] Ibid 3

Source: Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioral and programmatic response data in selected provinces, IOM, 2010 using results of HIV Sentinel Surveillance by the Provincial Health Offices

Figure 30: HIV prevalence among Thai and Migrant FSWs in selected province in 2005



Source: Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioral and programmatic response data in selected provinces, IOM, 2010 using results of HIV Sentinel Surveillance by the Provincial Health Offices.

The number of non-regular sex partners in the year prior to the interview was also higher, at an average of four, and exceeded five in some areas. The 2008 survey found that there were slight decreases in the number of non-regular partners from 2004,[31] but that the number of non-regular sex partners of migrants was higher than that for their Thai counterparts (average of two).[32]

The 2010 IOM report which assembled risk behavior data from the provincial health offices of Samut Sakon, Prachuap Kirikhan, Mukdahan, and Chiang Rai, reported consistent trends for the period of 2004-2006: the level of condom use in last commercial sex episode was over 90%, with the exception of Chiang Rai in which condom use increased from 77% in 2004 to 83% in 2006.[33]

[31] Ibid 3
[32] National sexual behavioral survey of Thailand, IPSR, 2006
[33] Ibid 1

B.2 HIV situation among displaced persons

The prevalence of HIV among displaced persons is rather low. In 2009 a sero-survey of 150 persons who were pregnant women found a level of HIV of 0.16%. The percent with syphilis was 0.3%. There are no risk behavior surveys for this population. But it has been observed that there might be some risk among the adolescent males who go outside the detention camps for various durations and may have sex with sex workers. There are no reports of injection drug use in the camps. STI prevalence was at trace levels in men and women at 0.05 per 1,000 and 0.0051 per 1,000 respectively.

C. Implementation of prevention of HIV in migrants and mobile populations

C.1 Policy and plan/projects address the problem of HIV among migrants and other mobile populations

1) The NASP for 2007-2011

The four groups, as defined at the beginning, include migrant workers, displaced persons, ethnic minorities and Thai laborers abroad. These groups are identified in the NASP for priority prevention interventions, treatment and mitigation of AIDS impact. There are a number of measures to be taken to improve AIDS knowledge and understanding, creating a supportive environment, supporting a safe lifestyle, supporting participation in prevention activities through the implementing partners, and supporting access to health services. The following are additional measure specific to certain groups:

- Integration of AIDS into the policy for labor migration
- Integration of guidelines and measures for prevention, care and support into the plan for the protection of Thai laborers abroad.
- Supporting access to health services for displaced persons under the agreement between Thailand and UNHCR. Even though this measure is specified in the five-year plan, there is no budget for the activity.

2) Integrated HIV prevention for most-at-risk populations by supporting outreach and integrated service networks

This project only covers migrants, and receives support from the GFATM Round 8 for five years of implementation from June 2009 to May 2014.

The key strategy is to expand the scope of access to and coverage of HIV prevention services for the target population by increasing participation of the NGOs and the target beneficiaries themselves. In addition, the project

aims to increase the user-friendliness of government services and link these with the NGO outreach activities. Another strategy is to strengthen the target population, and increase knowledge about sex and sex lifestyles, protection of rights and service providers in the public and private sector, and advocate for enabling policies.

The Raks Thai Foundation (Raks Thai) is the principal recipient in this effort. Raks Thai manages outreach to the community and drop-in centers, including condom re-supply. The DDC via the STI group and the Bureau of AIDS have developed user-friendly services in the area of HIV VCT and STI diagnosis and treatment. The project is implemented in 36 provinces including Bangkok.

3) Implementation of HIV prevention for displaced persons

This activity is implemented by 4 international NGOS including Aids Medical International (AMI), International Rescue Committee (IRC), Maltese International and the American Refugee Committee (ARC) under coordination with the UNHCR. The services include:

- Support for access to condoms (female and male) in clinical settings
- Provision of post-prophylaxis for survivors of sexual violence
- Campaigns to create awareness and concern about AIDS among the general population including short drama presentations and other media as delivered by volunteers
- Provision of education on sex and AIDS as integrated into the reproductive health curriculum for adolescents
- Targeted interventions for high risk groups such as males going out of the camps on a regular basis
- Support for universal access to VCT using the rapid test, and STI diagnosis as integrated through the ANC and medical clinics, among others.

4) Implementation of HIV Prevention for ethnic minorities

For the past period of time that AIDS has been spreading into this population, Thailand has not implemented a clear and continuous program of prevention. The resources for this usually come from foreign donors which has helped encourage organizations working with ethnic minorities to focus on AIDS and related health issues such as the AIDS Project of the Lisu Organization, the Project for AIDS Education in Hmong Communities, the Lahu Health Project, which can be considered a first step by ethnic minorities to become involved in the NASP. There have been attempts to create networks for ethnic minority health through a 4-pronged strategy of health development,

capacity building, strengthening networks, and public policy and communication with the community, society and the public at large.

In the two years covered by this progress report, the following prevention activities for ethnic minorities have taken place:

The highlands ethnic minority health network has built the capacity of a work team of ethnic minorities, collected data, created a database, analyzed data, produced media on ethnic minorities in the localities, and linked and coordinated with the hospital and government offices, and the district health office to develop the model of user-friendly services for ethnic minorities.

- Forums have been conducted for exchange of experience and knowledge between agencies working with ethnic minorities, and joined forces to create a network of organizations working in the field, specified directions and guidelines for collaborative work through the ethnic minority network to reduce duplication of the work with the various groups of beneficiaries and localities.
- The AIDS Activity Organization of the Thai Christian Council, which has also been working with ethnic minorities for a long time, supports the coming together of PLHIV who are ethnic minorities in Chiang Dao District of Chiang Mai.
- In Chiang Mai, a working group on AIDS was established with a focus on ethnic minorities, and produced a collaborative plan for prevention of AIDS among ethnic minorities in Chiang Mai.

5) HIV prevention for Thai laborers abroad

The Department for Thai Labor Abroad supports a program for awareness of HIV prevention by training workers expressing the intention to seek work abroad, to protect them and their partners from HIV, and reduce myths about AIDS. In 2009, 29 training sessions were held among 6,463 persons including 5,743 males and 720 females.

Thais going abroad for work need to have a health exam from one of 96 certified clinics including 37 government and 59 private clinics. Employers who conduct a repeat health exam and diagnose a forbidden illness (including AIDS) can send the Thai laborer back to Thailand who may receive compensation depending on duration of membership in the welfare fund for Thai workers abroad.

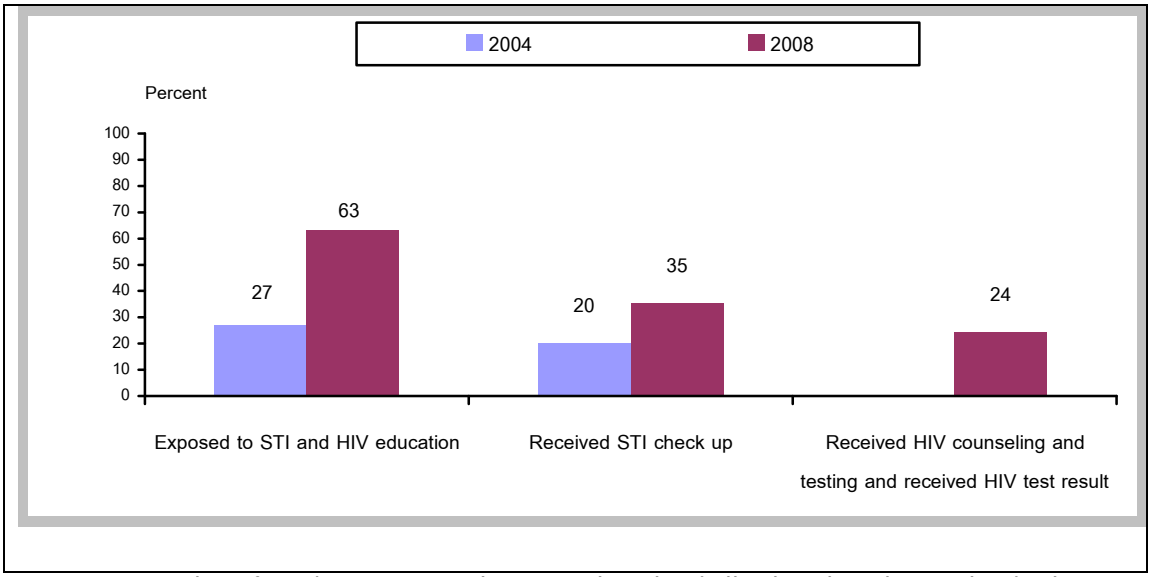
C.2 Results of the implementation

C.2.1 Coverage and access to activities for prevention and control of HIV among migrant laborers

During 2008 there were HIV prevention projects for migrant laborers in 23 provinces under the PHAMIT Project, the Planned Parenthood Association of Thailand (PPAT), and the World Vision Foundation. These activities were expanded to 36 provinces in 2009, mostly with the support of the GFATM Round 8.

The Raks Thai, PPAT and World Vision reached approximately 100,000 migrant laborers with HIV prevention services in 2008. The Raks Thai reported that their project beneficiaries had improved access to knowledge on HIV, AIDS and STIs frograde 87% in 2004 to 63% in 2008, with women having greater participation than men. The percent of migrants receiving STI exams increased frograde 80% in 2004 to 35% in 2008, and female migrants had about double the examination rate as males in 2008. Fully 24% had HIV VCT (Figure 31).

Figure 31: Percentage of migrant workers reached to key prevention interventions in 2004 and 2008



Source: Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT): The impact survey 2008, IPSR, 2008

D. Problem, obstacle and challenges

Gaps and challenges that still need to be addressed are numerous and touch on broader policy issues such as migrants' legal status, health insurance systems, and health systems budgeting. These in turn affect practical issues such as hiring of Migrant Health Workers and making ART available to migrants on a sustainable and on-going basis. Details are following;

- Policy for migrant worker is implementing as short term basic and ad hoc approach. A long-term, reasonable policy is needed.
- Memorandum of Understanding (MOU) with Laos, Cambodia and Myanmar on "The Employment of Workers" from those countries has not been successful in attracting high numbers of workers to migrate through formal channels.
- Health insurance covers documented migrants but estimated 1 million migrants are undocumented without insurance. Need to increase access to care and ART for migrant workers and make sustainable by including ART in the health insurance package.
- Under health insurance, 206 baht out of 1,300 baht per capita is for prevention and health promotion, 50 baht allocated to subsidize high cost care and treatment. Since it is low proportion of client under the scheme, total budget for health promotion is not enough to implement interventions.
- Need to institutionalize migrant health workers as part of service provision
- Quality Control and Quality Assurance should be implemented in expansion of interventions during 2010-2013

- Enhancing and expanding impact at national level should be a goal for prevention targeting migrant workers
- IBBS implementation will be conducted but still a need for other types of research to better understand transmission dynamics and sexual networks among migrant workers

E. Plan for addressing the problems and challenges

- Synthesize lessons learned from PHAMIT and other interventions for national scaling up.
- With support from the GFATM round 8, prevention, testing and treatment services are being scaled-up in the second phase of PHAMIT. The project has started since June 2009 and will be implemented till 2013. In order to intensify prevention interventions, an integrated package of services have been implemented, Standard Operation Procedure (SOP) will be developed or modified and will be tailored to make it appropriate for targeting sub-groups of migrant workers.
- WHO is supporting policy advocacy to ensure ART will be available and accessible for non-Thai HIV/AIDS patients among key stakeholders.
- Advocate for developing long term policy, improving medical health insurance package and registration system still continuous and closely monitor its progress will be implemented.
- In 2010, integrated biological and behavioral surveillance (IBBS) among migrant workers will be conducted as the first time in Thailand. It would be key data source for monitor progress of HIV epidemic and national responses. To complement with outcome and impact monitoring, program evaluation for migrant workers will be undertaking by 2011.

F. Best practices

F.1 Enabling Environment for Migrant Workers to Access HIV Services: The PHAMIT

(Prevention of HIV/AIDS among Migrant Workers in Thailand) Project (See details in Section IV: Best Practices)

Lessons Learned

The importance of participation by beneficiaries – The participation of migrants in interventions is a key element of PHAMIT's success. By building the capacity of migrants to assist in directly implementing activities and providing services, issues of accessing hard to reach populations and language barriers are overcome.

HIV prevention leads to the need for treatment – With regular exposure and sensitization to HIV prevention activities over the duration of the project, more migrants with HIV started coming forward needing assistance. Fortunately, PHAMIT's strategies were easily adjusted to accommodate migrant PLHIV's needs.

HIV programming for vulnerable and marginalized groups needs to support rights and communities – Migrant workers' security is directly impacted by broader issues of rights and policies, and their well-being is reflected by the conditions of their community. Ignoring these issues and singularly pursuing HIV programming-related activities leaves migrant workers and their families vulnerable to rights violations and other conditions that will undermine HIV-related gains. A holistic approach is required with migrant worker populations that addresses rights and community simultaneously with HIV related interventions.

F.2 Strengthening Access to VCT through Community Mobilization in Refugee Camps in Thailand

Actions for Change

In Mae La camp in 2001 there were 78 people who received pretest counseling and only 35 agreed to the test. Since then, efforts have been made to improve the availability and accessibility of HIV testing with impressive results. In the first nine months of 2009 there were 3,825 persons counseled and tested in Mae La Camp (registered population 30,033). The camp population has increased between 2001 to 2009, but the VCT uptake has increased markedly over what would be expected based on the population increase. Additionally, AMI expanded VCT to Umpiem and Nupo camps in 2005 where there has been similar success with 1,310 persons counseled and tested in Nupo Camp and 1,100 in Umpiem Mai during the first nine months of 2009.

Interventions and Positive Outcomes

The increased VCT uptake is due to a number of factors including the following: community involvement through the Karen HIV Education Working Group (many VCT counselors were chosen from this working group); the provision of mobile VCT which is preceded by educational sessions on HIV and the offer of VCT in community centers and sites; rapid testing and same day results; referral of STI and TB patients for routine offer of testing, and finally, mass awareness such as World AIDS Day and door-to-door campaigns conducted by AMI's VCT counselors.

Refugees currently have access to antiretroviral therapy with drugs supported by the government or AMI and with AMI providing most clinical services related to treatment in the camps. The availability of antiretroviral therapy for refugees encourages people to know their status as the option of treatment is available if they are HIV positive.

AMI's VCT counselors receive thorough training and have effective counseling aids in Burmese and Karen language suitable for a low literate audience (flipcharts, pamphlets and other IEC materials). The VCT training curriculum has been developed by the Karen HIV/AIDS Education Working Group with some support from external agencies.

The training of counselors for VCT is one month long and consists of two week's basic counseling training, one week's practical and one week on blood specimen collection. Information on CD4 counts and ARV treatment is included in the training. During the training much attention is given to the maintenance of confidentiality and privacy. This is critical in a closed camp setting in order to respect the rights of those accessing services and ensures community confidence in the services.

The VCT supervisor conducts monitoring with checklists to assess quality of services including a counseling checklist; an evaluation of each counselor is done every three months through observation of a counseling session and provision of feedback.

Persons testing positive are referred for further assessment to a clinical provider. This will include CD4 count to assess the need for ART; TB screening; referral for nutritional support and information about positive support groups available.

The UNHCR Health Information System data provides feedback by monitoring key indicators such as VCT uptake and percent of persons who return for post-test counseling and percent of HIV positive persons on ART. These data are used by the NGOs to monitor the access and quality of testing.

AMI have enrolled in Thailand's national laboratory quality assurance program for HIV testing to ensure accuracy and reliability of test results. This consists of participation in the national quality control scheme where quality control samples for specified HIV tests are distributed and the national quality assessment exercise which is conducted three times yearly.
The VCT is integrated with other HIV related activities including condom promotion. There has been a concerted effort to promote condoms since

2005 with much success. Initially there was strong resistance on religious and cultural grounds but now there are public promotion campaigns and demonstrations and wider availability of condoms.

Conclusion

Even in a low-prevalence setting, refugees will access HIV counseling and testing if the services are appropriately promoted and are provided to a satisfactory quality. Concerns about stigma should not be used as a reason to deny on-site access to VCT in camp settings if the context warrants this. Instead measures should be made to provide a quality service in languages that refugees understand with due attention to privacy and confidentiality. Counseling and testing services should be supported by linkages to other initiatives including positive support groups, community support, TB screening and treatment, and ART provision.

2.9 HIV Prevention among Prisoners

A. Background

Thailand has 142 prisons and other detention facilities with 209,427 inmates (as of December 2009). Of these, 85.9% are male and 14.1% are female. Drug-related offenses account for 57.1% with methamphetamines (meth) being the most common illegal drug involved (87%), followed by heroin (8%), opium (4%), and thinner (1%). Fully 18% were drug users while 82% were dealers/possessors of the drugs.

Health services for prisoners include an infirmary in the prisons and detention centers staffed by 1 to 2 individuals. There is a 500-bed hospital under the Department of Corrections (DOC) located in Bangkok. In the provinces, the regular hospitals provide care, with service subsidies from the NHSP for Thai nationals. Approximately 20% to 30% of prisoners are not eligible for NHSP benefits.

B. Situation of HIV/AIDS among prisoners

Currently, there is no formal surveillance of HIV among the prisoner population. The DOC has the policy to not conduct compulsory HIV testing. Voluntary testing is allowed as a guide to treatment. In June 2009, a total of 1,768 prisoners were known to have HIV (76.5% male). Fully 63.2% reported sexual behavior as the route of transmission, and 36.8% by injection drug use. A total of 1,172 were receiving ART and 723 had been treated for OIs.

A study conducted by the Medical Services Division (MSD) of the DOC in collaboration with other agencies reported the following:

- In 2005, the MSD conducted a study of prevention of HIV among 587 inmates in prisons and DOC detention centers in Bangkok with a history of addictive drug use. Of these, 89.3% had used meth, 3.4% had used heroin, 16.5% had injected drugs, and 10.7% had shared needles/syringes with others. A total of 9.5% reported ever having sex with someone of the same sex.
- In 2007, the MSD collaborated with the PSI Foundation to conduct a study of 200 prisoners with a history of drug addiction. The study found that 6% had ever injected drugs, while 68% had taken drugs orally. Fully 2% reported injecting drugs while in prison, and 75% reported having sex with someone of the same sex. A total of 88% reported having a tattoo done with shared equipment, while 67% reported modifying the foreskin of the penis using a shared sharp, and 32% said they used condoms.
- In 2008 the MSD collaborated with the TUC to study 584 young male inmates. Prior to incarceration, 49% had a history of addictive drug use including 4% injection. Risk behavior while in prison included using shared tattooing equipment (79%), penis foreskin modifications using a shared sharp (28%), having sex with another man (15%), and secretly injecting drugs (1%). Among those reporting sex behaviors, 15% said they used condoms.

C. Prevention of HIV among prisoners

1) The NASP for 2007-2011

The NASP specifies prisoners as a target population – both as a sub-group of IDU and MSM priority groups. It is hoped that prevention services could be extended to this population.

2) Guidelines for prevention of HIV among in-mates of prisons and detention centers

The DOC has issued the following guidelines for prevention and control of HIV/AIDS:

Prevention

- Build correct knowledge and understanding about HIV/AIDS including:
- Educational training for prisoners; training of peer educators to improve correct knowledge and understanding, reduce stigma of PLHIV, and learn about services in the prison.

- Educational training for staff, training resource persons and peer leaders in order to build correct knowledge and understanding and positive attitudes regarding PLHIV, gain cooperation in implementing prevention activities such as disseminating knowledge and distributing condoms.
- Production of educational media in a variety of formats to disseminate among the prisoners and staff, including requests for support from other agencies, to increase the knowledge of the prisoners.
- Conduct World AIDS Day campaigns.
- Provide condom services with condom supply support from the Department of Disease Control. Distribute condoms to the prisoners by clinical staff and DOC officials, peer volunteers, and by vending machines (only in Bang Khwang Prison).
- Provide HIV VCT for prisoners with risk behavior so that they can learn their serostatus on a voluntary basis to help in care and treatment and prevention of OIs.

Care and treatment

- PLHIV prisoners who are healthy and have no clinical symptoms are allowed to participate with the other prisoners as a regular inmate – there is no segregation. If they weaken and develop symptoms, they are confined to the infirmary or sent to the hospital to prevent spread of OIs and receive treatment as is their right.
- PLHIV prisoners who need ART can receive this through the NHSP, just the same as non-inmates.
- Capacity building for medical and public health staff for on-going care for PLHIV.
- Coordination with relevant agencies so that prisoners can have optimal access to services.
- Integrate TB control with HIV prevention through sputum exams to diagnose TB among all HIV+ inmates, and test for HIV among TB patients on a voluntary basis.

3) Project of integrated prevention of HIV for most-at-risk populations through outreach and integrated service networking

The male and female prisoners are a target population under the NAP who are most-at-risk for HIV. Thus, the GFATM is supporting active outreach to this population and the creation of integrated service networks using Round 8 funding for a period of five years from July 2009 to June 2014. The DOC is the Principal Recipient for this funding. The area of implementation

includes 32 prisons and detention facilities in 19 provinces including Bangkok.

D. Problems and challenges

- Lack of medical and nursing staff given the large number of prisoners. This reduces the ability to access services whether this is HIV VCT or ART, or whether they are eligible for benefits for these services under the NHSP.
- Some staff still has negative attitudes toward same-sex sex, and feels that condom distribution is a form of encouragement for more sex behavior. This limits the ability of the program to distribute condoms to all in need.
- There is still no system of methadone maintenance therapy for prisoners.

E. Plan for addressing the problems and challenges

Implementation of programs for prisoners according to the GFATM Round 8 program in collaboration with the Provincial Coordinating Mechanism, and it is expected that this support and collaboration will ensure that all relevant parties discuss and coordinate activities for maximum benefit.

3. Treatment, Care and Support for PLHIV and Affected Families

Thailand care and treatment program, including prevention and treatment for opportunistic infections and antiretroviral treatment (ART), has been effectively strengthened. Currently, it was included in all governmental healthcare schemes. An attempt to increase early access to treatment services has led to increase coverage of treatment and care for PLHIV. By 2009, there were 200,000 (coverage 75%) were currently receiving ART. Challenging for program effectiveness included a comprehensive approach to improve quality of life of PLHIV after ART and integrated TB and HIV treatment and care.

3.1 HIV Voluntary Counseling and Testing

The HIV VCT service is an important step for the infected to know their serostatus and access the treatment system at the optimal time. Knowing one's serostatus is an important way to ensure efficient and cost-effective care, and to learn how to assess one's risk, gain knowledge about HIV and AIDS and to learn how to best prevent HIV transmission.

The provision of couple counseling, especially for pregnant women and their partners, can help reduce the burden of ANC for HIV+ women. It is often a

difficult challenge for the pregnant woman who has just learned of her HIV infection to then have to inform her partner herself, and encourage the partner to be tested himself so that he can access treatment and services as appropriate.

Post-test counseling can help the PLHIV to look after themselves up until and through the time they start ART. This service also helps them to disclose their serostatus to the family or community, if that is one of their concerns and problems. Counseling is especially important, whether using individual, peer, or group formats, to help the infected person understand and be able to decide about having safe sex.

In the case of vertical transmission from the mother, informing the child needs to be tailored to the individuals, as this will facilitate ART decisions and help prepare the child as he/she matures and adopts a sexual lifestyle that is appropriate to his/her situation.

Access to HIV VCT

The UC program has included semi-annual HIV check-ups as a benefit for persons at risk of acquiring HIV infection. However, in 2008, only 170,000 persons took advantage of this benefit of the estimated 500,000 eligible. Most of those receiving service already had low CD4 cell counts and should have started on ART sooner.

In a study of 798 PLHIV, it was found that 53% learned/suspected they were infected because of episodes of OIs, whereas only 6% learned there serostatus because they had assessed themselves to be at risk and went for testing.[34] The national survey of sex behavior in 2006 conducted by the Institute for Population and Social Research of Mahidol University found that 19.1% of the population age 18-49 years had had an HIV test in the previous year.

The proportion being tested and receiving test results in the past 12 months declined among those with high risk. The rate of HIV testing with known results among FSW and MSW declined from 43.1% and 54.2% in 2007 to 36.3% and 35.2% in 2009 respectively. The study of BOE and among MSM in 3 tourist provinces indicated that the rate of HIV testing and knowing results decrease from 34.9% in 2007 to 21.3% in 2009, while the proportion for IDU was higher at 62.5%

[34] Dr. Sakchai Chaimahapreuk, Positive prevention for HIV/AIDS: Policy and practices, office of prevention and control 9, Phitsanulok, 2009

The accelerated MOPH strategy for TB control during 2008-9 led to more TB case-finding activity in clinical settings, including screening for HIV among newly-diagnosed TB patients using the principles of provider-initiated counseling and testing. This strategy increased HIV screening of new TB cases from 68.2% in 2007 to 87.6% in 2009[35] and led to the diagnosis of 8,414 and 5,815 HIV cases, or 21.3% and 17.2% of all TB cases screened for HIV in 2007 and 2009 respectively.

The subgroup of the population receiving highest coverage of HIV VCT are the ANC clients in public health service outlets because of the national policy of PMTCT which has mandated that all pregnant women receive this service. From MOPH reports in 2009, 99% of ANC clients were screened for HIV. Even though the level of coverage is high, the quality of service needs improvement. Data from a PMTCT evaluation study of women who delivered between October 2006 to December 2007 in 27 hospitals of 12 provinces in each region of the county show that 66% of the sample did not know their serostatus before the latest pregnancy, and 81% of these women received pre-test counseling and 93% received post-test counseling.[36] A pilot project to monitor quality of VCT in nine Bangkok hospitals sampled 1,344 persons who were tested for HIV and found that 86% received pre-test counseling and 81% received post-test counseling (HIVQUAL VCT, 2008).

Indicator	2007	2009
1. *% of risk population who received an HIV test and results in the past 12 months by group*:		
- Female sex workers (N: '07 = 4,168, '09 = 2,140)	43.1	36.0
- Male sex workers (N: '07 = 906, '09 = 1,500)	54.2	35.2
- MSM (N: '07= 906 , 09' = 1,500)	34.9	21.3
- IDU (N '09 = 741)	NA	59.7
2. *HIV screening of hospital clients*		
2.1 TB patients		
- % of new TB cases screened for HIV (N: '07=58,044, '09=38,556)	68.2	87.6*
- % of new TB cases with HIV infection	21.3	17.2*
2.2 ANC clients	99.8	99.3
(N: '07= 797,356, '09=791,775)		
- % of new pregnant women with HIV infection	NA	0.7

[35] Data for 2009 include only the first nine months of the year

[36] Bureau of Health Promotion, Department of Health, Bureau of Epidemiology, and the TUC

Indicator	2007	2009
3. *% of general population receiving HIV testing and results within the previous 12 months***		
- age18-49 year total (N=5,208)	19.1	
- age 18-49 year male (N=2,542)	16.3	
- age 18-49 year female (N=2,666)	21.8	
- age 18-49 year (N=347)	16.4	
- age 18-49 year N=873)	22.0	
- age 18-49 year (N=3,988)	18.7	

Remarks
* Data for first nine months of the year
** National survey of sex behavior: 2006

Plan for the development and promotion of access to HIV VCT[37]

The working group comprised of representatives from the DDC, DOH, Department of Mental Health, ACCESS, AIDSNet Foundation, NHSO, and the TUC have developed a system for quality improvement for HIV VCT that addresses counseling and testing procedures among those not yet needing ART to those ready for/or on treatment to ensure understanding and compliance with the regimen and to lead a quality life, a healthy sex life, and holistic health care in accordance with the following principles:

Promotion of access to HIV VCT in the general population by campaigns and public information dissemination to enable the population to assess their risk for HIV and understand the benefit of knowing one's serostatus from the earliest stage of infection. They will also learn of their eligibility for benefits package, and various channels to access VCT. Their confidence will be built in terms of the confidentiality of the VCT information and the quality of the service. There will be a phone hotline service for those informed through public media channels to access preliminary data in order to decide whether to use the service. This is especially important for those who do not yet have the courage to see someone face-to-face to discuss risk and HIV testing.

Support access to HV VCT for those at high risk through public-private collaboration networks. Deliver outreach services to access the high-risk populations, and use drop-in centers managed by NGOs; offer HIV VCT services, STI exams, and substitution therapy for heroin addicts. These services are to be user-friendly in both sectors to facilitate seamless referral

[37] Plan for developing the system and quality of counseling services in the care and treatment of PLHA: Proposed to the meeting of the subcommittee on development of services for PLHA on March 2, 2009.

between the NGO outreach and government service outlets in cases requiring more sophisticated care and treatment.

Develop the counseling system and develop capacity of staff to deliver quality counseling, and develop the monitoring and evaluation system.

Support the role of groups/networks of PLHIV for life after initiating ART by building the capacity of PLHIV to provide peer counseling for other PLHIV to help them adhere to the treatment regimen, conduct appropriate health behavior, and have safe sex if sexually active.

3.2 Antiretroviral Therapy and OI Management

Although Thailand has been successful in nationwide scaling up and increasing ART coverage, results from the projection and estimation revealed that there were 25% of PLHIV could not access to ART.[38]

The number of cumulative HIV infection and number of alive PLHIV in Thailand by 2009 from the Asian Epidemiological Model (AEM) projection[1] was 1,127,168 and 516,632, respectively. Of those, estimated number of PLHIV who met the indication criteria for ART in 2008 and 2009 were 266,369 and 275,621. For children, the number of HIV infected children (age < 15 year old) as 14,000 in 2008 was estimated from HIV prevalence among pregnant women and HIV perinatal transmission rate. Using SPECTRUM Model, number of HIV infected children needed ART in 2008 and 2009, estimated by were 9,284 and 9,450.

A. National Policy on Antiretroviral Treatment

The NASP for 2007-2011 proposed the implementation of ART services as one priority lists. The national program goal stated the continuum access to ART and comprehensive care, including clinical treatment, psychological and socioeconomic support. The main strategies are implementation and scaling up of care and treatment services nationwide to increase coverage and equally access by all, strengthening quality of services and standard of care by preparation of service infrastructure, human resource development at all levels and increase involvement of civil society and community services, and integrated HIV/TB care and treatment services.

B. National Guideline for Antiretroviral Treatment

For this reporting period, the national program has followed the standard national guideline, 2006-2007 which indicated the criteria for ART initiation by clinical definition (AIDS symptoms and signs) and immunological criteria by CD4 level less than 200 cell/ mm^3. The revised guideline (2010-2011) was

[38] The Thai Working Group on HIV/AIDS Projection (2005). The Asian Epidemic Model, Projections of HIV/AIDS in Thailand 2005 – 2025. 2008. FHI.

written by using WHO reference. It is being reviewed by technical experts before publication in October 2010.

C. Governmental Roles

Bureau of AIDS, DDC has major roles on providing technical support for innovative model, research and human resource development. The new models have been implementing during the reporting period included monitoring and surveillance of HIV drug resistance, quality improvement for care and treatment in children using HIVQAUL-T and prevention with positive in clinic setting. In addition, numbers of guidelines have been developed such as strengthening of voluntary counseling and testing and care and support of children affected by HIV/AIDS. Development of ARV drug adherence monitoring, expanded pediatric care and treatment by involvement of civil society have continued. Collaborative network includes the GFATM, TUC, civil societies and local organizations.

The NHSO, Social Security Office (SSO) and the Civil Servants' Welfare has supported for the expenses on ART, laboratory tests and prevention and treatment for opportunistic infections for Thai nationals who have the national identification numbers. NHSO has revised their regulation to cover the expense of second line regimens if clinical indicated. In addition, NHSO has supported the development and implementation of national monitoring and evaluation system for ART program and the strengthening of PLHIV networking. The HIV/AIDS treatment for migrants and those who are not eligible for universal coverage scheme, have been supported by the GFATM.

D. Civil Society Roles

During the past 5 years, the Thai Network of PLHIV (TNP+) together with ACCESS Foundation and Médecins Sans Frontières (Belgium) has supported the increasing of PLHIV participation in care and treatment program development and services through "Comprehensive Continuum of Care Centers". The joint collaboration between PLHIV and hospital staff as "co-service provider" is obviously seen in many hospitals. Peer leaders and volunteers have major roles in providing full information and understanding of the ART, counseling, group activities, and home visits to ensure the efficacy in ART and ability of self-care for treated persons. The peer leaderships and volunteers need training and human resource developments. Presently, there are 367 comprehensive continuums of care centers working with the hospitals with 42,763 clients (Updated by January 2010).

The major evolution during the past 2 years included:

- There are clear benefits on standard of care and treatment under the national health care coverage. It led to increase access of PLHIVs to ART and OI treatment, subsequently with reduction of morbidity and mortality.
- The national policy has supported in production and importing cheaper antiretroviral drugs such as importing Efavirenz, Lopinavir/Ritronavir, etc. through compulsory licensing, production of GPO-vir-s and GPO-vir-z by the Government Pharmaceutical Organization, Thailand. It has led to the reduction of treatment cost from 20,000 THB (USD 600) to 870-1000 THB (USD 26-30) per month
- Increasing of PLHIV human resources and personal capacity on care and treatment services. The program has developed with clear program goals, strategies and action plans to increase access to quality of care and treatment. The participation of PLHIV in program development and services are substantial both at policy and service levels. Presently, there are 1,726 leaders are working for the networks (updated by January 2010).
- The NHSO has a clear policy on providing budgetary support for PLHIV networks. Currently, there are 182 centers receiving NHSO support (January 2010). In 2011, the NHSO will provide budgetary support for 400 centers and 7 regional offices.

E. Coverage and Access to Care and Treatment

In Thailand, there are 1,014 ART facilities nationwide. As of September 2008 and 2009, there were 185,086 and 216,118 PLHIV receiving ART and the overall coverage were 67.14% and 75.76%, respectively. Generally, there were about 58% are supported by the NHSO under the Universal Coverage policy.

Although there are more than 200,000 persons receiving ART, most of them accessed to the treatment at late stage with AIDS symptoms or low CD4 level. Results from the NHSO monitoring system, 52.6% and 51.9% of PLHIV who started ART in FY 2008 and 2009 had AIDS symptoms and/or CD4 levels was less than 100 cells/mm.[39] This result indicated the possibility of less access to early HIV diagnosis and result notification among PLHIV. Other possible factors included having no knowledge on access to treatment services, not being referred by health care providers, no supported health care insurance, migration or socioeconomic problems. By now, there is no intensive exploring on this problem and its' related factors.

[39] National AIDS Program Monitoring (Data of 38,880 persons who started ART during Oct 1, 2007-June 30, 2009), National Health Security Office.

F. Treatment Outcomes

The statistical analysis from the NHSO monitoring system revealed 1 and 2 year survival rate among PLHIV treated with ART were 90.6% and 86.7%, respectively. It was consistent with the report among adult and children who started ART during October 1, 2007 – September 30, 2008 that 90.0% and 84.9% of them are alive and receiving ART at 12 month after ART initiation. Death rate and lost to follow up rate were observed higher among adults than children which were 7.8 and 4.6 among adults and 7.2 and 5.4 among children respectively.[40]

HIV drug resistance (HIVDR) is a major problem which has critical impact to the effectiveness of ART. In Thailand, current surveillance system revealed that the incidence of HIVDR at 1 and 2 years after ART initiation were 2.6% and 4.4% respectively. [41] The major resistance was observed in *Non-nucleoside reverse transcriptase inhibitors (NNRTIs)* including nevirapine and efavirenz. HIVDR leads to switching of the ART regimen from the first line to second line to ensure the effectiveness of stopping viral replication. Results from the monitoring system on "Early Warning Indicators for HIVDR" among persons receiving ART under UC found that 1.8% had to switch the first line regimen to the second line regimen at 1 year after ART.[42]

G. Opportunistic infection management

As with the ART, prevention and treatment of OI is also part of the benefit package under the universal health insurance, social security and civil servant medical benefit schemes. Tuberculosis, *Pnumocystic carinii* pneumonia (PCP) and Cryptococcosis are the common opportunistic infections in Thailand.

The evaluation of quality treatment in all 106 affiliated hospitals, the number of PLHIV clients as randomly estimated was 11,699 persons. Of these 87% of adult PLHIV in the treatment registration system received cotrimoxazole (CTX) for preventing PCP, while 82% of infected children received CTX for PCP prophylaxis. Coverage of the prevention of cryptocoocosis was 80% Coverage of TB screening has increased from 78% in 2006 to 96% in 2009 and 95% of persons with HIV/TB infections received TB treatment.

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[40] Ibid 2

[41] HIV Drug Resistance Surveillance among ART Patients, Bureau of AIDS and Thailand MOPH-U.S. CDC Collaboration

[42] HIVDR Early Warning Indicators, Bureau of AIDS, National Health Security Office and Thailand MOPH-U.S. CDC Collaboration

H. Best Practice

H.1 ART monitoring by using database from National AIDS Program

The MOPH has started the ART program since 1994 as a research projects. In 2005, it became a national program entitled as "National Access to ARV for People Living with HIV/AIDS (NAPHA)". The ART monitoring system was developed for monitoring of program outputs and outcomes. In 2008, with the Universal Coverage Policy, ART was included as one of the health care benefits under the responsibility of the NHSO.

In order to obtain key information for policy makers and service providers, the NHSO developed a monitoring system by deriving and using lessons learned from NAPHA program to monitor service deliveries and program outcomes. The soft ware program was generally known as National AID Program or NAP.

NAP has been used as monitoring system and information centers across 953 ART facilities, regional and central levels. There were 161,582 and 186,124 HIV infected persons registered to NAP at the end of FY 2008 and 2009 respectively. NAP could be designated as having highest number of information networks and registered clients, comparing with the monitoring system of other diseases.

Strengths of NAP include 1) Online system with systematic linkages between various modules, having security protection for personal identifiers (the national identification numbers which are encrypted and other personal information will not be accessed by public and absent in the database), accessible to more than 1,000 users at the same time, systematic linkage with Vender Management Inventory (VMI) for drug stock management, ability to generate reports for service delivery monitoring and available of communicating module for information sharing among users and program maintenance; 2) various modules for monitoring of care and treatment program, including VCT, HIV testing and other laboratory services, registration of HIV infected clients, follow up of treatment services, ARV management and approval of the second line ARV regimens, prevention of mother to child HIV transmission and post exposure prophylaxis modules.

Benefits from NAP Data

Facility level

- Use as monitoring records for budget reimbursement from the NHSO according to the provided services.

- Use as information sharing and transferring, i.e., quickly obtaining laboratory results for treatment plan
- Use for monitoring of service deliveries and treatment outcomes

Provincial and regional Level

- Use for monitoring of service deliveries and treatment outcomes of the province or region, including monitoring service performance of the facilities within the province or region.

National level

- Use for monitoring of service delivery at the facility level to ensure the benefit package was provided to PLHIV
- Use for monitoring of the distribution of compulsory licensing ARV
- Use for evaluation of program efficiency and effectiveness at national level
- Use for annual budgetary plan and preparation of ARV and medical supplies
- Use for public health and medical research

Challenges and remedial actions

Since NAP is online with high number of users, sometimes the system is traffic with slow processing. Currently, the NHSO has revised the system to improve the online services. Another challenge is data quality which was unreliable, especially during the first year of program implementation. The problem on transferring of NAPHA data, less skills and unclear understanding of parameters, as well as burden of data entering have led to the unreliable of the data. During the past years, to strengthen the improvement of data quality and encourage using of data for service monitoring program planning, the NHSO has revised the program and providing training, as well as set up the information centers for problem solving for the staff at service deliveries.

Action plan for 2010-2011

The data quality has been related to the knowledge and attitude of responsible persons at the facilities in using of data for monitoring and program planning. Increasing in data using by the local facilities, more reliable data with data completeness and correctness will be observed. The NHSO will collaborate with responsible network at all levels and technical organizations, including Bureau of AIDS and TUC to develop a software program called NAP Data Analysis and Reporting to generate a standard reports of key indicators, needed for monitoring of service deliveries and

program outcomes, and strengthen human resource capacity for using of these information for effective program planning and improvement.

H.2 Model development on HIV disclosure for children infected with HIV

Appropriate approaches for disclosure of HIV status to children infected with HIV is the very important step to increase the positive attitude in HIV status, as well as having knowledge and acceptation to cooperate in care and preventive interventions, especially when children are indicated for ART, starting puberty and reproductive age group or suspicious of their illnesses.

During 2006-2007, Faculty of Medicine Siriraj Hospital, Queen Sirikit National Institute of Health and TUC has piloted a model for HIV disclosure among children. Evaluation had been conducted by assessing the attitude and acceptation, as well as negative impact of HIV disclosure at 2 and 6 months after disclosure. Results has been analyzed from 163 children participated in the pilot has found no any negative consequence after the disclosure. The model has been scaled up to other hospitals nationwide.

Design of HIV disclosure for children infected with HIV

HIV disclosure for children infected with HIV is sensitive. Close and regular communication is needed among the responsible health care provider team to consider the appropriate steps and time for disclosure which are varied by case basis. “Client and Family Centered” is critically needed, so preparation of children and their family is considered as the first step. HIV disclosure is not only for result notification, but also the communication and counseling to ensure that children correctly know their status, having positive attitude with HIV infection and accept to cooperate for the intervention plan. Steps of the disclosure included:

Step 1: Assessment for readiness

To assess the readiness of children and care takers on HIV disclosure, interviewing and assessing of children attitude and care takers to verify current personal and environmental status of children and care takers. Criteria used for define children with capability on HIV status perceptions include:

- Age 7 year old or more who had HIV positive diagnosis
- Care takers are able to get regular counseling services
- Care takers have no serious illnesses or are admitted in hospital
- Children are not in the depressive status, committed suicide, having psychological illnesses of mental retard

Step 2: Preparation of readiness

Counseling basic is used for preparation of the readiness of children and care takers on HIV disclosure. Fear, concern and the expectation of care takers and children will be assessed and reduced by counseling process. By the meantime, encouragement of confidence and increasing skills on communication will be guided.

2.1 Preparation of readiness of care takers

The objective is to obtain information on the current relationship among care takers and children, including the supports from other family members, and prepare the readiness of care takers by reviewing potential problems, barriers and solutions. If the child takers are not ready for the disclosure, continuum assessment is needed.

2.2 Preparation of readiness of children

The objective of this step is to build relationship between children and counselors in order to increase adaptation and problem solving skills under the stressful pressure. In addition, counselors will get child background and environmental information, such as personal behaviors, temper, quality of life, adaptation skills, etc.

Step 3: HIV positive result notification by using counseling principle

The objective of this step is to assess the child's perception, acceptation and attitude on HIV infection, as well as fear and concern in illnesses, before result notification. If the children are ready, results can be disclosed, following with counseling on information of HIV disease, health related status, care and treatment. The psychological assessment will be provided along with the disclosure and counseling.

Step 4: Monitoring and evaluation

The objective of this step is to assess the consequence after disclosure, as well as reviewing the children understanding and acceptation on their health status, ability for self care, and problems and solutions.

Model scaling up

In 2007, a training curriculum on "Child HIV Disclosure" was developed. A year later it was used for training to 578 health care providers from 67 provincial and community hospitals in 10 provinces nationwide. Eighty percents of the trainees are nurses who are working at pediatric HIV clinics. After training, they are able to use the knowledge and skills to provide HIV disclosure to HIV infected children. In 2009, the model has expanded to 48 hospitals. Evaluation results found that 95% of trainees of 13 hospitals have used the knowledge and skills to provide HIV disclosure. At present, there are 482 HIV infected children already known their HIV status.

Lessons Learned

- Design of HIV disclosure is flexible due to underlying psychological status and environment factors of children and care takers and their families.
- Design and guideline of HIV disclosure for HIV infected children can be used by hospital healthcare providers
- Curriculum on "Child HIV Disclosure can be used for increase human resource capacity and scaling up of the HIV disclosure model

3.3 TB/HIV Co-infection Treatment

Tuberculosis is the most common opportunistic infection found among Thai PLHIVs. The written policy on HIV/TB was documented in 2004[43] with the following key strategies:

- Establish coordinating mechanism between TB and HIV programs as well as the surveillance of HIV infection among TB patients and providing capacity building to those who provide TB and HIV care to understand how to provide both TB and HIV services. Moreover, monitoring and evaluation system will be designed for this co-infection.
- Provide HIV VCT, OI prophylaxis and treatment if CD4 < 200 cell/cu.mm, and ART if CD4 < 250 cell/cu.mm. for and HIV information for prevention to TB patients.
- Provide TB screening to HIV+ cases by history taking for identification of suspected cases and having further diagnosis by laboratory testing and chest x-ray. The screening should be done regularly at every visit for HIV services. In addition, prevention of TB spreading in health care facilities is included. .
- Currently, the "Isoniazid Preventive Therapy (IPT)" has not been a consensus to be the national policy. However, it was proposed to implement in the healthcare facilities where the resources are available and is located in areas with high HIV epidemic.

The 2008-2009 TB/HIV program goals included the following indicators:

- More than 85% of registered TB persons for all health care schemes will receive voluntary counseling and testing for HIV
- More than 90% of newly diagnosed of HIV infection will receive TB screening
- More than 60% of TB/HIV infections will received treatment for HIV and TB

[43] TB Cluster, Guideline for TB/HIV management, Bangkok, Ak-sorn Graphic, 2009

TB/HIV Coverage

In this reports, the estimated coverage of TB/HIV treatment among TB/HIV infected persons was estimated from the estimated TB infection rate among Thai population by WHO as 142 per 100,000 population and the HIV infected rate among TB patients which was revised from 7.6% which were reported in 2007 to 17% in 2009. So the number of TB/HIV was estimated as 16,077 in 2009.

Results from the current monitoring system on the treatment services, revealed that 4,151cases are receiving TB/HIV and the coverage was 25.8%. The success rates of TB treatment revealed by the current monitoring system were 67.7% and 67.9% in 2004-2005 and the death rates (by all reasons). The overall death rate among newly diagnosed TB with positive sputum screening found 8.6% and 7.6% respectively.

TB/HIV program achievements

According to the national policy, the TB/HIV program has been implemented. The 2008-2009 program goals were achieved as indicated by 93% of HIV infected patients received TB screening and 87.6% of TB patients received HIV counseling and testing.

3.4 Care and support for HIV/AIDS-affected Children

A. Situation of AIDS orphans and other AIDS-affected children

Even though the prevalence of HIV among pregnant women showed a downward tendency from 1.53% in 2006 to 0.64 in 2009[44] with corresponding reductions in MTCT of HIV, the cumulative number of children affected by HIV/AIDS continues to rise.

The Thai progress report to UNGASS for the period from 2006-7 to the present indicated that there are still no new developments in creating a unified database of AIDS orphans and children affected by AIDS. Data from various sources are presented below.

The projections from UNAIDS, USAID, and UNICEF estimated that in 2010 Thailand would have 1,054,000 orphans age 0-14 (father and/or mother dead, all causes) or 6.3% of the total population under 15. Of these, 374,000 were estimated to be AIDS orphans (or 35.5%) or about one-third of all Thai orphans. [45] Using the multiple indicators cluster survey to assess the situation of Thai children in 2006, it was found that there were 854,215

[44] BOE, DDC, MOPH, 2009

[45] UNAIDS, USAID, UNICEF, Children on the Brink 2002: a Joint Report on Orphan Estimate and Program Strategies, July 2002, quoted in Country report : Thailand. East Asia and Pacific Regional Consultation on Children and HIV/AIDS, Hanoi, Viet Nagrade 82-24 March 2006

orphans age 0 to 17 years, or about 4.7% of the total population of 18,174,805 in that age group.[46]

At the societal level there is still negative stigma on AIDS and HIV even among HIV-negative children of a PLHIV. The MICS[47] survey found that 65% of women age 15 to 49 still refuse to buy food from someone they know is HIV+, and 37% would want to keep it a secret if someone in their family was HIV+. Children of PLHIV will also suffer the effects of the prejudice expressed by these women.

Regarding activities to support and care for the welfare and education of AIDS orphans and affected children, the MICS[48] survey found that only about one in five orphans received social/legal support, materials/supplies, medicines, and/or educational stipend. In addition, the survey found more chronic malnutrition and generally greater vulnerability than non-orphans: 15-16% of orphans were malnourished compared with 12% of non-orphans. The proportion in school is slightly different between orphans and non-orphans: 95.5% versus 96.4% respectively.

From a review of many studies in Thailand over many years, there is a range of adverse impact on children affected by AIDS such as the following:

- *Health problems:* Children with HIV who did not receive treatment at the appropriate time will experience OIs and death. Evaluation of the PMTCT program among 911 children born during October 2006 to December 2007 in 27 hospitals of 12 provinces in each region found that 56% received diagnosis of their serostatus.[49] In addition, some children who were diagnosed with HIV and had begun ART had difficulty taking the pills and receiving continuous re-supply of ARVs. Both HIV-infected and uninfected suffer from inadequate nutrition and under-development for their age.
- *Psycho-emotional difficulty:* The affected children experience depression from the loss of one or both parents and the lack of parental care. Some are frightened, angry, sad, or anxious after learning that their parents or they themselves are HIV+. Some children are raised in foster homes or homes of relatives, or are sent to orphanages. This causes stress among the children. Orphans who are infected are afraid of illness and worry about the strictness of the ART regimen. These stresses and anxieties may cause behavior that further erodes the

[46] UNICEF Thailand and the National Statistical Office, Summary Report of MICS, December 2005-November 2006.
[47] Ibid 4
[48] Ibid 4
[49] DOH and BOE, DDC, MOPH 2009

situation of the child and creates more challenges for their daily life and happiness.

- *Social problems:* Myths about AIDS give rise to stigma and discrimination against PLHIV and their families, including children. Some children are treated badly and excluded from the social circle. They are deprived of assistance, care and educational support that other unaffected children receive. They have fewer or no friends and this has a detrimental effect on their mental health. AIDS orphans are more likely to be the victim of bullying than other children.

B. Implementation of care and assistance for AIDS orphans and affected children

B1. Policy and plan addressing care and assistance for AIDS orphans and children affected by AIDS

Thailand has no AIDS law in particular, but there are measures and regulations that are relevant, such as the law on protecting the rights of the child (2003), the national proclamation to promote the development of children and youth, and the draft law on reproductive health rights.

Regarding the policy and strategy of Thailand, as a signatory on the convention of the rights of the child – which promotes the survival, protection and involvement of children – the portions that are relevant for AIDS-affected children include the following:

- The NASP has set a target of 80% of children and families affected by AIDS can access health, education and social services equal to others by 2011. The plan also specifies the responsible agencies to achieve this goal, especially with respect to AIDS-affected children. These agencies include:
  - the MSDHS, to look after policy and take responsibility for social welfare services for PLHIV, persons affected by AIDS, AIDS orphans and AIDS-affected children both in orphanages and in the community;
  - the MOPH to assist with health promotion, HIV prevention and treatment;
  - the MOE to assist with schooling, sex education, HIV/AIDS awareness, and reduction of stigma and discrimination in the schools;
  - the Ministry of Interior to be responsible for policy at the regional, provincial and local level;
  - the Ministry of Justice to be responsible for overseeing the process of justice, including laws relating to abuse; and
  - BMA, by virtue of its Division for the Control of AIDS, TB and STIs of its Health and Medical Departments.

- Policy and national strategic plan for child development according to "A World Fit for Children" 2007-2009

The United Nations General Assembly Special Session on Children, convened in May 2002, endorsed the document "A World Fit for Children." This provides guidelines for implementing programs for children during 2007-2016. Thailand has adopted these guidelines as approved by the Cabinet, and will implement a program under the leadership of the Bureau for Support and Protection of Children, Youth, the Disadvantaged, and Elderly. This Bureau will define measures and implementation strategies in collaboration with relevant agencies in the public and private sector across eleven components as follows:

- Family and the child
- Physical and mental health of the child
- Prevention and protection of children from injury
- AIDS and children
- Education and the child
- Children and recreation
- Children and culture and religion
- Mass media and children
- Participation of children
- Protection of children in special circumstances
- Laws, regulations and measures related to children and their enforcement

B2. Progress during 2008-9

From data on AIDS-affected children, the following activities can be reported.

Government

- *MSDHS*: Delivers welfare and assistance to AIDS orphans and affected children and families including counseling for parents/guardians, educational scholarships, and occupational scholarships, among others. In addition, the ministry supports HIV-infected and affected children at welfare centers of which there are four: in Chiang Mai, Nonthaburi, Udon Thani, and Songkla. The ministry identifies foster homes for orphans and gives financial support for foster families, provides milk, food supplements, health services, and arranges activities to promote understanding and acceptance through camps for foster families.
- *MOPH:* The Bureau of AIDS with the MSDHS and NGOs have developed a handbook with guidelines on living with children affected by AIDS in welfare centers and private institutions (2008).

- *MOE:* Supports free education or provides educational scholarships for orphans and children affected by AIDS, including a lesson plan on AIDS, sex education and life schools to help reduce prejudice and abuse in school.
- *MOI:* The Provincial Administration Organization supports and/or participates with agencies and NGOs in the field to provide care and treatment and assistance for PLHIV and their families, including children. They support the integration of children affected by AIDS in the community to reduce stigma, and provide financial and material support, and occupational support. The strength and effectiveness of activities depends on the local situation, capabilities and extent of the AIDS epidemic.

Civil society

- *The "we understand" group***:** This group works with hospitals, schools, NGOs, networks of PLHIV, mass media, and volunteers with support from UNICEF to develop models to support mental health, values, and sense of self-worth, and build the capacity of children with HIV through the creative arts. Psycho-social inputs are integrated with health care to provide a comprehensive development program for children with HIV. They have developed a handbook for developing video media, posters, and pamphlets for campaigns to improve understanding and care for children living with HIV.
- *Thailand National AIDS Foundation (TNAF):* With support from the MOPH and the GFATM, the TNAF implements a program of care for post-partum women and families living with HIV in the community. The activities are conducted in collaboration with the DOH and support quality of life development by providing comprehensive health care addressing the physical, emotional and social needs of infected women, their children and families in 41 provinces.
- *Thai Network of PLHIV (TNP+):* This group supports groups of PLHIV so that can look after children affected by AIDS, provide counseling for children and families, link them with services, and follow up infected children who are taking ART. In addition, this group collaborates with others for policy advocacy related to appropriate ART regimens for children, and treatment centers that are closer to home.

In addition to the above groups, many NGOs are helping AIDS-affected children and their families by providing social support or educational scholarships, counseling, activities to enhance quality of life. Some of these NGOs include the Foundation for Human Development Support, the

Rachaprachasmasai Foundation, World Vision Foundation, and the Siam-Care Foundation.

C. Problems and challenges

Policy management:

- Policies related to children are included in many of the plans of ministries, yet they often lack concrete implementation plans that result in real action.
- There is a lack of strategic data; the current data is inadequate for policy formulation and planning to resolve problems or improve services so that they are more appropriate for the needs of AIDS orphans and other affected children.
- Reform in the government sector has not led to clear plans for the care and assistance for AIDS affected children. There is no central coordinating body at the field level.
- Despite the existence of measures for the protection of children in orphanages and day care centers, there is inadequate implementation of these, and there still exist cases of rights violation and exploitation of children.

Providing services for the care, treatment and support:

- Development of the capacity of service providers for AIDS-affected children, in the government and private sector, so that services are more comprehensive, inclusive of physical, mental, and social dimensions is still not systematic, and coverage is not optimal.
- Budget for support of children and families affected by AIDS is only 500 baht per month. This is inadequate for families facing economic difficulty. Also, to receive that assistance one needs to disclose one's serostatus to the local administrative organization, and this is a barrier for some PLHIV.

ART on a continuous basis, and sex education for adolescents growing with HIV:

Adolescents face numerous changes during the transition from childhood to adulthood. This is especially true for adolescents with HIV. Some have more difficulty in adapting to adolescence than others, and this has implications for receiving uninterrupted treatment, and developing appropriate sexual behavior. Society may view adolescent PLHIV as spreaders of disease, resulting in pressure not to have romantic relationships, or only to be involved with other PLHIV.

Stigma and discrimination:

Stigma and discrimination of children in the community is still a problem in some communities. This has multiple adverse impacts on the child affected by AIDS. It is a continuing challenge to conduct knowledge and understanding campaigns in these communities to allow affected children to live in harmony with others.

D. Plan to address the problem and challenges

- Establish strategies for policy management through the Ministry of Social Welfare as the coordination focal point for government, private, and international organizations and experts. There needs to be policy development at the central level and concrete implementation of the policy at the central and field levels.
- Establish a system to implement capacity building and attitude development for staff of government and NGOs working with children affected by AIDS including physical and psycho-social dimensions, and prevention of new infections and protection of the rights of the child.
- Support and establish a system of care and support for children in orphanages and day-care centers of the private and public sector so they conform to standard.
- Support strategies in the community so that they are able to support and care for orphans and AIDS-affected children in a way that is appropriate and maximizes coverage.
- Support the development of models to lower stigma in the community, and models of user-friendly services for HIV-infected adolescents.
- Develop the monitoring and evaluation system at all levels including development of the database linkages concerning orphans and children affected by AIDS in Thailand.

E. Best practices

E.1 Integrated psycho-social services with clinical care and treatment by the "We Understand" group. (see details in Section IV: Best Practice)

E.2 Development of the quality of life of mothers, spouses, and children:

Development of strategies for prevention and solving problems at the policy level and community was by the Thai National AIDS Foundation (TNAF).

The TNAF has collaborated with the DOH to implement the Enhancing HIV-Related Care and Treatment for HIV Infected Mothers and their Partners and Children – Community Support Component project in 41 provinces in 4

regions. The results include the creation of 556 peer leaders among PLHIV and community volunteers through 96 sub-projects involving 100 groups/organizations. Capacity was developed for the care and assistance for 9,934 HIV-infected mothers and 4,654 children to help them access physical and psycho-social care. This activity was conducted in collaboration with 442 local tambon administrative organizations and the municipalities.

Key lessons learned:

- Developing the capacity of PLHIV support groups requires continuous attention. By building their capacity, social acceptance of PLHIV improves and this reduces stigma and aversion to PLHIV. The view of society changes toward a more positive image.
- Assisting children affected by AIDS in a comprehensive way requires links among the hospital and community. There needs to be a social safety net from the level of the tambon, district and province including multi-disciplinary teams from the tambon administrative organizations, local leaders, religious institutions, health center, health volunteers, schools, NGOs, and PLHIV support groups. At the same time, there had to emphasis on follow-up visits and regular meetings with PLHIV support groups to provide refresher support, to maintain motivation and a sense of spirit, especially for children of HIV-positive mothers, and build life skills in these children.
- Training for teachers and caretakers of children including the community health council is essential to help them understand AIDS and modify negative attitudes and prejudices against AIDS to lessen the adverse impact on AIDS-affected children. In this way, children can live more harmoniously in the community, and a support network is created. A good example is the project in Phayao which has activities to re-energize and provide moral support for children conducted by the community strengthening institutions. They have created a fund for children, an arts camp for children, arts for values activities which reflect aesthetics appreciation and development of the spirit. The local tambon administrative organization has a policy to support AIDS activities and scholarships for children to steer youth into becoming constructive adolescents who can value the right things, and have good self-esteem, and can realistically plan for the future jointly with the family.
- Opportunities to create sustainability of care and support for AIDS-affected children occur through the integration of AIDS planning with the routine plan of the local administrative organizations. A good example of this is in Pa Sak Tambon of Phu Sang District of Phayao which created the Health Network Fund which is a long-term plan similar to the one in Mae

Tha District of Lampang which does not segregate AIDS as separate or special issue – they simply treat it as another aspect of the community to be considered.

4. AIDS Vaccine Development

The year 2009 was one in which Thailand announced an important advance in the study and development of an HIV vaccine since that was the year in which the results of a Phase 3 clinical trial were released.

This Phase 3 study of a candidate AIDS vaccine was the result of the efforts of the MOPH to develop a vaccine that would be effective against the local strain of HIV as a measure to further control the spread of HIV in Thailand. The trial was implemented according to the national AIDS vaccine development plan approved by the NAPAC in 1993, and which designated the MOPH as the core implementation agency.

After completion of the first two phases of the Thai AIDS vaccine trial, the MOPH designated the DDC as the core implementing agency for Phase 3 in collaboration with a number of agencies and sectors as follows:

- The Research Committee included the Faculty of Tropical Medicine of Mahidol University, Armed Forces Research Institute for Medical Science, and the provincial health offices of Chonburi and Rayong.
- The trial sponsor is Walter Reed Army Institute of Research (WRAIR), office of Surgeon General, Department of Defense, USA
- Financial Support for the research was provided by the U.S. National Institutes for Health and the U.S. Army Medical Materiel Development Activities, U.S. Army Medical Research and Materiel Command via Henry M. Jackson Foundation.
- Support for the candidate vaccine was provided by the sanofi pasteur which developed the ALVAC-HIV (vCP1521) recombinant canarypox vector vaccine which was genetically engineered to express HIV-1 gp120 (subtype E: 92TH023) linked to the transmembrane anchoring portion of gp41 (subtype B: LAI), and HIV-1 gag and protease (subtype B: LAI); and VaxGen Company which supported the boost vaccine AIDSVAX ® B/E (currently sponsored by GSID -Global Solutions for Infectious Diseases) as a bivalent HIV gp120 envelope glycoprotein vaccine containing a subtype E envelope from the HIV-1 strain A244 and a subtype B envelope from the HIV-1 strain MN

The principal objective of the vaccine trial was to test the “prime-boost” approach using the candidate vaccines to measure the efficacy against strains E (CRF01_AE) and B of HIV (the most prevalent strains in Thailand)

among a group of volunteers. In addition, the trial aimed to assess the effect of the vaccine to reduce HIV viral load among those who became infected after receiving the vaccine.

The research team conducted the trial in Chonburi and Rayong Provinces among a population of uninfected volunteers, male and female, aged 18 to 30 years. Activities were conducted after ensuring the readiness of potential volunteer and the associated communities, including training and tests of readiness of staff and relevant individuals to implement the research starting in 2001. The first volunteer screening center was opened on September 24, 2003 and the first volunteer was recruited on September 29, 2003. From that point, the milestones of the trial include the following:

- Administered the vaccine to the first volunteer on October 20, 2003
- Recruited 26,675 volunteers from over 60,000 expressions of interest
- Administered the vaccine to the 16,402 person on December 30, 2005
- 13,976 volunteers received four (complete set) vaccine doses on July 31, 2006

At the time of this report, the Phase 3 AIDS vaccine trial activities were completed and the results were officially announced on September 24, 2009. It was found that the study vaccines were efficacious in reducing risk of HIV infection by 31.2% but was not effective in reducing plasma viral load. Although this level of efficacy is not high enough to allow for general use, this trial provided crucial information that can be used to improve the development of future AIDS vaccines to achieve higher levels of efficacy.

The research team has established four scientific advisory committees comprised of experts in AIDS vaccine and immunology including committees on Cellular Immunity, Humoral and Innate Immunity, Host Genetics, and Animal Models. These committees are to provide recommendations for further research activities to explore Correlate Protective Immunity, and to recommend future directions for the development of new generations of more effective AIDS vaccines.

IV. Best Practices

In the preparation of this report (2010), the method for selection of 'best practices' is described. Project staffs were invited to submit recommendations for their project as a best practice, to be selected by a committee of experts and technical specialists from the public and civil society sectors. A total of seven best practice projects were selected from 49 submissions. The seven nominees were then asked to submit a detailed description of their project and the justification for considering it as a 'best practice'.

An important criterion for selection included the presentation of supporting data in the project description to serve as an objective basis for consideration, and for study and comparison by other projects, both within and outside Thailand.

Another key criterion of selection concerned the degree of attention to the phenomenon of the feminization of HIV/AIDS in Thailand as reflected by the increasing proportion of the total caseload of HIV-infected who are women, and of the 30% of projected 11,753 new infections in 2009 that are estimated to be among wives infected by their husbands. There are few examples of projects addressing this trend; other topic areas were also given priority.

Examples of best practice projects for 2010 can be divided into three areas:

(1) Prevention and control of HIV/AIDS in the context of the feminization of HIV/AIDS in Thailand.

- Two projects working with people living with AIDS, the Real Lives Project implemented by the northern regional branch of AIDSNet; and the Voices and Choices Project (Phase 3) implemented by the Raks Thai Foundation.
- One project working with HIV-negative pregnant women with the cooperation of their partners: The Pre-natal Couple Care Project implemented by the Reproductive Health Division of the Department of Health and the Faculty of Nursing of Burapa University.
- One project working on comprehensive sexuality education for adolescents: Teenpath Project implemented by the Program for Appropriate Technology in Health (PATH) and partners.

(2) AIDS response for marginalized people in Thailand

- One project entitled "Anti-retroviral therapy in border areas of the Greater Mekong Sub-region: Experience of the Chiang Saen Hospital"

principally implemented by the Chiang Saen District Hospital and partners.

- One project entitled "Prevention of HIV/AIDS in migrant laborers in Thailand (PHAMIT)" implemented by the Raks Thai Foundation and partners.

(3) Holistic care and support for children in Thailand, for which there was one project as follows:

- The "Integrated Psycho-social and Medical care Project" principally implemented by the We Understand group and partners.

With UNFPA support, the best practices selection committee prepared a detailed report of these exemplary projects. The key content of the report is extracted below.

1. Prevention and control of HIV/AIDS in the context of the feminization of HIV/AIDS in Thailand

1.1 The Real Lives Project

This project is a collaborative implementation between persons living with HIV/AIDS (PLHIV) from the AIDSNet Foundation and partners. The strategy of the project is to improve the quality of life of PLHIV to build their confidence and help them find ways to have healthy and safe sex lives, and to avoid transmitting HIV or contracting new strains of the virus, and STIs. Project beneficiaries develop positive outlooks on their future and maintain their reproductive health and exercise options in pursuing intimate relationships and child-bearing. The Project builds positive self-acceptance and constructive relationships with family members and the community.

Process of implementation

The Project is implemented with full participation from the PLHIV beneficiaries at every stage in the process. These stages include planning, developing the intervention model, supporting the activities of the PLHIV groups, and development of the Real Lives training curriculum which is used to build knowledge and skills among the PLHIV attending clinical monitoring check-ups or participating in group activities at the local hospital or community.

The process of learning through the Real Lives curriculum relies on trained peer leaders who expand the teaching to an ever-wider circle of PLHIV. Evaluation of the Project is conducted by the groups of peer leaders, the network of PLHIV and the International AIDS Alliance as the donor.

Activities under the Real Lives curriculum create a forum for exchanging thoughts, conversation, and experience regarding coping with HIV infection and how to lead a constructive life from a holistic perspective. There are seven modules to the curriculum which cover content such as viable options for prevention of HIV, self-risk assessment, evaluating symptoms of STIs, developing a plan and readiness for disclosure of sero-status, identifying the origin of discriminatory practices, identifying solutions to problems, and sharing experience on choosing sexually healthy lifestyles.

Success

Quantitatively, the Real Lives Project was able to reach and support over 5,000 PLHIV. The Project was expanded from the Upper North to other parts of the country, including the Northeast region, through the expanded reproductive health initiative for PLHIV of the DOH of the MOPH.

In addition, the participants in the Project reported increasing condom use at last sex by 20%, and were 20% more likely to disclose their sero-status to their partner than persons not participating in the Project. A smaller percentage of Project participants (12%) said it was "difficult" to disclose their sero-status than non-Project participants (21%).

Qualitatively, the Real Lives Project built knowledge, understanding, prevention and health-seeking behavior, and promoted a greater awareness of rights, a way of thinking and decision-making regarding reproductive health among PLHIV and their partners, both among discordant and concordant couples. In addition, Real Lives built the capacity and skills of beneficiaries in communication and sharing experience with the peer leaders.

Important findings

Because of the Project's process of participatory learning through a "friends-help-friends" approach through non-judgmental discussion of behavior, thoughts, and attitudes, there was more open discussion and revelation of health maintenance behavior. The information from the direct experience of Project participants was highly relevant to other members of the Project and more easily applicable to their lifestyle than general information on prevention and health maintenance.

By using a participatory learning approach for both men and women, and using couple-based activities, it was easier for the Project to promote sexual behavior adaptations for healthier and higher quality lifestyles than was the case before implementation.

1.2 The Voices and Choices Project for HIV-positive Women (Phase 3: 2006-2009)

This Project is implemented through a women-centered strategy by the Raks Thai Foundation. A key concept of the Project is the importance of building the skills of peer leaders who are HIV-positive women through a learning process to maximize potential, physical energy, and positive changes in oneself and one's life.

Process of implementation

In Phase 3, the Project is continuing the work of earlier phases which included participatory research using HIV-positive women as part of the "life force group" followed by active outreach to recruit and build the capacity of a core group of peer leaders through participatory training of HIV-infected women. These peers became involved with hospital-based counseling services as persons with relevant experience, and were trained in aspects of counseling other women.

Now in Phase 3, the Project is focusing on increasing the self-determination of HIV-positive women concerning sex and reproductive health. The Project continues to train the peer leaders, and to promote exchange of experience and thoughts about sex, power, and male-female relationships. Meetings are convened in a safe space to create an atmosphere for relaxed openness. After gaining a more profound understanding of one's life circumstances and the root of personal problems, the participants can then discuss and help others address their challenges which are different across the varied regions and contexts that positive women find themselves in. Working together with the Project staff, they have created a training curriculum which uses a "friends-teach-friends" approach to deliver the content in order to help women accurately address problems in a way that is appropriate for each individual. The curriculum is being expanded to other groups of HIV-positive women in different regions of the country.

Success

Quantitatively, the Project has expanded the activities to cover 3,000 women. Peer leaders have increasingly been able to involve their male partners in the Project training activities.

Qualitatively, the peer leaders and other infected women who have been trained have greater knowledge and understanding about their personal circumstances of sex and reproductive health rights. They have more skills in communicating about sex to make sex more enjoyable and safe. They are able to communicate their needs and desires to their partner, service

providers, and other relevant individuals. The Project's friends-teach-friends curriculum has been integrated with other teaching programs. The Project's peer leaders participated in every aspect of development of a curriculum for reproductive health of HIV-infected persons of the Department of Health, and served as resource persons to provide advice on applying the curriculum from the outset to the national expansion phase at present.

Important findings

The process of strengthening the internal resolve of HIV-positive women so that they have greater self-confidence, dare to communicate their thoughts and make independent decisions, and are able to accept the consequences of these actions, is a key concept of this Project.

The person facing the challenges is her own teacher and develops an ability to diagnose and resolve problems independently. This ensures that the solution is the most relevant and appropriate action for the affected individual. The Project process also strengthens the authority and capacity of participants to experience real achievements.

1.3 Project to prevent infection among HIV-negative pregnant women through Pre-natal Couple Care.

This Project attempts to develop a system of ante-natal care (ANC) that helps HIV-negative pregnant women stay negative (despite the fact that their partner is infected) using couple participation. By building the couple's knowledge and understanding about HIV/AIDS and prevention, they can plan for the future in a way that is most appropriate for them. The principal implementing agencies for this Project are the Reproductive Health Division of the DOH and the Faculty of Nursing of Burapa University.

Process of implementation

Initially, the precursor for the Project was a pilot effort at the ANC and family planning clinics of six health promotion hospitals which promoted a minimum requirement of four joint visits by the pregnant woman and her partner. During these visits the couple received information about the health and care for the mother and infant, STIs and HIV and prevention, and the separate roles of the parents of the pregnancy. The Project promoted condom use among discordant couples and regular, voluntary HIV blood checks.

In the second phase of the Project (during 2007-2011) the model activities are being expanded through the system of regional, provincial, and district hospitals throughout Thailand. The model advocates that the father of the

pregnancy participate in the care of the pregnant woman and the infant, and must attend at least four visits together during the pregnancy, the delivery, and post-partum. The Project has developed a couple counseling curriculum for primary and secondary counseling for discordant couples. The Project has also developed techniques to help hospitals motivate couples to attend services together.

Success

During Phase 2, from July 2008 through September 2009, 724 discordant couples participated in the Project, or 19% of all ANC clients in the Project areas.

Implementation in 25 health facilities in three eastern provinces, Chonburi and the Faculty of Nursing of Burapa University during 2008 registered 3,242 new cases of couple counseling with 1,878 testing HIV-positive, or 57.9%. For five pilot project hospitals in Chonburi, there were 358 new cases of couple counseling, 340 of which both partners agreed to HIV testing, or 95%.

Important findings

Setting up a system of couple counseling is to create an open system of participation for sexual and reproductive health maintenance for both partners in a relationship. Couple ANC is an additional way to promote more warmth and love in the relationship.

1.4 The Teenpath Project

The PATH organization is the principal implementing partner working with the MOE and MOPH to promote comprehensive sexuality education (CSE) and prevention of HIV among school-based adolescents. Support for this Project is provided by the GFATM.

The Project attempts to deliver CSE in multiple dimensions of human development: relationships, life skills, sexual behavior, sexual health, and socio-cultural aspects. The Project focuses on adolescent's age 12 to 24 years.

Process of implementation

The Project uses a systematic strategy to work on school policy and with teachers to become agents of change to promote CSE for adolescents. PATH selected a variety of implementing partners in different regions to create a united force to broaden school teaching to include CSE as part of the basic education curriculum. In particular, the Project focused on vocational schools, non-formal education institutions, and branches of Rachapat

University. These groups worked together with technical guidance from PATH to develop the concept of introducing the CSE curriculum and training teachers how to deliver it. PATH helped with direct implementation in Bangkok and oversaw coordination, and overall direction of implementation throughout the Project sites.

Success

In the first five years of implementation, the Teenpath Project had ten managing partners to create pilot applications of CSE in model educational institutions for every grade level from primary to secondary and post-secondary levels. The Project was able to integrate CSE into the standard, formal curriculum, and build a network of instructors who were skilled in delivery of CSE and positive development of youth.

The Project created a team of CSE resource persons in the areas of implementation to help establish models of CSE for various grade levels including curricula for high school grades 7 to 12, the vocational school diploma program, an activity set for non-formal education institutions, and a curriculum for education faculty students.

Groups of adolescents were organized to help promote understanding of AIDS and sex education in the schools and the community. The Project created a cadre of youth peer leaders to play an active role in the Project. Local resources were mobilized to support sustained CSE. Favorable articles on CSE for adolescents appeared in the media more often, including quotes from Project partners.

Important findings

Having a clear policy to promote implementation of a CSE curriculum for adolescents at all levels on a continuous basis is an essential ingredient for local acceptance of the program by schools and the society.

It is crucially important to create understanding among educational administrators of the targets and concepts of CSE so that they see it as a natural learning process for youth regarding sex lifestyles by using a learner-centered approach. By giving voice to their thoughts and analysis, youth can participate fully in the information-exchange and learning process, and acquire accurate and factual information to inform life decisions.

2. AIDS responses for Marginalization People in Thailand

There are two projects under this heading that were selected as a best practice.

2.1 Anti-retroviral therapy (ART) in border areas of the Greater Mekong Subregion: Experience of the Chiang Saen Hospital

This Project has prepared and delivered ART in border areas of the greater Mekong subregion for many years, to serve border populations of laborers and migrants, domestic and foreign, who normally do not have access to subsidized treatment from other sources. Many sectors are involved in helping this Project, through coordination and the application of local wisdom, to deliver a locally appropriate and acceptable service. This Project provides an additional option to marginalized populations who otherwise cannot receive treatment.

Process of implementation

A Thai pilot project in 2004 demonstrated the feasibility of providing ART to ethnic minority populations living in border areas. But that was a short-term effort while ART is life-long. Therefore, the Chiang Saen Hospital developed a model for a longer-term approach. Since most of the persons in need of ART in this area are low-income cross-border migrants, the Chiang Saen Hospital collaborated with Medecins Sans Frontiere (Belgium) to devise a model ART program for cross-border populations on the Thai-Lao border. The model includes a reserve drug bank, laboratory monitoring, patient referral, counseling, and a combined patient admission, clinical monitoring and care form.

A review of records of ART patients at the Chiang Saen Hospital – both Thai and ethnic minorities – was conducted to study side effects of ART. It was found that there was lipodystrophy and vascular problems in 54.8% of patients. Therefore, the hospital developed a self-care program of lifestyle management and use of local wisdom to manage side effects and maximize health.

Later the program curriculum was modified to include Lao and Burmese local wisdom to be incorporated for patients from those cultures. After training patients and their relatives in these principles of care, the Project conducted community follow-up, and delivered refresher training courses, and selected experienced patients to be mentors for new patients and other vulnerable populations. In addition, the hospital developed educational media in three languages (Thai, Lao and Burmese) to improve the ability of staff to care for the patients.

Success

A total of 73 HIV-infected Lao and Burmese were being cared for by the Chiang Saen Hospital during July 2004 to June 2007. Of these, 98% had uninterrupted treatment records and a survival rate at 36 weeks of 96%.

Qualitatively, all patients on ART experienced improved health status, could carry out daily activities normally in their home communities, could help other infected persons, promoted prevention activities, and were closely linked with Thai counterparts continuously over time.

By including traditional lifestyle practices and local wisdom to help ethnic minorities to perform self-care helped patients and their families to achieve a better health result. They gained knowledge, understanding, and a sense of participation in the care process, and were dedicated to the ART process, more than if the Project never happened. They were able to counsel others and be a source of moral support to other infected individuals.

Important findings

The heart of the success of this Project is its appreciation of the value and equal status of all humans, and the promotion of full and meaningful participation of the multi-disciplinary team. By establishing a foundation for quality development of the organization, the responsible individuals can easily adapt to changing circumstances over time.

ART is a strategy for cross-border health services to access marginalized populations of the HIV-infected. This is one step in mitigating the impact of AIDS and STIs in cross-border areas, can reduce discrimination and stigma, and can help support prevention of spread of HIV and STIs in these locations. The policies of Thailand and its neighbors regarding cross-border collaboration and goodwill are factors behind the success and feasibility of any cross-border program such as this.

2.2 Prevention of HIV/AIDS in migrant laborers in Thailand (PHAMIT)

This Project has the objective of increasing condom use and reproductive health among migrant laborers and their families, and other related individuals from Lao P.D.R, Cambodia, and Myanmar. The Project focuses on the laborers in the fisheries and food industry in 19 coastal provinces, and factory, agriculture and construction laborers in three non-coastal provinces bordering Myanmar.

In addition, the Project gives special attention to sex workers and staff of entertainment establishments, both Thai and migrant. The Project is

principally implemented by the Raks Thai Foundation and seven partner agencies with funding from the GFATM.

Process of implementation

The Project uses a comprehensive, integrated approach that is flexible and adaptable. The Project applies active outreach to the target beneficiaries, provides field-based services, uses multiple means of communicating Project information, distributes condoms, and conducts referral for reproductive health care.

The Project outreach team is comprised of one Thai field coordinator, and at least one migrant health worker (MHW). Together they arrange Project activities at the laborers' residential neighborhood, work site, or places of recreation. The MHW is selected from the principal minority population of migrants in the locality. The MHW is given intensive training on HIV and reproductive health, and this training content is reinforced through a series of monthly meetings with annual refresher training courses.

A key feature of the implementing process includes migrant health volunteers (MHV) who are selected from the community of migrant workers. The MHV distributes information to the migrants and provides regular reminders to follow the guidance from the Project information, reduce/avoid risk behavior, and helps reach the otherwise "hard-to-reach" groups. The PHAMIT Project has developed educational media in many formats to deliver information on HIV, AIDS and various rights concerning health. These media are in a language that the migrants easily understand and include Burmese, Lao, Khmer, Karen, Lahu, Hmong, and Shan.

The Project established drop-in centers (DiC) to provide services and information, and serve as a meeting place for activities. The DiC is located in a place that is safe and convenient for the migrants to access, where they can relax and feel comfortable. They are encouraged to feel a sense of participation and "ownership" of the DiC. The DiC is also a referral axis for migrants who need treatment for STIs, maternal and child care, and other reproductive health services. The Project staff and volunteers follow up the results of the referral.

In coordinating with the local hospital, some the PHAMIT partners assist the mobile medical unit as interpreters (as needed) to facilitate the clinical care. The services include family planning and treatment for STIs.

There are two strategies for regular distribution of condoms: through condom vending machines, and through the MHVs and employers of the

migrant laborers. Condoms are also distributed on an ad hoc basis during community campaigns and special events.

Success

During the past five years of implementation, the Project has reached over 442,260 persons. In 2008 the level of HIV infection among migrant crew of fishing boats declined to a level in the range of 0.7 to 5%, or an average of 1.96%. This represents a five percent decrease from the level in 2004, and where the general migrant population had an infection level in the range of 0.4 to 2.5%, or an average of 1.38%, which is greater than in the Thai general population.

The percent of migrants who know that condoms are effective for preventing spread of HIV increased from 79% to 89%. The percent who said they had confidence that using a condom for every sex would help prevent transmission of HIV increased significantly in all groups and was mostly over 80%.

At the same time, among male migrants, self-reported condom use (one of the clearest indicators of risk reduction) as measured by the statement "Used a condom during last sex with a non-regular partner" increased from 43% in 2004 to 90% in 2008. At the end of 2008 PHAMIT had established a total of 38 sites in 21 provinces. MHWs were trained and assisted services in government hospitals of ten provinces which have a large number of migrants seeking hospital care.

Important findings

Participation of the beneficiaries is crucial to the success of the Project since this helps solve problems of access and overcome language barriers. AIDS work with vulnerable and marginalized populations needs to emphasize rights and community-based approaches.

3. Holistic care and support for children in Thailand

3.1 The Integrated Psycho-social and Medical care Project

This Project was implemented to develop a model of psycho-social care through the arts, and integrating components with clinical care to prevent and mitigate the impact of AIDS in children and youth living with HIV. The key implementers were the "We Understand" group, which is a network of people working in public and private-sector organizations with children and youth who are infected with HIV, artists, mass media specialists, and volunteers. There were many partner agencies and individuals involved as well.

Implementation process

The process of implementation started from addressing the psychological state of each child by applying artistic activities such as drawing pictures, photography, and producing plays. This was intended to help children know themselves better, share with friends, and develop a greater sense of self-worth. At the initial stage, the Project arranged youth arts camps, and used the products produced by the children as part of information campaigns for society to improve understanding in the care and acceptance of HIV-infected children. Other activities included AIDS awareness, sex education, life skills, occupational training, and follow-up education after completion of activities. In addition, the Project supported clinical follow-up of the infected children, and built the capacity of the family to help provide basic care.

Success

Quantitatively, twelve youth friends volunteer groups were established, comprising 200 members. The objective of the groups was to build the quality of life of children and youth living with HIV. The groups were supported in skills development and budget for conducting activities. The groups played an important role in supporting activities for 1,000 children and youth living with HIV in the Project area.

Qualitatively, the Project beneficiaries developed internally. Children's stress level was reduced, and children were better able to focus their attention, and to consider a wider range of options to address personal problems. The knowledge gained from participating in the Project has been reproduced in the form of a booklet and DVD for wider dissemination. The material includes a curriculum for those interested persons who want to replicate the Project model.

Important findings

Arts activity is one tool to help children to explore themselves, to address problems they are facing, and consider a variety of options to reduce the problems. The art work of children is a channel for communicating internal feelings to others, and as way to help service providers to more effectively help address and mitigate the impact on children.

When arranging the arts activities to address the psycho-social condition of children, it is most important to follow a procedure that allows the child to think freely and independently without external influence or trying to steer the process. Also, the process must create constructive relationships among the children in the group and with the facilitators. The art work should not

be judged, compared or valued against the work of others. Learning must be an on-going process.

V. Major Challenges and Remedial Actions

1. Progress made addressing challenges cited in the 2007 UNGASS report

1.1 Law, orders, and regulations not supportive for prevention and control of AIDS, and policy advocacy

In the 2007 report to UNGASS, the authors cited challenges in the area of law, orders and regulations that do not support the goals of the NAP such as the draft law on protection of PLHIV, the 1966 law on commercial sex establishments (2003 revision), and the draft law on ethical treatment of human subjects in research. The report offered recommendations to review the laws, orders, and regulations that are not conducive to HIV prevention and control.

The report of the review of laws and policies related to human rights and AIDS rights conducted by the Foundation for AIDS Rights in 2009 stated that Thailand has generally favorable laws that are supportive of HIV/AIDS programs such as the 2007 Constitution (Measures 4, 26, 26, and 30; and Section 3) which assure the rights and freedoms of Thai citizens, the Labor Protection Law, and the Child Protection Law. Also, the national AIDS implementation guidelines, issued on August 21, 2009, are facilitating aspects of the laws, orders and guidelines. Thus, there is no need for a separate AIDS Law such as that drafted in 2007 and which stirred considerable debate given some provisions that could be used to violate rights (see the section in this report on the civil society viewpoint).

In addition, there are strategies for the protection of the rights of PLHIV as developed by the Committee on Human Rights of the Rights and Liberties Protection Department of the Ministry of Justice. At the same time, civil society has a strong network for supporting PLHIV, and many NGOs play a strong role in policy advocacy that is supportive of AIDS prevention and control, such as the Foundation for AIDS Rights, TNCA, TNP+, etc.

1.2 Development of the management of prevention and control of AIDS

The 2007 report to UNGASS cited challenges for management development for the prevention and control of AIDS, both in terms of the national and provincial coordination strategy for implementation, capacity development for local administrative organizations and communities wishing to conduct AIDS prevention and control activities.

According to the NAPAC proclamation 1/2007 issued on April 4, 2007, the subcommittee for advancing the prevention program effort has the authority and responsibility to direct implementation so that it is consistent with NAPAC directives. During 2008-2009 the sub-committee, managed by the Coordination Center for Development of HIV Prevention Approach and Mechanism, has supported various agencies, government and NGO, to implement HIV prevention through three strategies including (1) public information campaigns on HIV/AIDS prevention; (2) strengthening of the HIV prevention networks; and (3) finding ways to ensure sustainability at the provincial and local administrative organization levels to accelerate and take ownership of the HIV/AIDS prevention agenda.

In developing the management system the Director-General of the DDC, in his capacity as secretary of the NAPAC, modified the structure of the National AIDS Management Center (NAMc) directly reportable to the D-G and which has responsibility for improving coordination of planning, monitoring and evaluation. The coordination and resolution of problems related to AIDS includes the following tasks:

- National policy development and strategies for prevention and control of AIDS.
- Program planning for prevention and control of AIDS, and guidelines for policy and strategy reform for implementation.
- Develop a unified strategy and implementation plan for monitoring and evaluation of HIV/AIDS prevention and control at the national level, and provide management and support to ensure that there is an accelerated program strategy for M&E at the country, zonal, and provincial level
- Manage and implement a data and information center to help address national HIV/AIDS problems, with linkages, compilations, analysis, and synthesis for dissemination and application to policy and implementation activities. This center should be a repository for data of problems and challenges, so that these can be compiled into recommendations for potential solutions to the policy level.

At the provincial level, Thailand is using a portion of the resources provided by THE GFATM grants for youth and high risk groups to support the Provincial Coordinating Mechanism (PCM) to help accelerate the provincial AIDS activities and improve coordination and management of these through its structure of subcommittees. Developing and improving the capacity of LAOs – especially at the tambon level – still is in the form of a pilot activity. From this status review, the LAOs still only pay out the 500 baht/month subsidy for PLHIV, and this is also problematic for PLHIV who do not want to disclose their serostatus, but who need the subsidy.

1.3 Prevention of HIV/AIDS in the general population and specific groups

The 2007 report to UNGASS cited challenges in the areas of awareness-raising and skills building in prevention, providing health services, care and treatment of the target population, and reduction of stigma and prejudice against PLHIV.

The following describes progress made in this area during the current report period.

There has been progress in work with most-at-risk population groups, for example in the area of harm reduction through collaboration of many sectors, including the addition of methadone maintenance therapy (MMT) to the package of benefits under the UC program starting in October 1, 2008. The NAPHA extensions project has increased access to ART for 2,000 migrants, ethnic minorities and undocumented persons in Thailand. HIV VCT, condom distribution and harm reduction have been extended to prisoners in some prisons; this service is still at the model-development stage, and there are certain operational obstacles to overcome.

To address care for children affected by AIDS, the CCM identified gaps in implementation and submitted a proposal for the GFATM Round 9 funding to improve care and psycho-social services for children. The proposal specifies that the We Understand NGO and partners in medical services and other technical areas would build capacity of children and youth living with HIV to participate more fully in the interventions. Unfortunately, the proposal was recommended to have a major revision and encouraged to resubmit.

Progress in PMTCT is evident in the introduction of triple therapy and treatment in accordance with CD4 levels through pilot projects in Zone 7 and four provinces. The pilot will be expanded to all provinces starting in October 2010. In addition, the "Staying Negative project was launched in MCH clinics which supports couple ANC and couple counseling to prevent HIV transmission among discordant couples.

Prevention of HIV for youth in school, the community, and work sites have not progressed as well as it should have as indicated by the lack of reduction in youth risk indicators. The curriculum on AIDS and sex education, based on life-skills foundation has still not been adopted as national policy. Some schools let the teachers introduce a sex education component to their courses, but the teachers can modify the content or use only certain sections to tailor it to their local classroom.

Improved sex and reproductive health (SRH) services that are youth-friendly, female-friendly, and welcoming to vulnerable populations, are still under development. Staff capacity is being built at service delivery sites in 43 provinces by using the best-practice model of the "Love care" Project of the NGO PATH as a template. The Udon Thani provincial hospital has developed a model for STI diagnosis and treatment and HIV VCT for sex workers and sexually diverse populations.

1.4 Treatment, care and support for PLHIV and affected families

Strengthening quality of HIV counseling and testing

The NHSO has included HIV counseling and testing twice a year in the benefit package of the Universal Coverage program. However, the 2008 and 2009 achievements have not met the target. Most of the clients receiving HIV counseling and testing were in advance stage with AIDS symptoms or low CD4 level. Bureau of AIDS has developed an active model to increase coverage of VCT in community and at the facility level.

With the collaboration between Bureau of AIDS, DDC and the NHSO, a protocol to increase coverage and strengthen quality of HIV counseling and testing services was developed in 2009. Major strategy included strengthening of quality counseling services, implementation of provider initiated counseling and testing, set up information sharing resources and public campaign to increase access and coverage of HIV counseling and testing among persons with HIV behavioral risks. However, remain challenging area include referring of HIV positive persons for early and appropriate treatment and care services. .

Expansion of and developing the quality of PLHIV support groups, and the role of faith-based organizations in patient care

Training and human resource developments on care and treatment services, as well as participating roles to support the services have been implemented and being ongoing conducted. The NHSO has clear policy on providing budgetary support for PLHIV networks, in addition to the budgetary support from the GFATM. Currently, there are 182 centers receiving NHSO support (January 2010). In 20111, NHSO will provide budgetary support for 400 centers and 7 regional offices.

Treatment and care for pediatric HIV infection

Bureau of AIDS, in collaboration with the NHSO and TUC, has expanded the pediatric care and ART services to district hospitals through the building human resource capacity of local hospital health care providers and staff of civil societies.

Preparations for the prevention of HIV drug resistance and treatment failure

Bureau of AIDS has collaborated with local specialists and international technical organizations to implement surveillance system on HIVDR and monitoring system to monitor early warning indicators of HIVDR and treatment failure. The ongoing process included development of guideline for interpretation of surveillance and monitoring data for action plan on quality improvement and HIVDR prevention. In addition, the revised guideline (2010-2011) was written by using WHO reference to ensure the standard and effective treatment protocol will be implemented.

Positive prevention

The model of positive prevention and health promotion for PLHIV has been piloted and reviewing by Bureau of AIDS. The training curriculum is being prepared by collaboration among civil societies and governmental organizations.

Development of management of TB-HIV co-infection

According to the national policy, the TB/HIV program has been implemented. The 2008-2009 program goals were achieved as indicated by 93% of HIV infected patients received TB screening and 87.6% of TB patients received HIV counseling and testing.

Access to ART among those not eligible to the universal health insurance program

Some groups of PLHIV including migrants, ethnic minorities are not eligible for ART under the national health insurance program. There is no national policy on supporting health care benefits under the UC program. A solution to this problem is provided by the GFATM supported program to procure ARV drugs for these populations. The challenge is how to sustain this support after the GFATM support ends.

2. Challenges for 2008-2009 and remedial actions

2.1 Access to HIV VCT

A review of the current situation reveals that PLHIV are entering the VCT system too late in their infection. Over half of the infected only appear for diagnosis and treatment when they experience symptoms of OIs. Thus, the challenge is how to motivate these persons to seek HIV VCT earlier, and to improve the quality of HIV VCT so that it is more user-friendly and appropriate for the various target populations.

2.2 Life after initiating ART

Thailand has been successful in extending treatment to PLHIV through the UC program such that 75.8% of the estimated eligible persons were receiving ART as of 2009 (or 200,000 persons). The majority of these persons is responding well to treatment, is feeling strong and healthy, and can function as productive members of society. A significant number of pediatric AIDS cases are also receiving treatment as they transition to adolescence – which is a challenging time for the infected youth who want to be accepted and treated normally. There are also issues of ART adherence and prevention of drug resistance and promotion of safe sex for adolescent PLHIV.

2.3 Standardized AIDS and sex education based on a life skills approach in schools and educational institutions for all levels.

Thailand has developed many sex education and life skills curricula including the DOH curriculum, which the MOE adopted for use in the schools as part of the health and physical education courses in 2002. However implementation of this has not been serious.

PATH developed the Teenpath curriculum for comprehensive sexuality education which uses six modules over 16 hours during an academic year. However, during the past 5 to 6 years of attempts to introduce this curriculum in the formal school program of study, comprehensive sexuality education is still used as guidance only; teachers can pick and choose what elements to include or not include in their regular courses. Thus, the UNGASS indicator of 30 hours of AIDS and sex education based on life skills for school students is still an urgent challenge.

2.4 Care for children and mothers impacted by the PMTCT program

A new trend in PMTCT programs is the inclusion of the male partner (husband) to participate in ANC and couple counseling to help the woman disclose her serostatus and encourage the man to be tested so that he can receive treatment as appropriate.

However, couple counseling is not easy especially in the case of discordant couples. There are also new challenges in informing children of their HIV infection and counseling for adolescent PLHIV who are pregnant, and providing on-going care for infected mothers and their newborns.

2.5 Access to user-friendly HIV prevention and health care services for most-at-risk population groups (MARPs)

At present, there are attempts to increase user-friendly services for MARPs to increase up-take for HIV prevention and health care services. These include addition of MMT into the UC benefits package, but there is low utilization of this benefit by those eligible.

In the view of groups working with MARPs, the key challenges in reaching these populations concern the enforcement of laws that inhibit access to services, government budget to NGOs to conduct outreach, and creation of client-friendly services for MARPs.

2.6 AIDS work in the context of decentralization

A result of government reform and decentralization of authority and budgeting to the LAOs for direct implementation has led to the disappearance or reduction of AIDS activities in some needy locations. Where it does exist, the locally-managed AIDS activities are more in the form of welfare rather than intensive prevention. This is because the LAOs lack the requisite knowledge and understanding of the problem of HIV/AIDS in their locality. They lack strategic information, and have no plan or guidelines and methods for implementation that are appropriate to the context. They lack trained staff and local participation of the community.

In addition, the targeted HIV prevention program of Thailand is overly dependent on the GFATM funding at present. Therefore, Thailand needs to urgently identify ways to sustain the essential National AIDS Plan components in the post-GFATM world by mobilizing local resources in the periphery so that communities can address AIDS problems cost-effectively.

3. Concrete Remedial Actions that are Planned to Ensure Achievement of Agreed UNGASS Targets

3.1 Accelerated Plan for HIV Prevention

The NAPAC has resolved, on July 24, 2009, that there be an accelerated plan to reduce new HIV infections by 2011 with suggested strategies as follows:

- Implement public information campaigns to raise awareness and concern about AIDS to increase prevention of transmission and support sex communication in the family.
- Support condom use by improving the image of condoms to be seen as a key to sexual health, and promote universal, continuous access of the target populations to condoms.

- Expand and develop prevention interventions for groups showing increased transmission tendencies, including the following:

Youth

A key measure is providing educational instruction about AIDS based on a foundation of life skills for at least 30 hours per academic year by:

- Establishing a national and ministerial policy to include 30 hours of AIDS education in the academic year in schools, and establish standards for all schools to have a teacher(s) specifically responsible for delivering the course content.
- Developing a core curriculum at the national level as a standard for the 30-hour program of instruction by specifying the core modules and additional modules. The instruction should not be integrated into an existing course but be distinct from others. There should be supportive activities both in and outside of school such as peer groups to advise others, AIDS and life skills groups, etc.
- Implementation of programs to build teacher capacity and provide on-going support through administrative policy from the zonal education offices in each region, school administrators, and technical support from the network of government agencies in the health and education sectors, NGOs, and international organizations.

MARPs including FSW, MSM, IDUs, migrants, and ethnic minorities

A key measure for this group is the development of a system of client-friendly health care that is MARPs specific, and remove obstacles to access by:

- Instituting coordination strategies to build understanding among service providers to reduce conditions related to law and policy that create barriers to accessing prevention and care services for MARPs. Improve coordination with relevant agencies in both the public and private sectors to build a network for collaboration.
- Increase participation of the MARPs to address service problems and to help refine the service model so that it is more of a client-based service and based on a foundation of respect for and protection of rights.
- Developing client-friendly services that are tailored to the MARPs can be done by adjusting existing services so that they are more appropriate to the lifestyle of the beneficiaries. Examples include opening after-hours clinics in locations that are easy to access; adjustment of attitudes and develop the capacity of service providers; coordination with civil society allies to establish links in the outreach program and referral to clinic

services; consider one-stop services by, for example, offering STI treatment in ART clinics.

Laborers

A key measure for this group is to expand coverage and quality of the use of national implementation guidelines for prevention of HIV/AIDS in the workplace.

3.2 Develop policies with participation of the various sectors – public and civil society organizations – to increase access to prevention and care among the hard-to-reach population groups

Policies enabling these populations include IDUs, migrants, and ethnic minorities to access HIV prevention and care are as follows:

- Harm reduction policy for IDUs, in coordination with the ONCB, the DMS, DDC, the 12D network, the PSI Foundation, and network of drug users.
- Policies for prevention and care for migrants and ethnic minorities, in coordination with the Buraeu of AIDS, the NHSO, the Office of the Permanent Secretary for Health, the Raks Thai Foundation, the Foundation for AIDS Rights, and TNP+.

3.3 Development of services and quality of counseling in the care of PLHIV

This component has the objective of helping PLHIV receive diagnosis of infection as early as possible, and to help PLHIV care for themselves as much as possible to maximize quality of life through the following measures:

- Develop and support access to counseling for the general population through public campaigns to increase concern for AIDS prevention, accurate self-risk assessment, and to gain knowledge about the benefit of knowing one's serostatus. Counseling through a hot line service will be provided as another channel for the population to obtain preliminary information in order to decided whether they need to go for diagnosis.
- Develop the Client Initiated Counseling and Testing (CICT) strategy; the Provider Initiated Counseling and Testing (PICT) strategy; and couple counseling with an emphasis on voluntary self-determined decision-making.
- Develop coordination strategies for service systems development to improve sustainability of these improvements.
- Support the role of groups/networks of PLHIV, and develop the capacity of PLHIV to deliver counseling services for other PLHIV by emphasizing quality of life development for PLHIV after initiating ART by implementing the following measures:

- Improve service quality in the area of counseling to increase awareness, understanding and preparedness for the PLHIV both before and after initiating ART in a comprehensive way on the topics of self-care, managing side effects and drug resistance, and developing a SRH behavior plan.
- Promote the role of Comprehensive Continuum Care Centers, and build the capacity of peer leaders of these centers to help improve quality of life services for PLHIV in various dimensions in a way that is more than just group activities and home follow-up visitation.
- Develop guidelines for field implementation at the community level with participation from all sectors in the area of care and assistance, and quality of life development of PLHIV so that they can live harmoniously in the home community.
- Develop guidelines for supporting the quality of life of pediatric PLHIV who are on the verge of adolescence so they can develop normally and have an appropriate and satisfying sex lifestyle.

3.4 Prevention and mitigating the impact on children and families of PLHIV starting with ANC services for the pregnant woman, including the following:

- Develop guidelines for supporting husbands to attend HIV VCT services with their wife at the ANC clinic to increase their participation in the decision-making and life planning decisions of the couple, and reduce the burden on the women in disclosing her serostatus to her partner.
- Develop quality of counseling services and skills of counselors so that they are prepared for new situations such as informing children of their serostatus, or counseling adolescents who are infected and pregnant.
- Develop the monitoring and care for mothers and infants after deliver continuously without causing adverse impact through disclosure of serostatus to the community.
- Develop guidelines for reproductive health services for adolescents with and without HIV infection.

3.5 Accelerating AIDS work through participatory ownership of the agenda by the province and local community

through the following measures:

- Specifying the targets for accelerated implementation by analyzing the data from various systems of surveillance, service statistics, estimates and projections, and other studies.
- Integrating AIDS work in the province by means of the following:
- Developing strategies of the PCM to accelerate action of the relevant provincial AIDS subcommittees to increase understanding and capacity

development of the province and LAOs in planning AIDS prevention activities by integrating the work into the strategic policy, plan and budget of the province and LAOs.

- Integrate HIV prevention for youth with the activities on sexual health promotion and prevention of drug addiction to stimulate interest and participation of the province and LAOs.
- Building capacity
- Develop strategies at the national level in working with the LAOs through coordination with the Department for Local Administration and the Committee for Decentralization to advance the HIV/AIDS prevention activities through the LAOs in the localities.
- Evaluate areas of good practice and analyze these to help plan guidelines for development and replication of LAO implementation of HIV/AIDS prevention and control.

3.6 AIDS rights protection

- Build understanding on human and sexual rights through a process of language communication.
- Establish a strategy of monitoring and oversight to identify rights violations in support of the protection of AIDS rights.

VI. Support from the Country's Development Partners

This section presents overview of support from international development partners including bilateral and multilateral organizations to reduce the HIV epidemic and mitigate the impact of AIDS. In 2008, about 15% of total AIDS expenditures or 1,011 million Thai baht (THB) was supported by international development partners. The support decreased to 7% or 482 million THB in 2009, because of completion of the GFATM Round 3: prevention targeting migrant workers.

It is well recognized that domestic funds are the major source of Thailand HIV and AIDS program support. Although contribution from international development partners is small, it is still critical to the national response. Firstly it fulfills "*national gaps"* on prevention, care and treatment, and secondly it plays role as "*technical catalyst"* including developing replication models that can be adopted by the national program as well as strengthening effectiveness of national responses and documentation. And lastly, Thailand is considered as an appropriate site on development of state-of-the-art approaches and has the potential and capacity to undertake south to south sharing experiences and expertise within the region and globally. International development partners work closely with government and civil society to implement, evaluate and document experiences and practices and disseminate these widely.

Details are described in 3 topics below; key support was received during 2008-2009 from the GFATM, other bilateral and multilateral organizations and future plan.

A. Key Support Received

A.1 Support received from the GFATM Grants on HIV/AIDS

Thailand had received the GFATM grants from Round 1, 2, 3 and 8 funding. The total amount of US$ 210 million has been approved. As of March 2010, US$ 160 million was disbursed. At the end of 2008, the GFATM Round 2 and 3 were completed successfully. Currently, Thailand is implementing Round 1- RCC and Round 8 for HIV/AIDS.

In Round 1- RCC focused on providing comprehensive HIV/AIDS prevention and care through province-based and central sector programs that cover all youth target populations in four main settings: – communities, schools, workplaces and health services. In addition, the Round 1-RCC program

focused on sub-population groups consisting of migrants and ethnic minorities. A total amount of US$ 98 million was approved for 6 years starting from 2008.

Round 8 emphasized scaling up an integrated package of HIV prevention services targeting most-at risk populations (FSW, IDU and MSM) and migrants in 43 provinces. Project activities started in June 2009 with the total amount of US$ 106 million allocated for the period until 2013.

A.2 Support from other bilateral and multilateral organizations

USG (Thailand MOPH-US CDC collaboration and USAID) is a key bilateral donor in Thailand with the budget for interventions of approximately US$ 2.5 million annually. Key support emphasizes replication of HIV prevention, care and treatment models that can be adopted by the national system, increasing the availability and capacity on strategic information and M&E in order to demonstrate the effectiveness of and improved performance of HIV programs.

Multilateral organizations in Thailand consist of WHO, UNICEF, UNFPA, UNIFEM, UNODC, UNDP, World Bank, IOM, ILO, UNHCR and UNAIDS. Total support was US$ 1.4 million in 2008 and increased to US$ 1.7 million in 2009. The United Nations effort is focused mainly on prevention, strategic planning, management and M&E, and accounted for 70% of overall support. Other areas included treatment and care, research, enabling environment and building capacity and meaningful involvement of civil society.

1) HIV prevention targeting MARPs and migrant workers

HIV and AIDS program targeting of MARPs is a key priority area that was supported by most of international development partners during 2008-2009. Success of Thailand's GFATM Round 8 application was a key result of good collaboration of development partners, CCM and local counterparts. Apart from the GFATM, activities supported for each MARP are listed below:-

HIV program targeting MSM

TUC provided Technical Assistance (TA) for development of a rapid HIV testing model, a quality measurement tool for HIV counseling and testing (VCT HIVQUAL), and peer-based HIV prevention models for MSM in 3 provinces; Phuket, Khon Kaen and Udon Thani.

While USAID through FHI and PACT has strengthened MSM, CBOs implemented HIV prevention and care targeting MSM and focused efforts in three "hotspots": Bangkok, Chiang Mai, and Chonburi (Pattaya). USAID

implemented communications campaigns to provide information and services related to HIV and STI prevention.

WHO supported development of clinical management of STI and life skills curriculum on HIV and STI prevention for MSM. ILO and UNICEF developed a joint project on reducing the HIV vulnerabilities of MSM at saunas in Bangkok.

HIV program targeting SW

UNFPA has provided support to improve access and increase utilization of SRH/HIV services among sex workers and their clients through development and utilization of evidence-based information for policy development and advocacy, and supporting provincial health offices to strengthen SRH/HIV services of FSWs in Dan Nok district of Songkla and Lampang. The projects have reached over 2,000 sex workers through outreach education, mobile clinics and quality RH/STI services.

UNFPA also provided support to Service Workers in Group Foundation (SWING) to provide outreach service to FSWs in Pattaya and to provide TA to develop an educational tool on sexual health and HIV for sex workers in karaoke settings. UNFPA and TUC strengthened capacity of STI/HIV services for male sex workers in Bang Rak Hospital (the national center for STI) and improvement of counseling processes and outreach, and mapping of establishments.

The interventions among IDU

UNAIDS, UNODC, WHO, TUC have supported development of a comprehensive harm reduction policy.

WHO supported development of comprehensive technical guidelines on HIV prevention among IDUs, including harm reduction for health care workers, and this was distributed to hospitals throughout the country to improve harm reduction services for IDUs.

WHO, UNAIDS and UNODC organized a policy study tour to Malaysia in 2009. World Bank supported a harm reduction expert to undertake a state-of-the-art review and provide recommendations to improve policy and program planning.

The interventions for migrant workers

Canada's South East Asia Regional HIV/AIDS Program, with funding from the Canadian International Development Agency (CIDA), and Rockefeller Foundation, supported strengthening networks on migrant sexual health.

Information, Education, and Communication (IEC) materials on HIV/AIDS were distributed in migrant concentrated areas such as Samut Sakorn and Ranong under the Migrant Health Program supported by IOM.

The materials were in the migrants' languages and the topics covered included basic information about the disease, mode of infection, condom use etc.

UNHCR supported the production of appropriate HIV IEC Materials, such as posters, leaflets and tools to be distributed in the camps for displaced persons along the Thai/Myanmar border.

2) Interventions among the general population

Apart from the MARPs, the international organizations mainly supported interventions among youth and reproductive age as follows:-

PMTCT

In 2009, UNICEF provided financial support for training in reproductive health for HIV-infected pregnant women. UNICEF also contributed towards improved program monitoring and identification of programmatic gaps, including financial support for development and testing of CHILD Plus monitoring software to monitor children born from mothers with HIV.

UNFPA has provided support to the DOH to implement a pilot project on male involvement to prevent intimate partner transmission of HIV through the MCH program in 6 Regional Health Promotion Centers of the DOH and four pilot provinces in Mae Hong Son, Lampang, Songkla, and Narathiwat. The key strategies of the project were finally accepted by the national MCH Committee to incorporate couple counseling into the PMTCT and MCH program. This program will strengthen Prong One of PMTCT to prevent HIV in pregnant mothers and keep the family HIV-negative. Policy on free VCT for couples of pregnant women attending antenatal care as part of the Universal Coverage package was developed and was launched successfully. The package has been endorsed in 2009.

UNFPA has also supported the DOH to develop and implement RH services for PLHIV. The project, with meaningful involvement of PLHIV, will reduce the problems of unintended pregnancy and forced contraception in PLHIV together with improvement of linkages between HIV and RH services. The pilot model has been well accepted by the national committee, and there are plans for national scaling up in the coming years.

HIV prevention among youth and reproductive age population

UNFPA has provided support to the DOH to establish the national standard for youth friendly health services together with the quality assurance system, supported the "Solution Exchange" to provide an electronic forum to the community of practitioners on HIV and young people that reached to over 900 members.

UNFPA worked closely with NHSO, the Health Promotion Fund, the Round 1-RCC and PATH to undertake a pilot model for VCT/STI/FP friendly services for young people in vulnerable situations in Bangkok (*Love Care Station*). Over 20,000 clients have received services from 14 private and public clinics in Bangkok, mobile counseling services, and web based consultation.

UNFPA has provided support for the 3rd year to the provincial health office in Lampang province to improve access to gender and culturally sensitive information, counseling, and services for HIV and FP among youth in 14 secondary and vocational schools through the comprehensive approach.

UNICEF supported the life skills-based education model targeting street Muslim youths that emphasizes culturally appropriate approaches in Islamic schools. The program will be monitored, evaluated, and documented in 2010.

UNAIDS together with UNIFEM conducted a study on "the Feminization of AIDS: Gender Power Dynamics within Marriages and Sero-Discordant Couples – Their Implications for Plans of Action in Thailand", which focused on the patterns of risk among married women or women in stable relationships.

Finally the national guidelines on the prevention and management of HIV/AIDS in the workplace were signed by the Prime Minister in August 2009. The ILO provided technical input during its development and also ensured they reflected a rights-based approach.

3) Support on care, support and treatment

TUC provided TA for development and expansion of the HIVQUAL-T quality care system, development and expansion of the pediatric ARV care network, development of positive prevention program and linkages to care for MSM, development of positive prevention messages and counseling tools for HIV outpatient clinic clients and perinatally HIV-infected youth, development of a quality-of-care program for STI clinic-based services (STIQUAL), and development of a pediatric HIV disclosure model.

UNICEF provided technical and financial support for piloting of comprehensive pediatric HIV care and treatment programs, including psychosocial support through innovative interventions such as art therapy for children infected with HIV. UNICEF also provided support to build capacity of TNP+ and PLHIV groups to promote their supporting roles in HIV pediatric care delivery as well as promoting advocacy roles of children living with HIV through media development to reduce stigma and discrimination throughout the country. UNICEF supported the development of peer support programs and sex education and reproductive health training for adolescents living with HIV, through strengthening of child and adolescent participation for those infected and affected by HIV.

USAID supported prevention with positives among MSM using a peer approach in Chiang Mai, home-based care to HIV-positive residents of Bangkok, and income-generation activities to reduce stigma and discrimination for PLHIV.

UNIFEM supported the HIV positive women's network effective contribution, and their inputs are reflected in the publication (i) " Diamonds- Stories of Women from the Asia Pacific Network of People Living with HIV (ii) participated in the research on 'Spousal/Partner Transmission on AIDS (iii) Advocated for issues of HIV positive women at the National AIDS Conference and seminars through the launch of the publication 'Diamonds.'

WHO emphasized policy advocacy to ensure that ART was available and accessible for non-Thai HIV/AIDS patients. Advocacy for health care service development for this underserved group is on-going and will need collaborative efforts from other stakeholders, including those in the local health care system, to ensure that the non-Thai population will have access to appropriate health care services including ART.

UNHCR supported INGOs to build the capacity of their VCT clinics, as well as the PLHIV support groups in 5 camps. UNHCR was a key player in advocating for the inclusion of displaced persons in camps and other persons of concern to UNHCR in the Thai National ART plan (NAPHA Extension Program). In addition UNHCR supported Thai orphans affected by AIDS in the Thai community near Mae Ra Ma Luang camp. In addition, UNHCR supported a small livelihoods program in two camps for PLHIV.

4) Other issues

Stigma and discrimination

A UN Joint Program supported AIDS Rights Advocacy and Stigma Discrimination Index Development. A Report to review legal and policy issues related to HIV and AIDS and human rights in Thailand is completed. A rights protection curriculum was developed and used in the training of 100 trainers who then trained 800 trainees. A guideline on human rights was produced for PLHIV and workers, and advocacy materials on human rights were produced and disseminated. A report on Stigma and Discrimination Development was produced and presented at the national meeting to raise public awareness on human rights and HIV and AIDS issues.

WHO provided support on strengthening the capacity and empowering of teenagers living with HIV/AIDS to mitigate the impact of stigma and discrimination.

Local Administrative Organization (LAO) and HIV/AIDS

Through support from UNDP, a case study on the role of LOA in financing and provision of health services in two selected provinces, Lampang and Nakorn Phanom, was conducted. The purpose of this study was to assess the trend and current roles of TAO and Municipalities.

Enhanced GFATM grant implementation in Thailand was conducted through local partner capacity building and improved multi-sectoral local response programming for AIDS on three aspects: (1) Assessment of capacity needs of local governments; (2) Planning and implementation for a Comprehensive Local Response to HIV; and (3) Development of guidelines for capacity development.

Capacity building

UNAIDS supported capacity building of civil society organizations through facilitating meaningful involvement in the 2010 Thailand UNGASS Report, Mid-term Review of the NASP for 2007-2011 and International Harm Reduction Conference.

In 2009, WHO supported the 12th National AIDS Seminar at which more than 2,000 health staff, official from various ministries, as well as staff from civil society organizations and PLHIVs participated. The seminar has been the forum for workers from all levels to share their knowledge and information and to strengthen their networks to provide service for clients in the NASP.

UNFPA has provided support to the DDC to establish the national working group on comprehensive condom programming with participation from all key stakeholders. The committee has done a situation analysis and drafted the first national strategic plan for comprehensive condom programming (CCP) which aims to promote the condom not only as a preventive tool for STI/HIV and unintended pregnancy but also for healthy sexuality and hygiene. The strategic plan has also comprehensively addressed the access to and utilization of condoms for demand creation as well as supply; coordination and leadership; management and support.

UNFPA has also supported DDC to develop training curricula and modules, provide pilot training of trainers (TOT), and pilot training of staff from LOAs for the management of comprehensive condom programming, and supported the initiatives to introduce the female condom into the condom programming in Thailand.

TUC has supported training for health care staff in a variety of technical areas including counseling and testing, provider sensitivity and STI management for MARPs; system development for External Quality Assessment (EQA) systems for HIV serology, CD4 testing, HIV viral load, opportunistic infections, and genotypic resistance testing; and training on laboratory diagnostics for HIV and CD4 testing, fungal and TB cultures, and molecular methods for STI examination, and technical assistance for expansion and development of laboratory networks as part of the national laboratory accreditation program.

UNHCR supported maintenance of a database of all HIV IEC materials which was shared with partners and were made available upon request. In addition, HIV/AIDS and TB publications were shared with all NGOs and disseminated through the monthly Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) Health meetings. UNHCR also networked throughout 2009 with the MOPH, UN agencies, INGOs, national NGOs, and the private sector in order to find ways to strengthen HIV programming for those persons of concern.

5) Support on monitoring and evaluation of HIV/AIDS prevention and alleviation

TUC is the key development partner providing technical support on development and expansion of HIV infection surveillance systems: HIV incidence surveillance using subtype BED IgG captured-based enzyme immunoassay, hand-held computer-based behavioral surveys in youth and FSW, advanced sampling techniques (respondent-driven and venue-day-time) for surveys of MSM and FSW, threshold surveys for HIV resistance and

HIV resistance cohort monitoring, and TA to Thai national M&E programs for use of PMTCT and care and treatment data as part of the National AIDS Program (NAP) database.

USAID through FHI and PACT worked closely with TUC to develop an M&E guide for the MSM prevention program that provided standardization of indicators to monitor the MSM HIV prevention program. Further, TA was provided to develop a program monitoring tool including data collection forms and database as well as a monitoring training module. Data use training was conducted early in 2009 for CBOs implementing MSM programs.

UNFPA supported the DDC on conducting training government staff on undertaking annual survey of sex workers and sex establishment as well as supporting knowledge management on synthesis approach to freelance sex workers and venue based sex workers.

WHO supported an Epidemiology Training Program on AIDS for Technical Health Officers from several provinces who are responsible for the analysis of epidemiological data on HIV/AIDS. In this training program, 20 participants upgraded their skills to ensure good quality surveillance, and to conduct well designed surveys and epidemiological research in their own provinces.

UNAIDS financially and technically supported the development of the mapping of evaluation studies for HIV prevention targeting MARPs and the M & E plan for prevention targeting MARPs.

UN joint program supported functions of sixteen national monitoring and evaluation working groups to provide technical direction and/or implement M&E for HIV epidemic and national responses.

UN joint program and USG provided financial and technical support to development of 2010 UNGASS that aimed at increasing availability of key HIV epidemic responses, improving the quality of reporting and mobilizing the full involvement of civil society and sub national counterparts. UNFPA has also supported documentation of best practices.

World Bank and UNAIDS supported a training on size estimation size of MARPs.

Key studies completed through support from development partners are as follows;

- WHO and UNAIDS supported the mid-term review of the NASP for 2007-2011.

- WHO supported a national sexual behavior study on children and youth in juvenile detention and protection centers and a study to estimate constant weight (fraction rate) of child deliveries in Thailand based on a survey in four provinces. The study aims to verify the coverage of ANC and birth deliveries service in Thailand compared to indicators from monitoring the progress of PMTCT activities.
- USAID completed an evaluation study on the prevention with positives model.

B. Actions that need to be taken by development partners to ensure achievement of the UNGASS targets.

Support from international development partners is vital to success of the HIV and AIDS program in Thailand. In 2010-2011, key action needs to be taken to ensure that the contribution of development partners can best serve national needs. At the same time, development partners need to be able to manage TA requests effectively;

- Strengthening collaboration on planning of TA within key donors and/or development partners and with national counterparts to improve effectiveness of technical assistance and yield good results for the national program.

- To ensure best use of the contribution from development partners, national counterparts need to be well informed on project development, implementation, results of models developed, particular lessons learned in order to ensure best practices have been adopted and scaled up by the national program effectively.

VII. Monitoring and Evaluation Environment

A. An overview of the current M&E system

Establishment of the National M&E unit and structure

The National M&E system, following the "*Three Ones*" principle, is an important tool for Thailand's National HIV/AIDS Program to promote effective management and accountability for the HIV /AIDS response. In early 2007, the National AIDS Prevention and Alleviation Committee (NAPAC) endorsed the development of the national HIV/AIDS M&E system as part of the National AIDS Strategic Plan (NASP) for 2007-2011. During 2008-2009, three key functions were identified and organizational responsibility clearly assigned;

- Monitoring the national HIV epidemic, including impact and outcome monitoring: The *Bureau of Epidemiology* (BOE) is the lead organization to develop and conduct comprehensive HIV and AIDS surveillance systems.
- Monitoring the national response: The *National AIDS Management Center* (NAMc) has played the role of the national HIV/AIDS M&E unit since its establishment in 2009. NAMc will develop, implement, coordinate and maintain the national M&E plan and system in collaboration with other organizations within the MOPH such as National Health Security Office (NHSO), the Bureau of AIDS, TB and STI (BATS), Department of Health (DOH) and other ministries such as the Ministry of Interior, Ministry of Education, Ministry of Labor, Ministry of Social Development and Human Security, civil society, bilateral donors and multilateral organizations.
- Developing the national evaluation and research agenda and plan for use of data: The *Consortium for Technical Assistance on Research and Evaluation* plays the role of the "*think tank to the national M&E unit"* and is managed and coordinated by NAMc. The Consortium consists of technical experts from multi-disciplinary areas from academia (local and international), implementers, epidemiologists, etc. The Consortium will provide state-of-the-art (SOTA) methodologies on technical aspects for program implementation, policy development, key strategic information and M&E.

These three key mechanisms have worked under the technical direction provided by the National M&E Steering Committee. In 2009, M&E Technical Working Groups (TWG) have been formed. TWGs are organized for each technical area and key target populations such as situation analysis and Health Information System. The TWGs consist of representatives from multi-

sectoral agencies including government, CSO, NGO, academia, PLHIV, MARP representatives, donors and UN organizations.

Development of the national M&E framework

A list of indicators used to monitor epidemic and national response is presented in the NASP for 2007 – 2011 and the Universal Access operational plan (UA plan). Further progress has been made to harmonize and integrate all efforts to develop an effective national M&E system for obtaining and utilizing high-quality strategic information for the HIV prevention, care and treatment.

To achieve the national M&E goal, Thailand calls for developing and strengthening a unified national M&E system, integrating efforts from all sectors and from both sub-national and national levels, monitoring the HIV epidemic and national response on prevention, care and treatment, developing an effective routine health information system integrating community-based data system with national system, improving the availability and quality of the surveillance systems to provide valid evidence for impact and outcome monitoring of national programs, increasing the availability, quality and use of research and evaluation data to improve the effectiveness and increase the cost effectiveness of the national response, developing capacity for conducting and using high-quality M&E at the national, sub-national and civil society level and finally increasing the use of program evidence and research findings for effective national policy development.

In 2009, two M&E plans have been developed; *The national M&E plan for HIV prevention targeting most-at risk populations"* and *The M&E plan for Tuberculosis including TB/HIV* through a participatory process with the multi-sectoral organizations involved in implementing these programs. In addition, joint Key Performance Indicators (KPI) have been developed as a harmonized tool among key government organizations to monitor progress of HIV and AIDS programs. Thailand will develop a comprehensive national M&E plan along with the new national strategic plan for 2012-2016.

In service of the shared vision depicted above, a number of achievements have been accomplished in 2008-2009 on key strategic information including monitoring and evaluation (M&E) activities as follows;

A.1 Comprehensive HIV and AIDS Surveillance System in Thailand

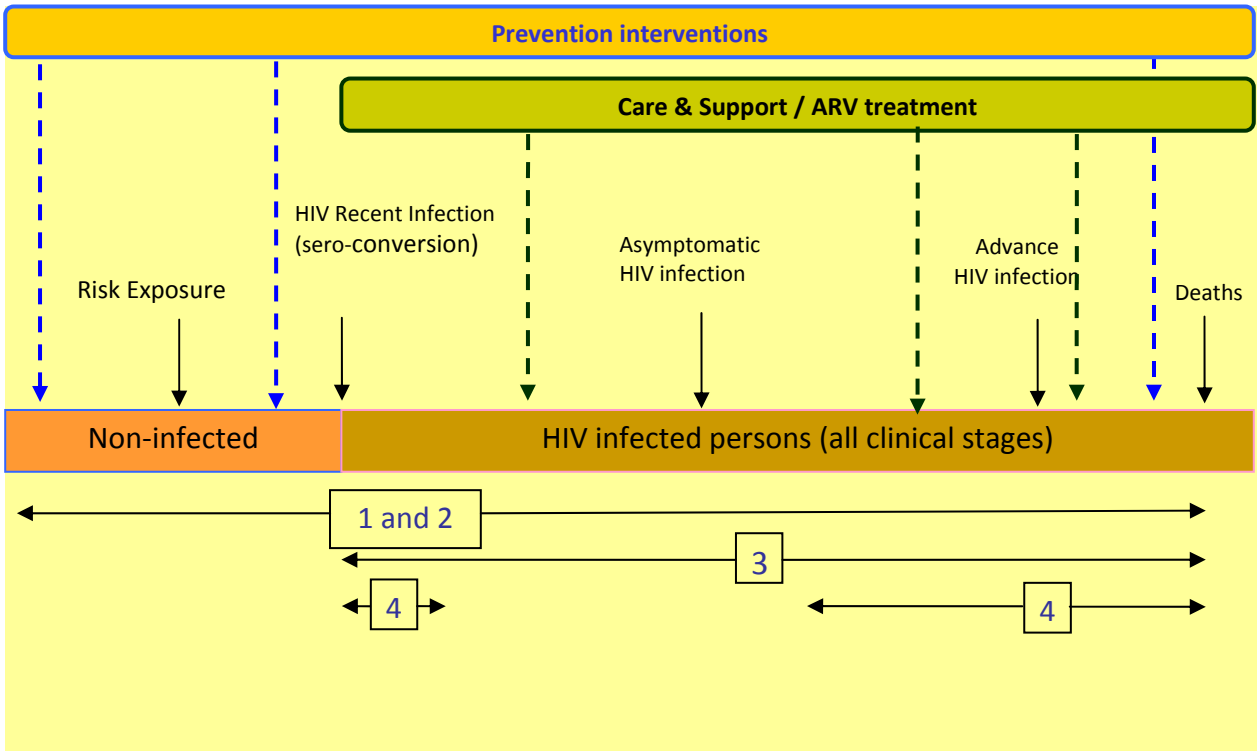
Thailand has developed surveillance systems according to the natural and course of disease. There are four types of surveillance systems that are used

to monitor the HIV epidemic, outcome and impact of national responses (see figure VIII -1).

Detail of each system is described as follows;

1) Behavioral Surveillance System
    a. Behavioral Sentinel Surveillance (BSS)
    b. Integrated Biological and Behavioral Surveillance (IBBS)
2) HIV serosurveillance
    a. HIV Seroprevalence Surveillance
    b. HIV Seroincidence Suveillance
3) Facility (hospital) based case reporting surveillance
    a. HIV newly diagnosis
    b. HIV infection-immunological criteria for ARV
    c. Advanced AIDS disease
    d. AIDS related deaths
4) HIV Drug Resistance Surveillance
    a. HIVDR Early Warning Indicators
    b. HIVDR surveillance among ARV treated patients
    c. HIVDR Threshold survey among FSW and ANC

Figure 32: Comprehensive HIV/AIDS Surveillance System-Thailand



1) Behavioral Surveillance System

- *Behavioral sentinel surveillance (BSS)*

The BSS was first implemented in 1995 among male and female factory workers, male conscripts, student in secondary school grade 8 and 11, vocational school and FSW. The implementation framework of the national BSS was completed in 2006. Twenty-four of the 76 provinces were randomly sampled to be the national reference sentinel provinces.

- *Integrated biological and behavioral sentinel surveillance (IBBS)*

Given the evolving of epidemic, new approaches have been developed with technical assistance from TUC to appropriately monitor the HIV epidemic and provide data for planning national responses. IBBS is the main data source to monitor core national prevention indicators and will be conducted every two years.

In 2009-2010, the NAMc and BOE have worked with prevention program implementers to harmonize and standardize key questions used in the IBBS across MARPs and MWs covering behavior change, coverage and intensity of exposure for community outreach activities, and use of HIV testing and counseling and STI screening services.

The IBBS in Thailand for FSW, MSM and IDU uses self-reported hand-held computer-assisted structured interviews to increase confidentiality and improve the reliability of data related to sensitive issues including sexual and other risky behaviors.

*IBBS among FSW***:** The first round of IBBS for FSW was conducted in 2003 among venue-based sex workers in selected provinces. Because of the shift in prominence from direct to indirect sex establishments, it was recognized that institutionally-based sampling is not sufficient to fully measure the HIV epidemic among FSW in Thailand. Recently, the BOE undertook a pilot of an integrated Biological and behavioral risk surveillance system using respondent-driven sampling (RDS) in three tourist provinces. This sampling methodology allows Thailand to accurately capture trends in the HIV epidemic for both venue and non-venue based FSW. The BOE plans to implement RDS in all sites starting from grade 8 in 2012.

*IBBS among MSM (MSM, MSW and Transgender***:** Thailand has conducted HIV sero-surveillance among male sex workers since 1997. A combined HIV prevalence and behavioral study initiated among MSM in Bangkok in 2003 revealed very high prevalence of HIV among MSM (17%). Since then the BOE has incorporated similar methods in the national surveillance system and expanded data collection to include Chiang Mai and Phuket Provinces in

2005 and 2007 and Udon Thani and Pattalung Provinces in 2008. The IBBS among MSM will be expanded to 13 provinces in 2009 onwards, using venue-day-time sampling for all rounds of data collection.

IBBS among IDU: In 2007-2008, the BOE conducted BSS of IDUs in Bangkok, Chiang Mai and Samut Prakarn. With support from the GFATM round 8, BOE and PSI plans to undertake the IBBS among IDU in 8 provinces in 2010, 2012 and 2014. With close collaboration between BOE and PSI, the IBBS of IDUs has collected broad information on the process of behavior change including attitudes, beliefs, the accessibility and availability of condoms and needles/syringes.

IBBS among migrant workers: The BOE has conducted annual HIV sero surveillance among fishermen and migrant workers in seven provinces since 1989. The IBBS among migrant workers will be first introduced in 2010 and implemented in 10 provinces. Subsequent rounds will be undertaken in 2012 and 2014 to monitor changes in the epidemic and HIV responses among MWs. The primary criteria for selection of these 10 provinces is the high density of migrant workers, most from Myanmar, Cambodia and Laos PDR, and the high capacity of provincial health office to undertake the initiative.

IBBS among youth: Thailand is conducting IBBS among male military conscripts as proxy for male youths since 2009. Lessons learned of its implementation will be closely monitored for potential scaling up in future.

2) HIV serosurveillance

- *HIV sero-prevalence surveillance (HSS)*

The HSS system has been used to monitor HIV epidemic in Thailand since 1989. It was expanded to all provinces in June 1990 among 9 sentinel population groups, including blood donors, pregnant women at ANC clinics, male military conscripts, male clients at STI clinics, male and female sex workers in venues, injecting drug users at treatment clinics, fishermen and migrant workers. In 2006, the national surveillance framework has been developed with the major revision of Standard Operation Procedure (SOP) and sampling methodology among pregnant women and FSW. However, with evolving risk behaviors and the changing nature of the HIV epidemic, institutional-based sentinel surveillance has limitations since it does not capture the HIV epidemic among non-venue based sex workers and IDU in the communities.

- *HIV sero-incidence surveillance-HIV BED IgG capture Immunoassay (BED CEIA) for HIV incidence surveillance*

The HIV incidence surveillance using BED-CEIA has been implemented as a part of HIV sentinel surveillance system in 24 provinces since 2004 among ANC and FSW while male military conscript has started in 2006. Because BED results are still of questionable accuracy, Thailand uses the information carefully and triangulates with other surveillance information to clearly understand HIV epidemic.

3) Facility (hospital) based case reporting surveillance

- *HIV, AIDS case reporting system (Passive surveillance system)*

With good collaboration of NHSO and BOE, Thailand is developing an integrated HIV symptomatic and AIDS case reporting system. All hospitals participating in national health insurance scheme have reported HIV data through the National AIDS Program (NAP). This computerized system can provide information on the number and characteristics of newly diagnosed HIV infection, HIV infection-immunological criteria for ARV, advance AIDS cases and AIDS related deaths.

4) HIV Drug Resistance Surveillance

- *HIVDR Early Warning Indicators*

NHSO and BOE have designed and developed the National AIDS Program–Early Warning Indicators (NAP-EWI). EWI can be analyzed from the NAP database. Thailand has adopted WHO methodology and recommendations to monitor appropriate ART prescribing practices, follow-up of retention to ART regimens, drug adherence, clinical appointments and treatment outcomes.

- *HIVDR surveillance among ARV treated patients*

It is aimed to monitor prevalence of ARV drug resistance from ARV patient cohorts of treatment services in 4 sentinel sites, and has been operational since 2006.

- *HIVDR Threshold survey*

Thailand has undertaken this method among FSW as an indirect measure of the effectiveness of prevention-with-positives program. The national advisory committee has been established to implement ARV resistance surveillance activities. The surveillance framework and protocol have been developed. Thailand has implemented ARV resistance surveillance among naïve recently-infected persons by integrating threshold surveys into the existing national HSS among FSW since 2006.

A.2 Routine Health Information System (RHIS)

There are number of key RHIS in Thailand to monitor progress of activities in different program areas;

1) Care and treatment monitoring system

The NHSO introduced *the National AIDS Program (NAP)* Database in 2007 which is a paperless system to monitor PLHIV care and treatment throughout the country. The management framework of the program consists of two parts: benefit package and support system. The benefit package includes drugs, laboratory services, counseling and condoms. The support system focuses on personnel training, quality improvement and M&E.

The NAP system consists of four core modules: registration, follow up, authorization (2nd line ARV), laboratory requests and reports, and four additional modules: VCT, PMTCT, PEP and reporting systems. Data in each module can be linked together by NAP ID number. The NAP system connects all facilities by a web application running in real-time on Internet Explorer with centralized database. All data is sent to the NHSO electronically. The system uses a PID (Personal Identification number) as a unique identifier.

NAP shares the data with VMI of the Government Pharmaceutical Organization so they can send the drugs to the hospitals as they are needed. This means community hospitals do not have to carry large stocks of drugs. The drugs will be sent to the community hospitals within two weeks of the request. Data is also used with HIVQUAL to monitor performance of care and treatment services as well as early warning indicators (EWI).

Currently, the NAP system is in process of modification to improve capacity to disaggregate VCT, care and treatment information by MARPs. However, the system has limitations to integrate community based services to its system that need to be improved in the future.

It is estimated that NAP covers about 60% of registered ART patients in Thailand. The rest of the ART patients are reported through other systems (*the social security, civil servant and other databases).* Fragmentation of care and treatment information system has been recognized by key stakeholders and has been identified as a priority task that calls for integration of the system to improve effectiveness of care and treatment program management.

2) Prevention of Mother-to-Child Transmission (PMTCT) monitoring system

There are number of PMTCT monitoring systems used in Thailand. The Perinatal HIV Intervention Monitoring System (PHIMS), operated by the DOH,

monitors PMTCT activities in 900 government hospitals, 76 provincial health offices and 12 regional health promotion centers. The Perinatal HIV Outcome Monitoring System (PHOMS), operated by the BOE, monitors HIV-infection outcomes in exposed children in 28 provinces. In 2007, USG supported DOH to develop a new monitoring system called "PHIMS plus." The variables in this system cover both PHIMS and PHOMS variables, and include variables on PMTCT-plus services and linkages to HIV care programs. DOH plans to use PHIMS plus in selected surveillance provinces only. And finally, the CHILD monitoring system is used to monitor children infected with HIV from their mother. The CHILD system is implemented in Health Promotion Centers Region 9 and 10.

Previously, ARVs for PMTCT and infant formula were supported by the DOH. However, starting from 2007, ARVs for PMTCT and formula will be supported by NHSO, which has a separate monitoring system called "National AIDS Program" (NAP). The change has impacted on completeness of coverage of PHIMS monitoring reports which has declined from 97% in 2001 to 75% in 2007. Further work is needed to be done to have effective consolidated systems for PMTCT in Thailand.

3) STI program monitoring system

The STI cluster, Bureau of AIDS, MOPH is the main organization responsible for developing and implementing the system to report key indicators on STI services including STI screening, STI reported cases and STI treatment.

To effectively monitor prevention efforts for targeted MARPs, NAMc and Bureau of AIDS are working closely to implement a number of activities to strengthen the STI reporting system, in particular, to develop a unified STI monitoring system by integrating STI activity and service and an STI case reporting system together.

The STI Record is now being developed to be a computerized system and will used to store individual data of clients. There are six components of the information record: demographic, risk behavior assessment, past history/present signs and symptoms, physical examination, STI management, and laboratory testing. HIV counseling and testing information is included in the risk assessment, STI management, and laboratory components of the record. Outputs from the STI Record are the STI case report and the STI clinic performance report for each population group. In 2009 this system was launched in 19 provinces. Expansion of the system will be implemented in 43 provinces under the GFATM Round 8 in 2010-2011.

4) TB/HIV monitoring system

The Smart TB program has been introduced and used by all health facilities under NHSO in order to monitor TB patients and co-infections of TB among PLHIV including TB as an HIV/AIDS care and treatment services. Since the system has been implemented recently, coverage of reporting and completeness of information still needs to be improved.

5) OVC program monitoring system

Currently, the OVC monitoring system is still fragmented. The national system does not exist except at the project level. It is very difficult to use monitoring data to monitor progress of the national response on OVC.

6) Integrated community based monitoring for HIV prevention targeting of MARPs into the national routine health information system

Civil society includes CBO, NGOs and the MARPs and MWs themselves who have a critical role in the prevention and care program and M&E system. Civil society is not a separate level of the M&E infrastructure, but must be a partner at all levels.

With support from the GFATM Round 8 in 2009, NGOs have developed and harmonized their own program monitoring system for specific MARP and MW. As part of the effort to improve data quality in the M&E system, NAMc worked in collaboration with implementing partners for harmonized indicator definition and developed data collection. The Unique Identifier Code (UIC) was developed and instituted as part of the RHIS to minimize double counting. Thailand also made an effort to use the system to monitor intensity of exposure in order to improve effectiveness of interventions.

Moving forward, Thailand will develop an integrated RHIS using area based approach. An integrated RHIS aims to build a community based monitoring system and its integration into the national system. It will be an interface system that allows different datasets including surveillance, NAP, STI, community based data system et al. to communicate with one another and be able to demonstrate the big picture of HIV/AIDS responses at sub-provincial, provincial, regional and national level.

A.3 Evaluation and research

During past two years, a number of key studies and surveys, assessments/reviews and evaluation efforts have been completed, and these provide key empirical data for program improvement and policy development as follows;

- Mid-term assessment of NASP for 2007-2011.

- Completed the vaccine trial phase III
- PMTCT national evaluation conducted in 2008 and completed in 2009
- The GFATM program evaluation; Prevention targeting migrant workers (PHAMIT), school based program, communities and workplace program and evaluation of ART treatment program.
- National survey of risk behavior among youth in juvenile centers
- Program Evaluation such as prevention with positives (PWP) supported by USAID, and IDU peer driven approach by Thai drug user network.
- National M&E system assessment has been done in 2008.

A.4 Capacity building on strategic information including M&E

Thailand has been successfully implementing a 3-month short course training on AIDS epidemiology for provincial surveillance managers since 2003. At the end of 2009, more than 150 provincial managers completed the training. Alumni from AIDS epidemiology course have become a good asset and network to manage and implement surveillance activities.

NAMc and PRs of the GFATM grants with support by USAID focus their efforts to improve M&E capacities among NGOs and CBOs as a critical component of the Community-based System Strengthening (CSS), particularly the GFATM Round 8 partners.

In 2008-2009, USAID through PACT and FHI have completed the development of standardized MSM program monitoring guide for Thailand and the development of unified data collection forms. PACT also has designed and implemented organizational strengthening activities with each partner that resulted in the use of standardized definitions, clear data collection protocols, and enhanced use of data to improve the quality of service delivery. This was achieved by linking coaching and systems development in M&E with broader organizational strengthening strategies that support quality of services including teamwork, standard setting, and strategic planning.

A.5 Data use

Data and information are of most value when they are used to inform decisions, and Thailand has aimed to develop tools and facilitate data use to enhance evidence-based decision making. Accomplishments on data use in 2008-2009 as follows:

1) Data use to enhance national strategy and policy planning and improvement

Thailand has launched a campaign namely " Reduced new infections by half in 2011" resulting from the in-depth analysis and advocacy project (the A2) as a data use tool for policy makers to clearly understand what currently drives the Thai epidemic and what the future directions are, as well as providing the best case scenario for the national response.

Review State of the Art of surveillance systems in Thailand and synthesis of Thai epidemic have been undertaken by TWG on HIV situation. This became critical information used for the 2010 UNGASS report as well as development of the acceleration plan 2010 targeting HIV prevention.

Development of HIV counseling and testing benefits package under the national insurance scheme due to in-depth analysis of NAP monitoring data.

Thailand has established a process to review literature, lessons learned from field experiences and experts from multi-disciplinary areas through a participatory process in order to identify national gaps.

Development of a mechanism towards Universal Access at national and sub-national level to entail meaningful involvement of civil society for data collection and to use UNGASS information for program planning and improvement. Through the process of developing the 2010 UNGASS, Thailand aims at developing a mechanism to involve civil society and sub-national administration for data collection and to use UNGASS information for program improvement and planning. The project has been piloted in 26 provinces. Provincial key stakeholders include government organizations, local authorities, NGOs, CBOs, PLHIV groups and networks which work together to collect and analyze data as well as develop provincial UNGASS reports.

2) Data use for program improvement

Quality Improvement in HIV Care and Treatment: HIVQUAL-T

The HIVQUAL project in Thailand, known as HIVQUAL-T, was implemented as a pilot program in 2003 with 12 hospitals, and now has been expanded to 914 locations throughout the country. The project has been implemented by Bureau of AIDS, NHSO and the institute of Hospital Quality Improvement and Accreditation (HA) through technical assistance by TUC.

The HIVQUAL-T is a performance measurement tool to facilitate analysis and use of existing clinical information for improving HIV care and treatment services. Given its successful implementation, the tool has been integrated

into NAP database. To date, benchmark of HIVQUAL-T performance measurement results goes beyond hospital setting and has been expanded at the provincial, regional and national level. HIVQUAL-T has also been expanded to include pediatric HIV/AIDS indicators began in 2006. About 100 provincial hospitals with high numbers of pediatric cases have participated.

Quality Improvement in STI services: STIQUAL

STIQUAL is a quality improvement model for STI and VCT services at the facility level. The main concept of the model is the measurement of service performance for the improvement of quality of care by integration of client data with the hospital quality management program. Health facilities will set STI performance targets according to the national standard. The STIQUAL software is a tool for measurement of coverage of STI and VCT services for quality improvement. The input is extracts from existing medical record forms and/or imported data from the STI Record database. The measurement can be done periodically but at least once a year. Outputs from the software are coverage of STI screening among risk groups, STI case management, and HIV counseling and testing.

The STIQUAL has been successfully piloted in 5 provinces, begun in 2009 under the collaboration of the STI cluster and TUC. Now it is currently being implemented in 19 provinces and there are plans to expand to 43 provinces as part of the GFATM Round 8.

MSM organizations to analyze and use monitoring data for program improvement

Improving the use of program monitoring data is a critical effort. USAID and its partners (FHI and PACT) have undertaken training to MSM-CBOs and conduct regular analysis and synthesis of monitoring data of community based data and provide feedback to implementing partners and key stakeholders. Thailand has a long term goal of building the capacity of CBOs in order to enable them to have the skill sets to be able to analyze and interpret their own program monitoring data effectively and routinely.

B. Challenges faced in the implementation of a comprehensive M&E system

The following is a summary of key progress made to overcome challenges during last two years:

- Sixteen of TWGs were established in 2009. Most TWGs met regularly. Key stakeholders actively participated throughout the process for development of the 2010 UNGASS report. Moreover, TWG on situation analysis has developed two synthesis reports that provided critical

findings for enhancing the HIV/AIDS strategy, improving the national M&E system and the 2010 UNGASS report.

- The M&E plan for HIV prevention targeting MARPs and TB/HIV were completed.
- With success of the GFATM Round 8 application, significant financial support has now been allocated for Thailand to strengthen national strategic information including M&E activities in 2009.
  - Thailand is conducting the MARP population size estimation study that is important information for implementers to monitor their progress on coverage. In addition, it is a critical parameter to improve accuracy of estimation and projection of HIV and AIDS in Thailand.
  - Scaled up of IBBS among MARPs
  - Area based approach for a comprehensive M&E has been endorsed and well accepted by key stakeholders. An operational framework, data warehouse/system, operational guide and training curriculum will be developed by the end of 2010.
  - There will be a launching of a provincial coordination mechanism (PCM) as key M&E mechanism at the sub-national level to draw upon collaboration, coordination and strengthen M&E capacity to relevant stakeholders including local administrations to better use of information for program and program planning.

Even though, Thailand has made a lot of progress during the last 2 years it still faces a number of key challenges as follows:

1. A comprehensive national M&E plan

It is needed to be developed as part of the new national HIV and AIDS strategic plan. This effort is vital for developing a unified M&E framework for the country.

2. Surveillance and surveys

- While a comprehensive HIV/AIDS surveillance framework exists, Thailand calls for improved quality of surveillance data including sample sizes, sampling technique and scale up of sentinel sites, increasing utilization of data, developing tools and strengthening human capacity on analysis and interpretation of data as well as technical skills to triangulate different datasets and types of data in order to get a clearer picture of the epidemic at national and sub-national levels.
- Increased reliability and accuracy of HIV incidence measurement is critical to monitor national prevention efforts.
- A survey of the general population in reproductive age and youth survey is needed to consolidate and harmonize efforts. It calls for strong

coordination on planning and a timeline for conducting a contraceptive and reproductive and health survey, national health survey and the multiple indicators cluster (MICS) et al.

3. Routine Health Information System (RHIS)

To develop an integrated and comprehensive Routine Health Information System for Thailand is a challenge for many reasons. Since a lot of information systems exist in different phases of development, in order to develop a unified monitoring system there needs to be full collaboration from key stakeholders and time to make the new system fully functional.

- Strengthening NAP system is needed as the main data source for national care and treatment system by integrating other data sources such as social welfare data system, MTCT system (PRIM and PROM) and others.
- Care and treatment information system for migrant population is still unclear of its implementation for the future. Now it reports under the NAPHA –extension project monitoring system.
- NAP system is not sensitive to disaggregation by MARPs.
- Orphans and HIV infected and affected children monitoring system is still fragmented and needs to be developed as a unified data collection and integrated system.

- Community based information for prevention, care and OVC that is mostly implemented by CBOs and NGOs is disconnected from the national system.
- Disclosure of most at risk population monitoring data is a major concern of civil society.
- Information from private health services and medical teaching universities is not included in the national system.

4. Evaluation and Research

Thailand is recognized as having high capacity for research. However linkage of using research findings to guide implementation and policy development is limited. In addition, there is a clear need for empirical data on what intervention works and what doesn't to support the national scaling up plan.

Thailand needs to develop a priority national evaluation and research agenda in collaboration with key stakeholders to increase availability and improve quality of evaluation and research as well as ensure use of data at all levels. Resulting from the process, Thailand will use the list of priority evaluation and research to leverage financial support, and then set up a process to determine appropriate methodologies (quantitative and/or

qualitative, experimental design versus non-experimental design) and control quality of the studies.

5. Capacity building on strategic information including M&E and data use

Strengthening strategic information including M&E capacity is long term goal. Thailand is putting emphasis on strengthening capacity of data use at all levels in the next 2 years. At the point of services delivery (facility and community level), project staff need to have capacity to use the program monitoring system effectively to monitor the progress of coverage and quality of programs.

At decentralized units such as the Tambon Administrative Organizations (TAO), the provincial and regional level has limited use of core national monitoring data (program, outcome and impact monitoring) to guide development of annual operational plans. At the national level there is a need to ensure national entities are well equipped to undertake synthesis and triangulation of data and use it for developing national policy and strategies.

C. Remedial actions planned to overcome the challenges

1. Support M&E TWGs to be active and well-functioning through developing a concrete activity plan to support M&E activities in 2010-2011. Key activities of TWGs should include:

- Develop a comprehensive national M&E plan for prevention, care and treatment by 2011.
- Develop national targets.
- Implement priority M&E activities as identified by each TWG in line with the national M&E plan.

2. With support from the GFATM, BoE is expanding IBBS sentinel sites to better understand the sub-national HIV epidemic among MARPs as well as improving quality of data. Analysis tools for IBBS will be developed in order to improve analytical skill among staff at different levels who are involved with the IBBS implementation.

3. In 2010-2011, there are number of activities that will be done to strengthen the routine program monitoring systems;

- Consolidate the care and treatment database
- Develop an OVC program monitoring system
- Strengthen the Smart TB program

- Develop an integrated Routine Health Information System (RHIS) using area based framework including the community based monitoring system and its integration into the national system. In next 2 years Thailand will focus on developing an integrated RHIS on prevention targeting for MARPs. As part of the effort, a data warehouse will be established to integrate all different types of data for analysis. An RHIS procedure and training manual on data quality and data use will be a part of the development.

4. Thailand will implement processes to develop national priority of evaluation and research agenda on prevention, care and treatment by 2010. With this process evaluation and/or research mapping of completed, on-going and planned studies will be undertaken in order to identify information gaps and needs for use of data to support national strategy.

Thailand will leverage funds from different sources to improve availability evaluation studies. In addition, processes will be established to ensure studies meet with minimum standards. Advocacy for policy makers to use data effectively for policy development and decision making will be implemented.

5. A series of capacity building including trainings and mentorship will be provided to CBOs, NGOs, sub-provincial and provincial, regional staff for effective implementation of a functional M&E system and use of data for improving program implementation and developing operation plans and the national strategy. Over the next 2 years, NAMc will play special attention to building M&E capacity of the local administration by working in close collaboration with the Provincial Coordination Mechanism (PCM) in 43 provinces.

Finally, Thailand will undertake a Monitoring and Evaluation Systems Strengthening assessment in 2011 to monitor progress of the national M&E system as compared to the assessment in 2008. Information will be used to develop a comprehensive national M&E plan 2012-2016.

D. The need for M&E technical assistance and capacity-building

1. State of the Art of evaluation methodology on prevention targeting for MARPs.
2. Expertise to develop community based health information system and its integration with the national system including prevention, care and OVC program.
3. HIV Incidence measurement.

Annex 1

Data for 2010 UNGASS , Thailand

Code	Indicator	Status
Government HIV and AIDS Policies		
1	AIDS Spending	7,208.5 mil. Bht
National Programme Indicators		
3	Blood safety	100.0
4	HIV Treatment: Antiretroviral Therapy – 2006	67.14
4	HIV Treatment: Antiretroviral Therapy – 2007	75.76
5	Prevention of Mother-to-Child Transmission – 2006	93.31
5	Prevention of Mother-to-Child Transmission – 2007	94.71
6	Co-Management of Tuberculosis and HIV Treatment	25.82
7	HIV Testing in the General Population	19.12
8	HIV Testing in Most-at-Risk Populations – SW	35.81
8	HIV Testing in Most-at-Risk Populations – MSM	21.33
8	HIV Testing in Most-at-Risk Populations - IDU	59.70
9	Most-at-Risk Populations: Prevention Programme - SW	NA
9	Most-at-Risk Populations: Prevention Programme - MSM	NA
9	Most-at-Risk Populations: Prevention Programme - IDU	NA
10	Support for Children Affected by HIV and AIDS	Not Applicable
11	Life Skills-based HIV Education in Schools	0
Knowledge and Behavior Indicators		
12	Orphans: School Attendance - Part A	95.50
12	Orphans: School Attendance - Part B	96.40
13	Young People: Knowledge about Prevention	37.42
14	Most-at-risk Pop.: Knowledge about HIV Prevention - SW	38.26
14	Most-at-risk Pop.: Knowledge about HIV Prevention - MSM	25.53
14	Most-at-risk Pop.: Knowledge about HIV Prevention - IDU	NA
15	Sex before the Age of 15	4.82
16	Higher-risk sex	9.40
17	Condom Use During Higher-risk Sex	50.90
18	Sex Workers: Condom Use	92.20
19	MSM: Condom Use	NA
20	IDU: Condom Use	41.98
21	IDU: Safe Injecting Practices	63.16
Impact Indicators		
22	Reduction of HIV Prevalence	0.58
23	Most-at-risk Pop: Reduction in HIV Prevalence - SW	3.17
23	Most-at-risk Pop: Reduction in HIV Prevalence - MSM	13.53
23	Most-at-risk Pop: Reduction in HIV Prevalence - IDU	38.67
24	HIV Treatment: survival after 12 Months on ART	85.14
25	Reduction in Mother –to- child Transmission	NA

3- Blood Safety		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Program monitoring system	
Data collection period	1 October 2008 – 30 September 2009	
Comments	1) Data from National Blood Center and Regional Blood Centers of Thai Red Cross Society including 371 blood banks of 942 government and private hospitals 2) Donated blood was 100% screened	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of donated blood units screened for HIV in a quality-assured manner	All	100.00
Numerator: Number of donated blood units screened for HIV in blood centers/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme	All	1,942,333
Denominator: Total number of blood units donated	All	1,942,333
4- HIV Treatment: Antiretroviral Therapy - 2008		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	ART Patient Registration	
Data collection period	1 October 2007 -30 September 2008	
Comments	1) Data from 5 data sources included 1.1) National AIDS Program (NAP program) from National Health Security Office, 1.2) Social Security Scheme (SSS), 1.3) Civil Service Medical Benefit Scheme (CSMBS), 1.4) GFATM supported Thailand AIDS Round 1 1.5) Government Pharmaceutical Organization (GPO) for ARV patients who are not covered above health insurance schemes. 2) According to the national protocol, ART will be provided to either symptomatic with CD4 250 cell/cu.mm. or asymptomatic with CD4 lower than 200 cell/cu.mm. 3) Denominator: Estimated number of adults and children with advanced HIV infection Adults : Asian Epidemic Model (AEM) Children: Spectrum provided by UNAIDS. 4) Denominator disaggregated by sex from AEM is not available.	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of adults and children with advanced HIV infection receiving ART	All	67.14
	Males	NA
	Females	NA
	<15	86.06
	15+	66.49
Numerator: Number of adults and children with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All	185,086
	Males	NA
	Females	NA
	<15	7,990
	15+	177,096
Denominator: Estimated number of adults and	All	275,653

children with advanced HIV infection	Males	NA
	Females	NA
	<15	9,284
	15+	266,369
4- HIV Treatment: Antiretroviral Therapy - 2009		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	ART Patient Registration	
Data collection period	1 October 2008 – 30 September 2009	
Comments	1) Data from 5 data sources included 1.1) National AIDS Program (NAP program) from National Health Security Office, 1.2) Social Security Scheme (SSS), 1.3) Civil Service Medical Benefit Scheme (CSMBS), 1.4) GFATM supported Thailand AIDS Round 1 5) Government Pharmaceutical Organization (GPO) for ARV patients who are not covered above health insurance schemes. 2) According to the national protocol, ART will be provided to either symptomatic with CD4 250 cell/cu.mm. or asymptomatic with CD4 lower than 200 cell/cu.mm. 3) Denominator: Estimated number of adults and children with advanced HIV infection Adults : Asian Epidemic Model (AEM) Children: Spectrum provided by UNAIDS. 4) Denominator disaggregated by sex from AEM is not available.	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of adults and children with advanced HIV infection receiving ART	All	75.76
	Males	NA
	Females	NA
	<15	85.46
	15+	75.43
Numerator: Number of adults and children with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All	216,118
	Males	NA
	Females	NA
	<15	8,076
	15+	208,042
Denominator: Estimated number of adults and children with advanced HIV infection	All	285,271
	Males	NA
	Females	NA
	<15	9,450
	15+	275,821
- Prevention of Mother-to-Child Transmission - 2008		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	1) Hospital record, monthly report on PMTCT from Department of Health (PHIMS), National AIDS Program (NAP) from National Health Security Office. 2) Birth registers from Ministry of Interior (MOI)	
Data collection period	PHIMS: 1 October 2008– 30 September 2009 Birth registration during calendar year (1 January-31 December 2008)	

Comments	1) Number of HIV infected pregnant women was calculated from multiplying number of live births with HIV prevalence in pregnant women from PHIMS. 2) Percentage of the infected pregnant women who received ART as reported from PHIMS 3) Type of ARV regimen was calculated from NAP	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of HIV-infected pregnant women who received ARV to reduce the risk of mother-to-child transmission	All	93.31
• Single –dose Nevirapine only		Not recommended
• Two types of ARV		71.66
• Three types of ARV		20.25
• ART for HIV infected pregnant women		NA
• Others		1.40
Numerator: Number of HIV-infected pregnant women who received ARV during the last 12 months to reduce mother-to-child transmission	All	5,926
• Single –dose Nevirapine only		Not recommended
• Two types of ARV		4,551
• Three types of ARV		1,286
• ART for HIV infected pregnant women		NA
• Others		89
Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	All	6,351
5- Prevention of Mother-to-Child Transmission – 2009		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	1) Hospital record, monthly report on PMTCT from Department of Health (PHIMS), National AIDS Program (NAP) from National Health Security Office. 2) Birth registers from Ministry of Interior (MOI)	
Data collection period	PHIMS: 1 October 2008– 30 September 2009 Birth registration during calendar year (1 January-31 December 2008)	
Comments	1) Number of HIV infected pregnant women was calculated from multiplying number of live births with HIV prevalence in pregnant women from PHIMS. 2) Percentage of the infected pregnant women who received ART as reported from PHIMS 3) Type of ARV regimen was calculated from NAP	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of HIV-infected pregnant women who received ARV to reduce the risk of mother-to-child transmission	All	94.71
• Single –dose Nevirapine only		Not recommended
• Two types of ARV		72.74
• Three types of ARV		20.55
• ART for HIV infected pregnant women		NA
• Others		1.42
Numerator: Number of HIV-infected pregnant women who received ARV during the last 12 months to reduce mother-to-child transmission	All	5,457
• Single –dose Nevirapine only		Not recommended
• Two types of ARV		4,191
• Three types of ARV		1,184
• ART for HIV infected pregnant women		NA
• Others		82
Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	All	5,762

6- Co-management of Tuberculosis and HIV Treatment		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Tuberculosis Patient Register	
Data collection period	1 October 2008 – 30 September 2009	
Comments	1) Numerator: TB patients with HIV positive from Tuberculosis Patients Register 2) Denominator was the estimated number HIV/TB patients in Thailand which was calculated by using WHO estimates on TB incidence (142/100000), HIV infection rate in TB patient (17%), yielding to the estimated number of 16, 077 new TB/HIV patients in 2009. New TB cases (all forms) = 142/pop * (66.59 million pop in 2009) = 94,557 cases. With HIV infection rate is 17 %, there will be 16, 077 new HIV/TB cases in 2009) 3) According to National standard guideline for ART for TB/HIV patients provide ART for HIV/TB patients with CD4 less than 250 cells/cu.mm. 4) Denominator disaggregated by sex and age is not available.	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of estimated HIV-positive incident TB cases that received treatment for TB and HIV	All	25.82
	Males	NA
	Females	NA
Numerator: Number of adults with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programming guideline) within the reporting year.	All	4,151
	Males	NA
	Females	NA
Denominator: Estimated number of incident TB cases in people living with HIV	All	16,077
	Males	NA
	Females	NA
7- HIV Testing in the General Population		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	National Sexual Behavioral Survey of Thailand 2006	
Data collection period	June – August 2006	
Comments	1) Data Source: Institute for Population and Social Research, Mahidol University 2) Target population were male and female aged 18-49 years	
Sample Size of Survey Respondents	**5,208**	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	All 15-49	19.12
	Males	16.33
	Females	21.84
	15-19	16.43
	20-24	21.99
	25-49	18.73

Numerator: Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results	All 15-49	996
	Males	415
	Females	583
	15-19	57
	20-24	192
	25-49	747
Denominator: Number of all respondents aged 15-49	All 15-49	5,208
	Males	2,542
	Females	2,669
	15-19	347
	20-24	873
	25-49	3,988

8- HIV Testing in Most-at-Risk Populations - Sex Workers		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	FSW: Behavioral Sentinel Surveillance (BSS) MSW: Integrated Biological and Behavior surveillance (IBBS)	
Data collection period	FSW: June – July 2009 MSW: June – July 2009	
Comments	BBS among FSW conducted in 8 provinces using venue based sampling technique IBBS among MSW conducted in 3 tourist provinces; Bangkok, Chiang Mai and Phuket Data source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**2,890**	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of most-at-risk populations who received an HIV test in the last 12 months and who know their results	All Sex Workers	35.81
	Males	35.20
	Females	36.03
	<25	29.04
	25+	40.92
Numerator: Number of most-at-risk populations who have been tested for HIV during the last 12 months and who know their results	All Sex Workers	1,035
	Males	264
	Females	771
	<25	361
	25+	674
Denominator: Number of most-at-risk population included in the sample	All Sex Workers	2,890
	Males	750
	Females	2,140
	<25	1,243
	25+	1,647

8- HIV Testing in Most-at-Risk Populations - MSM	
Indicator relevance	Relevant to our country
Type and Name of Data Measurement Tool	MSW: Integrated Biological and Behavior surveillance (IBBS)
Data collection period	June – July 2009
Comments	IBBS among MSW conducted in 3 tourist provinces; Bangkok, Chiang Mai and Phuket Data source: Bureau of Epidemiology (BoE)
Sample Size of Survey Respondents	**1,500**

Indicator	Disaggregation	Value
Indicator Value: % of most-at-risk populations who received an HIV test in the last 12 months and who know their results	All MSM	21.33
	<25	16.51
	25+	28.03
Numerator: Number of most-at-risk populations who have been tested for HIV during the last 12 months and who know their results	All MSM	320
	<25	144
	25+	176
Denominator: Number of most-at-risk population included in the sample	All MSM	1,500
	<25	872
	25+	628
8- HIV Testing in Most-at-Risk Populations - IDU		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Integrated biological and behavioral surveillance (IBBS)	
Data collection period	January 2008	
Comments	Indicators used IBBS which conducted in Bangkok Data source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**742**	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of most-at-risk populations who received an HIV test in the last 12 months and who know their results	All IDU	59.70
	Males	57.70
	Females	70.10
	<25	56.50
	25+	60.70
Numerator: Number of most-at-risk populations who have been tested for HIV during the last 12 months and who know their results	All IDU	463
	Males	383
	Females	80
	<25	13
	25+	450
Denominator: Number of most-at-risk population included in the sample	All IDU	742
	Males	630
	Females	112
	<25	23
	25+	718
9- Most-at-Risk Populations: Prevention Programmes - Sex Workers		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	NA	
Data collection period	NA	
Comments	BSS among female sex workers and IBBS among male sex workers as data sources for prevention coverage but current surveys have not used same definition as suggested in UNGASS guide. Results are not presented for this year but it will be available starting from 2010.	
Sample Size of Survey Respondents		
Indicator	**Disaggregation**	**Value**
Indicator Value: % of most-at-risk populations reached with HIV prevention	All Sex Workers	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA

Numerator: Number of most-at-risk populations reached with HIV prevention	All Sex Workers	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of most-at-risk population included in the sample	All Sex Workers	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
9- Most-at-Risk Populations: Prevention Programmes - MSM		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	NA	
Data collection period	NA	
Comments	IBBS is data source for prevention coverage among MSM but current survey has not used same definition as suggested in UNGASS guide. Therefore results are not available this year but it will be available starting from 2010.	
Sample Size of Survey Respondents	NA	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of most-at-risk populations reached with HIV prevention	All MSM	NA
	<25	NA
	25+	NA
Numerator: Number of most-at-risk populations reached with HIV prevention	All MSM	NA
	<25	NA
	25+	NA
Denominator: Number of most-at-risk population included in the sample	All MSM	NA
	<25	NA
	25+	NA
9- Most-at-Risk Populations: Prevention Programmes - IDU		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	NA	
Data collection period	NA	
Comments	No Data Available but it will be available starting from 2010 from IBBS.	
Sample Size of Survey Respondents	NA	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of most-at-risk populations reached with HIV prevention	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of most-at-risk populations reached with HIV prevention	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of most-at-risk population	All IDUs	NA

included in the sample	Males	NA
	Females	NA
	<25	NA
	25+	NA

10- Support for Children Affected by HIV and AIDS		
Indicator relevance	Not relevant to our country	
Type and Name of Data Measurement Tool		
Data collection period		
Comments	1) HIV Prevalence among pregnant women were 0.72% and 0.74% in 2008 and 2009, respectively 2) MICS in 2006 revealed 21.4% of all orphaned and vulnerable children aged 0-17 receiving at least one type of basic external support	
Sample Size of Survey Respondents		
Indicator	**Disaggregation**	**Value**
Indicator Value: % of all orphaned and vulnerable children aged 0-17 receiving at least one type of basic external support	All	0
	Males	0
	Females	0
Numerator: Number of all orphaned and vulnerable children aged 0-17 receiving at least one type of basic external support	All	0
	Males	0
	Females	0
Denominator: Number of included in the sample	All	0
	Males	0
	Females	0
11- Life Skills-based HIV Education in Schools		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	NA	
Data collection period	NA	
Comments	No Data Available	
	1) Life skill-based HIV education in schools in Thailand has been implemented by 3 approaches under the Ministry of Education: 1.1 Integrated into technical subjects at least 5 hours / academic year in primary schools 1.2 Life skills and sexual education at least 10-16 hours/academic year in secondary and vocational schools 1.3 Intensive sexual education at least 16 hours/academic year mainly in vocational schools with 68% coverage for only vocational schools 2) AIDS and sex -related campaigns/ activities are conducted biannually	
Sample Size of Survey Respondents		
Indicator	**Disaggregation**	**Value**
Indicator Value: % of schools that provide life skills based HIV education in the last academic year	All	
Numerator: Number of schools that provide life skills based HIV education in the last academic year	All	
Denominator: Number of schools included in the sample	All	
12- Orphans: School Attendance		

Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Multiple Indicators Cluster Survey (MISC)	
Data collection period	December 2005 – May 2006	
Comments		
Sample Size of Survey Respondents	**18,174,805**	
Indicator	**Disaggregation**	**Value**
Indicator Value: Part A - Current school attendance rate of orphans aged 10-14	All	95.50
	Males	NA
	Females	NA
Numerator: Number of children aged 10-14 who lost both parents and who attend school	All	34,822
	Males	NA
	Females	NA
Denominator: Number of children aged 10- 14 who have lost both parents	All	36,463
	Males	NA
	Females	NA
Indicator Value: Part B - Current school attendance rate of children aged 10-14 both of whose parents are alive and who live with at least one parent	All	96.40%
	Males	NA
	Females	NA
Numerator: Number of children aged 10-14 both of whose parents are alive , who are living with at least one parent and who attend school	All	3,916,803
	Males	NA
	Females	NA
Denominator: Number of children aged 10-14 both of whose parents are alive who are living with at least one partner	All	4,063,073
	Males	NA
	Females	NA

13- Young People: Knowledge about HIV Prevention		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	National Sexual Behavioral Survey of Thailand 2006	
Data collection period	June – August 2006	
Comments	1) Data Source: Institute for Population Study and Social Research, Mahidol University 2) Target population were male and female aged 18-24 3) Only those who answered the questions were counted as denominator for each question. Number of those who answered each question was not the same as well as those who answered all 5 questions. Thus, summation of denominator for disaggregated values is not equal to the total.	
Sample Size of Survey Respondents	**3,020**	
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to all five questions	All 15-24	37.42
	Males	44.39
	Females	30.46
	15-19	29.37
	20-24	40.45
Numerator: Number of respondents aged 15-24 who gave correct answer to all five questions	All 15-24	1,129
	Males	669
	Females	460
	15-19	242

	20-24	887
Denominator: Number of all respondents aged 15-24	All 15-24	3,017
	Males	1,507
	Females	1,510
	15-19	824
	20-24	2193
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	All 15-24	95.50
	Males	96.02
	Females	94.97
	15-19	95.28
	20-24	95.58
Numerator: Number of respondents aged 15-24 who gave correct answer to question 1	All 15-24	2,884
	Males	1,449
	Females	1,435
	15-19	787
	20-24	2,097
Denominator: Number of all respondents aged 15-24	All 15-24	3,020
	Males	1,509
	Females	1,511
	15-19	826
	20-24	2,194
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex?	All 15-24	95.89
	Males	96.62
	Females	95.17
	15-19	95.16
	20-24	96.17
Numerator: Number of respondents aged 15-24 who gave correct answer to question 5	All 15-24	2,895
	Males	1,457
	Females	1,438
	15-19	786
	20-24	2,109
Denominator: Number of all respondents aged 15-24	All 15-24	3,019
	Males	1,508
	Females	1,511
	15-19	826
	20-24	2,193

Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 3, can a healthy-looking person have HIV?	All 15-24	84.00
	Males	83.17
	Females	84.78

	15-19	81.33
	20-24	85.00
Numerator: Number of respondents aged 15-24 who gave correct answer to question 3	All 15-24	2,536
	Males	1,255
	Females	1,281
	15-19	671
	20-24	1,865
Denominator: Number of all respondents aged 15-24	All 15-24	3,019
	Males	1,508
	Females	1,511
	15-19	825
	20-24	2,194
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 4, can a person get HIV from mosquito bites?	All 15-24	58.02
	Males	65.98
	Females	50.07
	15-19	51.69
	20-24	60.40
Numerator: Number of respondents aged 15-24 who gave correct answer to question 4	All 15-24	1,751
	Males	995
	Females	756
	15-19	427
	20-24	1,324
Denominator: Number of all respondents aged 15-24	All 15-24	3,018
	Males	1,508
	Females	1,510
	15-19	826
	20-24	2,192
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 5, can a person get HIV by sharing food with someone who is infected?	All 15-24	67.89
	Males	72.48
	Females	63.31
	15-19	59.63
	20-24	71.00
Numerator: Number of respondents aged 15-24 who gave correct answer to question 5	All 15-24	2,049
	Males	1,093
	Females	956
	15-19	492
	20-24	1,557
Denominator: Number of all respondents aged 15-24	All 15-24	3,018
	Males	1,508
	Females	1,510
	15-19	825
	20-24	2,193
14- Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers		

Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	FSW: Behavioral Sentinel Surveillance (BSS) MSW: Integrated Biological and Behavior surveillance (IBBS)	
Data collection period	FSW: June – July 2009 MSW: June – July 2009 BBS among FSW conducted in 8 provinces using venue based sampling technique IBBS among MSW conducted in 3 tourist provinces; Bangkok, Chiang Mai and Phuket Data source: Bureau of Epidemiology (BoE)	
Comments	Source: Bureau of Epidemiology	
Sample Size of Survey Respondents	2,935	
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to all five questions	All Sex Workers	38.26
	Males	29.33
	Females	41.33
	<25	29.44
	25+	44.74
Numerator: Number of respondents who gave correct answer to all five questions	All Sex Workers	1,123
	Males	220
	Females	903
	<25	366
	25+	757
Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	All Sex Workers	68.89
	Males	58.27
	Females	72.54
	<25	66.29
	25+	70.80
Numerator: Number of respondents who gave correct answer to question 1	All Sex Workers	2,022
	Males	437
	Females	1,585
	<25	824
	25+	1,198

Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 2,	All Sex Workers	91.41

can a person reduce the risk of getting HIV by using a condom every time they have sex?	Males	85.33
	Females	93.50
	<25	92.20
	25+	90.84
Numerator: Number of respondents who gave correct answer to question 5	All Sex Workers	2,683
	Males	640
	Females	2,043
	<25	1,146
	25+	1,537
Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 3, can a healthy-looking person have HIV?	All Sex Workers	78.64
	Males	76.53
	Females	79.36
	<25	75.78
	25+	80.73
Numerator: Number of respondents who gave correct answer to question 3	All Sex Workers	2,308
	Males	574
	Females	1,734
	<25	942
	25+	1,366
Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 4, can a person get HIV from mosquito bites?	All Sex Workers	70.32
	Males	69.33
	Females	70.76
	<25	66.05
	25+	73.58

Numerator: Number of respondents who gave correct answer to question 4	All Sex Workers	2,066
	Males	520
	Females	1,546
	<25	821
	25+	1,245

Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 5, can a person get HIV by sharing food with someone who is infected?	All Sex Workers	77.85
	Males	74.67
	Females	78.95
	<25	74.01
	25+	80.67
Numerator: Number of respondents who gave correct answer to question 5	All Sex Workers	2,285
	Males	560
	Females	1,725
	<25	920
	25+	1,365
Denominator: Number of all respondents	All Sex Workers	2,935
	Males	750
	Females	2,185
	<25	1,243
	25+	1,692
14- Most-at-risk Populations: Knowledge about HIV Prevention - MSM		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Integrated biology and behavioral surveillance (IBBS)	
Data collection period	June – July 2009	
Comments	Indicator used data from 3 tourist provinces; Bangkok, Chiang Mai and Phuket Data source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**1,500**	
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to all five questions	All MSM	25.53
	<25	18.81
	25+	34.87
Numerator: Number of respondents who gave correct answer to all five questions	All MSM	383
	<25	164
	25+	219

Denominator: Number of all respondents	All MSM	1500
	<25	872
	25+	628
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner	All MSM	53.53
	<25	49.54

who has no other partners?	25+	59.08
Numerator: Number of respondents who gave correct answer to question 1	All MSM	803
	<25	432
	25+	371
Denominator: Number of all respondents	All MSM	1,500
	<25	872
	25+	628
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex?	All MSM	86.33
	<25	85.55
	25+	87.42
Numerator: Number of respondents who gave correct answer to question 5	All MSM	1,295
	<25	746
	25+	549
Denominator: Number of all respondents	All MSM	1,500
	<25	872
	25+	628
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 3, can a healthy-looking person have HIV?	All MSM	79.20
	<25	77.52
	25+	81.53
Numerator: Number of respondents who gave correct answer to question 3	All MSM	1,188
	<25	676
	25+	512
Denominator: Number of all respondents	All MSM	1,500
	<25	872
	25+	628
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 4, can a person get HIV from mosquito bites?	All MSM	68.80
	<25	61.93
	25+	78.34
Numerator: Number of respondents who gave correct answer to question 4	All MSM	1,032
	<25	540
	25+	492
Denominator: Number of all respondents	All MSM	1500
	<25	872
	25+	628

Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 5, can a person get HIV by sharing food with someone who is infected?	All MSM	69.60
	<25	62.04
	25+	80.10
Numerator: Number of respondents who gave	All MSM	1,044

correct answer to question 5	<25	541
	25+	503
Denominator: Number of all respondents	All MSM	1,500
	<25	872
	25+	628
14- Most-at-risk Populations: Knowledge about HIV Prevention - IDUs		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	No data Available	
Data collection period	No data Available	
Comments	Thailand is undertaking IBBS in 2010	
Sample Size of Survey Respondents		
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to all five questions	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of respondents who gave correct answer to all five questions	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of all respondents	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of respondents who gave correct answer to question 1	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of all respondents	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA

Indicator	Disaggregation	Value
Indicator Value: Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex?	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of respondents who gave correct answer to question 5	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of all respondents	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 3, can a healthy-looking person have HIV?	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of respondents who gave correct answer to question 3	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of all respondents	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 4, can a person get HIV from mosquito bites?	All IDUs	
	Males	
	Females	
	<25	
	25+	
Numerator: Number of respondents who gave correct answer to question 4	All IDUs	
	Males	
	Females	
	<25	
	25+	

Denominator: Number of all respondents	All IDUs	
	Males	
	Females	
	<25	
	25+	
Indicator	**Disaggregation**	**Value**
Indicator Value: Correct answer to question 5, can a person get HIV by sharing food with someone who is infected?	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Numerator: Number of respondents who gave correct answer to question 5	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
Denominator: Number of all respondents	All IDUs	NA
	Males	NA
	Females	NA
	<25	NA
	25+	NA
15- Sex before the Age of 15		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	National Sexual Behavioral Survey of Thailand 2006	
Data collection period	June – August 2006	
Comments	Data Source: Institute for Population Study and Social Research, Mahidol University	
	Target population were male and female aged 18-24	
Sample Size of Survey Respondents	**3,024**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	All 15-24	4.82
	Males	8.32
	Females	1.31
	15-19	5.17
	20-24	4.68
Numerator: Number of respondents aged 15-24 who report the age at which they first had sexual intercourse as under 15 years	All 15-24	59
	Males	51
	Females	8
	15-19	18
	20-24	41
Denominator: Number of all respondents aged 15-24	All 15-24	1,224
	Males	613
	Females	611
	15-19	348
	20-24	876

16- Higher-risk Sex		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	National Sexual Behavioral Survey of Thailand 2006	
Data collection period	June – August 2006	
Comments	Data Source: Institute for Population Study and Social Research, Mahidol University Target population were male and female aged 18-49 years	
Sample Size of Survey Respondents	5,208	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	All 15-49	9.39
	Males	17.88
	Females	0.95
	15-19	23.56
	20-24	17.54
	25-49	7.19
Numerator: Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	All 15-49	395
	Males	375
	Females	20
	15-19	41
	20-24	107
	25-49	246
Denominator: Number of all respondents aged 15-49	All 15-49	4,206
	Males	2,097
	Females	2,109
	15-19	174
	20-24	610
	25-49	3,422
17- Condom Use During Higher-risk Sex		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	National Sexual Behavioral Survey of Thailand 2006	
Data collection period	June – August 2006	
Comments	Data Source: Institute for Population Study and Social Research, Mahidol University Target population were male and female aged 18-49 years	
Sample Size of Survey Respondents	**5,208**	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of women and men aged 15-49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse	All 15-49	50.88
	Males	52.93
	Females	14.29
	15-19	63.41
	20-24	48.62
	25-49	49.80
Numerator: Number of respondents aged 15-49 who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	All 15-49	202
	Males	199
	Females	3
	15-19	26
	20-24	53

	25-49	123
Denominator: Number of all respondents aged 15-49 who reported having had more than sexual partner in the last 12 months	All 15-49	397
	Males	376
	Females	21
	15-19	41
	20-24	109
	25-49	247
18- Sex Workers: Condom Use		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	FSW: Behavioral Sentinel Surveillance (BSS) MSW: N/A	
Data collection period	June – July 2008	
Comments	BSS among FSW used data from 54 provinces Data among MSW is not reported since questions in the survey used to construct this indicator are difference from standard definition that suggested in the UNGASS guide. But this indicator will be available starting from 2010 onward. Data Source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**9,557**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of female and male sex workers reporting the use of a condom with their most recent client	All Sex Workers	92.20
	Males	NA
	Females	92.20
	<25	NA
	25+	NA
Numerator: Number of respondents who reported that a condom was used with their most recent client	All Sex Workers	8,812
	Males	NA
	Females	8,812
	<25	NA
	25+	NA
Denominator: Number of all respondents who reported having commercial sex in the last 12 months	All Sex Workers	9,557
	Males	NA
	Females	9,557
	<25	NA
	25+	NA
19- MSM: Condom Use		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	N/A	
Data collection period	N/A	
Comments	Thailand undertook IBBS among MSM in 2003, 2005, 2007 and 2009. However questions in the survey used to construct this indicator are difference from standard definition that suggested in the UNGASS guide. But this indicator will be available starting from 2010 onward.	
Sample Size of Survey Respondents	N/A	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of men reporting the use of a condom the last time they had anal sex with a	All MSM	NA
	<25	

male partner	25+	
Numerator: Number of respondents who reported that a condom was used the last time they had anal sex	All MSM	
	<25	
	25+	
Denominator: Number of all respondents who reportd having had anal sex with a male partner in the last six months	All MSM	
	<25	
	25+	
20- IDUs: Condom Use		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Integrated biological and behavioral surveillance (IBBS)	
Data collection period	June – July 2008	
Comments	IBBS conducted in Bangkok Data source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**474**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of IDUs reporting the use of a condom the last time they had sexual intercourse	All IDUs	41.98
	Males	44.58
	Females	28.57
	<25	40.00
	25+	42.07
Numerator: Number of respondents who reported that a condom was used the last time they had sex	All IDUs	199
	Males	177
	Females	22
	<25	8
	25+	191
Denominator: Number of all respondents who report having had sexual intercourse in the last month	All IDUs	474
	Males	397
	Females	77
	<25	20
	25+	454
21- IDUs: Safe Injecting Practices		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Integrated biological and behavioral surveillance (IBBS)	
Data collection period	June – July 2008	
Comments	IBBS conducted in Bangkok Data Source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**741**	
Indicator	**Disaggregation**	**Value**
Indicator Value: % of IDUs who report using sterile injecting equipment the last time they injected drugs	All IDUs	63.16
	Males	62.96
	Females	64.29
	<25	60.87
	25+	63.23
Numerator: Number of respondents who report using sterile injecting equipment the last time they injected drugs	All IDUs	468
	Males	396
	Females	72

	<25	14
	25+	454
Denominator: Number of respondents who report injecting drugs in the last month	All IDUs	741
	Males	629
	Females	112
	<25	23
	25+	718
22- Reduction in HIV Prevalence		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	HIV Sentinel Sero Surveillance	
Data collection period	June – July 2008	
Comments	Data Source: Bureau of Epidemiology (BoE)	
Sample Size of Survey Respondents	**28,147**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of young women and men aged 15-24 who are HIV- infected	All 15-24	0.58
	15-19	0.47
	20-24	0.66
Numerator: Number of antenatal clinic attendees aged 15-24 tested whose HIV test results are positive	All 15-24	162
	15-19	60
	20-24	102
Denominator: Number of antenatal clinic attendees aged 15-24 tested for their HIV infection status	All 15-24	28,147
	15-19	12,782
	20-24	15,365
23- Most-at-risk Populations: Reduction in HIV Prevalence - Sex workers		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	HIV Sentinel Sero Surveillance (HSS)	
Data collection period	June – July 2009	
Comments	Data Source: Bureau of Epidemiology (BoE) HSS has been conducted in venues based sentinel sites	
Sample size of the study	**15,259**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of most-at-risk populations who are HIV-infected	All Sex Workers	3.17
	Male	14.17
	Female	2.79
	<25	NA
	25+	NA
Numerator: Number of most-at-risk populations tested whose HIV test results are positive	All Sex Workers	484
	Male	72
	Female	412
	<25	NA
	25+	NA
Denominator: Number of most-at-risk populations tested for their HIV infection status	All Sex Workers	15,259
	Male	508
	Female	14,751
	<25	NA
	25+	NA
23- Most-at-risk Populations: Reduction in HIV Prevalence - MSM		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Integrated biology and behavioral surveillance (IBBS)	
Data collection period	June – July 2009	

Comments	Indicators presented in this report used data from 3 tourist provinces; Bangkok, Chiang Mai and Phuket Data source: Bureau of Epidemiology (BoE)	
Sample size of the study	**1,500**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of most-at-risk populations who are HIV-infected	All MSM	13.53
	<25	NA
	25+	NA
Numerator: Number of most-at-risk populations tested whose HIV test results are positive	All MSM	203
	<25	NA
	25+	NA
Denominator: Number of most-at-risk populations tested for their HIV infection status	All MSM	1,500
	<25	NA
	25+	NA
23- Most-at-risk Populations: Reduction in HIV Prevalence - IDUs		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	HIV Sentinel Sero Surveillance (HSS)	
Data collection period	June – July 2009	
Comments	Results from HSS conducted in methadone clinics. Data Source: Bureau of Epidemiology. However Thailand has IBBS using Respondent Driven Sampling (RDS) in Bangkok that showed HIV prevalence among IDU as follow; Total 23.3%, Male 24.1% and Female 19% aged 25+ 23.2%	
Sample size of the study	**150**	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of most-at-risk populations who are HIV-infected	All IDUs	38.67
	Male	37.96
	Female	46.15
	<25	NA
	25+	NA
Numerator: Number of most-at-risk populations tested whose HIV test results are positive	All IDUs	58
	Male	52
	Female	6
	<25	NA
	25+	NA
Denominator: Number of most-at-risk populations tested for their HIV infection status	All IDUs	150
	Male	137
	Female	13
	<25	NA
	25+	NA
24- HIV Treatment: Survival after 12 Months on ART		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	ART Patient Registration	
Data collection period	October 2007 – September 2008	
Comments	Data from National AIDS Program database- NAP Data source: National Health Security Office (NHSO)	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of adults and children with	All	85.14

HIV known to be on treatment 12 months after initiation of ART	Male	77.85
	Female	93.24
	<15	90.02
	15+	84.89
Numerator: Number of adults and children who are still alive and on ART at 12 months after initiating treatment	All	23,076
	Male	11,100
	Female	11,976
	<15	1,190
	15+	21,886
Denominator: Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART and those lost to follow up	All	27,103
	Male	14,259
	Female	12,844
	<15	1,322
	15+	25,781
25- Reduction in Mother-to child Transmission		
Indicator relevance	Relevant to our country	
Type and Name of Data Measurement Tool	Data not available	
Data collection period		
Comments	• Data from spectrum is not available • Evaluation conducted by MOPH in 2007 found level of transmission of HIV from mother to infant was 2.9% based on laboratory diagnostic. If dead infants are included in the analysis transmission rate was 5.6%.	
Indicator	**Disaggregation**	**Value**
Indicator Value:% of infants born to HIV-infected mothers who are infection	All	NA
Numerator: Estimated number of new infant HIV infections	All	NA
Denominator: Estimated number of HIV positive pregnant women	All	NA

Annex 2

National Expenditure on HIV/AIDS 2008-2009

Thai Working Group on National AIDS Spending Assessment
Reporting date March 10, 2010

1. Background

As required by UNGASS country report 2010, the Thai working group on National AIDS Spending Assessment (NASA) convened several rounds of work session among partners in and outside Ministry of Public Health (MOPH), who are most knowledgeable on spending on HIV/AIDS. These work sessions were tasked to estimate the total spending on HIV/AIDS for 2008 and 2009.

This report continues the last report of 2007 spending, table 1 provides background spending on HIV/AIDS in 2007

Table 1: Total AIDS expenditure, 2007, current year price

	2007
Total AIDS expenditure, million Baht	6,728
Forecast Total Health Expenditure, million Baht	248,852.4
Total AIDS expenditure 2007	
per capita population, Baht	105
per capita PLWHA, Baht	11,600
% GDP	0.08%
% THE	2.7%

Source UNGASS country progress report for January 2006-December 2007

2. Objectives

1) To estimate the magnitude, sources and profile of expenditure on HIV/AIDS for 2008 and 2009
2) To produce key indicators on total expenditure on HIV/AIDS in terms of
- Baht per capita Thai population
- Baht per capita PLWHA,
- Percent of GDP
- Percent of Total Health Expenditure (THE)

3. Methodology

3.1 Methods

1. With the application of National Health Account [OECD System of Health Account, version 1.0: 2000], a two dimensional matrix of

financing sources by healthcare function was produced. We deliberately do not produce the third dimension on AIDS expenditure by public and private healthcare providers, as there is limited policy utilities and huge time consuming to produce such data.

2. Compile secondary data on actual expenditure on HIV/AIDS where available from relevant financing agents.
3. Where there is no ready reference secondary data on spending on HIV/AIDS, the Working Group applied different impute methods, based on PQ approaches (P refers to price or unit cost, Q refers to quantity or services rendered, mostly relied on epidemiological data). For example, expenditure on ART, opportunistic infections and laboratories from health insurance schemes. There are three public health insurance schemes operating in Thailand in 2008 and 2009, the Civil Servant Medical Benefit Scheme, the Social Health Insurance and the Universal Coverage Scheme. Private insurance was deliberately excluded as it applies pre-application screening and excluded PLWHA to join in member of private insurances.

3.2 Data sources

1. Actual spending on HIV/ AIDS was retrieved from mostly government spending records in various Departments across different Ministries, as well as donor sources, such as Ministry of Public Health, National Health Security Office who is responsible for universal access to ART program and OI for HIV patients under the Universal Health Care Scheme (UC), the Comptroller General's Department of the Ministry of Finance on expenditure on HIV/AIDS for the Civil Servant Medical Benefit Scheme, Social Security Office who spent for their social health insurance members and the Global Fund and other donors from outside country.
2. The most update GDP for 2008 and 2009 were retrieved from the website of the National Account Office of the National Economic and Social Development Board [50]
3. Total Health Expenditure for 2008 was retrieved from the National Health Account 1994-2008 of Thailand, however; the total health expenditure for 2009 was estimated based on historical growth of THE [51].

[50] National Account Office, the National Economic and Social Development Board http://www.nesdb.go.th/econSocial/macro/NAD/1_ggdp/statistic/menu.html [access 23 February 2010].

[51] Thai working group on National Health Account. National Health Account 1994-2008 http://www.ihppthaigov.net/nha/thai_nha_1994-2008.xls [access 10 March 2010]

4. Number of people living with HIV/AIDS in 2008 and 2009 based on estimation from the registration system of the National Health Security Office.

3.3 Scope

1. We use actual spending on HIV/AIDS, not budgeting figures.
2. This study covers only spending by government and donor resources. We deliberately exclude household spending on HIV/AIDS, as there is no any national dataset capturing household spending specifically on HIV/AIDS. In the context of universal coverage, household spending on HIV/AIDS is likely to be extremely low; all OI services were fully covered by each of the three insurance schemes and also ART is universally covered by all three schemes, free at point of services. There is no co-payment. However, there may be certain proportion of patients seek ART services from private hospitals, for which households bear the full cost of these treatment. However, it is unknown on the magnitude of these patients, voluntarily opted out from insurance scheme.
3. Due to gross lack of data, we did not cover expenditure by local government
4. Fiscal year (October to September) for government expenditure and calendar year (January to December) for international expenditure are treated equivalent.
5. Healthcare function applies the 8 items of expenditure proposed by UNGASS template.

4. Results

4.1 Financing context in Thailand

Table 2: background data on healthcare financing 2008-09, current year price

	2008	2009
Population	63,121,000	63,396,000
Total Health Expenditure (THE) per capita, Baht	5,739	6,183
THE per capita, US$	171	178
Exchange rate, Baht per US$*	33.13	34.72

Source: Total Health Expenditure for 2008 refers to Thai NHA 1994-2008[2]. The total health expenditure for 2009 was estimated based on historical trend of 1994-2008 by the Working Group (Average geometrical growth rate was 5.3%).

Note: Exchange rate quote from Bank of Thailand

Background data on healthcare financing indicated that in 2008, Thailand spent 5,739 Baht per capita for health of the Thai population, or US$ 173 per capita (exchange rate 33.13 Baht per US$), see Table 2. Per capita total health expenditure slightly increased to US$ 178 in 2009.

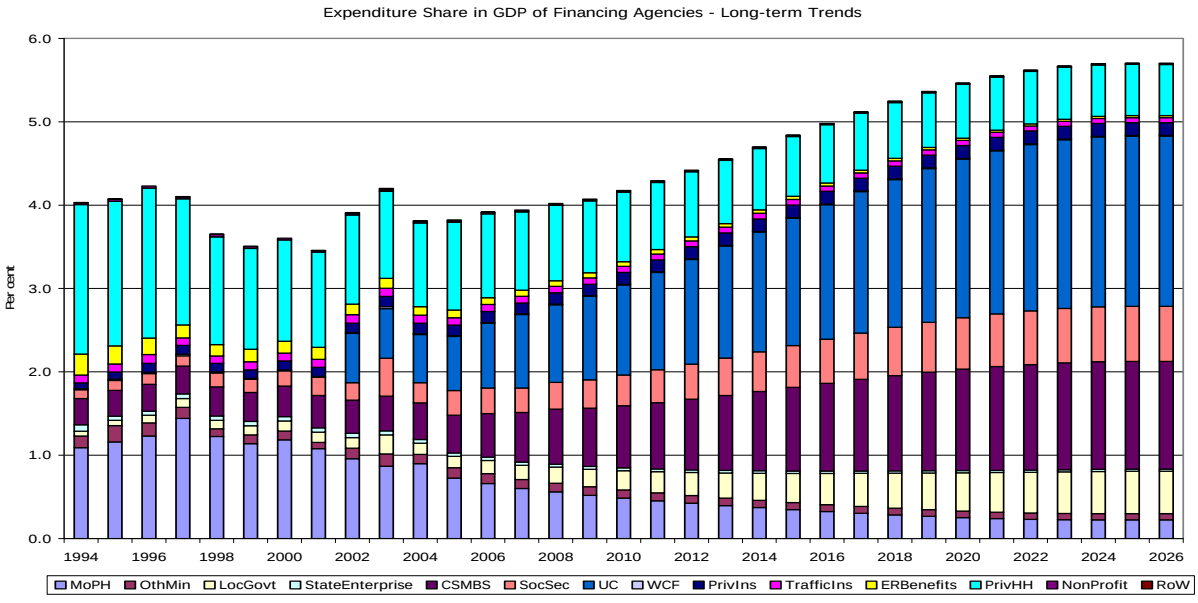
Table 3: Total health expenditure and selected NHA indicators, selected year 1994 to 2008, current year prices

NHA indicators	1994	1997	2001	2002	2005	2006	2007	2008
THE, Total Health Expenditure, million Baht	127,655	189,143	170,203	201,667	251,665	290,573	314,712	363,771
THE as % of GDP	3.5%	4.0%	3.3%	3.7%	3.6%	3.7%	3.7%	4.0%
Public Financing Agencies (%)	45%	54%	56%	63%	64%	68%	73%	75%
Private Financing Agencies (%)	55%	46%	44%	37%	36%	32%	27%	25%
THE, Baht per capita	**2,160**	**3,110**	**2,732**	**3,211**	**4,032**	**4,625**	**4,992**	**5,739**
THE, USD per capita	**86**	**99**	**61**	**74**	**100**	**122**	**144**	**171**

Source: Thai Working Group on NHA, 1994-2008

Table 3 provides a time series between 1994 and 2008, for some selected years; THE as percent of GDP had never reached beyond 4.0%. The public financing agencies play increasing role in financing health in Thailand, from 45% in 1994 to 75% in 2008; while a decreasing trend of the proportion of private source of finance was observed; down from 55% in 1994 to 25% in 2008.

Figure 1: Long term THE projection 2006 to 2026 based on 1994-2005 NHA



Based on 1994-2005 NHA, a long term projection of total health expenditure between 2006 and 2026 was conducted jointly by ILO and a number of Thai researchers [52]. In figure 1, by 2026, total health expenditure would be

within the capacity of the government to afford, less than 6% of GDP, whereby the general tax funded universal coverage would have the highest share of financing sources; this was followed by Civil Servant Medical Benefit Scheme expenditure. Private household spending would be equivalent to that of by Social Health Insurance Scheme. Historically, donors' resources play insignificant role in financing health in Thailand, less than 0.05% of total health spending.

4.2 How much Thailand spent on HIV/AIDS?

Table 4: Total AIDS expenditure, 2008-09, current year price

	2008	**2009**
Total AIDS expenditure, million Baht	6,928	7,208
Total Health Expenditure, million Baht	363,771	383,051*
Total AIDS expenditure 2007, as		
per capita population, Baht	110	114
per capita PLWHA, Baht	14,275	14,417
per capita population, US$	3.3	3.3
per capita PLWHA, US$	430.9	415.2
% GDP	0.08	0.08
% THE	1.9	1.9

* Total Health Expenditure for 2009 was estimated based on historical trend of 1994-2008 by The Working Group

In 2008, the total expenditure on HIV/AIDS was 6.928 billion Thai Baht. This is equivalent to 110 Baht per capita Thai population, or 14,275 Thai Baht per capita PLHIV, given the total number of 485,325 PLHIV. The total expenditure on HIV/AIDS accounts for 0.08% of GDP in 2008, or equivalent to 1.9% of Total Health Expenditure, See table 4.

In 2009, there was a slight increase of Total AIDS expenditure, 114 Baht per capita population or 14,417 Baht per PLHIV. There was a very marginal increase of AIDS spending. Therefore the ratio between AIDS spending and GDP or THE was unchanged in two years; remained at 0.08% of GDP and 1.9% of THE respectively for both years.

What are HIV/AIDS expenditure used for?

Table 5: Total AIDS expenditure by functions, 2008-09, current year price

[52] Scholz W, Sakulpanich T, Long term projection of total health expenditure in Thailand, 2006-2026. Nonthaburi, Health Systems Research Institute. 2009

	2008		2009	
	Thai Baht, million	Percent	Thai Baht, million	Percent
1. Prevention	1,500	21.7%	987	13.7%
2. Care and Treatment	4,560	65.8%	5,483	76.1%
3. Orphans and Vulnerable Children (OVC)	50	0.7%	52	0.7%
4. Program Management Administration Strengthening	397	5.7%	250	3.5%
5. Incentive Human Resources	44	0.6%	208	2.9%
6. Social protection and social services excluding Orphans and vulnerable Children	219	3.2%	171	2.4%
7. Enabling Environment and community Development	2	0.0%	8	0.1%
8. Research excluding operational research	156	2.3%	49	0.7%
Total	**6,928**	**100.0%**	**7,208**	**100.0%**

In the light of the universal ART adopted by the Royal Thai Government since 2003, a majority share of total AIDS spending was used for care and treatment, up to 65.8% in 2008 and increased to 76.1% in 2009. At the same time, expenditure on prevention reduced from 21.7% in 2008 and to 13.7% in 2009. Six other spending items were small; see Table 5. In 2009, OVC and research got less than 1% share, program management and administration strengthening got 3.5% share, incentive for human resources 2.9% and social protection and other social services, 2.4%.

What are sources of financing HIV/AIDS?

Table 6a: Total AIDS expenditure by sources and functions 2008, current year price

	Total	Domestic sources	International
1. Prevention	22%	20%	30%
2. Care and Treatment	66%	71%	34%
3. Orphans and Vulnerable Children	1%	1%	0%
4. Program Management Administration Strengthening	6%	3%	22%
5. Incentive Human Resources	1%	1%	1%
6. Social protection and social services excluding Orphans and vulnerable Children	3%	4%	0%
7. Enabling Environment and community Development	0%	0%	0%
8. Research excluding operational research	2%	0%	13%
Total	**100%**	**100%**	**100%**
Total, million Thai Baht	**6,928**	**5,917**	**1,011**
Column percent	**100%**	**85%**	**15%**

Table 6b Total AIDS expenditure by sources and functions 2009, current year price

	Total	Domestic	Interna-

		sources	tional
1. Prevention	14%	13%	29%
2. Care and Treatment	76%	80%	15%
3. Orphans and Vulnerable Children	1%	1%	0%
4. Program Management Administration Strengthening	3%	2%	17%
5. Incentive Human Resources	3%	1%	33%
6. Social protection and social services excluding Orphans and vulnerable Children	2%	3%	0%
7. Enabling Environment and community Development	0%	0%	1%
8. Research excluding operational research	1%	0%	4%
Total	**100%**	**100%**	**100%**
Total, million Thai Baht	**7,208**	**6,726**	**482**
Column percent	**100%**	**93%**	**7%**

Financing HIV/AIDS program relied mostly on domestic resource, 85% of total spending in 2008 and 93% in 2009. This reflected government financial commitment and we foresee good financial sustainability, as it relies less on donor resources.

Expenditure profile of donor resources significantly differed from that of domestic resources. Domestic resources concentrate most on care and treatment (71% and 80% in 2008 and 2009 respectively). The Thai HIV/AIDS program purchased generic medicine from locally produced ARV and imported generic ARV while donor resources had limitation to purchase generic, only WHO Pre-qualified mostly brand products were allowed to purchase using resources from the GFATM.

Also donor resources spread throughout the eight major spending items, in particular 33% on incentive for human resources, 29% on prevention, 17% on program management and administration strengthening, 15% on care and treatment. See Table 6a and 6b

4.5 How much different domestic source contributes to financing HIV/AIDS?

From the systems analysis, we categorize five groups of domestic financing sources for HIV/AIDS, (1) the MOPH (all relevant departments) is the main stakeholder for HIV/AIDS prevention and control, (2) other ministries such as Ministry of Education, Ministry of Defense, blood safety program spearheaded by the Thai Red Cross, (3) the National Health Security Office is responsible for the provision of OI services and ART for members of the UC scheme, (4) the Civil Servant Medical Benefit Scheme covers the formal sector public employees for treatment of OI and provision of ART, (5) The

Social Health Insurance covers the private sector employee, is responsible for provision of ART and OI services for its members.

Table 7a: Total AIDS expenditure by sources and functions 2008, current year price

Expenditure profiles	Total	Domestic resources					International
		MOPH	Others	NHSO	CSMBS	SHI	
1. Prevention	22%	37%	43%	24%	4%	4%	30%
2. Care and Treatment	66%	4%	8%	73%	96%	96%	34%
3. Orphans and Vulnerable Children	1%	20%	0%	0%	0%	0%	0%
4. Program Management Administration Strengthening	6%	30%	7%	2%	0%	0%	22%
5. Incentive Human Resources	1%	2%	1%	1%	0%	0%	1%
6. Social protection and social services excluding Orphans and vulnerable Children	3%	0%	39%	0%	0%	0%	0%
7. Enabling Environment and community Development	0%	0%	0%	0%	0%	0%	0%
8. Research excluding operational research	2%	6%	2%	0%	0%	0%	13%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total, million Baht	**6,928**	**245**	**556**	**3,349**	**831**	**936**	**1,011**
	100%	**4%**	**8%**	**48%**	**12%**	**14%**	**15%**

Table 7b Total AIDS expenditure by sources and functions 2009, current year price

Expenditure profiles	Total	Domestic resources					Interna-tional
		MOPH	Others	NHSO	CSMBS	SHI	
1. Prevention	14%	43%	47%	11%	3%	3%	29%
2. Care and Treatment	76%	0%	1%	88%	97%	97%	15%
3. Orphans and Vulnerable Children	1%	16%	0%	0%	0%	0%	0%
4. Program Management Administration Strengthening	3%	36%	8%	0%	0%	0%	17%
5. Incentive Human Resources	3%	1%	1%	1%	0%	0%	33%
6. Social protection and social services excluding OVC	2%	0%	37%	0%	0%	0%	0%
7.Enabling Environment and community Development	0%	0%	0%	0%	0%	0%	1%
8. Research excluding operational research	1%	4%	4%	0%	0%	0%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total, million Baht	**7,208**	**324**	**461**	**3,939**	**937**	**1,064**	**482**
	100%	**4%**	**6%**	**55%**	**13%**	**15%**	**7%**

Among the domestic sources of finance, National Health Security Office--responsible for the UC Scheme has the major share of spending, 48% in 2008 and 55% in 2009 respectively, as the NHSO is responsible for UC scheme which covers 75% of total Thai population, see Table 7a and 7b.

Civil Servant Medical Benefit Scheme and Social Health Insurance has a similar share, 12% and 14% in 2008, and 13% and 15% in 2009 respectively; Table 7a and 7b. Different source of finance has different spending profiles. While all three public insurance schemes concentrate more on care and treatment, MOPH and other ministries concentrate their spending on prevention, 43% and 47% respectively and also on other items.

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Annex 3

National Composite Policy Index: Viewpoint of Civil Society

March 20, 2010
Thai NGO Coalition on AIDS

A. Human rights: support for rights and respect for humanity

Challenges in the past report period (2006-7)

In the previous report period for Thailand (2006-7) many challenges were itemized concerning human rights including problems of access, the draft law for protection of PLHIV, the 1966 law on sex establishments (revised in 2005), the draft law on protection of human subjects in research, plus recommendations for reviewing laws and measures that do no facilitate the prevention and control of AIDS.

There was also a statement on policy advocacy for support and protection of rights to health services such as access to alternative regimens, access to services by migrant laborers and their dependents, and IDUs, lack of access to ART for those not covered by the National Health Security Program (NHSP), and recommendations for closing the gaps and differentials in access to health services, and support for developing strategies to campaign for rights, based on respect for diversity of ethnicity, religion, culture/beliefs, age group, and sex/sex lifestyle/sex orientation.

Success and findings (2008-9)

There is considerable success to report. From the 2009 review by the Foundation for AIDS Rights (FAR), it can be said that Thailand has favorable laws that promote the prevention program efforts. The Thai Constitution (as revised in 2007) has various supportive measures, such as Measure 4 regarding protection of human rights and freedom, Measure 26 regarding provision of service that respects humanity, rights and freedom of the population, Measure 28 regarding the right of citizens to invoke aspects of the constitution to file law suits, Measure 30 prohibition of unfair discrimination based on place of birth, ethnicity, language, sex, age, disability, physical characteristic or state of health, individual status, socio-economic status, religious beliefs, education, or political opinion. Also noteworthy is Section 3 of the Constitution which broadly protects the rights and freedoms of the Thai population including rights related to life, body, individual, justice, development, education, health service, and freedom to worship, express opinions.

In addition, criminal, civil and commercial laws are also relevant including: the NHSP, National Health Law, Patent Law, Labor Law, and Child Protection Law. There are also national guidelines for prevention and control of AIDS in various types of work sites, as announced on August 21, 2009.

All of this shows that Thailand has legal strategies and policies that are favorable for AIDS control work, and eliminates the need for a separate AIDS law, such as the draft law that was prepared in 2007 and which was opposed because it could be used to violate certain rights.

The National AIDS Strategic Plan (NASP) for 2007-11 specified that there be a 3rd strategy for protection of AIDS rights related to dissemination and awareness raising about these human rights provisions at the individual and group level. At the same time, the Universal Access Plan emerged, and this informed the refinement of policy, measures, and various projects such as the policy to reduce HIV incidence by half by the year 2011. Project development from Round 1 and Round 8 support shows that Thailand has given importance to marginalized populations, and has implemented a wide range of activities with external funding.

Strategies to advance the cause of rights have been developed to add to the protections that already existed. The Rights and Liberties Protection Department (RLPD) of the Ministry of Justice joined the network on rights protection and has addressed rights violations in collaboration with the PLHIV network groups and the Foundation for Rights Protection. Other constructive rights promotion activities include the sub-committee on control and advocacy of AIDS prevention under the National AIDS Prevention and Alleviation Committee (NAPAC).

In 2009, NGOs, through FAR, reported on the status of human rights related to HIV/AIDS in Thailand for 2007-8. The PLHIV network conducted a survey of stigma and discrimination against PLHIV in 2009, and the Thai NGO Coalition on AIDS (TNCA) issued a report analyzing policy related to AIDS through the view of sexual and reproductive health rights. In producing these reports, there has been lively discussion, debate and exchange of information on policy, implementation and health services, support for knowledge including the wording, in legal terms, policy and medical measures which often are not sensitive to the need for respect and honoring humanity. The result is stigma and social discrimination, for example in using the terms “risk group;” “mother-to-child transmission’” etc. This shows the need to review our knowledge base that is used in

implementation on AIDS, and to work in greater harmony with respect for rights, absent of prejudice.

In addition, there has been important progress in the area of support of rights to accessing treatment, such as the addition of VCCT budget as part of the benefits of the NHSP, the addition of methadone maintenance therapy to the NHSP benefits package, and the NAPHA extension project to extend treatment for 2,000 cross-border migrant laborers, ethnic minorities, and undocumented persons.

Challenges/recommendations for the next report period (2009-10)

Regarding the Cabinet Resolution of October 20, 2009 which approved the national human rights master plan, Version 2 for 2009-2013, civil society has the view that there are still challenges remaining in ensuring good application of the policies and laws. Civil society thus recommends that there be a process for coordinated planning to build the structure/strategies so that the various components of the human rights package of services are integrated with the NASP. It is also recommended that there be coordinated implementation between the National Human Rights Commission (NHRC) and the RLPD of the Ministry of Justice in their roles and responsibility to advance the national human rights master plan Version 2 for 2009-2013. There should be a sub-committee to monitor rights protections related to AIDS by having the RLPD under the plan monitoring committee play the role of watch-dog for rights violations in the government sector.

Civil Society finds that, even though Thailand has favorable policies in many areas, there still are obstacles that are not being addressed. The human rights strategy is still not very influential in the area of AIDS and, at the implementation level, it has not advanced in a way that is consistent with the changing circumstances. The rights monitoring strategy needs to be strengthened in the area of AIDS, including system strengthening for rights protection at the structural and implementation levels so that they are harmonized.

In addition, the staff implementing the rights protection strategy still lack knowledge and understanding about AIDS; this should be addressed. This is especially relevant for staff of the RLPD and the NHRC. There should be guidelines for implementing the policies and laws so that there is concrete action.

As for implementation of the 3rd strategy for AIDS rights protections, as specified in the NASP for 2007-11, the implementation should be steered

more toward a "rights-based" approach through the integration of knowledge and action based on a foundation of thought and consideration of the medical, socio-cultural, and rights dimensions. For this to work there needs to be a process of learning and training in using a rights-based approach for the relevant units and offices. Also, there needs to be some promotion campaigns by recognizing those agencies that properly use a rights-based approach and those that don't. Those using the proper approach would receive public recognition and a certificate. This should be done as a collaboration between the NHRC, the RLPD and NGOs.

There will be a need to improve understanding that the implementation of human rights with AIDS activities is not to confer special privileges for anyone or any group. Instead, it needs to be seen as a form of ensuring that affected people are treated fairly, without discrimination. There will need to be a comprehensive understanding of rights in the various dimensions of law, the political realm, and culture, and emphasize the correction of attitudes and misunderstandings. This will include aspects of law, policy, and reduction of prejudices against AIDS that are linked with other attributes such as sex, age, ethnicity, and race.

In addition, there should be refinements of the strategic plan in the area of monitoring and evaluation to integrate sex rights, knowledge about sex, gender and sexuality.

The survey of experience of stigma and discrimination related to AIDS conducted by the PLHIV network shows that any time there is misunderstanding about AIDS, there will be the view that PLHIV have a different set of rights than the uninfected. This touches on the area of AIDS rights and situations in which officials and individuals violate the rights of and discrimination against PLHIV even though they know they have rights but do not accept this or have misconceptions about AIDS. They still have prejudices and make value judgments which discriminate. Therefore, there needs to be action on this matter continuously as an indicator of progress toward the goal of eliminating stigma and discrimination based on someone's HIV infection. There should be support for acceptance and inclusion of PLHIV harmoniously in society. There should be a review of the increase in knowledge and understanding about AIDS, toward building a foundation for AIDS understanding over the long-term for everyone in society.

The state of AIDS knowledge in Thailand is still not stable and there is lack of consensus on certain issues. This impedes increasing understanding,

viewpoints, explanations, and communication of facts and various measures. This also applies to service providers in both the health and legal sector regarding HIV infection and transmission. Thus, there should be a process of knowledge review from multiple dimensions in order to develop a knowledge base which is consistent with the state of social services and technological progress in medicine that evolves rapidly. This involves training in HIV/AIDS with a special view toward attitudes, decisions, value judgments, stigma, and human rights. The training would be for service providers and medical and public health staff.

In the process of presenting the report of policy analysis of the response to AIDS by the Norwegian Church Aid in 2009, there was reference to the challenge of supporting the respect for humanity and elimination of stigma and discrimination by no longer viewing or using the term "risk group" or "highest risk group". This stigmatizes those individuals as spreaders of HIV and a social enemy. This results in their being viewed unequally, and causes them to suffer discrimination in a way that prevents them from exercising free will in making their life decisions in a safe and constructive way.

Also, there needs to be a cessation of any action that creates social stigma or segregation and discrimination, or that leads to difficulty in management of the lives of vulnerable and marginalized populations. These actions should be made illegal. The goal should be regulations or customs that facilitate access to services, ability to conduct self-care and prevention in a way that is equal to others. They need to be empowered to enjoy equal rights to health, education, domicile, employment as all others in society.

Civil society feels there is a need for a subcommittee (under the NAPAC) for control and monitoring stigma and discrimination of PLHIV including those affected by AIDS and their families. Finally, there should be support for civil society to prepare reports and conduct public campaigns to disseminate the status of rights, and promote human rights, including more study reports for analysis as a basis for future planning of the NASP.

B. Implementation of health services

Challenges in the previous report period (2006-7)

The previous report specified certain challenges related to health services as part of the Universal Access Plan especially regarding prevention in certain groups and access to treatment, increasing user-friendly services, reduction of prejudice, beliefs, that lead to value judgments, stigma or discrimination, including the views of society and culture in working on AIDS.

Success and findings in the report period (2008-9)

There were many successful areas of achievement in the previous report period. Thailand has a clear policy and increased support for prevention. This includes the creation of a subcommittee to accelerate HIV prevention and the policy to reduce incidence by half by 2011, and the additional funding to make this happen from the GFATM Round 8 to continue activities started under previous rounds and provide greater emphasis to the vulnerable populations of IDU, MSM, SWs, and migrant laborers. Representatives from the beneficiary populations played a greater role in strategic planning or policy formulation and implementation at the national and provincial level.

In the area of PMTCT, the ART regimen was improved to include triple therapy with expansion from pilot to national coverage starting in October 2010. The Staying Negative Project was launched in MCH clinics which advocated couple counseling. These developments reflect a greater attention to the mother/wife in the family. Quality of life promotion was also featured along with sex and reproductive health rights for PLHIV, starting with those initiating ART and women appearing for ANC who learn that they are infected. This effort is being expanded to national coverage.

Support for access to VCT improved through the inclusion of the VCT into the benefits package of the NHSP including a hotline for AIDS, health and sex to increase access to services.

Harm reduction involves many sectors and players, including the legal and justice system. National level committees were formed and learned more about the actual situation of vulnerable populations, and this increased concern for the need for services. Methadone maintenance therapy (MMT) was added to the benefits offered by the NHSP starting in October 1, 2008. The NAPHA extension project improved treatment access for 2,000 migrant laborers, ethnic minorities and undocumented persons. HIV VCT, condoms re-supply and harm reduction was introduced into prison populations on a pilot basis and the service model is being refined.

For children, there is a committee that monitors the rights of the child under the Ministry of Social Development and Human Security (MSDHS). The focus is on children affected by AIDS – both infected and uninfected. In addition, there has been model development by the We Understand group in collaboration with clinical and technical medical services to build the capacity of children and youth with HIV so that they can actively participate in AIDS work.

Challenges and recommendations for the next period (2010-11)

There has been progress in many areas including providing comprehensive and integrated services for prevention, care and treatment and mitigating the impact in a way that does not discriminate and builds on a foundation of respect for humanity and is consistent with the NASP for 2007-11.

Nevertheless, civil society views the target to reduce incidence by half by 2011 as strategy that places undue emphasis on "risk groups" and is driven by epidemiological considerations and is only a short-term approach to control. Indeed, it will have long-term negative effects for the populations classified as "highest risk groups" who will be stigmatized, segregated and discriminated against, and which will make it harder to reach them with services, to protect their rights and individual liberties.

It also creates confusion to deconstruct "risk behavior" and view it in isolation instead of being a part of a constellation of factors/conditions relating to power, inequality, sexual relations, and ethnicity. Thus, there needs to be more of a multi-dimensional view of risk including epidemiology, socio-cultural factors, and human rights. The services and service providers need to be adaptable and adapt services so that they are more respectful and honor humanity. There should be a discontinuation of the use of the terms "risk group" and "group of highest risk" to lead society toward a positive outlook of a healthy sex life built on respect, understanding, safety and happiness.

Civil society recommends that there be more policies, measures and services that address respect for human rights, and acceptance of the diversity of sex, gender, and sexuality. They need to view issues less in terms of female, male, or masculine, feminine and more in terms of people who find themselves along a continuum of sex, gender and sexuality – not something that is right or wrong, or less human or respectable in any way. There should be no actions that make this diversity illegal; this will make it only harder to reach them so that they can be equal and productive members of society.

AIDS service providers and related persons should receive training to better understand sexual diversity, gender and sexuality so that they can provide services that are based on a foundation of respect and honor of one's humanity.

Implementing these measures requires courage to create new policies and services that give more importance to women's reproductive health rights, as those with less social power, between genders, and couple dynamics,

family relationships, the community and society. This is needed to help women communicate about sex, their bodies, selecting a partner, having children or terminating a pregnancy in ways that are safe and satisfactory.

Civil society feels that, over the past 10 years, the PMTCT program still overly emphasizes the health of the infant. It does not look at the social discrimination suffered by the mother as someone who has infected her newborn. It does not consider the woman's body, her decision options, and pregnancy planning, carrying the pregnancy, or choosing abortion. These decisions need to be based on comprehensive information for the pregnant woman and her partner.

VCT in MCH services for pregnant women are not yet totally voluntary. This is because staff are too eager to screen women for PMTCT services. This short-cuts the decision-making process for the woman. Therefore, civil society feels there is a need for greater respect for the reproductive health rights of the woman based on user-friendly sexual health services, with promotion of more couple-based services for ANC clients to help women communicate their feelings and wishes to their partner.

The policy to promote greater coverage of VCT is shifting more to Provider Initiated Counseling and Testing (PICT). While, ostensibly, the purpose is to increase service options and choice, if the policy is used for more aggressive case-finding to prevent transmission or to speed persons into ART there is the opportunity for abuse and infringement of the rights of the client, who needs to experience a comprehensive information and decision-making process at her own pace.

An important missing piece of the policy mosaic is the need for respect of readiness, informed willingness, and individual-determined decision-making. A person coming for counseling needs the full spectrum of information to assess actions and options in the context of their vulnerable risk situations so they can make self-determining decisions; so that they can accept or deny HIV blood testing. The staff must support and accept this decision and maintain total confidentiality of the patient record as a basic right of the client.

At the same time, while VCT is a benefit under the NHSP, most of the eligible persons are not aware of this, and so there is underutilization. In addition, HIV testing of youth under 18 is problematic because it conflicts with the "guidelines for doctors on AIDS" (Thai Medical Council, 2002) which specifies that in terms of respecting the confidentiality for the client and informing of blood test results to a client under 18 who is single...needs the

involvement and consent of the parent/guardian. An important challenge is to find ways so that youth have more access to HIV VCT and referral that is appropriate and acceptable to them – and which is legal and is in the best interests of the youth. Civil society, through the NGO "PATH" has assembled the relevant laws or regulations and summarized these for the subcommittee for preparing guidelines for consideration by the Thai Medical Council.

Promoting rights of access to services for undocumented persons is lacking supportive policy, and this is an obstacle to access to services such as lack of a comprehensive harm reduction policy. Use of the law on prostitution to harass and arrest prostitutes or MSM who carry condoms as evidence of crime is counterproductive. Foreign migrant laborers or ethnic minorities or others who are in Thailand illegally are also hard to reach and can't access treatment since they are not eligible for the ART program under the NHSP, or because the NAPHA extension quota of 2,000 was already filled.

Ethnic minorities, or hill tribe people, both documented and undocumented, can't often exercise their rights to service under the NHSP, or they receive disrespectful service. There should be a health fund to support ART for this group and accelerate the Thai documentation process for the undocumented. It has been proposed that 50 baht of the 1,300 baht health insurance payment for migrant laborers be used to seed the fund for the undocumented migrants.

Concerning services in prisons it is found that most prisoners don't understand their rights, and authorities usually overlook these gaps and don't want the prisoners to know what they are entitled to. Treatment is slow to arrive and prisoners without the 13-digit ID card are not eligible for subsidized care. Some are foreign PLHIV and can't access local treatment. Their embassies should take a more active role in helping these inmates.

Care for children affected by AIDS in orphanages (public and private) is under standard in some cases and can be considered a rights violation. These include segregation of sleeping quarters, and inappropriately using children for fund-raising. There should be training and information dissemination for the relevant staff with the MSDHS as the responsible agency.

C. Promoting knowledge and education

Challenges in the previous report period (2006-7)

Important challenges were raised in the previous report in the area of comprehensive sexuality education (CSE) and access to youth-friendly health services for adolescents.

Success and findings in the current period (2008-9)

The DOH of the MOPH has studied the content of sex education and improved this so that it is more comprehensive, and submitted this to the Ministry of Education (MOE) for integration into the formal school health education curriculum over a period of time starting in 2002. The curriculum has six modules: (1) human sexual development; (2) interpersonal relationships; (3) personal and communication skills; (4) sexual behavior; (5) sexual health; and (6) society and culture. Yet the results of this are not yet satisfactory.

The Teenpath project has taken sex education further to create a CSE curriculum built on the original six modules with a new emphasis on three dimensions: (1) sexuality in all its human dimensions; (2) positive youth development; and (3) using a learner-centered approach to teaching. However, the curriculum is still mostly used as guidance, and it is up to the discretion of the teacher whether and how to apply it. The MOE has still not adopted the CSE approach into the formal curriculum.

Challenges and recommendations for the coming period (2010-11)

Civil society recommends that there be support for CSE on a continuous basis with greater coverage in the formal and non-formal educational systems. The teachers' capacity and attitudes need strengthening. The NAPAC needs to charge the subcommittee for accelerated HIV prevention to consider measures to advance this as part of the human rights approach, as an adolescent's right to accurate and practical information about sex through CSE.

Comprehensive sexual health services are needed, in a site that is youth-friendly and that are sensitive to gender-specific issues and provide opportunity for counseling and other information as needed. The site should be a place for relaxation for youth and point of first contact for referral if health problems arise. The site can help educate parents, the family and society about the needs of adolescents to create a broader environment for learning CSE. This is a fundamental adolescent right. The DOH can work with the relevant NGOs, Foundation for Children, adolescent networks as a working group to advance these principles and practices.

At the same time, there is a need for social campaigns on CSE – not to promote anything immoral – but to build healthy values in youth about sexual choice and lifestyles that reflect reality yet are consistent with nature, society, culture, and the economy which are changing rapidly. The MOPH and NGOs who are GFATM grantees can take action with youth and other populations on this topic to make it a part of routine social policy in the years ahead.

D. Structure and strategies for policy development, planning and implementation

Situation in the previous plan period (2000-7)

The previous progress report cited a challenge in the monitoring and evaluation system and management development of the NASP both in terms of the strategy of coordination at the national and provincial levels, and the capacity of local administrative organizations and the communities to conduct AIDS prevention and control.

Success and findings in the current report period (2008-9)

There was progress in reforming the structure to increase strategies for accelerated action such as Order 1/2007 of the NAPAC on April 4, 2007 to create the subcommittee for advancing the HIV prevention efforts which has the authority to monitor consistency of implementation with the guidelines such as more integrated and transparent implementation to increase cost-effectiveness. The subcommittee also provides oversight for funds mobilization to augment Round 1 and 8 GFATM assistance in accordance with the NASP for 2007-11.

At the same time there were modifications to the strategy for accelerated action at the provincial level through the Provincial Coordinating Mechanism (PCM) which can be considered a new element of the provincial structure to manage national budget and local resources for AIDS prevention and control.

Challenges and recommendations for the coming period (2010-11)

There is a need, at the national and provincial AIDS committee levels, for independent decision-making and local participation from various sectors in accordance with decentralization of authority to more aggressively address the problems of AIDS in a more participatory and cost-effective way.

There is a need for reforming the national and provincial steering committee process so that leadership is not conducted single-handedly (by the chairperson). That is an antiquated form of management. The Country

Coordinating Mechanism (CCM) is a more modern way of collaborative management, with corresponding development of the PCM (which is on-going). These proposed changes need to be monitored to assure that there is cost-effective implementation of accelerated prevention and control.

An important cog in the wheel of accelerated programming is the cog of technical support from the various technical agencies at the national and provincial level which needs to address technical capabilities more strongly and comprehensively than currently is the case.

As more accelerated programming occurs, civil society has the view that the strategy needs to be modified to include more of a human rights protection focus, especially sex rights, to create a new model of prevention that respects rights and honors humanity, and which is sensitive to sexual diversity. This will help move away from the compartmentalized approach to prevention that has "boxes" for group-specific activities, AIDS knowledge creation, condom and lubricant distribution, etc. Instead, the new approach, based on human rights, will blend all the elements together in a way that is appropriate and relevant for a given beneficiary so that decisions are informed, and made at the pace of decision-maker in a way that is best-suited to themselves in order to enjoy a healthy and safe sex life.

Civil society recognizes that the GFATM assistance has galvanized prevention interventions at the community level with more grassroots agencies involved, however there is inadequate sharing of experience across these agencies. This is partly due to the style of management of grants by the Principal Recipient which does not encourage sharing among the sub-recipients.

Another area of concern is that the Thai program (including civil society) is now too dependent on GFATM assistance. Therefore, the government and civil society need to brainstorm together on how to proceed in a post-GFATM world and how that will affect interventions, and devise an appropriate strategy for mobilizing funds to continue the success and cost-effective implementation that has occurred so far.

Civil society recommends that there needs to be further development of the long-term plan which addresses sexual and reproductive health, and protects and respects sexual and human rights. The long-term view will provide consideration for sexual diversity, gender and sexuality which is a basic human right and should be part of the national AIDS plan.
Attention must be paid to policy, plans and measures addressing AIDS as they relate to other policies and laws which impact on individual sexual rights so that genuine progress in this area can be made.

In the area of monitoring and evaluation, even though there have been efforts to involve civil society, there is still too much classification and segregation by groups, especially the vulnerable populations. There is too much of a narrow focus on the outputs and outcomes of a given activity, without attention to the broader impact. This is an area where civil society can contribute – to help evaluators see the indirect ramifications of various interventions.

The NAPAC and its subcommittees need to ensure that there is rights protection and to continue to push for policies and laws to eliminate obstacles to rights protection.

In addition, there needs to be adequate surveillance and monitoring of the problems and impact of stigmatization and discrimination regarding sex and AIDS. A subcommittee to monitor and eradicate stigma and discrimination of PLHIV and affected persons and their families would be another strategy to help the accelerated program to respond to the AIDS problem in Thailand.

Annex 4

Report on Stigma Index Survey

10 December 2009

Background

Stigma index survey is a major activity under the project on AIDS Rights Advocacy and Stigma Index Development, especially the component on **stigma-discrimination index survey** which was designed based on the stigma index user guide and questionnaire globally introduced through regional workshops facilitated by IPPF, UNAIDS and various international NGOs. There were nine countries participating in this global initiative. Thailand is one of the countries has participated in this initiative.

With the two components on AIDS rights advocacy program and stigma-discrimination index survey, the project was developed across multi-partnership with key national and international partners such as Thailand Network of People living with HIV/AIDS (TNP+), Thai NGO Coalition AIDS (TNCA), Ministry of Justice (MOJ)'s Department of Rights and Liberty Protection, Foundation for AIDS Rights (FAR), Ministry of Public Health's Department of Disease Control (DDC), Public Media, Academic Institution, National Human Rights Commission (NHRC) and UNAIDS as well as key UNAIDS cosponsoring agencies, namely UNDP, UNICEF, UNFPA and UNESCO. The project was implemented by FAR together with TNP+ that looked after the component on the stigma-discrimination survey. The project was implemented during February 2009 – January 2010.

The stigma-discrimination survey component was implemented with three major activities: training of research assistants; field data collection; and local and national workshops or meetings to analyze the data and to disseminate the results.

The training of research assistants was conducted in April and May 2009 involving 13 research assistants who were the people living with HIV and volunteered to serve the project to assist the research principal in data collection and analysis. The training was a series of workshops conducted by the research principal from Ubon Rachathani University together with TNP+ and FAR team. The workshops were organized to make the research team to understand about the project concept and background, research tools (user guide and questionnaire), research theories, research methodology and data collection and analysis. Field exercise and pre-test were also included in the training process.

Data collection was undertaken by the research team composed of the research principal and 13 research assistants between June and August. In this process, 233 respondents were interviewed.

Data analysis was then undertaken in October and November by the research team, though a series of meetings were convened to allow the research assistants to participate in the initial analyzing process after field data collection, especially the stage of cleaning the raw data and defining key terminology related to the research framework.

In the meantime, the research team and FAR organized meetings in 7 regions aiming to disseminate the initial results and gain feedback on the research findings from various groups of participants. The meetings were attended by key representatives from the networks/groups of the people living with HIV, MOPH officers and CSOs at provincial and local levels. In this regard, each meeting was attended by about 100 participants.

In addition, FAR and key partners organized 4 additional meetings funded by UNDP (as an additional funding support for these particular meetings) in November to involve wider audiences focusing and to build a campaigning foundation for World AIDS Day (WAD) event (In Thailand TNCA, FAR and partners organized WAD event and activities on 28-29 November) that would jointly address WAD theme on Universal Access and Human Rights at the country level. The meetings were actually attended by those who were the key actors to address the issues and cases related to stigma and discrimination as well as build networks and partnership. These included TNP+ members, lawyers, NHRC members, MOJ officers, academia, local government organizations and CSOs at local levels. The attendance was ranging between 70-200 participants.

National Launch of the Report

As planned under the project mentioned above and as a part of national AIDS campaigning process and as an event to celebrate the International Day of Human Rights, the launch of the report on stigma-discrimination index survey was organized on 10 December. It was a national workshop to present final results of the index survey and seeks final comments from key national mechanisms before the completion of the project. The launch was attended by 115 participants from various levels and types of key concerned government agencies, non-governmental organizations, public independent institutions, UN agencies, public media and academia. In this regard, high level officials at Director-General level from 3 key departments under MOJ and MOPH attended the meeting and provided very good comments. A

number of government departments concerning human rights and HIV sent their technical staff to attend the meeting and made useful comments. Special guests who functioned as the commentators came from prominent background and popularity including Magsaysay Awardees and member Thai PBS TV Board, Director–General of the Department of Rights and Liberty Protection and Director-General of Prosecutors' Legal Assistance Division.

Key agenda were welcoming address by UNAIDS Country Coordinator, introductory remark by TNP+ representative, Opening remark by Representative of UN High Commission on Human Rights, HIV/AIDS stigma and discrimination play by research assistants and TNP+ volunteers, Presentation on survey results by research principal, comments by special guests and open discussion.

Key activities

After the official ceremony, the launch started with an HIV/AIDS stigma and discrimination role-play. The play was consisted of a series of 10 scenes in which each scene showing a different form of HIV/AIDS stigma and discrimination was played out.

Presentation of research results

Research objectives

This survey research aims 1) to obtained relevant data as a national set on HIV/AIDS stigma and discrimination for those who are infected in Thailand in terms of types, occurrences and impact; 2)to develop an understanding of HIV/AIDS stigma of discrimination and the rights of those who are HIV positive and those who are affected; and 3)to develop an index on HIV/AIDS stigma and discrimination, which could be used to determine the extent of the problem and what changes take place over time.

Research team

The research team was composed of one research principal from Ubon Rachathani University and 13 research assistants who were the people living with HIV(PLHIV) including 10 males and 3 females, but representing different sexual identities. These 13 people came from the different regions of the country.

The Questionnaire

The questionnaire was globally developed in collaboration with four organizations: GNP, ICW, IPPF and UNAIDS. The questionnaire was translated by UNAIDS Thailand and then further adapted to the Thai situation.

Target group of the research and characteristics of respondents
In total, 233 PLHIVs were interviewed. These people belong to the TNP+ network and were distributed throughout the country.

The distribution by sex and gender were: 57 males, 148 females and 28 members of the 'third sex'. Age distribution: 57.5% were aged 30-39 and 26.2% were aged 40-49. Period of time infected with HIV: 35.2% believed they were infected for 10-14 years; 29.2% for 5-9 years; and 6.9% for less than one year.

Minority status: Close to half of the participants (43.8%) belonged to a minority group – they were gay, MSM, injecting drugs, belonged to an ethnic minority group or had been or were prisoners. 11.6% had a disability

Education: 52.3% had only had primary education. 30.5% had secondly education.

Employment: The majority of the respondents lacked secure employment. Only 16.3% had a full-time employment. 20.6% were unemployed.

Research findings

Stigma caused by outsiders or surrounding factors:

- Over a third (34.3%) of the correspondents indicated that they are restricted from participating in community activities. Of these people, 57.8% believed this was because their HIV status was known.
- Based on the questionnaire, 94.9% of the respondents indicated that they were excluded from religious activities.
- A third of the respondents (32.2%) indicated that they had lost their jobs because of their HIV status.
- Over a quarter (26.2%) of the respondents had been rejected from taking on new employment because of their HIV status.
- A fifth of the respondents had been denied access to medical services (many other respondents indicated that they were not denied access to medical services but they had to queue up or undertake other activities in order to gain medical services, which were perceived to be different from those who are not infected with HIV).

Self-stigma

- 64% felt embarrassed being HIV positive
- 47.6% felt guilty that they were HIV positive
- 42.9% blamed themselves for being HIV positive
- 43.8% lacked a sense of belief in themselves
- 16.7% wanted to commit suicide
- 21.9% felt that they should be punished for being HIV positive
- 64.4% were afraid of gossip
- 57.5% were afraid of harassment by verbal abuse or harassment
- 54.5% thought that people were afraid to have sex with them, because of their HIV.

Main issues were discussed:

- Stigma and discrimination faced by children infected and affected by HIV/AIDS in school

This was a theme that was presented in the play about stigma and discrimination and was picked up by the audience as an important issue. Discussion focused on the problem of eight HIV positive children who were refused entry to study at a school. These children were living at a Christian Home for children, and thus received institutional support. But despite that they were denied access to their local school, because of their HIV status.

- Problems of harassment of sex workers by police

A representative from the sex workers organisation SWING complained that police officers were harassing male and transgender sex workers. They were searching the sex workers to see if they had condoms and if they did they would then accuse them of being sex workers and then would demand money from them. The sex workers did not feel they were in a position to complain, as they feel they need to maintain good relations with the police, despite what is going on.

- Stigma and discrimination at work

A number of participants complained about factories demanding health check ups, including a HIV test for future employees. The area around Rayong province is an industrial area, with numerous factories, employing large numbers of people. PLHIV are being discriminated against as they are being denied employment opportunities.

- Stigma and discrimination that HIV positive people receive at hospitals

This was another issue presented in the play about stigma and discrimination. A number of government officials felt that what was presented in the play was extreme and that to some extent was past history.

However, PLHIV representatives at the meeting indicated that presently, medical staff was still trying to persuade HIV positive women not to have children, to get sterilized and to have abortions if they were pregnant.

- HIV positive migrant workers and their access to ARVs and for OI care

Reflecting the large number of migrant workers in the South of Thailand the participants expressed their concern for these people and their access to care and treatment. Migrant workers, whether registered or not, have numerous problems accessing care. Unless their health problems have become serious, many migrant workers will not want to visit a Thai government hospital. They find it difficult communicating to hospital staff because of language difficulties and because of cultural misunderstandings. Also, because of the language barriers they may not fully understand the treatment regime, and thus not fully taking their medications.

Further, migrant workers often fear arrest, deportation or the need to pay bribes to reach the hospital, even for those who are registered as many employers keep their legal documents. Finally, migrant workers and their family members who are HIV positive are denied access to ARV medications. It is not clear what can be done for these people. The meeting, however, noted that the situation has improved with changing government policies in allowing these people access to these medications – for at least those who are registered migrants. For unregistered migrants, a limited number of them had access to ART only under the project funded by the Global Fund to fight against AIDS, TB and Malaria (GF-ATM).

- Fishermen

Accessing fishermen with health messages and care is difficult. The fishermen may appear at a port for a short while, before going back out for a long period of time. At times the fishermen are away from a Thai port for up to a year or more. During that time the fishermen are known to undertake risk behaviours such as piecing their penises, tattooing and visiting sex workers whenever they arrive ashore.

- Lack of ID Cards

This theme was related to the migrant workers; however government officials at the meeting indicated that they were coming across a small number of Thais who did not have ID cards, for one reason or the other. Without this card it was very difficult to provide any services for them.

- Lack of awareness among government officials of their duties

The meeting noted that at times government officials were unaware of their duties in relation to providing services to PLHIVs. This was often resulting in

forms of HIV/AIDS stigma and discrimination. Examples of this included government officials announcing the HIV status of PLHIV, without seeking the approval of the persons in question.

- Forced blood testing

A discussion took place about applicants for a hotel position being forced to take a HIV blood test. This resulted in the organisers of the meeting providing information about the ASO project that is being led by TBCA.

- Statement that created this debate concerned PLHIVs having children

A participant felt that PLHIVs who were having children were not being responsible to their children or to the society as a whole. She argued that future parents should think seriously about having children, that they should only have children if they had the economic means to do so and also were able to physically look after them. She claimed that she and her non-governmental organisation were looking after too many children, as a result of PLHIV having children and not being able to look after them due to economic factors, health issues or because of the death of one or both of the parents.

- Another statement that created a debate was about the 'criminalization' of HIV/AIDS

A lawyer in the meeting stated that laws about HIV/AIDS would imply that there are the guilty and the innocent in relation to HIV/AIDS. This led to statements indicating that HIV positive people should not have sex or that they should have only sex with an informed partner.

Others in the audience indicating that such an approach would only lead to greater HIV/AIDS stigma and discrimination and that people would not disclosure their HIV status, or would not want to be tested for HIV. It was also pointed out that the logical conclusion of such an approach was that it should be illegal for anyone with any STI to have sex.

A further statement that created debate was the use of the phrase of PLHIV infecting those who were pure. For many people in the meeting this statement indicated that PLHIV were guilty and those who were not infected were pure and innocent. It implied that PLHIV had HIV because of their bad behaviour; they had been drug users, sex workers or homosexuals or had done something else which they had been punished for.

Another statement during the meeting indicated that some participants felt that PLHIV had more rights than those who were HIV negative. Some participants believed that PLHIV were getting more rights than other people.

They were getting their medications and other medical expenses free while others in the community with other medical problems were not getting the same conditions.

Key conclusions and recommendations

The meeting found the report reflected that there were still stigma and discrimination against the people living with HIV in Thai society, though responses to HIV and AIDS have been implemented for more than 25 years. The occurrences found in the findings of the report pointed out that stigma and discrimination against various groups of population still remain no matter how difference they are: health, race, religion, culture, education.

Those who are part of the HIV network (PLHIV) and those working on issue of HIV and AIDS in Thailand should be involved in a process of ensuring that there is a better understanding of 'rights'. This understanding should be of all dimensions of rights, whether it is legal, political, or cultural.

The meeting found that stigma and discrimination against PLHIVs is a structural problem in association with other problems such as migration and drug. The important root of problem is attitude toward HIV/AIDS leading to attitude against PLHIVs. It has become an illusion resulting in actions that have to control and restrict. If service providers are trapped into this attitude, it would make their services come out with stigma and discrimination.

Knowledge and understanding about human rights for those who are responsible at policy and in their mechanisms and working level, especially in government agencies are not sufficient. There is a need for building understanding and awareness raising.

This report is just a start up and not able to solve all problems. There is a need for further study to gain more knowledge, identify measures and develop more tools to solve problems more seriously.

The groups that are facing more serious stigma and discrimination are prisoners as after they are released from the prisons, they are hardly offered a job. Or, drug users who do not have access to tools to prevent them from HIV infection such as needle and syringe.

This survey and the findings assisted the TNP+ in moving forward the human rights works within their networks. With FAR, TNP+ team on human rights in 7 regions have been developed. Key milestones are developing outreach team and setting up hot line centers.

Annex 5

Policy on Implementing Reproductive Health: View of Civil Society

Representatives of civil society are members of the working group on monitoring policy on implementing PMTCT and have reflected on general policy and implementation issues in another section of this report.

In addition, ten of the NGOs combined their voices[53] to express the opinion on the importance of monitoring policy on reproductive health (RH) in parallel with the following objectives: (1) monitor progress in sexual and reproductive health (SRH) by comparing the plan with accomplishments; (2) emphasize studies through the view of impacted individuals of policy makers to fill in gaps between practice and policy; and (3) present recommendations for more comprehensive action in subsequent phases.

This study focused on UNGASS targets related to SRH in the prevention sections 52, 53, 54, human rights in sections 59, 60, 61, and in reduced vulnerability of certain populations in sections 62, 63, and 64 of UNGASS targets. This study also focused on SRH of PLHIV and general service recipients, support for comprehensive sexuality education (CSE) and violence against women. This follow-up study used data from (1) field data collection; (2) use of secondary data sources related to SRH policy; and (3) UNGASS forum meeting proceedings on problem analysis and recommendations at three times during 2009-10.

Source of field data

I. Interviews on UNGASS progress for the 2008-9 report period

1. Interviews on SRH with 21 persons from 15 NGOs/agencies
    a. Staff of the MOPH (policy level) 1 person
    b. Adolescent AIDS expert (international) 1 person
    c. NGO workers in youth programs 8 persons
    d. Representatives from youth networks 11 persons
2. Interviews on SRH in five regions, one province per region including Trad (East), Nakorn Sri Thammarat (South), Phayao (North), Ubon

[53] Comprised of members from Raks Thai Foundation, Foundation for Women, PATH, Women AIDS Network, NCA, TTAG, Foundation for Understanding Women's Health, PPAT, PDA, and SWING

Ratchathani (Northeast), and Ayuthaya (Central) for a total of 326 interviews.

a. Service providers (counseling in ANC, ARV, FP) 24 persons
b. Couple counseling clients at ANC clinic 238 persons
c. Male or female PLHIV with a child under 2 64 persons

II. Interviews conducted under the Voices and Choices Project with HIV+ women

1. In-depth interviews with 64 persons on SRH policies on PMTCT
   a. Health staff (PH nurses at the provincial health office) 46 persons
   b. 6 PLHIV network coordinators and 12 PLHIV peer leaders
2. In-depth interviews (IDI) from the Voices and Choices Project
   a. Staff and nurses who were trained 18 persons
   b. PLHIV 110 persons

III. Interviews on SRH and sex communication among 934 PLHIV (Voices and Choices Project) including 652 women and 282 men in 15 provinces.

Locations of data collection under the Voices and Choices Project

Health staff and AIDS nurses in 9 provinces: Chiang Mai, Lamphun, Ubon Ratchathani, Pattalung, Yala, Trad, Chantaburi, Chonburi, and Bangkok

PLHIV from 15 provinces: Chiang Rai, Chiang Mai, Phayao, Lamphun, Ubon Ratchathani, Khon Khaen, Udon Thani, Srisaket, Pattalung, Nakorn Sri Thamarat, Surat Thani, Ranong, Trad, Chantaburi and Nonthaburi

Results of the study[54] are summarized in the following paragraphs.

1. SRH services for PLHIV and general clients[55]: PMTCT

Pre-test counseling

The policy of the DOH is that testing be voluntary. The results of the monitoring study found that most providers (63.6%) had not heard of Provider Initiated Counseling and Testing (PICT). Only 36.4% understood the difference between VCT and PICT; 40.9% understood that VCT is voluntary and PICT is to persuade someone to be tested.

The benefit of PICT is that it increases service coverage, but some clients aren't ready to know the results. The advantage of VCT is that there is voluntary acceptance to be tested. Most providers (70%) thought that most

[54] Full report of Civil Society is part of a comparative study of policy and RH services among nine countries Argentina, Belize, Brazil, Indonesia, Kenya, Peru, South Africa, Thailand, Uganda as implemented by GESTOS, Brazil, with support from the Ford Foundation.
[55] These data are percents of RH, from UNGASS surveys by Civil Society for the 2008-9 report period (totals can be seen for each group).

services at present use VCT and most (45%) used approximately 15 to 20 minutes for the counseling session. They felt that only 5% offered PICT; and other services (25%). Most of the service providers had counseled before (91.3%) and most (90.5%) had been trained but needed refresher training (45.8%). Most felt that pregnant women (77.3%) decided to have the HIV test voluntarily. Only 22.7% thought that it was involuntary. In any event, in the meeting of the PMTCT working group of UNGASS, it was felt that HIV testing of pregnant women is routine PICT and not purely VCT.

Counseling can help the client accept the test results. Fully 69.5% of PLHIV thought that pre-test counseling helped a lot, while 22% thought it helped somewhat. But 64% felt the more important thing is to give the client time to decide, while 6% said that listening to the client needed improvement, along with risk assessment (35.4%).

Counseling for PMTCT

In the 2008-9 report to UNGASS, Civil Society cited some problems with the PMTCT program in that there seemed to be an over-emphasis on the health of the infant. Mothers needed more comprehensive information, especially about treatment since they didn't know enough about the side effects and other aspects.

A study[56] affirmed that single-dose Nevirapine is associated with treatment failure post-partum, both in the mother and infant. In this study, 62.5% said that Nevirapine was effective; only 45.8% mentioned the problem with resistance, or drug reactions (54.2%), and the name of the drug and method of consumption (50.0%).

Post-test couple counseling

There is another area of discrepancy between service provision and needs of PLHIV in the area of learning test results when appearing for couple and family counseling. This study found that most PLHIV women told their serostatus to their partner (82.7%) while all males (who came with their wife for ANC) told their wives their serostatus.

Fully 24.5% of women encountered problems after disclosure, such as physical abuse (9.4%); and 26.9% said they were not able to disclose their serostatus. Both male and female PLHIV reported problems of divorce *after*

[56] "Progress of medical science in treatment and prevention." Dr. Teera Worathanarat, Department of Community and Social Medicine, Faculty of Medicine, Chulalongkorn University. Summary of the 12th National AIDS Seminar.

disclosure of serostatus during couple counseling (20%) in contrast to the opinion of service providers that couple counseling works (45%). What the PLHIV say they want help with is moral support (67.9% of women and 75% of men). They also want someone to listen to their feelings more than hearing someone talk about the test results and impact. In addition, they don't want any one to disclose their status in their stead (only 5.7% of women and 16.7% of men wanted the service provider to tell someone else their serostatus.)

Being prepared to hear the results of the child's serostatus PLHIV are concerned that their infant is infected. To prepare themselves, the PLHIV said they needed both information and moral support *before* hearing the results. But *after* knowing the test result, they want moral support more than information. By contrast, the counselor feels that information is more important and that families are playing a more important role in accepting the results. Nevertheless, 68% of counselors never had training on informing clients of their child's blood test result, though 63% had given counseling to post-partum women. So there is a need for strengthening provider skill in this area.

Unplanned pregnancy

In the view of counselors, unplanned pregnancy among PLHIV arises from multiple factors. An important motivation is that there is family pressure to have a child, or the woman was not able to deny unprotected sex because she was still dependent on the husband, or the woman wanted to ensure the commitment of the husband.

Only 54% of the counselors felt that they had received adequate in-service training on contraception to advise PLHIV. But 79.2% felt confident in advising women about contraceptive choice while on ART, and could advise on unplanned pregnancy. Hospitals don't separate their data as to whether the PLHIV pregnancy was planned or unplanned. Fully, 66.7% of service providers felt that the woman should abort an unplanned pregnancy – but all they advise is to seek service elsewhere and advise them to take good care of their child.

Prevention of unplanned pregnancy:

The service providers said that their hospital (86.4%) had a policy to support sterilization for women with two children, and provided the service as a benefit under the NHSP. They advise sterilization as the 5th choice for post-partum contraception followed by condoms, oral contraceptives, injectable, and sub-dermal implant. PLHIV reported that they received encouragement

to have sterilization as the 2nd choice after condoms. About half of female PLHIV said they felt pressured to have a sterilization (58.5%) and 43% actually agreed to a sterilization. Counselors felt that the male partner should have the sterilization rather than the women (45.5% versus 42.9%) but, in practice, it is more likely that the female PLHIV will have the sterilization.

Advice on contraception for PLHIV and non-infected women is not identical. PLHIV are advised to use condoms, get sterilization, have an implant, or abstain from sex more than general population women. For the latter the advice is usually oral contraceptives or the injectable. PLHIV mostly use condoms, sterilization or oral contraceptives, including some who abstain from sex.

A finding that is noteworthy concerning PLHIV pregnancy is that 59.6% of women said that they knew that they were HIV+ before getting pregnant, and that the counselor is confident in advising about contraception (79.2%). However, if the PLHIV wants to have a child, only 4.5% of counselors are "very confident" that they can give good advice (47.8% were "confident" and 39.1% "somewhat confident").

Prevention counseling

For the general population, 77% of prevention counseling is group format. The counselor tries to elicit participation of the male partners through a "parents' school" strategy.

Even though the government feels the couple ANC approach is working, this study found that only 69% of male partners joined the ANC and only 50% received information and participated in couple activities. About 93% of pregnant women and their husbands felt that they received adequate information from the couple counseling, but 62% of men had a risk assessment, which was less than for that of women (82%). Fully 78% of men and 64% of women felt they were not at risk of HIV. Over 80% of both men and women are confident they will not acquire HIV in the future, even though condom use is very low: 23.1% of men and 16.8% of women said they used a condom at last sex, even through 19% didn't know the serostatus of their partner. Prevention counseling is advantageous in increasing condom use, but not yet to optimal levels.

2. Promotion of comprehensive sexuality education (CSE)

There are a number of sex education curricula in Thailand, including the MOE, the PPAT, the Ban Peuan Jai Wai Teen, and the CSE pilot program of PATH. The three NGO sex education curricula show the relationship

between sex behavior and society. This is important because it is very hard to change teen sex values once they set in, especially in the area of unsafe sex behavior. New sex education approaches in Thailand have not yet demonstrated long-term behavioral impact. (High school and vocational student condom use is low but at different levels: see the Teenpath evaluation report by Health Counterparts.)

Sex education needs to be sustained since adolescents' process information differently as they age. Other considerations concern access to different media and conflicting messages in society which want to entice or seduce youth into risk. There are also the social and peer pressures that affect risk behavior. The 15 agencies interviewed in this study agreed that *sex education should give importance to gender and life skills for youth.* In addition, condom use behavior in youth and the general population is still low.[57] The reasons are different in interesting ways between youth, the general population and PLHIV as shown below:

Reason for not using condoms

Youth	General Population	PLHIV
1. Trust the partner 2. Tried them but didn't like 3. No supply, couldn't afford 4. Inconvenient 5. Too embarrassed to buy or ask for 6. Unprepared; emergency sex 7. The attitude of the condom provider/distributor is authoritarian, or receiver is too meek	Male: *With regular partner: trust her* *With non-regular partner: trust her/didn't prepare/couldn't find an outlet/don't like* Female 1. Not able to negotiate condom use 2. Afraid of looking too experienced or infected 3. Condoms are associated with commercial sex, sex power relationships, roles of the male and women, economic vulnerability	Male 1. Problems with use (characteristics and size) 2. Emotion/feeling (don't like; less sensation) 3. Haven't disclosed serostatus to partner 4. Believe in safety of withdrawal Female: 1. No power to negotiate terms of sex (didn't dare, difficulty communicating with partner) 2. Haven't disclosed serostatus to partner

[57] From the national survey of sex behavior, 2006, it was found that males use condoms 12% of the time with regular partners and 47% with casual acquaintances, and 94% with sex workers. A survey of 17-20 year old adolescents in Chiang Mai by Dr. Arunrat Tangmankongworakul found that of the sample of 1,749 57.8% were in a love relationship, and 63.3 of these were sexually active, with condom use at 18%.

Sources:
Male youth: Ad hoc study and IDIs with youth sex educators (2009)
General male population: From the national survey of sex behavior, 2006, Institute for Population and Social Research, Mahidol University
General female population: Research study on women, risk and vulnerability for HIV, and HIV prevention, as part of the Project of Office of the Study of Health Policy and Social Welfare, Mahidol University (2009)
PLHIV: From the report of Voices and Choices Project, Raks Thai Foundation (2009)

The roots of the problem are the following:

1. The conceptual model of sex still lacks a gender perspective and an acceptance of the changing roles of male and female relationships. This leads to a continued emphasis on staying a virgin until marriage (for women). But this approach does not give the youth the skills to implement this or other strategies on sex communication. The current formal approach to sex education doesn't build sex negotiation skills in women for safe sex or no sex.
2. Teachers still pick the modules for sex education that conform to their beliefs and values. This prevents the teaching from being relevant to the current situation in society.
3. There is still no clear policy on CSE at the ministerial level, and there is no leadership to advocate for such a policy to see CSE as a form of immunizing youth from the risks they will face, and build the necessary life skills to prevent the risks. The current approach doesn't take into consideration religion, language, disability, and sexual diversity.

Consequences of these problems of lack of relevant sex education for youth include the following:

- Unplanned pregnancy and declining age at HIV infection of new cases
- Condoms are still viewed solely as a disease prevention tool; false attitudes toward condoms are not addressed and corrected; youth don't learn the communication skills to persuade their partner to use condoms. These factors result in less-than-optimal results from condom promotion campaigns.
- Client-friendly services are beneficial but still lack proper expansion. There is no integration into the system; youth are still not confident to go for counseling or treatment.

3. Violence against women

Laws related to violence against women

There are laws related to violence in the family in the 2007 law which became effective in June, 2008. This law protects family members, children,

spouses, co-habiting couples and other family members with the principles of promoting harmony in the family, with less harsh penalties than in the Criminal Code regarding assault. Thus, women who suffer abuse in the family may not receive a fair hearing, and may suffer repeat abuse if forced to remain in the household.

Sexual violence including rape is covered under the Criminal Code and didn't include marital rape (Measure 276) until 2007, but interpretation is subject to variation (Measure 277). A charge is dismissed if a youth age 13-15 agrees to marriage if the sex partner is under 18.

Abortion is allowed in cases of rape or if the female is age 13 to 15 years or has a mental health problem.

Activities to combat the sexual exploitation of female youth and children
There is no specific law to address this. There is still confusion about what constitutes this and the extent of the problem. There are also problems of accessing the victims of sex exploitation.

Readiness to provide shelter and support for female victims of violence or sexual exploitation and violence
Provincial hospitals have crisis center services to protect women and girls who are victims of violence. The Ministry of Social Development and Human Security (MSDHS) has opened shelters at the provincial level for children and families to protect women and their children who are victims of violence. However, since many cases of violence occur in the outer districts it is questionable how many really have access. Also, the police don't always take this issue seriously.

Services for prevention of STIs, contraception, and legal abortion
The MOPH has issued guidelines for clinical facilities on prevention of HIV from rape and contact with blood or body fluids from PLHIV. In the case of rape, the guidelines call for counseling, emergency contraception, and post-exposure prophylaxis for HIV.

Public data system for information compilation and sharing with the public on violence against women
The Office for Women's Activities and the Family is responsible for this area as stipulated by law. While there is data on the number of rapes, there is no database for incidents of spousal violence or admissions to the provincial crisis centers for cases of violence against women. This data system is under development.

National campaign on violence against women and sexual exploitation of adolescents

At present efforts to combat violence against women occur at the central level but lack continuity or an effective strategy for offering protections. Women lack information on where to go, or who to seek to get out of an abusive situation. Campaigns are needed to fill these gaps so more women at the community level can access services.

Laws against female trafficking

Thailand has a law forbidding human trafficking inclusive of women and men, and not just for prostitution, but also other forms of forced or slave-like labor.

Support for female victims of trafficking in the area of reproductive health and HIV counseling

Thai women are tricked into international prostitution rings but do not want to reveal their situation to seek help when returning to Thailand. Authorities who are in contact with these women when they return need to be sensitive to these issues. There are currently no laws to help compensate victims of international trafficking or to subsidize SRH care, health support and HIV VCT.

Area of concern

Women returning from abroad don't want to reveal their identity out of personal safety. Even though they are victims of trafficking, they often are viewed as criminals when they return. There should be SRH services and HIV VCT for these women regardless of whether they were trafficked or not – to protect the anonymity of those that were.

Recording of cases of violence against women who suffer abuse as a result of disclosing their serostatus

This is still a gap that needs filling. This may result from lack of confidentiality of serostatus, or lack of counseling which considers this dimension and the potential for violence. HIV+ women may not be ready to disclose their status because they are still financially and/or emotionally dependent on their partner.

Some of these women are abandoned by their husbands when he learns of her serostatus, and the women thus become household heads and have to take care of children and themselves by themselves.

Some providers violate these women's rights by disclosing their serostatus, or pressure them to have sterilization without realizing that these actions

are a form of violence. Similarly, the women themselves don't always recognize what happens to them as violence, and thus do not seek help. Remedial action is needed for both provider and the PLHIV women.

Other forms of violence against infected women include:

1. infected adolescent females are forbidden to have boyfriends;
2. girls as young as 13 are sexually violated, have abortions and then post-abortion sterilizations;
3. they are the last to receive physical examination even though they arrived earlier than others; there is extra cost in sterilizing equipment that is exposed to their bodily fluids;
4. aren't encouraged to think expansively or independently about marriage and child-bearing decisions;
5. receive compulsory blood screening when applying for work;
6. have to reveal their serostatus when going for benefits such as the welfare subsidy of 500 baht.

Strategies for supporting male and female children with HIV the NASP for 2007-11 contains a strategy for prevention care and treatment for children affected by AIDS as a key target group.

This emphasizes: (1) Developing the service system for affected children including prevention, care and education; developing services for serostatus results disclosure for children and adolescents, protecting the rights of children and reducing stigma and segregation of children affected by AIDS, and developing the data system to monitor and evaluate the status of the problem; (2) Develop and support the capacity of the child, family, community and society to prevent and control problems of children affected by AIDS. Provide care for children to help them economically, gain knowledge, skills, and confidence as a form of social immunization from problems later on. Campaign and promote understanding in the society, and work together to solve problems of children affected by AIDS.

A problem in practice is following up affected children due to lost contact with the mother in the post-partum period. There is also a lack of SRH services for adolescent PLHIV, and for AIDS orphans for whom there is no problem monitoring system. In addition, staff of the Ministry of Social Welfare and staff of private child care centers lack the understanding and sensitivity in care for children affected by AIDS. There are still sub-standard services in welfare and child centers and cases of child rights violations.

4. Areas for special consideration

Links between sex education, sex and reproductive health

Condoms are still a disease prevention tool, with an image of behavioral control rather than couple caring, and this impact on use/non-use such as attitudes, beliefs, negotiating use, etc. These factors are an explanation for the less than optimal condom use levels among adolescents and married couples.

Teaching sex education requires adult understanding of children. But parents and teachers still think about sex in traditional ways, and can't see the evolution of practices that is taking place in society. Parents and teachers themselves have trouble communicating about sex and safe sex and sexual happiness. Thus, it is difficult for them to communicate clearly and honestly to their children and students.

The conceptual thinking about sex (gender, sexuality, and sexual diversity) is missing from traditional approaches to sex education and SRH services, at the level of policy and senior management. When this is combined with the disease control approach of the authorities it becomes a punitive approach rather than one of understanding (e.g., by portraying women as spreaders of HIV, who should not marry or have children, or should get sterilized, should disclose their serostatus, etc.). This reduces the ability to provide viable options, especially for women.

Different perspectives on the problems

Despite there being a PMTCT policy, there is still a constant level of infection among pregnant women. Authorities don't understand why the number of HIV+ pregnant women doesn't decline. The focus of the DOH program is not on the reproductive age couple, but focuses narrowly on vertical transmission. This gives rise to repeat pregnancies and more vertical transmission, resulting in warnings from health staff for PLHIV to not get pregnant, that their child will be orphaned, that they will both be stigmatized, and that more social problems will result. In fact, the PLHIV woman is aware of these consequences but still may want to have a child. In sum, HIV+ women who want to get pregnant are still not well-accepted in Thai society, and counseling services are not well-prepared for this.

From a policy study[58] it was found that the problem of pregnancy among HIV+ women is seen as a problem coming from inadequate or poor quality counseling. The counselor usually says: *"Whatever I tell her, she will*

[58] Study of reproductive health policy – Voices and Choices Project by Sulaiporn Cholwilai 2010

become pregnant again." There is pressure on both the provider and the HIV+ woman. The subtext is *"You are HIV+, so how come you got pregnant?"*

What is driving this attitude is the target reduction of ANC HIV from 0.88 in 2006 to 0.85 in 2007 and from 0.05% each year thereafter. In addition there is the target to reduce MTCT of HIV from 3% in 2006 to under 3% in each year thereafter. Thus, it can be seen that the emphasis is not client-centered, but is target-centered. Often staff are not sure that what they are doing is correct policy or not, and actions out of ignorance may result in violations of SRH rights – such as pressuring PLHIV to have a sterilization or not protecting the confidentiality of the woman's HIV status during couple counseling.

In the evaluation by the government[59] there was a specification that are gaps in coverage such as PLHIV women who are not yet eligible for treatment but can't be located, because the women do not want to reveal their serostatus out of fear of repercussions and stigma. Children born to these HIV+ mothers miss diagnostic appointments. The DOH does not have data on these gaps and lacks a strategy for filling them. So the view of civil society is not always aligned with that of the government in terms of the causes and barriers to greater coverage of services.

Counseling that emphasizes the seropositive leads to a lost opportunity to counseling HIV-negative pregnant women.

Even though couple counseling has been beneficial for women so that they can learn of their infection during the current pregnancy, and receive help for further prevention, couple counseling is problematic for women who are not yet ready to disclose their serostatus to their partner, or who have marital problems, or who had an unplanned pregnancy. These women might be lost to the system because of couple counseling. Thus there should be more flexibility in the choice whether to have couple counseling or not rather than making it a condition of ANC.

Recommendations

1. There needs to be a policy for positive sex education that views different sex lifestyles on an equal basis, in which there is no stigma or discrimination based on sex, and promotes responsible sex behavior for everyone, every age, and sex.

[59] Progress report of Thailand to UNGASS of the PMTCT working group, 2010

Sex education needs to cover not only adolescents in school and out-of-school but also adults, because adults often portray a negative attitude about sex which increases risk behavior or reduces access to safe sex. These attitudes exacerbate sexual coercion and violence in the family and sexual violence in general.

Every agency in the country at every level, from the central to the peripheral, needs to understand the modern concept of sex education as integrated into the HIV prevention plan and general health plans, and plans to promote equality between male and female, and plans for women and children that already exist.

2. SRH services are needed including those for victims of family or sexual violence, and PLHIV women, that are user-friendly for both sexes of all ages, and provide access to services, information, counseling, and which eliminate barriers to service based on sex, mobility, religion, disability, age, or health status.

There is a need to increase convenience of service and access to services by promoting one-stop services through better linking among units within a facility and good links with external agencies and the community.

3. There is a need to build sustainability in the system for learning sex education and SRH services that are user-friendly by implementing a national policy on sex education with a clearly responsible government coordination agency to link government and civil society groups broadly and use existing laws and policy so that they are effective, such as laws against violence, protection of victims of trafficking, etc.

4. There is a need to build community participation in the sex education efforts and SRH services that are user-friendly to improve access to youth and other groups not yet covered.

5. There should be provision of education on sex, and SRH services must recognize the importance of couple power dynamics related to sex, and recognize that sex lifestyles affect attitudes and behavior, including access to services. The service system should conduct more outreach to give services and sex education for males to reduce their underutilization of information services about positive sex, promote responsible relationships, and family relationships (e.g., contraception, child care, condom use, AIDS prevention, reduction of using force to get one's way in the family, etc.).

They need to see that sex education and SRH services are a way of expanding understanding about sex and society which has to overcome obstacles such as ingrained male attitudes about sex and the role of men in the family, and understand the inappropriateness of male violence in the family that has been a part of Thai society for many generations.

6. Sex education and SRH services for PLHIV must reduce the focus on the women as the driver of the epidemic, and instead view her as a client with human rights and who is entitled to equal services with informed consent in every service outlet. Staff must see that controlling the decision-making and options of women is a form of discrimination and rights violation.

7. There should be support for participatory studies and research, and setting up databases on SRH (public and NGO or civil society network).

8. There is a need to expand and support collaboration between relevant agencies in the government and NGO sectors on outreach for SRH, AIDS and rights, and reduce gaps in service linkages within and among outlets.

There needs to be a database to expand results or modify the process of learning by participatory data sharing between government and NGOs with both quantitative and qualitative data. Relevant agencies should see the importance of collecting data that are sensitive to sexuality such as data on sex segregation, data on unplanned pregnancy of PLHIV, data on family violence. This will help inform SRH policy and services at the central and peripheral level.

9. Gender-based violence must be understood in broader terms than merely physical assault. It must be seen to be a function of societal constructs, inclusive of psycho-emotional violence. Gender-based violence must be seen as an integral part of traditional culture and which is linked to rights violations such as rape in the family, violence in the family, human trafficking, especially for young girls and children, which limits sex education opportunities for youth, stigmatizes and blames teen girls for getting pregnant while in school, gives rise to prejudice against women who have diverse sex lifestyles from the mainstream, victimizes women as spreaders of HIV or as socially irresponsible when PLHIV want to re-marry or have another child, promotes prejudice against those who chose to be gay, katoey, lesbian, or transgender.

10. There is a need to build strength of the system of counseling in government, NGO and community groups by emphasizing pre-and post-test counseling, peer-to-peer counseling, and empowerment and option counseling. There needs to be an emphasis on help for vulnerable populations, or those without power to negotiate the terms of sex, such as women, children or infected adolescents.

11. There is a need to establish a policy and plan that is clear for the implementation of attitude development about sex, AIDS and rights among the government, policy makers and service providers, provincial administrators and the general public.

12. There is a need to establish a policy, plan, program of action and budget for supporting NGOs or CBOs working on AIDS, sex and SRH for groups that are hard to reach such as children and youth affected by AIDS, sex workers, foreign migrant laborers and ethnic minorities.

Annex 7
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12. National Technical Working Group on Monitoring and Evaluation for HIV Prevention among Reproductive Age Population and Family

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2.	Pol Maj Gen Dr. Jantana Wittawasiri	Police General Hospital, Royal Thai Police
3.	Lt Col Paprakorn Benjakun	Royal Thai Army Medical Department
4.	Lt Cdr Ngem Puongnak	Royal Thai Naval Medical Department
5.	Wg Cdr Jamrun Chaladkid	Directorate of Medical Services, Royal Thai Air Force
6.	Ms. Suchada Wongwanliyanon	MSDHS

7.	Mr.Nawin Taraseang	Bureau of Policy and Strategy, Office of Permanent Secretary, MOL
8.	Ms.Ratjana Neatseangtip	National Statistical Office
9.	Ms.Paradee Chansamon	Bureau of Reproductive Health, DOH, MOPH
10.	Ms. Kira- tikan Klatsawat	Bureau of Epidemiology, DDC, MOPH
11.	Ms.Nittaya Phromponcheanbon	Duang Prateep Foundation (DPF)
12.	Ms.Suparat Suksakulwat	Thailand Business Coalition on AIDS (TBCA)
13.	Mr.Boripat Donmon	Thai Network for People Living with HIV/AIDS (TNP+)
14.	Ms.Sukanya Thongtamrong	UNFPA
15.	Mr. Sompong Chareonsuk	UNAIDS
16.	Ms. Kruatip Jantharathaneewat	Bureau of AIDS and STIs, DDC, MOPH
17.	Ms.Wilaiwan Koikawpring	Department of Labour Protection and Welfare, MOL
18.	Ms.Lisa Kantamala	Bureau of AIDS and STIs, DDC, MOPH
19.	Ms. Manoros Haohan	National AIDS Management Center, DDC, MOPH

13. National Technical Working Group on Monitoring and Evaluation for HIV Prevention among Sex Workers

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3.	Ms. Sarinya Pongpan	Bureau of Epidemiology, DDC, MOPH
4.	Ms.Sombat Srivajana	Bureau of AIDS and STIs, DDC, MOPH
5.	Mr.Somchai Fonghirundrat	Bureau of AIDS and STIs, DDC, MOPH
6.	Mr.Praween Payapwipapong	Population and Community Development Association (PDA)
7.	Ms.Jantawipa Apisuk	Empower Foundation
8.	Ms. Supatra Nakapiew	Foundation for AIDS Rights (FAR)
9.	Mr.Thawat Ankko	Planned Parenthood Association of Thailand (PPAT)
10.	Mr.Jamrong peangnongyang	SWING Foundation
11.	Ms.Aree Prommo	Institute for Population and Social research, Mahidol University
12.	Dr. Taweesap Siraprapasiri	UNFPA
13.	Dr. Chitlada Utaipibool	Thailand MOPH - U.S. CDC Collaboration
14.	Ms. Wipada Maharatanaviroj	Bureau of AIDS and STIs, DDC, MOPH
15.	Ms. Chollada nandavisai	Thailand MOPH - U.S. CDC Collaboration
16.	Mr. Taitat Paipilai	National AIDS Management Center, DDC, MOPH

14. National Technical Working Group on Monitoring and Evaluation for HIV Prevention among MSM

1.	Dr. Werasit Sittitrai	Office of Policy and Planning, Thai Red Cross Societies
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4.	Ms. Nipa Ngamtrairai	Medical Services Division, Department of Correction
5.	Ms. Ratree Sirisreetreeluck	Bureau of AIDS and STIs, DDC, MOPH
6.	Ms. Narumon Yenyarsan	Bureau of AIDS and STIs, DDC, MOPH
7.	Ms. Kira-tikan Klatsawat	Bureau of Epidemiology, DDC, MOPH
8.	Ms. Supatra Nakapiew	Foundation for AIDS Rights (FAR)
9.	Mr. Kamolset Kenggarnruae	King Chulalongkorn Memorial Hospital, Thai Red Cross Societies
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12.	Ms. Pimpawun Boonmongkon	Center for Health Policy Studies, Mahidol University

13. Ms. Chomnad Manopaiboon	Thailand MOPH - U.S. CDC Collaboration
14. Dr. Jittinee Khienvichit	Family Health International
15. Mr. Panus Rattakitvijun Na Nakorn	USAID
16. Mr. Rapeepun Jommaroeng	UNESCO
17. Mr. Chatwut Wangwon	Thailand MOPH - U.S. CDC Collaboration
18. Dr. Chitlada Utaipibool	Thailand MOPH - U.S. CDC Collaboration
19. Mr. Danai Linjongrat	Rainbow Sky Association of Thailand
20. Ms. Yupin Chinsanguankiat	Bureau of AIDS and STIs, DDC, MOPH
21. Ms. Wassana Nimvorapun	National AIDS Management Center, DDC, MOPH

15. National Technical Working Group on Monitoring and Evaluation for HIV Prevention among IDUs

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2. Dr. Viroj Veerachai	Thanyarak Institute, DMS, MOPH
3. Dr. Panrudee Manopaiboon	Health Department, BMA
4. Dr. Manop Srisuphanthavorn	Department of Correction
5. Ms. Nipa Ngamtrairai	Medical Services Division, Department of Correction
6. Ms. Yaowaret Nakayothinsakul	Thanyarak Institute, DMS, MOPH
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8. Ms. Supojanee Chutidamrong	Office of the Narcotics Control Board (ONCB)
9. Dr. Jaruwat Busarakamruha (DDS.)	Bureau of Health Service System Development, DHSS, MOPH
10. Ms. Niramon Rattanasuporn	Bureau of Epidemiology, DDC, MOPH
11. Ms. Wassana Nimvorapun	National AIDS Management Center, DDC, MOPH
12. Ms. Chitra Onnom	Bureau of AIDS and STIs, DDC, MOPH
13. Ms. Supatra Nakapiew	Thai NGO Coalition on AIDS (TNCA)
14. Mr. Sakda Puaekchai	Thai Drug User Network (TDN)
15. Ms. Lawan Sarowat	PSI Thailand Foundation
16. Mr. Piyabutr Nakapew	PSI Thailand Foundation
17. Ms. Karyn Kaplan	Thai Aids Treatment Action Group (TTAG)
18. Ms. Arom Konchom	Raks Thai Foundation
19. Mr. Sopon Sunhok	Thai Network for People Living with HIV/AIDS (TNP+)
20. Ms. Baralee Meesuk	Asian Harm Reduction Network (AHRN)
21. Ms. Sivalee Kasemsilp	Thai Harm Reduction Network (THRN)
22. Dr. Apinun Aramrattana	Chiangmai University
23. Ms. Usaneya Perngparn	College of Public Health Sciences, Chulalongkorn University
24. Mr. Sompong Chareonsuk	UNAIDS
25. Mr. Gray Sattler	UNODC
26. Mr. Prin Visavakum	Thailand MOPH - U.S. CDC Collaboration
27. Ms. Chaweewan Panjabutr	Thanyarak Institute, DMS, MOPH
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29. Ms. Yaowalak Jittakoat	PSI Thailand Foundation
30. Ms. Busaba Warakamin	National AIDS Management Center, DDC, MOPH

16. National Technical Working Group on Monitoring and Evaluation for HIV Prevention among Migrants and Mobile Population

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6.	Ms. Jatuporn Wongkaew	Thailand Overseas Employment Administrative, MOL
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8.	Mr. Sahaphap Poonkesorn	Bureau of Epidemiology, DDC, MOPH
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10.	Ms. Jarunee Sriripan	PATH
11.	Dr. Jaruwaree Snidwongse	World Vision Foundation of Thailand
12.	Ms. Thongphit Pinyosinwat	Raks Thai Foundation
13.	Mr. Brahm Press	Raks Thai Foundation
14.	Mr. Satean Tanprom	Foundation for AIDS Rights (FAR)
15.	Dr. Bhassorn Limanonda	College of Population Studies, Chulalongkorn University
16.	Dr. Penpak Utit	Faculty of Nursing, Chulalongkorn University
17.	Dr. Nigoon Jitthai	International Organization for Migration
18.	Ms. Aree Mungcharuensuk	WHO
19.	Dr. Taweesap Siraprapasiri	UNFPA
20.	Ms. Dungta Phalakornkul	Bureau of Health Service System Development, DHSS, MOPH
21.	Dr. Surasak Thanaisawanyangkul	Bureau of AIDS and STIs, DDC, MOPH
22.	Ms. Tassanee Surawanna	Raks Thai Foundation
23.	Mr. Taitat Paipilai	National AIDS Management Center, DDC, MOPH