



# 2012 Thailand AIDS Response Progress Report



คณะกรรมการแห่งชาติ  
ว่าด้วยการป้องกันและแก้ไขปัญหาเอดส์  
NATIONAL AIDS COMMITTEE



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## INTRODUCTION

This Thailand AIDS Response Progress Report 2012 covers the two-year period from 2010 to 2011. It describes the current situation of the epidemic in Thailand and any changes since 2007, the beginning of the prior Thailand National AIDS Strategic Plan (2007-2011). It also describes the policies and programmes undertaken in Thailand between 2010 and 2011 to address the epidemic and presents the achievements made in this reporting period. This report represents Thailand's 5th country progress report for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), since such reporting began in 2002.

In 2011, the United Nations (UN) conducted a review of accomplishments of HIV and AIDS prevention efforts among signatory countries of the UNGASS Resolution of 2001 and of the Political Declaration on AIDS of 2006, at a summit meeting held between 8 and 10 June 2011. Thailand, along with other Member States, adopted Resolution 65/277, a new Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. This historic agreement renewed previous commitments and set seven concrete targets for 2015.

These targets are as follows:

- Target 1 : Reduce sexual transmission of HIV by 50% by 2015
- Target 2 : Reduce transmission of HIV among people who inject drugs by 50% by 2015
- Target 3 : Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths
- Target 4 : Have 15 million people living with HIV on anti-retroviral treatment by 2015
- Target 5 : Reduce tuberculosis deaths in people living with HIV by 50% by 2015
- Target 6 : Reach a significant level of annual global expenditure (USD 22 - 24 billion) in low-and middle-income countries
- Target 7 : Mobilize critical enablers and synergies among development sectors

In order to monitor global progress, the United Nations Programme on HIV/AIDS (UNAIDS) requested UN Member States to report bi-annually on national progress of the AIDS response toward the 2015 targets. This report



therefore also presents the measurements of the core indicators for the Global AIDS response progress reporting (Thailand), 2006-2011, and indicates the progress of the Thailand AIDS response in terms of these seven targets.

The Department of Disease Control (DDC) of the Ministry of Public Health (MoPH), as secretariat of the National AIDS Committee (NAC), joined with the Thai National Coalition on AIDS (TNCA), the Thai Network of People living with HIV/AIDS (TNP+) and UNAIDS to coordinate the compilation of this report. Thus, the multi-sectoral task force that prepared this report included representatives from the government, civil society, technical specialists and international agencies. This report was prepared with the full collaboration and participation of all related sectors. The representatives from government, civil society and international organizations were appointed to a technical task force charged with facilitating data collection and analysis for the overall report and receiving endorsement on their interpretation from key stakeholders. Together with the contributors, the representatives assembled, analyzed and synthesized relevant information into the content for the report.

The task force representatives worked with 13 working groups, each focused on a specific required component of the report. Working groups included representation from 12 departments of the MoPH, nine departments of other ministries, 17 civil society organizations, and eight international agencies. Working groups compiled and analysed relevant information to produce a draft report for discussion and consultation with the larger assembly of programme partners and key stakeholders.

Two consultative meetings were convened during the report development process. The purpose of the first meeting was to review initial findings among technical experts in each of the areas being reported on. In the second meeting, a total of 210 persons, representing 28 government organizations, 26 civil society organizations and eight international organizations from national and sub-national levels participated to review and endorse findings presented by the different working groups.



Data collection for the National Commitments and Policy Instruments (NCPI) component of the Report was undertaken with the assistance of two technical specialists. Data was collected from 24 government departments and through meetings with the constituencies of non-governmental organizations (NGOs); and their findings and recommendations were presented at the consultative meetings referred to above.

Through the report-preparation process, the implementing partners achieved consensus among themselves regarding the status of HIV and AIDS in the country and the progress of implementation and developed guidelines for a renewed effort toward the national goals. Moreover, they will be able to use this report as a tool for policy advocacy to support the accelerated implementation of HIV and AIDS programmes on a continuous basis.

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## ACRONYMS

AEM	AIDS Epidemic Model
AFRIMS	Armed Forces Research Institute of Medical Sciences
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
ASO	AIDS-response Standard Organization
BATS	Bureau of AIDS, TB and STIs
BMA	Bangkok Metropolitan Administration
BOE	Bureau of Epidemiology
BSS	Behavioural surveillance survey
CCP	Comprehensive condom programming
CHAMPION	The project entitled: Comprehensive HIV Prevention among MARPs by Promoting Integrated Outreach and Networking
DDC	Department of Disease Control
DiC	Drop-in centre
DOC	Department of Corrections
DOH	Department of Health
EVAW	End violence against women
EWI	Early warning indicators
FSW	Female sex workers
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPO	Government pharmaceutical organization
HIV	Human immunodeficiency virus
HLM	High Level Meeting (where political declaration on HIV and AIDS were agreed)
HSS	HIV sentinel serosurveillance
IBBS	Integrated biological and behavioural sentinel surveillance
ILO	International Labour Organization
IPSR	Institute of Population and Social Research
IPV	Intimate partner violence
KAP	Key affected population
KPI	Key performance indicator
LAO	Local administrative organization
M&E	Monitoring and evaluation
MHV	Migrant health volunteers
MHW	Migrant health worker

MICS	Multiple indicator cluster survey
MMT	Methadone maintenance therapy
MOE	Ministry of Education
MOJ	Ministry of Justice
MOL	Ministry of Labour
MoPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
MSM	Men who have sex with men
MSW	Male sex workers
NAC	National AIDS Committee
NAMc	National AIDS Management Center
NAP	Soft-ware for treatment and care for PLHIV: National AIDS Programme
NAPHA	National access to anti-retroviral programme for people living with HIV and AIDS
NAS	National AIDS strategy
NASP	National AIDS strategic plan
NCPI	National commitment and policy instrument
NETF	National evaluation task force
NGO	Non-governmental organisation
NHSO	National Health Security Office
ODPC	Office of Disease Prevention and Control
ONCB	Office of the Narcotics Control Board
OSCC	One stop crisis centre
PCM	Provincial coordinating mechanism
PCR	Polymerase chain reaction
PrEP	Pre-exposure prophylaxis
PHAMIT	The project entitled: Prevention of HIV and AIDS among Migrant Workers
PHIMS	Perinatal HIV information monitoring system
PICT	Provider initiated counselling and testing
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child HIV transmission
PR	Principal Recipient
PWID	People who inject drugs
RDS	Respondent driven sampling
RIHIS	Routine integrated HIV information system
SI	Strategic information
SR	Sub-recipient
SSR	Sub-sub-recipient

STI	Sexually transmitted infection
SW	Sex worker
TA	Technical assistance
TB	Tuberculosis
TBCA	Thailand Business Coalition on AIDS
TDN	Thai Drug Users Network
TG	Transgender people
TNCA	Thai NGO Coalition on AIDS
TNP+	Thai Network of People Living with HIV/AIDS
TRP	Technical review panel
TUC	Thailand MoPH-US CDC Collaboration
UC	Universal coverage
UIC	Unique identifier code
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	Office of the United Nations High Commissioner for Refugees (United Nations Refugee Agency)
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

## EXECUTIVE SUMMARY

HIV continues to spread in Thailand, almost 30 years after the first outbreak. The main driving force of the epidemic has been unsafe sex. Data reveal the absence of a sustained decline in HIV prevalence among sentinel populations. In fact, high HIV prevalence has been observed among key affected populations, including men who have sex with men, non-venue based female sex workers and people who inject drugs. Furthermore, a slight increase in HIV prevalence has been observed among the younger generation over the past few years. These data provide a warning signal that the rate of HIV could start increasing again in Thailand unless prevention activities are intensified and aggressively rolled-out.

It is estimated from the AIDS Epidemic Model that in 2012 Thailand will have 9,473 new cases of HIV infection. Estimates suggest that 34 per cent of new infections in 2012 will be among heterosexual married couples or lovers whom one of partner living with HIV, while only seven per cent will be among people in casual sexual relationships. The remainder will be among the key affected populations. Most infections are projected to be the result of unsafe sex.

Numerous actions to combat the spread and impact of HIV and AIDS were implemented by the government and civil society groups in 2010 and 2011, with support from development partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, United Nations agencies and the United States Government. Actions were implemented in the areas of policy development and planning, prevention, and treatment and care. Existing programmes were continued and new initiatives begun, including programmes to raise awareness; change behaviour and attitudes; identify biomedical responses; provide counselling, testing and treatment; improve service delivery; and develop better monitoring and evaluation tools and processes.

Spending on treatment and care represented the majority of the government's expenditure on HIV and AIDS in 2010 and 2011. As a consequence of the resources invested in this area, Thailand's anti-retroviral treatment (ART) programme has been very successful and has greatly improved access to ART. Spending on prevention increased in this reporting period from the year 2009 but the proportion was lower than in the year 2008. Nearly half the budget for prevention was from international sources, with the majority from the Global Fund. Meanwhile the proportion of spending for creating an enabling environment, a vital factor in reducing new HIV infections among key affected populations, was low. Spending on monitoring and evaluation was also low.

The Thai Government has recognized the need to ensure sustainable domestic funding for its HIV prevention and monitoring activities. Establishment of an HIV prevention fund was indicated as a priority area in the drafted National AIDS Strategy for 2012-2016.

## I. STATUS AT A GLANCE

### (A) STATUS OF THE EPIDEMIC

The spread of HIV in Thailand began nearly 30 years ago and continues today. The epidemic in Thailand started among injecting drug users and the virus was spread further through unsafe behaviour, and today unsafe sexual behaviour remains the driving force of the epidemic.

**Table 1: Key figures of PLHIV, Thailand**

Statistics *	Yr. 2005	Yr. 2011
People living with HIV/AIDS	580,000	495,000
Women living with HIV/AIDS	220,000	194,000
Children living with HIV (<15 years)	19,000	13,000
- 0 – 4 years	4,700	1,900
- 5 – 9 years	10,200	3,600
- 10 – 15 years	4,100	7,500
New HIV infections/year (15 – 49 years)	16,400	10,020
New paediatric infections/year (0 – 15 years)	800	350
Annual AIDS deaths in adults (15 – 49 years)	18,200	24,100
Annual AIDS deaths in children (0 – 15 years)	1,190	440
Children affected by HIV/AIDS (including orphans and children living with HIV; 0-15 years)	247,000	258,000

\* Data from 2011 Global AIDS Report and Asian Epidemic Modeling Program

Though Thailand has had a strong national response to HIV and AIDS since 1992, which succeeded in rapidly slowing the spread of the virus during the decade that followed, HIV continues to spread – with troubling trends – among key affected populations and their partners, namely men who have sex with men (MSM), including male sex workers (MSW) and transgender (TG); female sex workers (FSW); and people who inject drugs (PWID). Incidence remains high in the key affected populations and the data from HIV sentinel sero-surveillance (HSS) surveys and other sources show a pattern of spread of HIV among certain subgroups of the general population

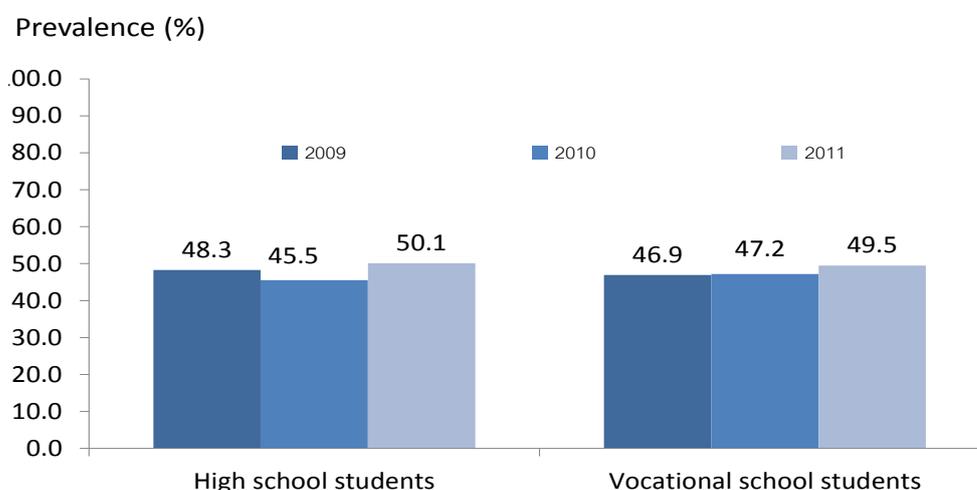
While the HSS survey does not include a representative sample of the general population of reproductive age (15-49 years), surveillance among three proxy groups is able to suggest trends of HIV spread in the general population. These three groups are: ante-natal care (ANC) clients (pregnant women), in which declining trends in HIV infection have been noted; military recruits (males) at the time of induction, among which stable levels of HIV infection have been noted; and blood donors aged between 20 and 24 (youth), among which increasing levels of HIV infection have been noted.

Behavioural surveillance surveys (BSS) among factory workers, as a proxy for the working-age population, found that between 13 and 14 per cent have more than one sex partner, which remains a concern for HIV prevention among the general population. There are particular concerns relating to youth. Although there has been a fairly stable trend of HIV prevalence among young pregnant women, i.e. those aged between 15 and 24 years (0.58 per cent in 2008; 0.44 per cent in 2010-2011): and among young male military recruits, i.e. those aged between 20 and 24 years (0.5 per cent in 2008-2009; 0.6 per cent in 2010-2011), behaviour data indicate increased risk behaviour (sex with more than one partner in the previous 12 months) among youths in school settings (vocational school students: 11.8 per cent in 2007; 13.6 per cent in 2009; 16.3 per cent in 2011; high school students: 3.9 per cent in 2007; 4.5 per cent in 2009; 5.1 per cent in 2011).

When compared with the data for the previous two-year reporting period (2008-2009), data for the past two years (2010-2011) indicate that there have been *no improvements* in HIV knowledge and understanding (less than 30 per cent among high school and vocational students and 36.5 per cent in army recruits in 2011).

Behaviour data also indicate an increase in unprotected sex among youth. Only half of the school students who had multiple sex partners used condoms at last sexual intercourse; and among patients with STIs, the highest number of cases was in the 15-24 year age group similarly suggesting increasing levels of unprotected sex at earlier ages.

**Figure 1: Condom use (at last sexual intercourse) among students with more than one sexual partner in the past 12 months, 2009-2011**



Source: Bureau of Epidemiology and TUC

An integrated biological and behavioural sentinel surveillance (IBBS) survey was implemented in 2010 among migrants from Cambodia, Myanmar and Lao PDR working in six selected provinces (three coastal and three inland provinces, chosen for their potential for high HIV rates). The results from this IBBS indicated that among migrant workers the median HIV prevalence was 0.6 per cent (between 0.3 and 5.0 per cent). The IBBS found that HIV prevalence varied by nationality among migrants (Cambodian 3.1 per cent, Myanmarese 1.5 per cent, Laotian 0.9 per cent) and type of occupation (seafood processing 2.7 per cent, deep-sea fishing 1.7 per cent, agriculture 1.3 per cent). Data indicate that prevalence among migrant workers has remained fairly stable since 2006.

Comprehensive HIV knowledge was found to be low among migrant workers, with only a quarter of migrant workers able to answer all five HIV and AIDS knowledge questions correctly. High risk behaviour among young migrants was elevated, with 27.5 per cent of male migrant workers under the age of 25 having more than one sex partner in the previous 12 months (the highest rate of multiple partners was among the fishing boat occupation group), use of condoms was low, and only 8 per cent of migrant workers had benefitted from HIV counselling and testing in the previous 12 months and knew their test results.

Three sub-populations involving men who have sex with men (MSM, MSW and TG) contribute to the sustained incidence of HIV in Thailand. HIV has spread rapidly among men who have sex with men in recent years; in 2010 41 per cent of all new HIV infections in Thailand were among this group. Comparing data from three large cities in Thailand (Bangkok, Chiang Mai and Phuket) indicates that HIV prevalence among MSM is highest in Bangkok (31.3 per cent in 2010, up from 19.2 per cent in 2005), with lower prevalence observed in Chiang Mai (13.0 per cent in 2010, up from 8.3 per cent in 2009) and Phuket (6.9 per cent in 2010, up from 6.0 per cent in 2009).

From surveys conducted in 2010 in these three provinces (Bangkok, Chiang Mai and Phuket) it was found that HIV prevalence among MSM (excluding MSW and TG) was 20 per cent, followed by 17.7 per cent among MSW and 10.4 per cent among TG. In all three provinces HIV prevalence was lower among TG than among MSM overall (2010: Bangkok 7.7 per cent, Chiang Mai 12 per cent and Phuket 9.9 per cent), but the prevalence has not declined in recent years. Among MSM there was a significant difference in prevalence by age group, with higher rates among older MSM. While HIV prevalence among MSM aged between 25 and 29 was 32.4 per cent, the rate among those aged between 15 and 24 was 12.1 per cent.

When looking at the proportion of MSM, MSW and TG reporting having had an HIV test in the prior 12 months and who knew their results, it was found that over half of the MSWs (49.0 per cent) had been tested and knew their results, followed by TG (41.3 per cent). The lowest rate was among MSM (14.9 per cent). HIV prevention programmes reached only 43.8 per cent of MSMs but reached over two thirds of TGs (67.5 per cent) and 61.0 per cent of MSW. Despite this, the rate of reported condom use at last sexual encounter was highest among MSM (80.2 per cent).

Data from HSS surveys among venue-based FSW found that HIV prevalence among these women has declined steadily over time, dropping from 2.8 per cent in 2008 to 2.7 per cent in 2010 and 1.8 in 2011. The HSS survey in 2010 found that HIV prevalence is lower among the younger age group (< 25 years) of venue-based FSW.

Recent data indicate that HIV prevalence among non-venue based sex workers is higher than among venue-based sex workers in selected provinces (Bangkok in 2007: 20 per cent among non-venue based vs 4.6 per cent among venue-based FSW; Chiang Rai in 2007: 10 per cent vs 6.9 per cent; Chiang Mai in 2010: 5 per cent vs 3.1 per cent). Furthermore, the IBBS of 2010 for non-venue based FSW in Chiang Mai, Chonburi and Phuket found that, unlike among

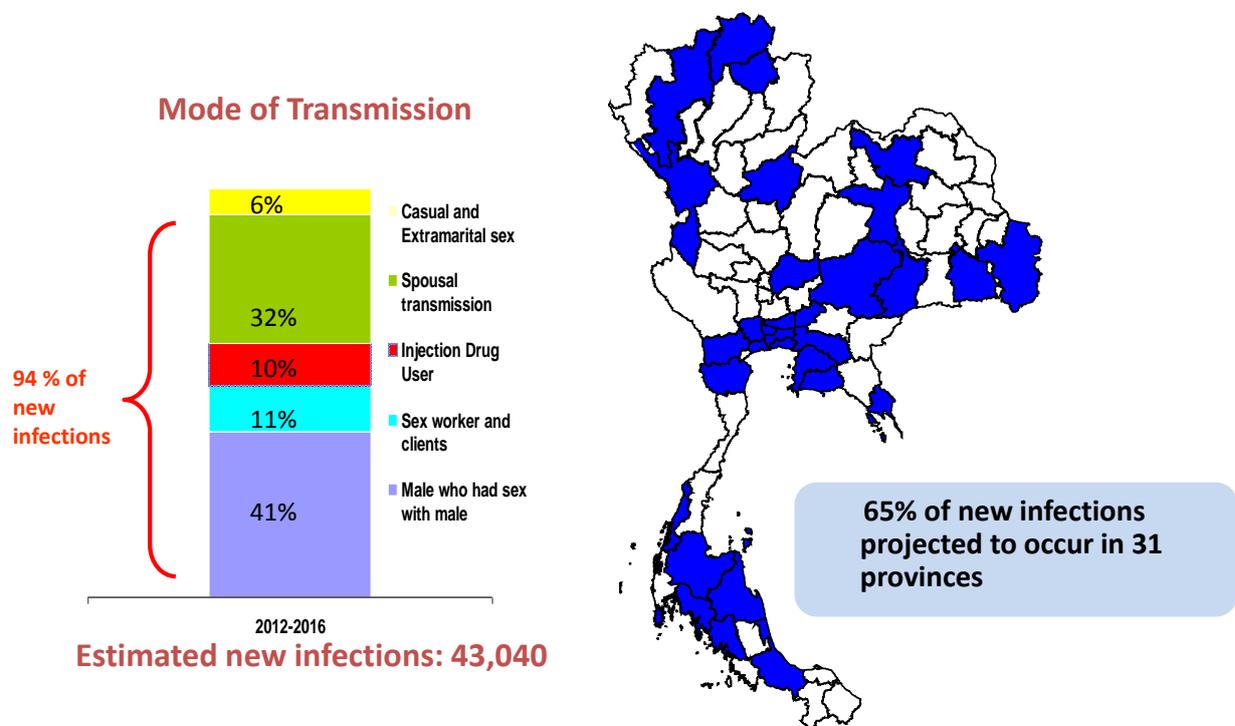
venue-based FSW, the level of infection among non-venue based FSW was highest among the age group under 25 years (2.6 per cent). These figures are troubling because the sex work pattern in Thailand is rapidly changing, shifting from venue-based sex work to a much more diffuse setting of non-venue based sex workers, based on street, mobile phone and internet networks. The high prevalence among non-venue based FSW is also worrisome as a large proportion of non-venue based FSW is not covered by HIV prevention programmes and may not be receiving the same level of care and information as venue-based FSW.

The IBBS among venue-based FSWs revealed that the percentage answering the five HIV and AIDS knowledge questions correctly was rather low (under 40 per cent of FSW responded correctly) and this has not changed over the past five years. Almost all (95.6 per cent) venue-based FSWs reported using condoms with their last customer, but only 45.4 per cent of FSWs reported using condoms with a lover or husband. Half of the venue-based FSW reported receiving an HIV test in the past 12 months and knew the results. Comparing younger and older FSW, the survey found that more of the younger FSWs (aged 25 years or younger) than older FSWs (aged over 25 years) had access to voluntary counselling and testing (VCT) and used a condom with their most recent customer.

The 2010 IBBS conducted in Bangkok, Chiang Mai and Songkla, using respondent driven sampling (RDS), which better represents people who inject drugs (PWID) in communities, found that HIV prevalence among PWID was 21.9 per cent. The HIV prevalence among those who inject heroin and/or opium who present for treatment at drug treatment and rehabilitation centres around the country has remained consistently high in recent years, at levels ranging from 30 to 50 per cent, depending on the location. While the self-reported use of sterile needles and syringes by PWID is rather high (77.7 per cent), condom use at last sex during the previous month and access to HIV prevention remain low (46 per cent and 29.4 per cent, respectively). The data indicate that females who inject drugs use sterile needles and condoms less frequently than males who inject drugs, and HIV prevalence in female injectors was estimated at 30.8 per cent compared with 24.2 per cent among male injectors.

The AIDS Epidemic Model (AEM) is used to estimate new HIV infections as well as the prevalence among people living with HIV and AIDS (PLHIV) in need of treatment. It is estimated that 43,040 new HIV infections will occur between 2012 and 2016. Among these new infections, 62 per cent will be through transmission among MSM, FSW and their clients, and PWID. Estimates from the application of the AEM also suggest that in 2012 one in three new HIV infections in Thailand will occur among married and unmarried couples in intimate partnerships, while a much smaller rate (6 per cent) of new infections will be among casual sex partners.

**Figure 2: Prediction of where new infections will occur in Thailand, 2012-2016**



Source: Thai working group, AIDS Epidemic Model

## **(B) POLICY AND PROGRAMME RESPONSES**

### **(i) NATIONAL AIDS STRATEGIC PLAN**

Between 2010 and 2011, the final two years of the four-year period covered by the National AIDS Strategic Plan (NASP), a review process was undertaken to assess the HIV and AIDS situation in Thailand and the corresponding implementation of policies, plans and programmes, and to assess the remaining gaps and challenges for improving responses to HIV and AIDS as well as to identify the next steps to be undertaken in order to reach the set targets. This review process was undertaken through collaboration between government agencies (both health and non-health), civil society and academics. A significant outcome from the review was a call for collective and synergistic efforts, especially among the line ministries, to deal with the national HIV and AIDS response.

### **(ii) SUPPORT FROM THE POLITICAL SECTOR AND LEADERSHIP**

In 2010 and 2011, the political sector of Thailand, especially the prime minister, provided support for implementation of the NASP. The Prime Minister pushed for a cabinet resolution approving guidelines for inter-ministerial integration on the HIV and AIDS strategy, and provision of budget support for full coverage of HIV-related services. In addition, there was high-level participation from senior leadership in technical forums and HIV/AIDS campaigns. Government agencies and civil society organizations drafted policies to extend and improve quality health care coverage, which were then approved by national committees, including the policy for harm reduction for PWID. However, budget allocation for implementation of the plan is still pending.

### **(iii) MEASURES TO PROTECT HUMAN RIGHTS**

Thailand has laws and regulations in place to protect the rights of the population and guard against discrimination, including against discrimination towards those affected by HIV and AIDS. Under Article 30 of the Thailand Constitution, it is clearly specified that there must be no discrimination against persons based on ethnicity, place of origin, gender, age, language or religion.

In the past two years, there has been visible progress in the area of human rights in Thailand. There is now a master plan for human rights for the period between 2009 and 2013, which includes support for and protection of AIDS rights. With regard to the rights of people living with AIDS, a subcommittee for the “Support and Protection of AIDS Rights” was established under the

National AIDS Committee (NAC). The NASP for 2007-2011 specified that protection of the rights of people living with AIDS was to be an integral part of all implementation strategies. In spite of these measures to protect people's rights, in practice these rights are not always upheld because enforcement of the laws is unevenly applied. Furthermore, there are other laws that impede the implementation of policies and programmes on AIDS prevention, treatment and care and discriminate against some groups of population, for instance the drug law of 1979, which considers drug users as criminals.

#### **(IV) PARTICIPATION OF CIVIL SOCIETY**

Civil society groups in Thailand have actively participated in the prevention and control of HIV and AIDS since the beginning of the epidemic nearly three decades ago, and these groups increasingly play an important role in voicing the needs of the people who are affected by HIV and AIDS. Many of the components of the new National AIDS Strategic Plan for 2012-2016 arose from the advocacy efforts of civil society organizations, in particular, the establishment of the "Support for Protection of AIDS Rights" subcommittee.

In addition, civil society participated in or had representation in strategy formulation discussions for prevention and control of HIV and AIDS from the level of the NAC, to the Committee for Inter-country Collaboration, the Task Force on Strategic Proposals and the Task Force on National Monitoring and Evaluation.

Some obstacles to the full participation of civil society in policy planning and the budgeting process have been identified and ways must be considered to overcome these obstacles. There is also a strong need for improvement in the system of technical assistance to civil society groups. Concerned government organizations should improve their procedures so as to enhance the meaningful participation of civil society, for instance the preparation of documents in Thai and early calls for consultation.

#### **(V) PREVENTION**

Over the past two years, affected groups have received greater attention, with special HIV prevention projects targeting youth, most-at-risk populations and migrant workers, with financial support from external sources, mainly from the Global Fund to Fight AIDS Tuberculosis and Malaria (Global Fund). Many areas need improvement, however, for HIV prevention activities to be more effective. These include addressing and reducing stigmatization of certain population groups considered "most at risk". This has been difficult with the small budgets available to NGOs focused on this topic. Efforts also need to be

applied to put the policy on harm reduction into implementation, expand client-friendly services at hospitals and develop a better system of coordination between civil society and government departments.

There has been some improvement toward integration of the National AIDS Plan prevention strategies with provincial plans, but this has only occurred in a few provinces. Thus, integration of prevention into the routine services at the provincial level still needs improvement, and local communities need to be more aware and supportive of HIV and AIDS issues, including fostering more positive attitudes to PLHIV, if there is to be successful sustainability of the work.

### ***Prevention of mother-to-child transmission***

In 2010 and 2011, the coverage of prevention of mother-to-child HIV transmission (PMTCT) services remained very high, with 94.2 per cent of antenatal care clients who are HIV positive (HIV+) receiving anti-retroviral (ARV) prophylaxis and 99 per cent of HIV-exposed infants receiving ARV prophylaxis.

Over the past two years there have been important programmatic enhancements, including prescription of HAART triple therapy for HIV+ pregnant women, regardless of their CD4 level (Option B), to eliminate the transmission from mother to child, recommended HIV counselling and testing for partners of HIV+ pregnant women, and a scale-up of virological testing approaches for early infant HIV diagnosis.

The MoPH has implemented several key initiatives to improve coverage and quality of PMTCT services, including a national scale-up of couples counselling, identifying mechanisms to effectively implement the new policy on couples counselling, improving the data collection system related to PMTCT, improved software capability for data analysis related to PMTCT service delivery, launching new PMTCT software (PHIM-3) that compiles data on required indicators related to HIV testing, and investigation of a financially sustainable mechanism for offering PMTCT services to migrants. Furthermore, additional indicators related to HIV-related services for pregnant women, their partners and family members were recently included in the national monitoring and evaluation (M&E) system, to be consistent with global reporting recommendations.

### ***Prevention among the population of reproductive age***

In 2010 and 2011 efforts have been made to modify knowledge, attitudes, and practices among the general population (15 – 49 years). This includes education and awareness raising, testing promotion, and adoption of digital strategies for dissemination of key messages.

Furthermore, the continuation of the AIDS Response Standard Organization (ASO) approach for private businesses has put more emphasis on the quality of HIV-related services provided by private businesses. To be awarded ASO certification, workplaces must have their own policy in place for dealing with HIV issues, including prevention, referral for treatment and AIDS rights protection for their employees.

A significant milestone has been that the National AIDS Committee announced national guidelines for adoption of HIV/AIDS rights-based policies and programmes in the workplace for both public and private worksites.

### ***Prevention among youth***

In 2010 and 2011 there were some achievements in terms of efforts to prevent HIV transmission among youth, including development of a national policy and an associated strategy for reproductive health, which includes expansion of youth-friendly services, delivery of sex education in communities by NGOs, and strengthening of life skills through school-based education.

Effective implementation of the national strategy is hampered, however, by incomplete implementation in three areas. The first is insufficient sex education in schools. No national consensus has been reached on a standard sex education curriculum that is applicable for different levels of classes. A 16-hour curriculum exists but has only been implemented on a limited scale (in 9 per cent of basic education schools and in 28.7 per cent of vocational schools). To date there has been no evaluation of the effectiveness of this programme of instruction in altering behaviour. Second, there is a lack of youth-friendly service delivery. Most centres still do not meet the felt needs of the affected population and not all geographical locations are yet providing these services. Third, youth under the age of 18 who desire HIV counselling and testing still require parental consent, and this requirement restricts the ability of these youth to access services.



Various actions have been proposed to improve responses, including creating an enabling environment for safe sex; building a positive attitude among the public about sex education and for comprehensive life skills education to enable youth to access accurate information; producing innovative educational media that meet youth preferences; delivering standard youth-friendly services equitably and with full coverage, and enacting policy to allow access to voluntary counselling and testing for youth under 18 years without parental consent.

### ***Prevention among migrant workers***

Important achievements of the HIV Prevention Programme for Migrants (PHAMIT) project during the two years between 2010 and 2011 include the distribution of more than 2.5 million condoms, the distribution of HIV risk-reduction related media to over 250,000 migrant workers, and the provision of HIV counselling and testing to over 4,000 migrant workers. Furthermore, 2,500 migrant workers were screened for STIs and those with positive diagnoses received appropriate treatment and case management.

While the efforts so far are commendable, several issues need to be addressed in regard to this target group. First, the policy to hire trained migrant health workers (MHW) to assist in health care facilities (especially in the hospitals) is yet to be approved. Second, funding sources for HIV prevention among migrants need to be secured and clear guidance regarding permissible ways to use this funding is needed. Third, gaps still remain with regard to the availability and accessibility of ART among migrants.

The following measures are proposed to address these issues. First, the continuation of HIV related services for migrants needs to be planned for the period after the termination of support from the Global Fund. Second, the benefit package for both prevention and treatment for migrants needs to be reviewed to meet the same standard as that provided under the national health insurance. Third, a clear policy on ART provision for migrant workers is needed. Finally, any monitoring system needs to uphold the rights of migrants and must feed data into the implementation of evidence-based responses.

### ***Prevention among men who have sex with men***

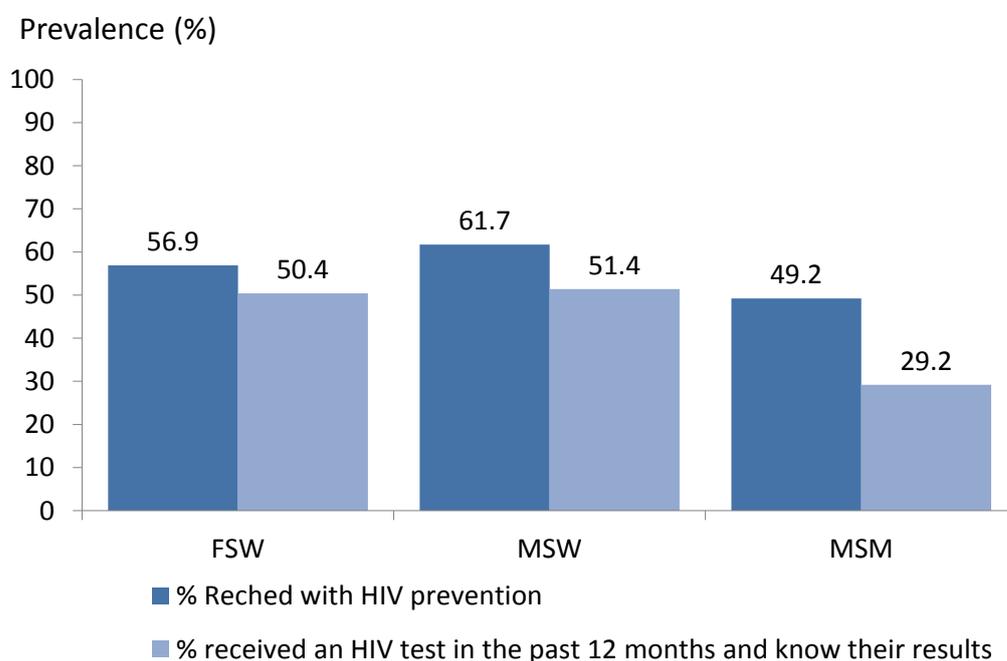
Survey data from 2010 indicate that HIV prevention programmes reached 43.8 per cent of MSMs, over two thirds (67.5 per cent) of TGs and most MSWs (61.0 per cent).

In 2010 and 2011, the government accelerated the expansion of HIV prevention interventions among MSM, MSW and TG, targeting these three populations utilizing multiple channels. Measures implemented to support treatment, care and support through collaboration with civil society and the private sector. The Comprehensive HIV Prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION) project, which focuses on HIV prevention among key affected populations (KAPs), was implemented, with support from the Global Fund, in 30 provinces, beginning in late 2010. Furthermore, the Department of Disease Control strengthened related work in 47 provinces outside the CHAMPION target areas, mainly through condom distribution and supporting initiatives by local NGOs in HIV awareness-raising.

Some success was achieved in reducing HIV incidence among the three populations (MSM, MSW and TG), but implementation of activities over the past two years was difficult in some respects. Many local communities either do not see HIV prevention as a priority or lack the capacity to effectively programme HIV prevention activities for these populations. Furthermore, leadership among the affected populations is at times weak, particularly in terms of creating awareness and concern among community leaders regarding the need to support interventions and policies targeting these groups. In addition, the strategic data required for planning and quality improvement initiatives is lacking. The poor quality of services, stigma and discrimination against these populations has resulted in decreased motivation among affected populations to seek HIV prevention services.

The recommended steps to improve responses for these groups are: first, improve coverage to target hidden groups, especially young MSM and TG, through social media addressing stigma and discrimination related to gender and sexuality; second, develop national guidelines and standard operating procedures (SOP) to standardize efforts in the area of HIV prevention among MSM and TG; third, address the capacity gap of service providers through training and re-training and links to overall organization development of NGOs and community-based organizations (CBOs) managing HIV services; fourth, strengthen local coordination, leadership and capacity through provincial coordinating mechanisms (PCMs) to address coverage and the quality of services; and fifth, strengthen the capacity of local and national policy makers to routinely generate, analyse and use information about MSM, MSW and TG.

**Figure 3: Percentage of FSW, MSW and MSM reached with key services in 2010**



Source: IBBS survey, Bureau of Epidemiology

### ***Prevention among female sex workers***

Survey results from 2010 indicate that 50.4 per cent of venue-based FSWs had been reached with prevention programmes. In 2010 and 2011, implementation of HIV prevention programmes continued, with the support from the Global Fund Round 8 as well as from the government, civil society and the private sector, through initiatives such as establishing drop-in centres (DiCs), distributing condoms and lubricant, and beginning the innovative Comprehensive Condom Programme (CCP), among others. These activities were implemented to increase access to HIV prevention services and expand coverage, increase the quality of services, intensify outreach, build the capacity of service providers and civil society workers, increase the participation of stakeholders, mobilize resources and strengthen networks.

Accomplishments in the past two years include increased coverage and quality of STI and HIV services. For instance, with the Global Fund support, the coverage of STI clinics has increased from 5 clinics in 5 provinces in 2009 to 26 clinics in 17 provinces in 2011; the participation of community leaders

increased; local resources were mobilized; policy advocacy took place through the “sex work is work” campaign; and the Subcommittee on Rights was formed, with representatives from FSW groups and other civil society groups working in this area.

There remain many challenges relating to efforts to increase the effectiveness of HIV prevention programming targeting FSW. One issue is the complexity of data collection at the national level for this population (multiple sources of data and differing techniques of data collection make it difficult to consolidate the data into a national picture of the situation). Furthermore, the referral system from outreach services provided by NGOs to VCT and STI services in hospitals needs to be improved for better linkages. In addition, FSW who are non-Thai lack access to free health care services, which is provided for Thai nationals. In this way, some laws and regulations are still an obstacle to access to prevention and health care.

### ***Prevention among people who inject drugs***

In 2010 the National AIDS Committee approved a harm reduction policy. This policy was also presented to the National Narcotics Control Board and approved as an intervention option, with pilot implementation schemes to begin in ten provinces for in the year 2011. In parallel, six complementary projects, funded by international donors, including the CHAMPION project funded by the Global Fund, were implemented in selected provinces.

There remain many challenges to address, especially the lack of understanding among the public of the underlying concepts and guidelines for harm reduction for PWID. The negative consequences and law violation of the needles and syringes programme are still debated in Thailand, and during the current reporting period the MoPH, civil society and international organizations actively advocated for full implementation of all aspects of harm reduction, and availability of voluntary, community-based treatment options. Other issues include the drug suppression and compulsory treatment policy, which impacts on access to prevention services; the low quality of services provided; dependence on external grant funding for sustainability of current pilot approaches; and enduring stigma and discrimination, which limits access to services.

To improve responses, it is necessary to: first, implement the HIV prevention plan among PWID under the National AIDS Strategy 2012-2016; second, build up understanding among drug users and those who work with drug users and with PLHIV, as well as the public, on the harm reduction programme; third,

explain channels to solve problems related to laws to facilitate the implementation of the harm reduction programme, consistent with the concept of viewing drug users as patients; fourth, advocate for the implementation of the subcommittee for support and protection of AIDS rights; fifth, establish a demonstration site for comprehensive harm reduction services; and sixth, advocate for a uniform standard of health.

#### **(VI) TREATMENT, CARE AND SUPPORT**

The combination of advocacy by civil society in the area of treatment, care and support combined with government actions has resulted in considerable progress in terms of comprehensive coverage of services for the entire eligible population. The government has continuously allocated the required budget to support the holistic care required and often provided by PLHIV. During the past two years, the government allocated a large budget to treatment, care and support through the National Health Security Office, which resulted in significantly increasing equitable coverage and access to care and treatment. The challenges are to maintain the efficiency of treatment using the 1<sup>st</sup> line regimen and to prevent drug resistance.

Other areas of progress include: development and expansion of paediatric treatment, positive prevention, and the development of models of care and treatment through self-management; development of a patient monitoring information system to support the national AIDS programme (NAP) database, including HIVQual-T, STI-Qual and early warning indicator (EWI) tools, including capacity building of staff in the use of the data; planning for improvement and expansion of counselling services for hard-to-reach and vulnerable populations, and the general population; and coordination with civil society groups and the community to improve access for PLHIV to services and public welfare assistance.

To address the remaining challenges, there is a need to expand care and treatment, especially ART, in the context of revised guidelines, which has led to a much larger treatment-eligible population. Those who do not hold Thai citizenship such as migrant workers, undocumented Thais and displaced persons are currently not eligible for state-sponsored ART, so mechanisms to ensure access to treatment for these populations must also be developed.

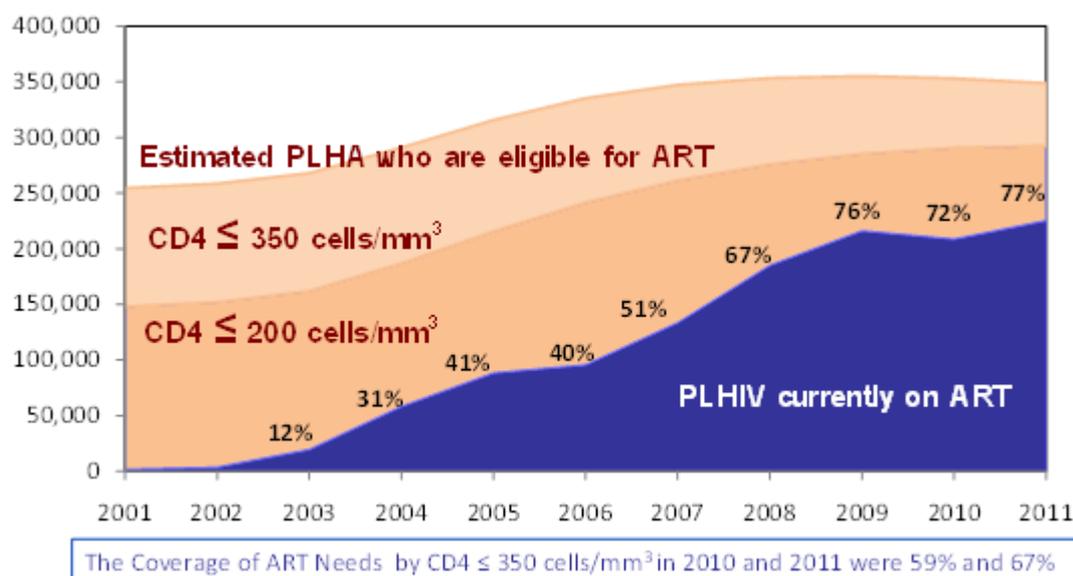
### ***Anti-retroviral therapy***

As of end 2011, 225,272 PLHIV were receiving anti-retroviral therapy at 943 healthcare facilities nationwide, of which 96 per cent were governmental hospitals. Of those on treatment, 97 per cent were adults and three per cent were children. Male and female ART clients ratio was 1:1.

Using the most recent HIV treatment guidelines by the World Health Organization (WHO), however, which recommend ART initiation at CD4 levels  $\leq 350$  cells/mm<sup>3</sup>, ART coverage was calculated at 59 per cent in 2010 and 65 per cent in 2011. Coverage of ART among females is significantly higher than among men (82 per cent vs. 54 per cent). The number of patients newly initiated on ART has remained relatively stable over the past few years, with 35,618 reported in 2011. The number of children receiving ART has been decreasing over the past few years due to the success of the PMTCT programme nationwide, resulting in fewer new infections among children, combined with a steady transition of paediatric HIV cases being transferred to adult care as they age. The retention rates of ART have been fairly stable since 2009. The rates in 2010 and 2011 at 12 and 24 months following ART initiation were 83 per cent and 80 per cent, respectively.



**Figure 4: ART coverage by estimated number of ART needs**



Source: National Health Security Office, Social Security Office, Civil Servant Medical Benefits, Department of Disease Control and Asian Epidemic Model

The overall death rate in Thailand from AIDS-related causes was 8.8 per cent in 2011. The adult HIV-attributable death rate was higher than that of children (8.9 per cent vs. 4.2 per cent); and the HIV attributable death rate among men was higher than among women (10.3 per cent vs. 7.0 per cent). A significant cause of higher rates of AIDS-related mortality is related to late diagnosis and late entry into care and treatment. Treatment initiation at an advanced AIDS stage remains a major problem in Thailand.

More than 90 per cent of all people living with HIV/AIDS have their anti-retroviral treatment financed by one of three governmental health security schemes: universal coverage, social security and the civil servant medical benefit scheme. Some patients, such as migrants, are unable to benefit from any of these three schemes, however. Treatment coverage for these populations not covered by government schemes is currently being largely supported by the Global Fund.

In 2011, only three per cent of ART facilities (18 of 574 surveyed facilities) in Thailand reported drug stock-out experiences. Most of these occurred during the 2011 floods. Although the overall stock-out period was very short, about half of all affected patients had to either change their ART regimen or

temporarily stop ART. To respond to anti-retroviral medication shortages during the 2011 floods, the TNP+ together with the AIDS ACCESS Foundation, in collaboration with the National Health Security Office, the Department of Disease Control in the MoPH, and the Thailand MoPH and United States Center of Disease Control Collaboration (TUC), developed and implemented an emergency response action to help PLHIV in flooded areas access their medication and reduce treatment interruption.

### ***Co-management of tuberculosis and HIV***

Thailand is one of the 22 high-tuberculosis-burden countries. Based on tuberculosis (TB) programme records, in 2011, 90.8 per cent of Thailand's TB patients were tested and counselled for HIV. According to a HIVQUAL-T survey, there was an increase in TB screening among adults and children in HIV care over the past two years, rising from 97 per cent in 2010 to 98.9 per cent in 2011.

Using the estimated number of TB/HIV co-infection cases, based on the TB incidence rate among patients living with HIV, as identified by the WHO, 27.7 per cent of HIV-positive incident TB cases received treatment for both HIV and TB.

Current national guidance on isoniazid preventive therapy (IPT) recommends considering IPT where feasible. This is particularly the case for children under 5 years of age.

In 2010 and 2011, achievements in the prevention and care of TB in patients with HIV included the allocation of funds by the National Health Security Office for TB prevention at the provincial and community levels and treatment of TB in 140 prisons. In 2010, the protocol for Thailand's second national TB prevalence survey was approved and the survey is scheduled to be conducted in 2012.

Challenges associated with the reduction of tuberculosis prevalence in patients with HIV include the need for improvement in the quality of directly observed treatment short course (DOTS), in order to ensure the success of treatment for tuberculosis, particularly in large cities such as Bangkok. There is also a need to strengthen integrated TB/HIV services; to ensure greater application of national guidelines for multi-drug-resistant (MDR)TB control, including provision of training in the control and prevention of MDR-TB; and to strengthen the M&E system related to tuberculosis control (particularly in the area of data collection from private hospitals).

### ***Care and support for children affected by HIV and AIDS***

This population includes children who are living with HIV as well as children in families in which a father or mother is ill with HIV or has died from AIDS. Data on this population provide for inconclusive analysis as there has been no systematic approach to data collection focused on this population. The number of children infected with HIV receiving ART in 2011 was about 6,510. Many children affected by HIV and AIDS receive care and assistance in many areas, from multiple government ministries, such as the MOPH, the MSDHS and the Ministry of Education as well as from private institutions and non-governmental organizations. Actual coverage levels or corresponding levels of quality are unknown due to limited data collection. A significant number of affected children are in the care of welfare institutions because their parents are poor or because of associated stigma and discrimination in caring for this population.

An important achievement during the reporting period includes the successful application for funds from the Global Fund for a five-year period in the amount of 42 million USD, to be used for programmes of care and support for vulnerable children, including children affected by HIV and AIDS in high HIV prevalence areas. The programme includes integration and strengthening of health, social protection and community systems. Regarding treatment, there have been improvements recommended to the models for care of HIV+ children by the Sri Nakarin Hospital of KhonKaen Province and the Chiang Rai Prachanukroh Hospital. In addition, there has been joint planning with the AIDS ACCESS Foundation to scale up application of their model throughout the country. In the National AIDS Strategic Plan for 2012-2016, it is specified that children affected by HIV and AIDS will be a core focus population whose needs will have to be addressed and responses evaluated.

A key remaining challenge, as noted above, is that to date there has been a lack of quantitative and qualitative data about children affected by HIV and AIDS, including coverage of services. Stigma and discrimination continue to impede access to services, and HIV+ children who are transitioning through adolescence and who need treatment and care for psycho-emotional stress, as well as reproductive health care, still do not have sufficient access to these services.

## **(VII) RESPONSE TO INTIMATE PARTNER VIOLENCE**

Thailand does not have updated data that could be used to respond to the issue of Intimate Partner Violence (IPV). Only a few sources of information are available on the subject, such as reports from the Office of Women's Affairs and Family Development (OWAFD), the MSDHS, and the National Statistics Office's 2009 Reproductive Health Survey. Data from these sources reveal that only a small number of women have reported IPV and reported cases have been mostly in terms of physical rather than sexual abuse. The only reliable source of information on IPV is the survey on Violence in Intimate Relationships and Women's Health (2003) undertaken by the Institute for Population and Social Research of Mahidol University and the Foundation for Women, supported by WHO. This study found that out of 2,818 ever-partnered women aged between 15 and 49 interviewed in Bangkok and in an upper-central province, nearly 50 per cent of respondents reported having experienced physical or sexual violence by their intimate partners.

Despite the lack of up-to-date data on IPV, several national efforts were initiated by government agencies and NGOs in 2010 and 2011 to address the problem of intimate partner violence. Efforts included the campaign led by the United Nations Women (formerly UNIFEM) Goodwill Ambassador, Her Royal Highness Princess Bajrakitiyabha, in which Thailand contributed 622,189 actions taken by Thai individuals on the end of violence against women, as part of the "UN Women Say No-UNITE Campaign" in support of the UN Secretary-General's UNITE to End Violence against Women campaign.

In addition, Thailand included targets for ending violence against women in the Women's Development Plan (in the National Development Plan 2007-2011), the Joint Strategic Plan and Action Plan in Support of the Protection Against Domestic Violence Against Women Act (2009-2013), and the MSDHS implementation of policies and programmes on Ending Violence Against Women (EVAW). Furthermore, the Raks Thai Foundation and the Thai Positive Women's Network explored the intersection between HIV and violence against women and a number of research projects were carried out to enhance knowledge on this particular issue.

In 2010 and 2011, under the leadership of Her Royal Highness Princess Bajrakitiyabha, Thailand successfully initiated and facilitated the 2010 adoption by the UN General Assembly on the UN Rules for Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (known as the Bangkok Rules). At the same time, justice organizations developed guidelines



supporting implementation of the *Domestic Violence Act*. In addition, the One Stop Crisis Centre (OSCC) organization has planned to set up centres in 150 community hospitals nationwide, in addition to the existing 783 OSCCs set up in 2009.

Gaps remain to be filled in this area, starting from a lack of knowledge and understanding on the concepts of gender and sexuality, the need for improved data quality and research, and the need to strengthen coordination among involved organizations. Other challenges include the need for effective implementation of the *Domestic Violence Act*, clearer structure and working mechanisms of OSCCs, strengthening of the referral system for affected women, increasing accessibility to services for non-Thai women, improving understanding of the vulnerability of HIV positive women, and strengthening national mechanisms to promote gender equality.

### **(C) PROGRESS MADE ON THE KEY CHALLENGES REPORTED IN THE 2008-2009 COUNTRY PROGRESS REPORT**

#### **(i) ACCELERATED IMPLEMENTATION AND BUILDING A SENSE OF OWNERSHIP AMONG STAKEHOLDERS FOR PREVENTION AND CONTROL OF HIV AND AIDS**

On 24<sup>th</sup> July 2009, the NAC passed a resolution to produce an accelerated, integrated plan in 2011 for HIV prevention to reduce new infections by half. The National AIDS Management Center (NAMc) and the Coordination Centre for Development of the HIV Prevention Approach and Mechanism effort (secretariat office of the Subcommittee for Advancing the Prevention Programme), in collaboration with partners from the government and civil society sectors, developed a plan for accelerated implementation over a period of 24 months and then presented recommendations for funding to the NAC. Due to the severe flooding in many parts of the country in 2011, the government was unable to provide funding for the recommended actions, however, despite approving of them in principle. The issue was forwarded to the Thailand Health Promotion Foundation and the National Health Security Office (NHSO) for consideration.

In addition, Joint Key Performance Indicators for HIV prevention have been developed to facilitate an effective and coordinated inter-ministerial response. These indicators have been approved at cabinet level.

**(II) POLICY DEVELOPMENT THROUGH ACTIVE PARTICIPATION OF THE GOVERNMENT AND CIVIL SOCIETY TO INCREASE ACCESS TO PREVENTION, CARE AND TREATMENT FOR HARD-TO-REACH POPULATIONS INCLUDING PWID, MIGRANTS AND ETHNIC MINORITIES**

Since the end of 2009, the Office of the Narcotics Control Board (ONCB), the Department of Medical Services, the DDC, the 12D Network, the PSI Foundation, the Thai Drug Users Network, and related partners, including the Attorney-General, the Ministry of Interior, the Police Department, and with technical assistance from UNAIDS, the United Nations Office on Drugs and Crime (UNODC) and the WHO, produced a draft harm reduction policy for PWID. The Senate Health Subcommittee convened a hearing to solicit opinions. The draft was approved by the NAC and referred to the National Drug Control Committee, which instructed the ONCB to conduct a pilot implementation of the policy in 10 provinces. The Council of State interpreted the policy as promoting the use of injection equipment for illegal drug use, however, and the policy is therefore considered as promoting crime. Thus, unless there is a dissolving of parliament and a new government is elected with a different interpretation, further action cannot be taken.

Cross-border migrants and ethnic minorities have been identified as a target group for reduction of AIDS mortality in the coming five-year NASP for 2012-2016, which stipulates universal access to treatment and quality care and standard services. As yet, there has been no implementation of the policy of HIV prevention, care and treatment for this group, however.

**(III) DEVELOPMENT OF THE SYSTEM OF COUNSELING SERVICES AND IMPROVEMENT IN QUALITY**

The NHSO approved a plan to improve the system and quality of counselling services, with the objective of increasing entry into HIV treatment services at the earliest possible time, and to ensure that those receiving ART are able to take care of themselves more fully and experience a greater quality of life. The NHSO approved a budget for the first year of the plan period in the amount of 30 million THB, with the BATS/DDC as the coordinating agency for implementation.



#### **(IV) PREVENTION AND REDUCED IMPACT ON CHILDREN AND FAMILIES OF PLHIV THROUGH MEASURES BEGINNING AT THE TIME OF ANC SERVICES FOR THE INFECTED**

The DOH has expanded the programme to increase measures to prevent HIV among pregnant women. This is through greater partner participation (“Couples ANC”), and the DOH is in the process of integrating this service into the routine system. In addition, the DOH instituted a new programme, the Sai Yai Rak programme, which requires all health service outlets in the MoPH system to conduct pre- and post-test couples counselling, while ensuring confidentiality, and including, as an evaluation indicator, the participation of at least 20 per cent of the husbands or partners of pregnant women presenting for ANC.

#### **(V) PROTECTION OF THE RIGHTS OF PEOPLE LIVING WITH AIDS**

The NAC has appointed a subcommittee to support and protect the rights of people living with HIV and AIDS. The subcommittee includes members from the government, civil society and technical sectors.

#### **(D) KEY CHALLENGES IN 2010 AND 2011 AND REMEDIAL ACTIONS**

##### **(I) PREVENTION OF HIV INFECTION**

###### **Challenges:**

Over the past two years it has been observed that there is not enough outreach to maximize intervention exposure (to prevent HIV) among the key affected populations, i.e. MSM, sex workers and PWID as well as hard-to-reach groups such as migrant workers and ethnic minorities.

Although sex education in schools has been greatly expanded, there is still insufficient coverage. Gender sensitivity continues to be a weak component in sex education. Programme expansion and quality control remain major challenges because of a lack of clear policy support and resource allocation from the education sector.

Access to condoms, including affordability, remains a challenge due to the commitment to establish a sustainable infrastructure that appeals to youth and the key affected populations at the community level. Furthermore, social stigma relating to non-marital sex tarnishes the image of condoms.

### **Remedial actions:**

In 2010 and 2011, the Global Fund supported programme on HIV prevention targeted youth, MSM, FSW, PWID, prisoners and migrants for major interventions.

### **(II) TREATMENT, CARE AND SUPPORT FOR PLHIV AND CHILDREN AFFECTED BY HIV AND AIDS**

#### **Challenges:**

*VCT:* The number of people in all groups seeking VCT services is still low. Low utilization can be attributed to problems accessing testing services and the fact that use of tests that provide same-day results are still under consideration. This means that a significant proportion of individuals tested do not return for their results.

The majority of people living with HIV enter into care at an advanced stage of disease progression. In 2010 and 2011, around 50 per cent of newly registered HIV+ people had CD4 less than 100 cells/mm<sup>3</sup> and 60 per cent of those with newly initiated ART had CD4 less than 100 cells/mm<sup>3</sup>.

*Adolescents living with HIV:* Youth living with HIV who are becoming sexually active are a key concern as they tend to have lower ARV drug compliance and often engage in unsafe sex. The increased risk among adolescents and the inability to address this issue effectively is due to a lack of expertise in child psychology and adolescent sexuality on the part of health care providers, and a lack of psycho-social support regarding disclosure on the part of adolescents.

*Access to ART:* Migrant workers in Thailand are ineligible to access government-subsidized ART. Furthermore, there are still discrepancies in ART services among three schemes of health services provided to Thai PLHIV.

#### **Remedial actions:**

In 2011, the Bureau of AIDS, TB and STIs (BATS) of the DDC, in collaboration with government and civil society organizations, with grant support from the National Health Security Office, launched a project to improve the HIV continuum of care, including VCT, pre-ART and ART.

In addition, the DDC and the ACCESS Foundation, with a grant from the Global Fund, began implementation of a project on care for vulnerable children, including children infected and affected by HIV and AIDS in high HIV prevalence areas. Systems surrounding health, social protection and community care will be strengthened and integrated to provide holistic care for vulnerable children and children affected by HIV and AIDS.

Furthermore, in 2010 and 2011 the Global Fund supported the provision of ART for 2,700 migrants living with HIV under an extension project by the BATS as part of the National Access to ART for PLHIV. Thailand has recently made efforts to extend the provision of work permits. Whereas this extension was previously only reserved for registered migrants, the newly adopted policy now affords work permits to unregistered migrant workers following certification of their nationality, and these people are eligible to receive ART under the social security scheme. But in 2011 there were around 3,000 migrants on the waiting list for such services, according to lists kept by civil society organizations.

### **(III) REDUCTION OF STIGMA AND DISCRIMINATION**

#### **Challenges:**

Help and health-seeking behaviour related to STIs, VCT and access to clean needles, methadone and condoms are impeded by stigma and negative attitudes about sex and harm reduction among service providers, parents, community leaders and society as a whole.

Furthermore, a lack of gender sensitivity is pervasive in the areas of HIV programming, service provision and communication. Violence against women is a significant co-factor for HIV vulnerability of women and needs to be addressed more vigorously.

In addition, sex workers, PWID and migrant populations continue to face limited access to both prevention and care services because of policy and legal barriers as well as stigma and language differences, and these groups are often subject to human rights violations in the forms of involuntary testing and disclosure of test results.

#### **Remedial actions:**

In late 2011, the NAC Subcommittee to Support and Protect AIDS Rights organized a seminar on the issues of involuntary testing for HIV and harm reduction and is working on drafting an operational plan to support and protect the rights of people living with HIV and AIDS.

In addition, with a grant from the Global Fund for HIV prevention among key affected populations, the Foundation for AIDS Rights facilitated a workshop on AIDS rights, aiming to establish rights protection mechanisms at the provincial level. Furthermore, the Foundation for AIDS Rights, in cooperation with civil society partners, collected and published an annual report on AIDS rights. The report was shared with government agencies, civil society groups and international organizations in Thailand.

#### **(IV) PROGRAMME MANAGEMENT**

##### **Challenges:**

*Strategic information:* Inadequate data systems and data gathering protocols do not provide for analysis of successes and identification of specific areas where programme effectiveness is limited. Data from private health services continue to be difficult to obtain.

*Multi-sector collaboration:* Greater collaboration between government, civil society and the private sector is needed to increase the impact of prevention and care efforts related to HIV, sexual health and harm reduction. The business sector and community groups should be more involved to ensure that employees and community members receive adequate, non-stigmatized, non-discriminating HIV and AIDS-related services for prevention, care, social protection and impact alleviation.

##### **Remedial actions:**

In 2011, the national strategic information and monitoring and evaluation plan for AIDS response for the period between 2012 and 2016 was developed by the National AIDS Management Center through broad consultation with government agencies, civil society groups and development partners.

A curriculum of M&E training, focusing on the Routine Integrated HIV Information System (RIHIS), was developed and used to train principal recipients, sub-recipients and sub-sub-recipients of the Global Fund grants as well as the Office of Disease Prevention and Control and members of the provincial coordinating mechanism. Three provinces were piloted to develop area based monitoring and evaluation system was piloted in three provinces.

## **(E) KEY SUPPORT FROM INTERNATIONAL DEVELOPMENT PARTNERS**

In 2010 and 2011, international development partners to Thailand provided support for HIV and AIDS prevention and treatment in three key areas. Firstly, support was provided, mainly by the Global Fund, to address the country's gaps on scaling-up HIV prevention. Secondly, the United States Government (through the TUC and USAID) and UN agencies continued to provide technical and financial support for developing innovative models to improve the efficacy and effectiveness of the national response to the epidemic, as well as for replicating models and spreading them nationwide. Thirdly, support was provided in terms of making key strategic information available, strengthening the M&E structure and improving the use of data for strategic planning and management and enabling evidence-based decision making and planning.

The overall financial contribution from international development partners (1,145 million THB in 2010 and 1,422 million THB in 2011) made up about 15 per cent of total AIDS spending in 2010 and 2011, an increase from 7 per cent in 2009. The major share of the contribution from international development partners went towards prevention, 42 per cent in 2010 and 2011, which represented a significant increase from 29 per cent in 2009. The largest contribution was from the Global Fund, with complementary technical assistance from the United States Government (USG) and UN agencies.

## **(F) MONITORING AND EVALUATION**

During the past two years, Thailand has mobilized agencies, developed plans and allocated budgets for monitoring and evaluation. In 2010, a new national M&E plan was developed relating to programmes for prevention of new infections in key affected population. It has been evident since then, however, that there are shortcomings in many areas, including in staff capacity, the amount of the budget allocated, and management, which is not yet unified. More effort is needed to make M&E more effective so as to produce accurate and reliable information for decision making and planning. It is clear that there is still a need for technical and financial support from international donors.

In recognition of the importance of M&E, the National AIDS Strategic Plan for 2012-2016, which was developed in 2011, incorporated M&E components as one of its three core priorities, with the emphasis on Strategic Information (SI). The plan measures progress towards achieving national goals and objectives, including Thailand's commitment to reaching "the three zeros": zero new infections, zero AIDS-related deaths and zero discrimination, in an efficient and timely manner.

Through partnership and collaboration between government organizations (health and non-health), civil society and academics, several significant achievements were made during the reporting period (2010-2011). At the national level, joint key performance indicators were developed and were committed to by line ministries for collective and synergistic efforts towards a national HIV and AIDS response. Furthermore, a routine integrated HIV information system was initiated for monitoring the HIV prevention programme targeting the KAPs, including both community and facility-based services.

In addition, success was achieved in leveraging financial support to undertake critical evaluation studies and successfully implement key research and studies. In mid-2010, a national evaluation agenda for HIV and AIDS was developed and seven priority evaluation questions were selected through a national consensus workshop. In 2011, Thailand established a National Evaluation Task Force as a national mechanism to manage the implementation of evaluations, ensure technical quality and data use for decision making. As of December 2011, five evaluations had been undertaken, with funding of USD 1.2 million.

### **(G) NATIONAL AIDS SPENDING ASSESSMENT**

The National AIDS Spending Assessment notes that total expenditures on HIV and AIDS programs totaled 7,733 million THB (approximately 257.8 million USD) in 2010 and 9,922 million THB (approximately 330.7 million USD) in 2011. These figures were 0.08 % and 0.09% of the Gross Domestic Product (GDP) in 2010 and 2011 respectively, and 2.0% and 2.4% of all health expenditures in 2010 and 2011, respectively.

A sizeable percentage (85%) of expenditures came from domestic sources for both years. The government budget through the National Health Security Office (NHSO) provided for a significant portion of HIV/AIDS spending largely focused on care and treatment. With respect to AIDS-spending categories, care and treatment accounted for 73% of overall HIV-related spending. The amount of spending for the care and treatment category increased significantly from 5,676 million THB (approximately 186.7 million USD) from 2010 to 7,261 million THB (approximately 237.2 million USD) in 2011. Prevention accounted for 13% of overall HIV-related spending for both years. A significant proportion of funding for prevention came from external sources (47.8% and 44.3% for 2010 and 2011 respectively), of which 90% and 93% for the two years came from the Global Fund Against AIDS, Tuberculosis and Malaria.



Spending on the enabling environment, which has been indicated as one key factor to achieve the zero stigma and discrimination goal in the National AIDS Strategy for 2012-2016, accounted for 1.3% and 1.4% of total HIV/AIDS spending in 2010 and 2011 respectively.

The country has recognized the needs of ensuring sustainable domestic funding for its HIV prevention activities, particularly to continue activities already initiated with GFATM support. Establishment of an HIV prevention fund has been indicated as a priority area in the National AIDS Strategy Plan for 2012-2016.

**Table 2: Thailand AIDS spending for 2011 and 2012**

AIDS spending Categories	2011		2012	
	mil. THB	%	mil. THB	%
1. Prevention	1,015	13.1	1,334	13.4
2. Care and treatment	5,676	73.4	7,261	73.1
3. Orphans and vulnerable children (OVC)	24	0.3	24	0.3
4. Program management and administration strengthening	195	2.5	320	3.2
5. Incentives for human resources	147	1.9	207	2.1
6. Social protection and social welfares (excluding OVC)	224	2.9	224	2.3
7. Enabling environment	124	1.6	169	1.7
8. Research excluding operational research	330	4.3	383	3.9
<b>Total</b>	<b>7,733</b>	<b>100.0</b>	<b>9,922</b>	<b>100.0</b>



## (H) OVERVIEW INDICATORS FOR THAILAND

**Table 3: Core indicators for Global AIDS response progress reporting (Thailand), 2006-2011**

Core indicators for Global AIDS response progress reporting		Year of data collection						Remarks
		2006	2007	2008	2009	2010	2011	
<b>Target 1 Reduce sexual transmission of HIV</b>								
<b>General Population</b>								
1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	37.4						Data not available The most recent data that is available regarding HIV prevention among the general population is from the 2006 National Household Survey.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the aged of 15	4.8						
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	9.4						
1.4	Percentage of adults aged 15-49 who have had more than one partner in the past 12 months who report the use of a condom during their last intercourse*	50.9						
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	19.1						
1.6	Percentage of young people aged 15-24 who are living with HIV	1.0	0.6	0.58	0.58	0.44	0.44	National estimates were derived from the HSS, which reports a median figure of the averages for each province.



Core indicators for Global AIDS response progress reporting		Year of data collection						Remarks	
		2005	2006	2007	2008	2009	2010		2011
<b>Target 1 Reduce sexual transmission of HIV</b>									
<b>Sex workers</b>									
1.7	Percentage of sex workers reached with HIV prevention programmes	Data not available						50.4	Thailand adopted a standard definition for this indicator in its 2010 IBBS survey.
	- FSW (venue based)	Data not available						61.0	Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
1.8	Percentage of sex workers reporting the use of condom with their most recent client	Data not available						95.6	Thailand adopted a standard definition for this indicator in its 2010 IBBS survey. Data on consistent condom use is available from 2006 to 2010.
	- FSW (venue based)	88.3		89.2			88.0	Source: IBBS in three provinces	
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Data not available						47.8	Thailand adopted a standard definition for this indicator in its 2010 IBBS survey.
	- FSW (venue based)	44.3		54.2			49.0	Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)	
1.10	Percentage of sex workers who are living with HIV	Data not available							Source: The HSS survey reports a median figure of the HIV prevalence among provinces.
	- FSW (venue based)	3.8	2.6	3.6	2.8	1.9	2.7	1.8	Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
	- MSW	15.6		20.7			16.0		
<b>Men who have sex with men</b>									
1.11	Percentage of MSM reached with HIV prevention programmes	Data not available						43.8	Source: Yr 2005, 2007: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket) Yr 2010: IBBS in 12 provinces
1.12	Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner	79.9		81.0			80.2		
1.13	Percentage of MSM that have received an HIV test in the past 12 months and know their results	28.5		35.2			14.9		



1.14	Percentage of MSM who are living with HIV	19.2		24.5			8.0		
<b>Core indicators for Global AIDS response progress reporting</b>		<b>Year of data collection</b>						<b>Remarks</b>	
		<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>		
<b>Target 2. Reduce transmission of HIV among people who inject drugs</b>									
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringes programs	Data not available				9.8		Source: IBBS in 3 provinces (Bangkok/surrounding areas, Chiang Mai, and Songkla) using RDS (weighted)	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse					46.0			
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected					77.7			
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results					40.7			
2.5	Percentage of men who inject drugs who are living with HIV					21.9			
<b>Target 3 Eliminate mother-to-child transmission of HIV</b>									
3.1	Percentage of HIV positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission	90.1	95.9	93.6	95.0	94.2	94.0		
3.2	Percentage of infants born to HIV-positive women who receiving a virological test for HIV within 2 months of birth					75.8	73.1		
3.3	Mother-to-child transmission of HIV					3.8	3.0	Source: Service reports using virological testing	

Core indicators for Global AIDS response progress reporting		Year of data collection						Remarks
		2006	2007	2008	2009	2010	2011	
<b>Target 4. Anti-retroviral Treatment</b>								
4.1	Percentage of eligible adults and children currently receiving anti-retroviral therapy							Estimated number of adults and children with advanced HIV infection using AEM (Asian Epidemic Model)
	- CD4 <200 cells/ml	41.0	52.9	67.1	75.8	71.8	77.0	
	- CD4 <350 cells/ml	-	-	-	-	59.1	64.6	
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti-retroviral therapy			79.3	85.1	80.7	83.1	
<b>Target 5. Reduce tuberculosis deaths in people living with HIV</b>								
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	32.6	n/a	24.1	25.5	26.1	27.7	
<b>Target 6. Reach a significant level of annual expenditure</b>								
6.1	Domestic and international AIDS spending (millions of THB)	n/a	6,728	6,928	7,208	7,733	9,922	
<b>Target 7. Critical enablers and synergies with development sectors</b>								
7.2	Proportion of even-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the previous 12 months						Data not available	Thailand currently plans to integrate IPV into its 2013 Reproductive Health Survey.
7.3	Current school attendance among orphans and non-orphans aged 10-14						Data not available	Updated MICS data will be available in late 2012 or early 2013.
	- Orphans	95.5					Data not available	
	- Non-orphans	96.4					Data not available	
7.4	Proportion of the poorest household who received external economic support in the last 3 months						Data not available	Data will be available at the end of 2012 or early 2013.



## II. OVERVIEW OF THE AIDS EPIDEMIC

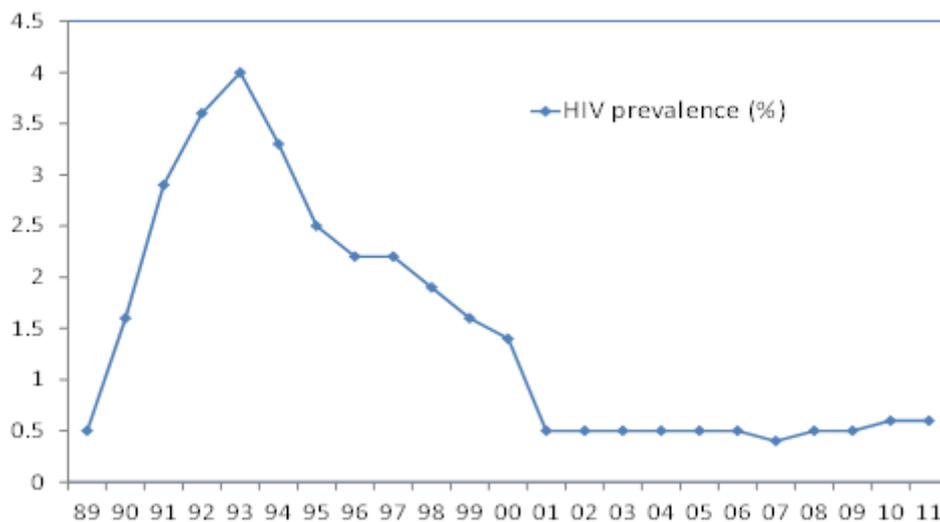
### (A) HIV TRENDS IN THE GENERAL POPULATION

#### A.1. PREVALENCE OF HIV IN THE GENERAL PUBLIC

Army recruits, blood donors and pregnant women who visit ANC clinics are used as proxy groups to measure HIV prevalence in the general population. Although HIV prevalence rapidly declined in the general population between 1995 and 2007, as indicated by HIV surveillance among these groups, the data since 2007 indicates that during the past five years this decline in HIV prevalence has tapered out, with prevalence remaining constant in most groups, with even an increase among some groups.

Army military recruits tested HIV positive at a level of 0.5 per cent in 2011, a figure that has remained fairly constant for the past ten years, but with a slight increase in prevalence in recent years. There also seemed to be increasing incidence of HIV among the blood donor population aged 20-24 years (Figures 5-6).<sup>1</sup>

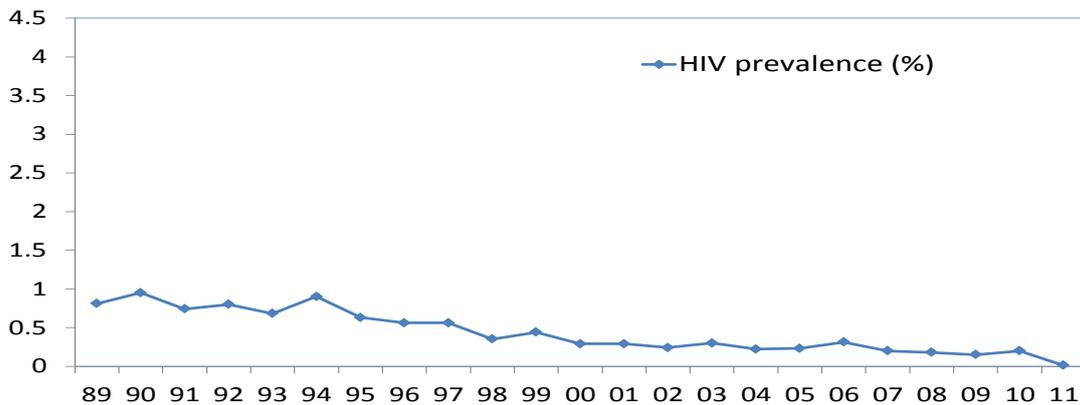
**Figure 5: HIV prevalence among male military conscripts, Thailand, 1989-2011**



Source: HIV serosurveillance, The Armed Forces Research Institute of Medical Science (AFRIMS)

<sup>1</sup> HIV serosentinel surveillance by Bureau of Epidemiology and AFRIMS

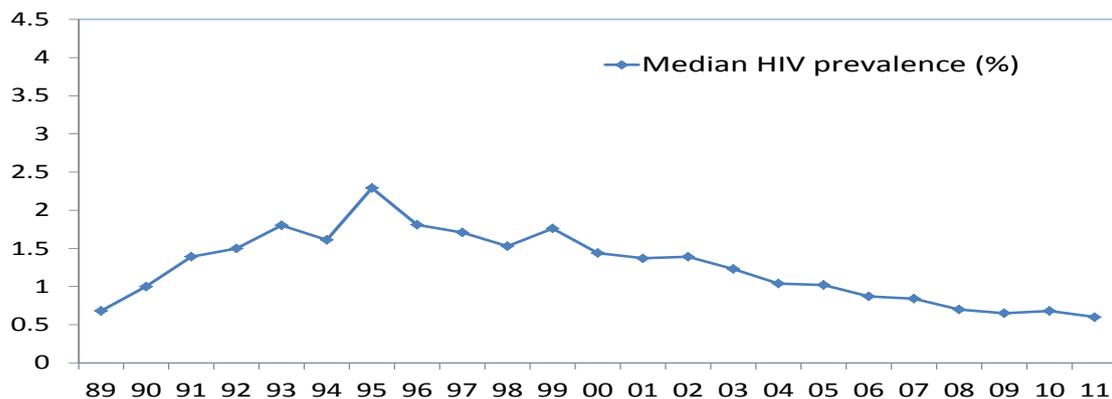
**Figure 6: HIV prevalence among blood donors, Thailand, 1989-2011**



Source: HIV Serosurveillance, Bureau of Epidemiology

Results of the HSS conducted by the Bureau of Epidemiology in 68 sites around the country in 2010-2011 indicated that the HIV prevalence level among ANC clinic clients (pregnant women) was 0.6 per cent, representing a continuing decline in prevalence over the past three years, from 0.65 per cent in 2010 and 0.7 per cent in 2009.<sup>2</sup> Among young pregnant women (less than 20 years), there is increasing prevalence, however. Data from the HSS indicate that prevalence of HIV in young pregnant women increased from 0.2 per cent in 2010 to 0.4 per cent in 2011.

**Figure 7: Median HIV prevalence among pregnant women in Thailand, 1989-2011**

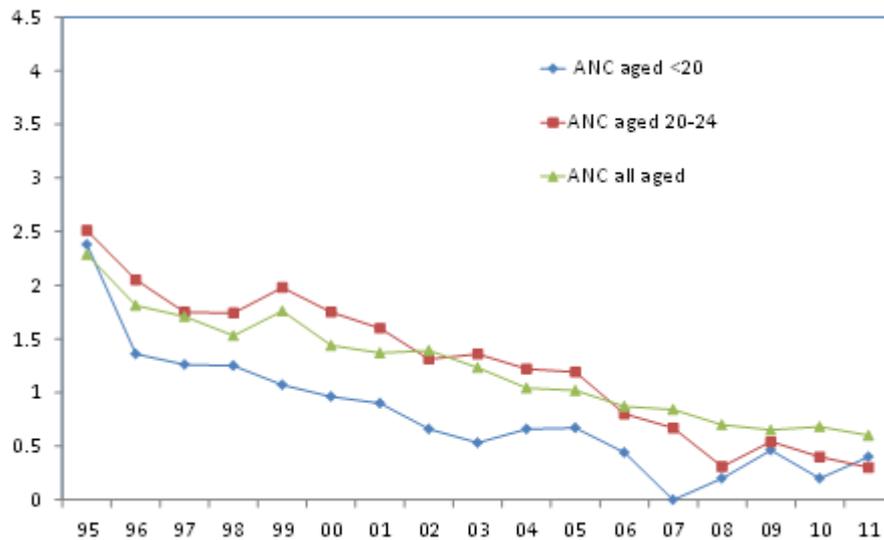


Source: HIV serosurveillance, Bureau of Epidemiology

<sup>2</sup>PHIMS from Department of Health and Bureau of Epidemiology



**Figure 8: Median HIV prevalence among pregnant women, classified by age group, Thailand, 1995-2001**



Source: HIV serosurveillance, Bureau of Epidemiology

Findings from surveys conducted by the Bureau of Epidemiology indicate that condom use by male labourers (at last sex with a casual partner) in 2011 was the same as the level of two years ago. On the other hand, condom use by male labourers aged under 25 (youth) at last sex with a male sex worker declined over the past two years. These findings are consistent with the findings of the Thai Business Coalition on AIDS (TBCA). It is possible to hypothesize that the inconsistent condom use among men with multiple partners, men having sex with female or male sex workers might impact on HIV incidence patterns, especially among those aged under 25 years.

From the 22 BSS sentinel sites, the assessment of AIDS knowledge and understanding among labourers and factory workers as measured by correct answers to the five UNGASS AIDS knowledge questions found that knowledge and understanding had declined rather noticeably in 2011, compared with knowledge and understanding in 2009.

Among upper high school and vocational school students (youth) and among army recruits, knowledge about HIV and AIDS declined in the period between 2010 and 2011 (less than 30 per cent of students and 36.5 per cent of army recruits answered the UNGASS questions correctly). At the same time, the tendency to have more than one sex partner increased in all three groups of youth, especially among vocational school students, with a slight increase in the level of condom use.



**Table 4: BSS data on HIV risk among youth, 2009-2011**

Groups	Indicators	Yr 2009 (N)	Yr 2010 (N)	Yr 2011 (N)
High school students (male and female aged 16 yrs)	% had sex with more than one partner in past 12 months	4.5 (15,231)	4.8 (17,126)	5.1 (19,151)
	% of those had sex with more than one partner in past 12 months used condom during their last intercourse	48.3 (685)	45.5 (824)	50.1 (979)
Vocational students (male and female aged 16 yrs)	% had sex with more than one partner in past 12 months	13.6 (15,039)	14.8 (14,736)	16.3 (14,183)
	% of those had sex with more than one partner in past 12 months used condom during their last intercourse	46.9 (2,045)	47.2 (2,172)	49.5 (2,307)
Army recruits (male aged 21 yrs)	% had sex with more than one partner in past 12 months	38.8 (1,646)	38.7 (2,451)	42.9 (2,579)

Source: Behavioural Surveillance Survey, Bureau of Epidemiology

Among the different strains of HIV spreading around the world, the HIV sub-type C accounts for 50 per cent of cases, followed by A (12 per cent), B (10 per cent), E (5 per cent) and other subtypes. Sub-type E predominates in Southeast Asia, including Thailand. Specifically, the Thai variant is CRF01\_AE and accounts for 95 per cent of local cases followed by the sub-type B MN strain (4 per cent), and a hybrid strain called 01B (1 per cent).

In past programme implementations, there have been campaigns to promote condom use in sexual encounters, but these campaigns have not been enough to stop the spread of HIV, especially not among married couples, who generally do not use condoms. Additional measures are needed to reduce incidence, such as an AIDS vaccine. There is an urgent need for greater vaccine research on the strains common to Thailand (sub-type E) as international research is mostly focusing on a vaccine for HIV sub-type B which is more common in Europe and North America, but such a vaccine would only be of marginal use for prevention in Thailand.

## **A.2. MOTHER-TO-CHILD TRANSMISSION**

The rate of HIV transmission from mother-to-child was estimated to be 3.0 per cent in 2011. Current data indicate higher rates of HIV incidence among women not receiving ante-natal care than among those receiving it. Explanations for this are unclear, but may be because women with less access to ANC (e.g. undocumented migrants) may have higher rates of HIV infection, or because women diagnosed with HIV in a prior pregnancy are less inclined to disclose their HIV status in the current pregnancy, particularly if they are already receiving ARVs for their own health.

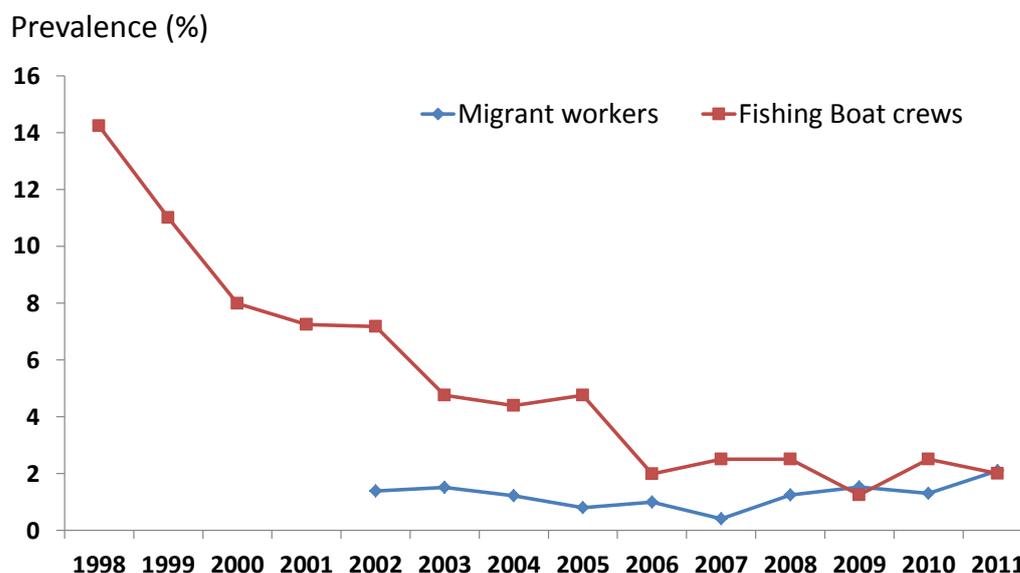
National prevention of mother-to-child-transmission (PMTCT) data obtained during the 2010-2011 reporting period found that all (1,324) health facilities at the district level and above provide free PMTCT services. Over 99 per cent of pregnant women were tested for HIV in 2011 and 94 per cent of HIV-positive pregnant women received ARVs to reduce mother-to-child transmission (MTCT). Rates for these indicators have remained above 90 per cent over the past three global reports covering the past six years, demonstrating continued national commitment to reducing MTCT of HIV.

In 2011, 73.1 per cent of infants born to HIV-infected women received a virological test for HIV. While this figure is recognized as being laudable, efforts are underway nationally to further increase coverage of virological testing of HIV-exposed infants. Rates of cotrimoxazole prophylaxis are somewhat lower (42 per cent) and efforts are also underway to widen coverage. Data on breastfeeding practices are not collected as breastfeeding is not recommended in Thailand for HIV-infected women.

## **A.3. HIV SITUATION AMONG MIGRANT WORKERS**

In 2011, the overall HIV prevalence was 2 per cent among fishermen, compared to 2.1 per cent among migrant workers. HIV prevalence among non-Thai migrant workers has increased since 2007, rising from 0.41 per cent in 2007 to 2.1 per cent in 2011. HIV prevalence among fishing boat crew, almost all of whom are non-Thai, has declined since 1997 and has remained fairly stable since 2006 (Figure 9).

**Figure 9: HIV prevalence among non-Thai migrant workers and fishing boat crews, Thailand, 1998-2011**



Source: HSS among fishing boat crews and migrant workers, Bureau of Epidemiology

Migrant workers are considered as migrants coming from the three neighbouring countries of Myanmar, Cambodia and Lao PDR. It is estimated that in 2011 the total number of migrants in the country, including children and other dependents, was between three and four million, of which around 80 per cent come from Myanmar.

The number of migrants registered annually fluctuates and is dependent on the migrant policy that year, which changes frequently. During the period between 2010 and 2011, the numbers of migrant workers registered were as follows:

- As of March 2010, there were 932,000 migrants registered with an annual temporary work permit, and in August 2011 another 853,000 were registered.
- As of December 2011, the number of migrants under the Nationality Verification process, which gives a passport to documented migrants, was 631,000.
- The total cumulative number of those who entered the country legally with a passport under the MOU, which began in 2005, was 101,000 as of December 2011.
- The Ministry of Labour (MOL) estimates that there are another 1.3 million or more undocumented migrant workers in Thailand.

Factors that affect migrants' vulnerability to HIV include language barriers, inaccessible services and lack of legal status. Those migrants that are registered with a work permit receive health insurance but undocumented migrants, considered by the government as "illegal", do not have insurance and therefore avoid public services out of fear of arrest and deportation, and are therefore generally harder to reach with prevention and treatment programmes.

In 2010, the first round of Integrated Biological and Behavioural Surveillance targeting migrants under the "second generation surveillance" was conducted by the MoPH's Bureau of Epidemiology. This was done in collaboration with NGOs under the Prevention of HIV and AIDS among Migrant Workers in Thailand Project (PHAMIT), with support from the Global Fund. The results of the 2010 IBBS will serve as a baseline to make it possible to monitor trends in HIV prevalence among migrants over time more accurately.

The survey sample was from a geographically diverse set of 10 sentinel provinces.<sup>3</sup> The 10 selected provinces are along the Thailand border or along the coast, and were selected for having a high HIV prevalence among pregnant women in the Thai population and which provided a diverse representation of the migrant population. The sample of migrants was cross-cutting, taking into consideration nationalities and occupations of migrant workers from within the age range of 15 to 49, with 52 per cent of respondents being female and 48 per cent being male (N=3,001). Results were not weighted. About 25 per cent of the surveyed migrant workers were between 15 and 34 years old and the median age was 29 years. About 60 per cent were from Myanmar, while 20 per cent were from Lao PDR and 20 per cent were from Cambodia.

The six provinces with the highest prevalence of HIV and STIs, indicating areas with high-risk behaviour, were then selected for further analysis.<sup>4</sup> Data was then disaggregated by age group, with special emphasis on the age range of 15 to 24 to match the Global Indicators. The serosurveillance results from the IBBS for migrant workers in the six selected sentinel provinces for the year 2010 indicated that among migrant workers the median HIV prevalence was 0.6 per cent (between 0.3 and 5.0 per cent). The prevalence of sexually transmitted infections was 0.7 per cent for *C. trachomatis* and 0.9 per cent for *N. gonorrhoea*.

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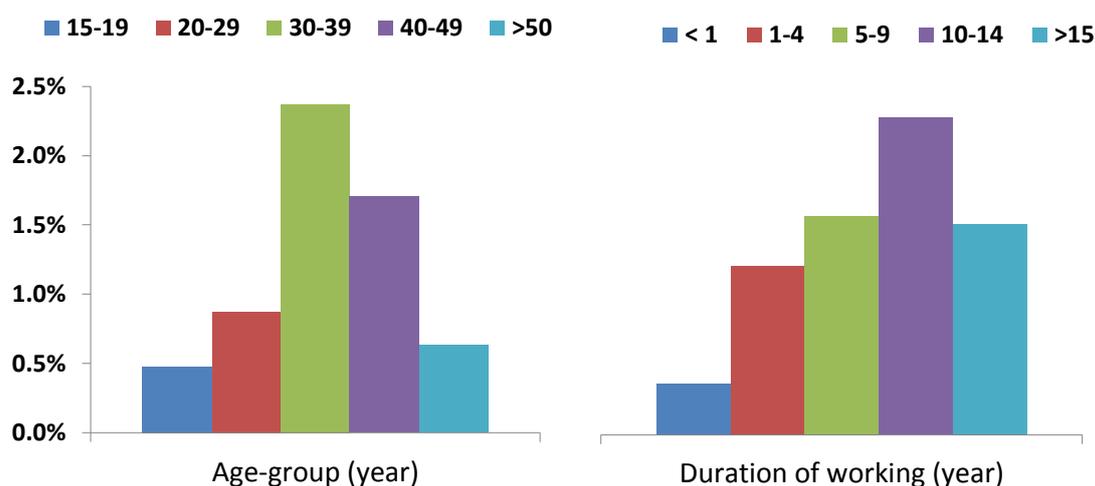
<sup>3</sup>Chiang Mai, Kanchanaburi, Tak, Nakhon Phanom, Ubon Ratchathani, Trad, Chonburi, Songkla, Trang, Samut Prakan

<sup>4</sup>Chiang Mai, Kanchanaburi, Nakhon Phanom, Trad, Songkla, Samut Prakan

HIV prevalence did not differ significantly between women and men (1.34 per cent vs 1.26 per cent). When classified by age, the highest HIV prevalence was observed among those in the 30 to 40 year age group, which was 2.4 per cent. The percentage of HIV prevalence among young migrant workers (aged 15-24) was 1.1 per cent, and the prevalence was higher among these females than among young migrant males (1.4 per cent vs. 1.0 per cent).

An examination of migrant workers who had worked in Thailand between less than one year and 14 years found that HIV prevalence was significantly correlated with the number of working years in Thailand (Figure 10). HIV prevalence was highest among those who had worked in Thailand for between 10 and 14 years (2.3 per cent).

**Figure 10: HIV prevalence among non-Thai migrant workers classified by age-group and duration of working in Thailand, 2010**



Source: IBBS among non-Thai migrants in 10 sentinel provinces, Bureau of Epidemiology

HIV prevalence was highest among Cambodian migrant workers (2.2 per cent). Lower prevalence was observed among Myanmar (1.2 per cent) and Laotians (0.5 per cent). Among the migrant workers there were disparities in HIV prevalence by occupation (which to some degree corresponds with the primary nationality present in that type of work). Distribution of HIV prevalence classified by occupation revealed that fishermen and fishermen-related (those who recently had worked as fishermen and wives of fishermen) had the highest HIV prevalence, 2.3 per cent and 2 per cent, respectively. Factory workers, general labourers (construction) and agricultural labourers had lower HIV prevalence, at 1.1 per cent, 0.9 per cent and 0.7 per cent respectively.

With regard to geographic distribution within Thailand, the highest HIV prevalence, 5 per cent, was observed in Trad, which is located at the border of Thailand and Cambodia and is a province in which there is a big fishery industry and much border-trading business. HIV prevalence in other provinces was much lower, ranging between 0.3 and 1.7 per cent.

Global indicators as reported in the 2010 IBBS in the six sentinel provinces:

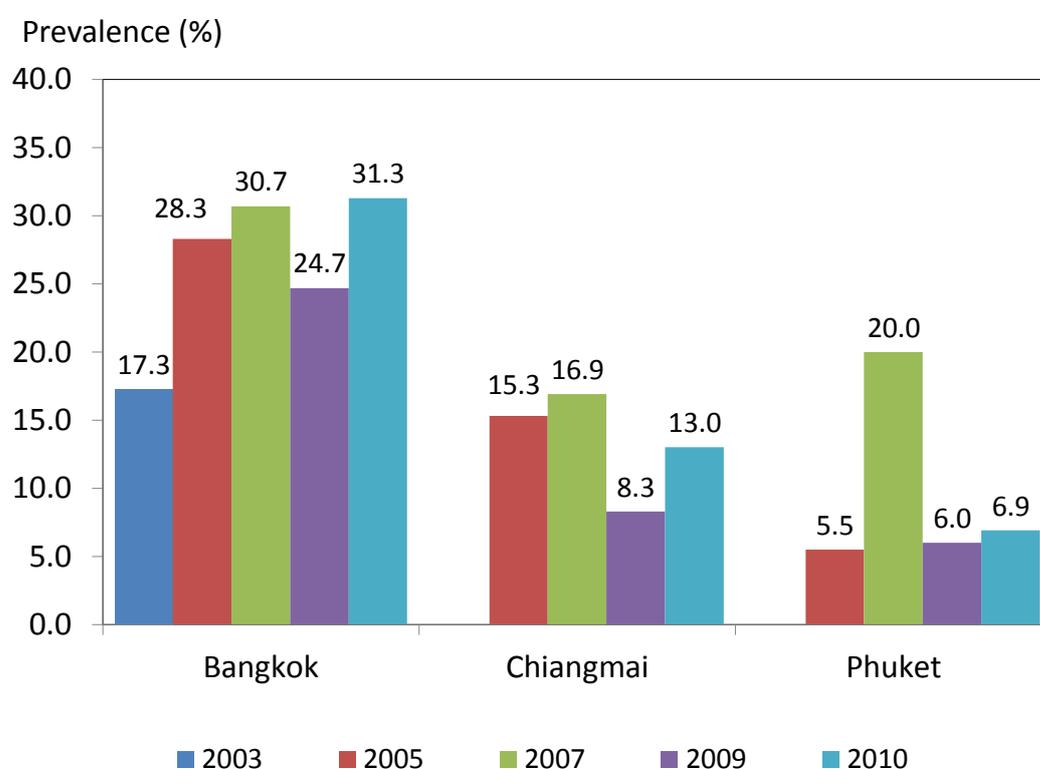
- *Five core UN questions* –The overall percentage of migrants responding accurately to all five questions in the six key provinces was 25.5 per cent. Only 20.1 per cent of men and 24.4 per cent of women age 15-24 answered all five questions correctly. The two greatest misconceptions were regarding whether or not a healthy-looking person can have HIV and whether or not mosquitoes transmit HIV.
- *More than one partner* - The percentage of migrants under the age of 25 reporting more than one partner in the last 12 months was 27.5 per cent of males and 6.3 per cent of females. Young men in the age range of 15-24 in coastal areas, meaning those working on fishing boats, had the highest percentage at 32.4 per cent.
- *Condom use*– 37.3 per cent of all respondents who had more than one partner in the last 12 months had used a condom at the most recent sex, with 35.9 per cent of males and 30 per cent of females aged 15-24. The lowest rate of condom use was among women in coastal provinces at 10 per cent.
- *Had an HIV test and know the results* - only 8 per cent of all migrant respondents had had an HIV test in the previous 12 months and knew the results. Of the men in the age range of 15-24, overall only 6.5 per cent had been tested and knew the results compared to 12.7 per cent of migrant women in this age range.

## (B) HIV TRENDS IN KEY AFFECTED POPULATIONS

### B.1. HIV SITUATION AMONG MSM

With one third of new infections coming from MSM, MSW and TG, these groups are key drivers of the overall epidemic trajectory in Thailand. The findings of surveys in three large cities in Thailand: Bangkok, Chiang Mai and Phuket, indicate that the spread of HIV is continuing among MSM in these locations, with no evidence of decreasing trends in recent years. The highest MSM prevalence is in Bangkok, considered an epicentre of infection among MSM in the country, where the prevalence in 2010 was 31 per cent, up from 19.2 per cent in 2005. Lower prevalence was observed in Chiang Mai and Phuket, where HIV prevalence in 2010 was 13 per cent and 6.9 per cent, respectively (Figure 11), up from 8.3 per cent and 6 per cent in 2009. The prevalence among older MSM (aged  $\geq 25$ ) in 2010 was higher than that among younger MSM (32.4 per cent vs 12.1 per cent), reflecting the longer period of sexual activity of older MSM and thus their higher likelihood of becoming infected. These figures have not changed significantly since 2007.

**Figure 11: HIV prevalence among MSM in Bangkok, Chiang Mai and Phuket, Thailand, 2003-2010**



Source: IBBS Survey among MSM, 2003-2010, Bureau of Epidemiology and TUC

The national IBBS among MSM was expanded to cover sentinel provinces and business centres in other regions of Thailand. The survey findings revealed that HIV prevalence in other regions ranged from 1.8 to 12.7 per cent; the median prevalence was 8 per cent.

The data from 2010 on the percentage of MSM who have received an HIV test in the past 12 months and know the result, indicate that there has been little change in HIV test uptake over the past five years. The 2010 percentage of MSM who had received an HIV test in past 12 months and knew the result (25.6 per cent) is very similar to the 2005 figure of 28.5 per cent. The data also indicate that the rate for testing among MSM aged 25-59 (37.8 per cent) is higher than the rate for testing among MSM aged 15-24 (23.7 per cent). The low HIV test uptake among young MSM is attributed to the current policy of requiring parental consent for a person below 18 to undergo HIV testing, the prevailing stigma attached to being tested and also the low perception of risk by young people.

In 2010, 43.8 per cent of MSM who were reached with HIV prevention programmes in the previous 12 months knew where to get HIV test and had been given condoms and lubricant in the previous 12 months. There were no differences between the different age groups. The figures for access to condoms and lubricant by MSMs of different ages, (61.5 per cent among those aged 25-59 and 62.1 per cent among those aged 15-24) are similar because all outreach activities aggressively include condom distribution.

In 2011, eight out of 10 MSM reported using a condom during an anal sex with their most recent male partner in the previous six months, registering at 84.5 per cent for both younger and older MSM; slightly higher than in 2005 (79.9 per cent), 2007 (81.0 per cent) and 2009 (80.4 per cent). Condom usage among MSM in 2011 had increased from 2010. In 2010, seven of 10 MSM consistently used condoms during anal sex with all partners in the previous six months, with a higher rate among MSM aged 25-59 (75.4 per cent) than among MSM aged 15-24 (66.4 per cent).

Overall, given that HIV prevalence among MSM, MSW and TG has not decreased since 2005, the latest data relating to these groups suggests that, as of 2012, the impact of prevention activities has not yet been seen, especially in Bangkok.

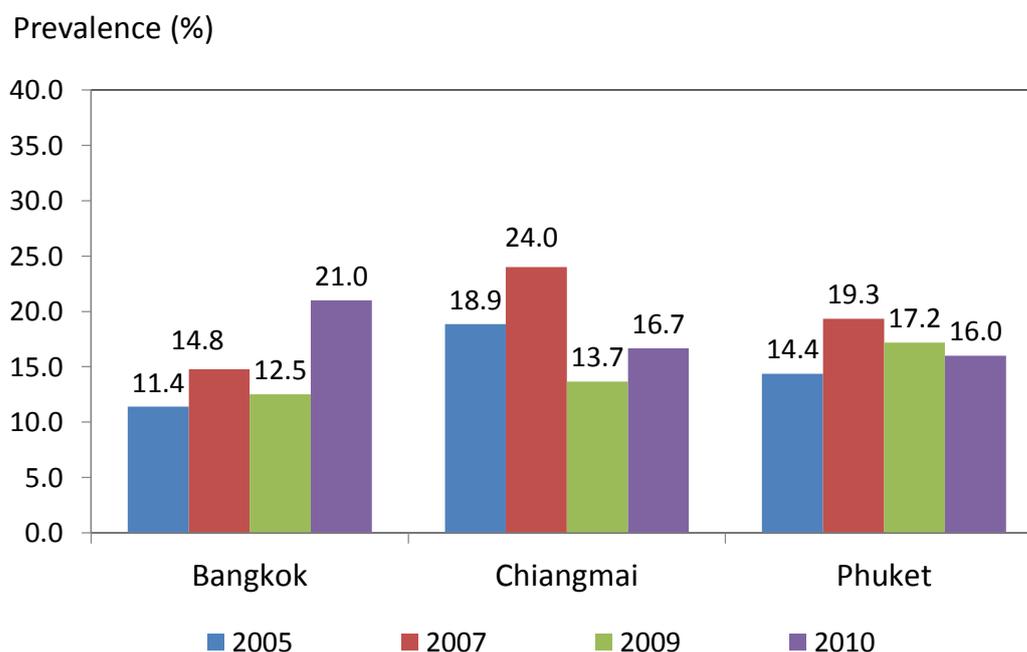
## B.2. HIV SITUATION AMONG MALE SEX WORKERS

In 2010 the overall HIV prevalence among MSW was 16.0 per cent, with the prevalence of HIV higher among MSW aged 25-59 than among MSW aged 15-24, 21.1 per cent compared to 14.8 per cent.

HIV prevalence among MSW at male entertainment venues, such as gay bars, in the three surveyed cities of Bangkok, Chiang Mai and Phuket shows a rising trend, increasing from 11.4 per cent in 2003 to 21 per cent in 2010 in Bangkok.

HIV prevalence among MSW in Chiang Mai and Phuket was higher than HIV prevalence among MSM and TG in these cities. In 2010, HIV prevalence among MSW was 16.7 per cent in Chiang Mai and 16 per cent in Phuket, falling from 24 per cent in Chiang Mai and 19.3 per cent in Phuket in 2007. HIV prevalence in Bangkok and Chiang Mai increased between 2009 and 2010, however. (Figure 12).

**Figure 12: HIV prevalence among male sex workers, Bangkok, Chiang Mai and Phuket, Thailand, 2005-2010**



Source: IBBS Survey among MSM, 2003-2010, Bureau of Epidemiology

There is high condom distribution coverage among MSW because those working in venues are easy to reach by both NGOs and government agencies, the latter still implementing the “100% Condom Use Programme”. In 2010, 72 per cent of MSW reported receiving condoms and lubricant in the previous 12 months. This rate is a slight improvement from 65.5 per cent in 2009. According to the global definition, however, only 61 per cent of MSW were reached with an HIV prevention programmes in 2010. Fewer younger MSW (aged <25) were reached by HIV prevention programmes than those in the older age group (58 per cent compared to 66 per cent).

The 2010 rate of condom use with their most recent client among MSWs is 88 per cent and stable since 2005. However rate of consistent condom use in 2010 (use in the previous six months) is the close to the 2005 rate of 58.8 per cent. In 2010, more than half of MSW (57.5 per cent) reported consistent condom use every time with their partner in the previous six months, down from 2007 when it was 67.1 per cent and down from 2009 when it was 73 per cent. In 2010, the use of condoms by MSW aged 15-24 (at 50.7 per cent) was lower than for MSW aged 25-59 (at 65.5 per cent).

In 2010, nearly half of the surveyed MSW (49 per cent) had received HIV test in the previous 12 months and knew the results. A higher rate was observed among older MSW (aged 25-59), at 58.6 per cent compared 45 per cent among MSW aged 15-24. The percentage of MSW who received an HIV test in the previous 12 months and knew the result has improved slightly since 2003. From 44.3 per cent in 2003, it peaked in 2007 at 54.4 per cent. The current rate of 51.4 per cent (in 2010) is a significant improvement from the 2009 rate of 40 per cent.

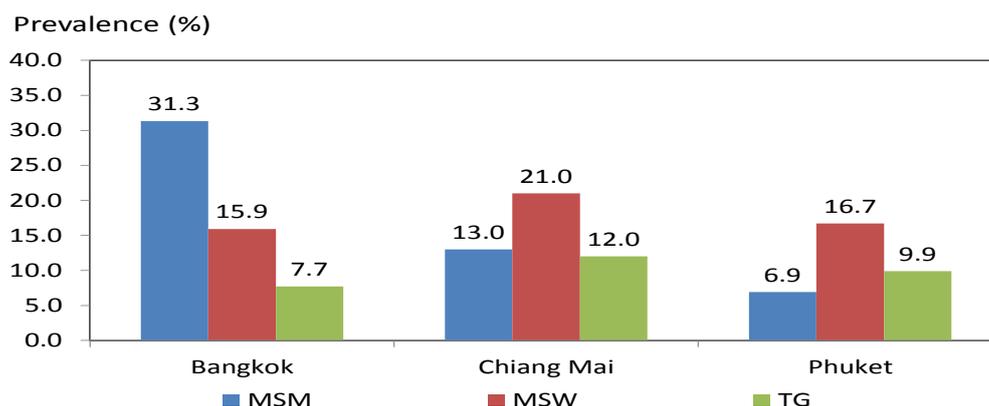
HIV testing and outreach among MSW is slightly higher than among MSM. This testing and outreach is normally coordinated with establishment owners, due to a long-standing policy of promoting voluntary counselling and testing and STI screening among sex workers in venues and the requirement of many establishment owners that MSW provide proof of VCT and STI screening. The same cannot be said from non-venue based MSW as many non-venue based MSW operate independently and are not easy to reach.

### **B.3. HIV SITUATION AMONG TRANSGENDER**

In 2010, the HIV prevalence among TG was 10.4 per cent, on average. The prevalence has declined since it peaked at 16.8 per cent in 2007, but has increased from the 2009 rate of 9.6 per cent. The prevalence among older TG (aged 25-59) is almost three times higher than among TG aged 15-24. Bangkok

had lower prevalence among TG than in the other surveyed cities in 2010, with prevalence at 7.7 per cent in Bangkok, 12 per cent in Chiang Mai and 9.9 per cent in Phuket. Comparison between HIV prevalence among TG, MSM and MSW in these three cities indicates that HIV prevalence among TG was lower than that among MSM and MSW (Figure 13).

**Figure 13: HIV prevalence among MSM, MSW and TG in Bangkok, Chiang Mai and Phuket, Thailand, 2010**



Source: IBBS Survey among MSM, 2010, Bureau of Epidemiology

Results of a 2010 survey found that the percentage of TG who knew an HIV testing place and had been given condoms (67.5 per cent) was higher than that of MSM and MSW. The 2010 testing rate (received an HIV test and knew their result) of 41.3 per cent among TG is an improvement from 30.4 per cent in 2005, 33.6 per cent in 2007 and 22.4 per cent in 2009. Older TG (aged 25-59) had a higher testing rate than TG aged 15-24 (52.1 per cent compared to 34.2 per cent). Among all TG, 68 per cent were reached with HIV prevention programmes in 2010, and no difference was observed between age groups. In 2010, around 60 per cent of TG has been consistently using condoms in the previous six months.

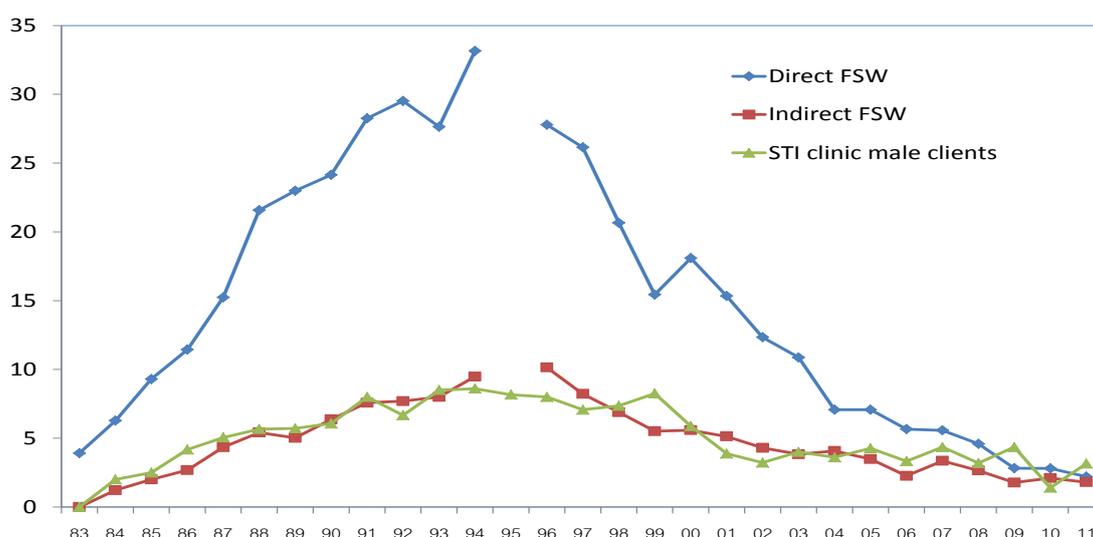
#### **B.4. HIV SITUATION AMONG FEMALE SEX WORKERS**

FSWs are believed to be one of the highest risk populations for HIV. Following massive efforts by multiple sectors and partners in the NASP, through mass communication, individual outreach and condom promotion, a rapid decline in HIV prevalence was observed among FSW, including both brothel-based or direct establishment FSWs (D-FSW) and non-brothel-based FSWs or indirect FSWs (I-FSW) - FSW who are working at establishments where the sexual

services are hidden by entertainment activities such as karaoke, massage and restaurants.

Data from HSS surveys among venue-based female sex workers found that HIV prevalence among these women has declined steadily over time: reducing from 2.8 per cent in 2008 to 2.7 per cent in 2010 and then to 1.8 per cent in 2011. Compared to the decline observed since the mid-1990s, however, the trend during the past few years has been fairly constant (Figure 14). The HSS surveys found that HIV prevalence is lower among the younger age group of female sex workers. This was confirmed by the findings of the IBBS of 2010 for non-venue-based FSW in Chiang Mai, Phuket and Chonburi, which found that HIV prevalence among FSW aged 25 years old and above is higher than among younger FSW.

**Figure 14: HIV Prevalence among female sex workers and male at STI clinics, Thailand, 1983-2011**

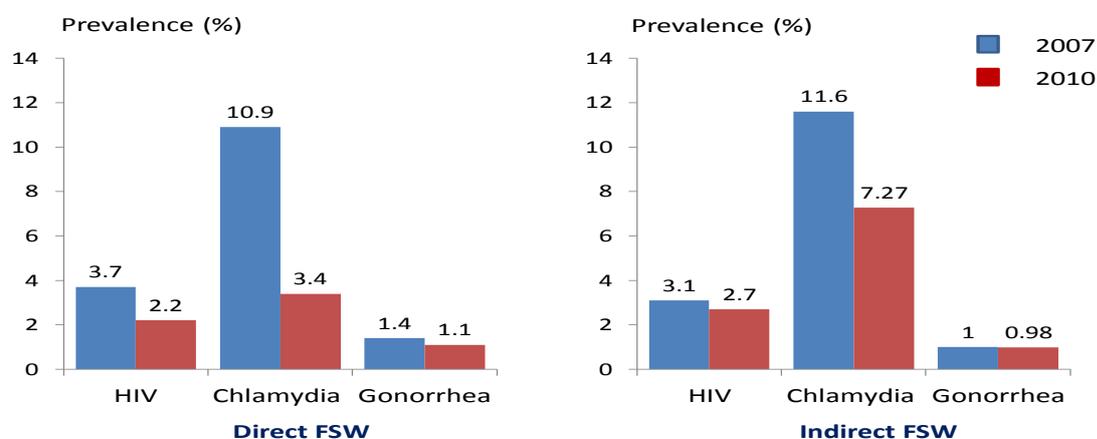


Source: HIV Serosurveillance, Bureau of Epidemiolog

Results from the integrated biomarker and behavioural surveys conducted in 2007 and 2010 in 12 sentinel provinces revealed a decline in HIV and STI (*Neisseria gonorrhoea* and *Chlamydia trachomatis*) prevalence among both D-FSW and I-FSW (Figure 15).



**Figure 15: HIV and STI prevalence among female sex workers, Thailand, 2007 and 2010**



Source: IBBS Survey, 12 sentinel provinces in 2007 and 2010, Bureau of Epidemiology

Prevalence surveys, using respondent-driven-sampling, conducted in 2007 (Bangkok and Chiang Rai) and 2010 (Chiang Mai, Chonburi and Phuket) among non-venue-based FSW, including street-based FSWs and FSWs soliciting in public areas and through phone contact and internet FSW networks, revealed higher HIV prevalence among non-venue based FSW than among venue-based FSW (Table 5). These findings led to serious public health concern with regard to controlling the spread of HIV, and concern over the difficulty of access to preventive measures among non-venue based FSW.

**Table 5: Comparison of HIV prevalence among “non-venue-based FSW” found by RDS with HIV prevalence among “venue-based FSW” found by HIV serosurveillance, 2007 and 2010**

Type of FSW	2007		2010		
	Bangkok	Chiang Rai	Chiang Mai	Phuket	Chonburi
Non-venue FSW <sup>1</sup> (n)	20% (519)	10% (87)	5.0% (287)	1.4% (285)	1.2% (284)
Venue-based <sup>2</sup>					
– Direct FSW (n)	4.6% (264)	6.9% (72)	3.1% (128)	2.8% (284)	-
– Indirect FSW (n)	1.6% (314)	1.2% (573)	0.98% (205)	2.6% (274)	-

Source: Bureau of Epidemiology, DDC, MOPH and TUC

<sup>1</sup> IBBS using Rapid Driven Sampling (RDS) among non-venue based FSW

<sup>2</sup> HSS or IBBS among venue based FSW

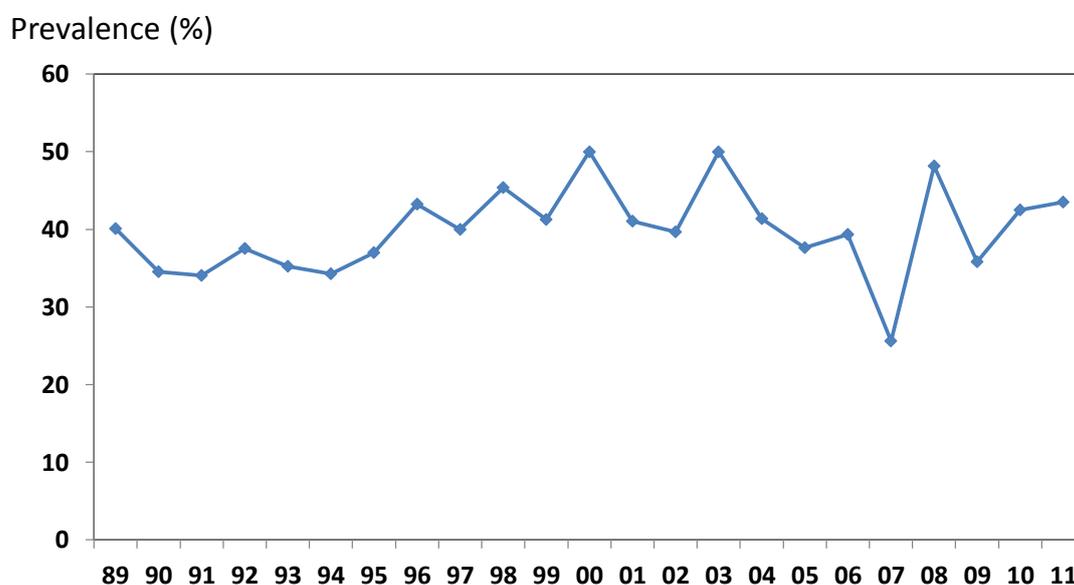
The BSS, which is conducted annually, found in 2010 that correct answers to the five HIV/AIDS knowledge questions were rather low among FSW (33.7 per cent in 2010), with no change during the prior five years. Fully 95.7 per cent of FSW reported using condoms with their last customer; yet only 45.4 per cent of FSW reported using condoms with their spouse or partner.

Regarding access to health services, the IBBS conducted in 2010 found that the percentage of FSW reached with HIV prevention programmes, i.e. the percentage of FSW who know where to get an HIV test and who have been given condoms through an HIV prevention programme, was 50.4 per cent, which is similar to the percentage of FSW who have had an HIV test in the past 12 months (47.8 per cent). Though the percentage of female sex workers who accessed HIV testing and know their results in past six months remains at around the same level as the previous three years (2008 to 2010), progress can be observed in terms of the quality of counselling intervention emphasized by the Global Fund 8 programme.

#### **B.5. HIV SITUATION AMONG PEOPLE WHO INJECT DRUGS**

The level of HIV among PWID remains high and shows no sign of decline. The findings of the HSS conducted by the Bureau of Epidemiology indicate that over the past 13 years the prevalence of HIV among people who inject drugs attending detoxification clinics throughout Thailand ranged between 30 and 45 per cent (Figure 17). In 2011, prevalence was 43.5 per cent. In recent years only a few provinces had sufficient numbers of PWID clients for the survey, however, thus the results may not represent the country profile.

**Figure 16: HIV prevalence among PWID, Thailand, 1998-2011**



Source: HSS among IDU who visit detoxification clinics, Bureau of Epidemiology

A survey in 2007 in two provinces (Chiang Mai and Bangkok) using respondent driven sampling, which was more representative of PWID in the community, found HIV prevalence among PWID of 10.8 per cent in Chiang Mai and 23.3 per cent in Bangkok. Results from the IBBS conducted in 2011 indicate that HIV prevalence among PWID in Chiang Mai had more than doubled; rising to 22.8 per cent, while HIV prevalence among PWID in Bangkok had declined slightly to 21.3 per cent. The sentinel sites of the 2011 IBBS were expanded and preliminary results from Songkhla indicate a similar prevalence: 21.2 per cent.

The IBBS measured HIV prevention behaviour and found that 46.0 per cent of PWID used condoms at their most recent sexual encounter, with males reporting higher use (54.3 per cent) than females (40.2 per cent). Use of an unused needle at last injection was 77.7 per cent overall (males 77 per cent and females 56 per cent).

In 2011, the percentage of PWID who had attended HIV voluntary counselling and testing in the prior 12 months and knew the results was 40.7 per cent, but only 29.4 per cent had ever received condoms or unused needles. Less than half (41.3 per cent) could correctly answer the standard HIV knowledge and prevention questions. These data indicate that access to HIV prevention is still low among PWID.

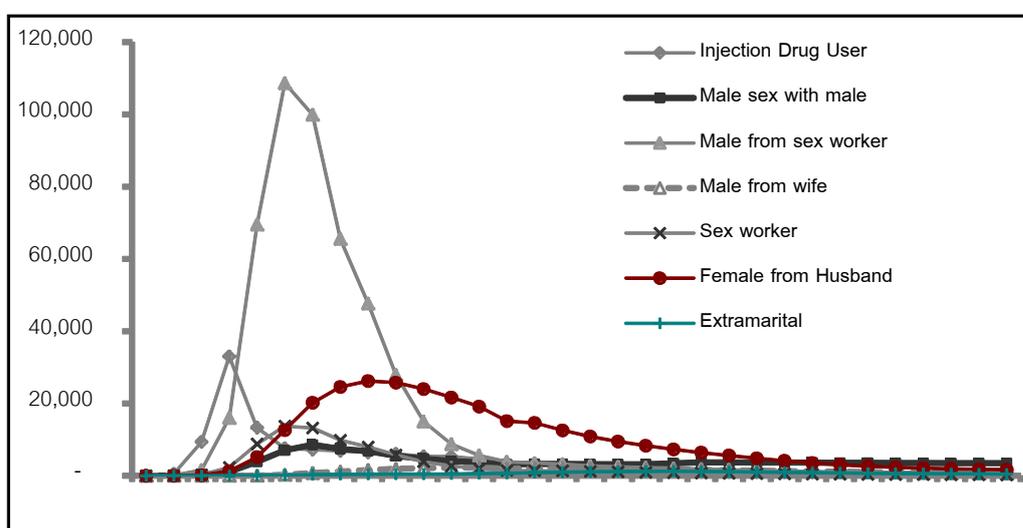
Survey results also indicate that a variety of drugs are injected; no longer only heroin as in the past. In the month prior to data collection, drug use for injection involved at least five drugs: heroin (48.6 per cent), methamphetamines (37.9 per cent), dornicum (14.5 per cent), methadone (7.7 per cent) and opium (0.7 per cent).

### III. ANALYSIS OF THE HIV SITUATION AND PREDICTIONS FOR FUTURE SPREAD OF HIV AND AIDS IN THAILAND

#### (A) PROJECTION OF THE HIV AND AIDS EPIDEMIC

The AIDS Epidemic Model (AEM) and policy analysis were used to estimate and predict the HIV situation as well as define different scenarios on prioritization of programme implementation to achieve the prevention, care and treatment goals. The AEM baseline projection was generated by updating specific epidemiological, behavioural factors and population size from secondary data sources to produce epidemiological trends (Figure 17).

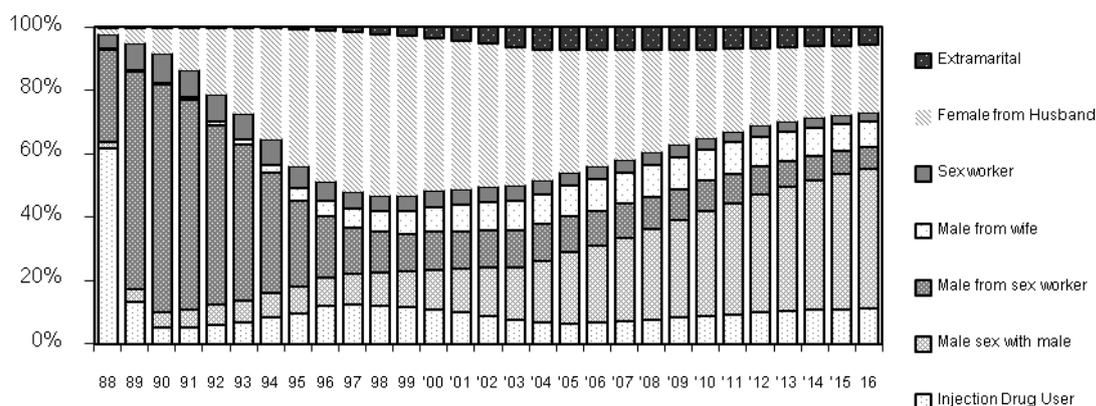
**Figure 17: Estimates of the number of new cases of HIV by population and risk factors, 1985-2016**



Source: AIDS Projections Working Group and A<sup>2</sup>Thailand

It is noteworthy that for the period between 2011 and 2016 it is projected that the highest proportion of new cases will be men infected sexually by other men and women infected sexually by a husband or steady partner (Figure 18). These data clearly show the critical areas for attention in order to prevent new infections.

**Figure 18: Projected new infections by population and risk factors, 1988 – 2016**



Source: AIDS Projections Working Group and A<sup>2</sup>Thailand

With the current intervention responses, the results of the projection and estimation revealed that between 2012 and 2016, new infections among MSM, sex workers and clients and intravenous drug users will make up about two-thirds of all new infections, while new infections through sex between husbands and wives and through casual sex will make up about one-third (Table 6).

**Table 6: Projected new infections by population, 2012-2016**

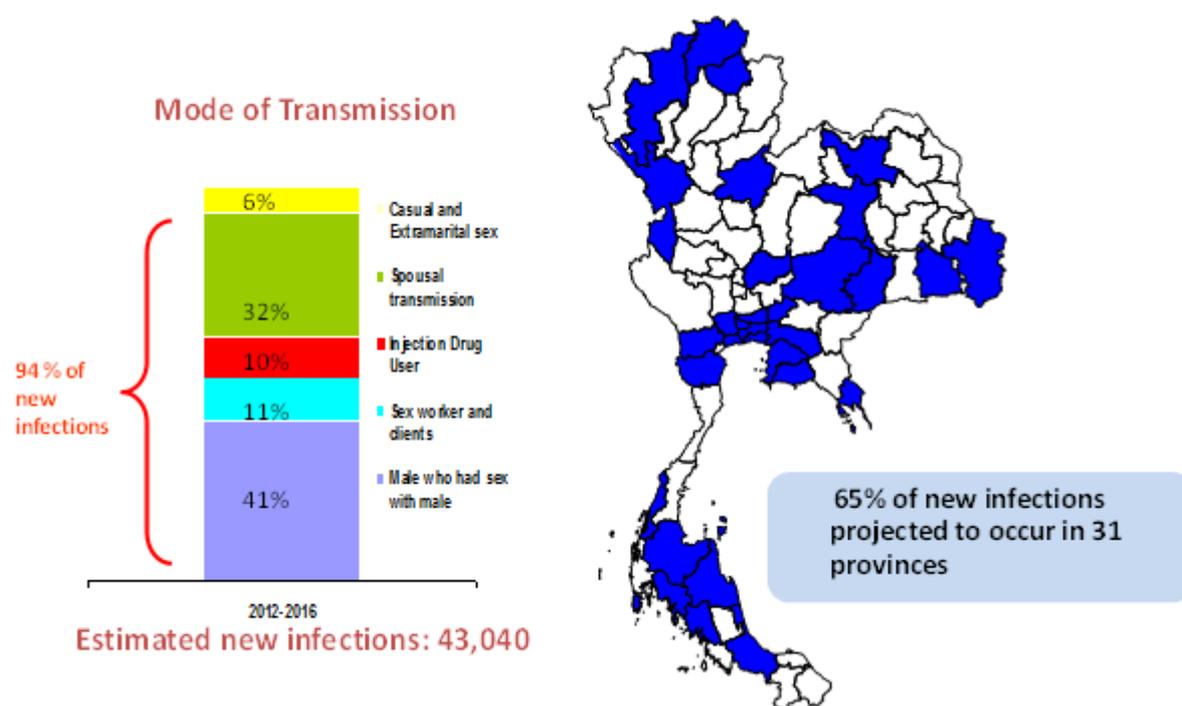
Year	PWID	MSM	SW clients	SW	Spousal	Casual sex	Total
<b>2012</b>	916	3,530	841	321	3,231	634	<b>9,473</b>
<b>2013</b>	905	3,510	755	290	2,920	579	<b>8,959</b>
<b>2014</b>	894	3,493	680	265	2,674	530	<b>8,535</b>
<b>2015</b>	884	3,480	614	243	2,475	488	<b>8,184</b>
<b>2016</b>	875	3,471	557	224	2,313	450	<b>7,890</b>
<b>Total</b>	26,746				12,613	2,681	<b>43,040</b>
<b>% of new infections</b>	62%				32%	6%	<b>100%</b>

Source: AIDS Projections Working Group and A<sup>2</sup>Thailand

Using the AEM, it is projected that if HIV prevention is not accelerated in Bangkok, there will be 12,000 new infections in Bangkok in five years time, 70 per cent of which will come from MSM (including TG and MSW).

To achieve the national programme goal of reduction of new infections by two-thirds by 2016, the priority in the 2012-2016 national strategy should be intensive intervention scale-up to reduce HIV transmission among men having sex with men, sex workers, injecting drug users, spouses. Thirty-one out of 77 provinces should be prioritized for the intensive implementation (Figure 19). This could potentially result in the prevention of 25,000 new infections nationwide in the period between 2012 and 2016

**Figure 19: Prioritized target populations and geographic locations, 2012-2016**



Source: AIDS Epidemic Model. AIDS Projections Working Groups

## **(B) PROJECTION OF PLHIV, AIDS PATIENTS, ART CLIENTS AND AIDS DEATHS**

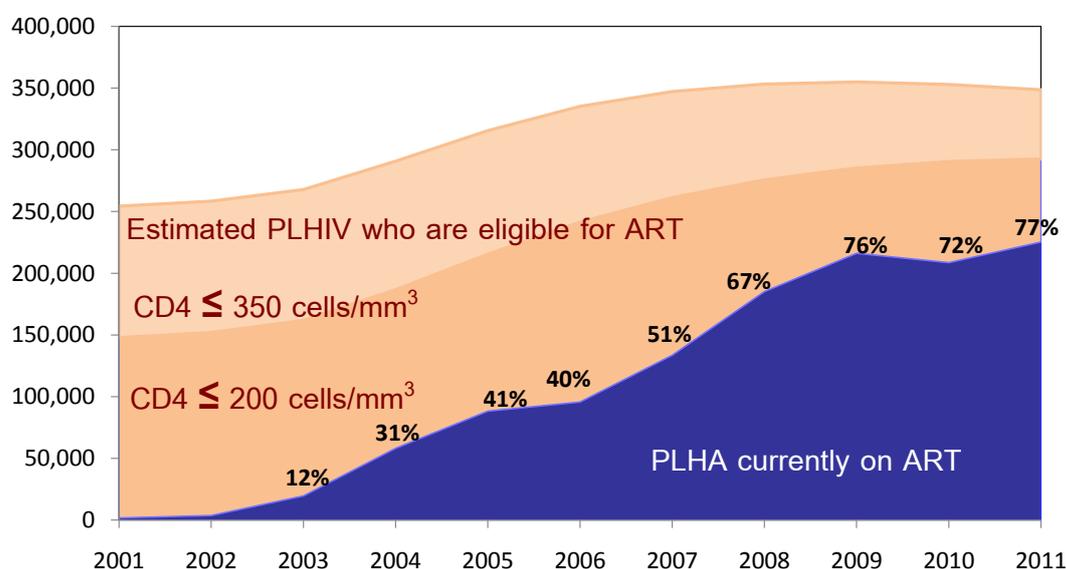
Results from AEM projections indicate that in 2011 there were about half a million PLHIVs in Thailand, with 283,612 progressing to a stage requiring ART. Over time, the numbers of PLHIV plateau and decrease in accordance with the effectiveness of the control programme (Table 7).

**Table 7: Number of PLHIV and AIDS patients as projected by the AEM, 2010-2016**

	2010	2011	2012	2013	2014	2015	2016
<b>New HIV infections</b>	10,853	10,097	9,473	8,959	8,535	8,184	7,890
<b>Cumulative HIV infections</b>	1,138,014	1,148,111	1,157,583	1,166,543	1,175,078	1,183,262	1,191,157
<b>New AIDS cases</b>	46,272	42,992	39,728	36,643	33,819	31,286	29,013
<b>New AIDS deaths</b>	28,160	27,650	26,829	25,733	24,701	23,559	22,289
<b>Cumulative AIDS deaths</b>	638,696	666,347	693,176	718,909	743,610	767,168	789,458
<b>People living with HIV</b>	499,324	481,770	464,414	447,640	431,475	416,099	401,700
<b>ART eligible PLHIV</b>							
• CD4 $\leq 200$ cells/mm <sup>3</sup>	281,139	283,612	283,883	282,612	280,062	276,628	272,688
• CD4 $\leq 350$ cells/mm <sup>3</sup>	352,962	348,671	342,554	335,311	327,285	319,148	310,297

Thailand’s anti-retroviral treatment programme, supported by the Government of Thailand, has greatly improved access to ART, with more than 200,000 PLHIVs being treated. The overall coverage, according to Thailand’s standard of ART initiation criteria, CD4 level  $\leq 200$  cells/mm<sup>3</sup>, increased from 72 per cent in 2010 to 77 per cent in 2011. Using the latest WHO guidelines, with ART initiation criteria as CD4 level  $\leq 350$  cells/mm<sup>3</sup>, the ART coverage in Thailand was 59 per cent in 2010 and 65 per cent in 2011 (Figure 20).

**Figure 20: ART coverage by estimated number of ART needs**



The Coverage of ART Needs by CD4  $\leq 350$  cells/mm<sup>3</sup> in 2010 and 2011 were 59% and 67%

Source: National Health Security Office, Civil Servant Medical Benefits, Department of Disease Control and AEM



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, particularly the elderly and children, who are impacted by AIDS, there is even a greater need for material and human resources, including medical supplies in sufficient quantity to meet the growing needs.

## **IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC**

### **(A) NATIONAL HIV/AIDS AUTHORITY**

The National AIDS Committee (NAC), comprising representatives of various government agencies and civil society organization, has been responsible for policy making for the national AIDS response since 1997. The NAC is chaired by the Prime Minister. The Director General of the Department of Disease Control is the secretariat of the NAC, and the National AIDS Management Center (NAMC) is the secretariat office.

At the country level, the NAC comprises four subcommittees: the Subcommittee for Advancing the HIV/AIDS Prevention Programme Effort; the Subcommittee for AIDS Vaccine Trials; the Subcommittee for Programme, Budget, Monitoring and Evaluation for HIV/AIDS Prevention and Alleviation Coordination; and the Subcommittee for the Promotion and Support of AIDS Rights, which was proposed by civil society and established in 2011.

At the provincial level, the Provincial AIDS Sub-Committee, chaired by either the provincial governor or provincial vice-governor for each province, is responsible for the development of the provincial AIDS strategy and integrating this strategy into the provincial development strategy. In most provinces, the provincial public health office serves as the secretariat of the Provincial AIDS Subcommittee, through the Provincial AIDS Management Center.

### **(B) NATIONAL AIDS STRATEGIC PLAN 2007-2011**

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

The NASP for 2007-2011 was the result of participation and collaboration by all relevant sectors, government, civil society and international organizations.

Targets set for the end of the NASP in 2011 were to:

- Reduce new HIV infections by at least half.
- Provide access to ART for those in need.
- Provide access to social support for at least 80 per cent of PLHIVs, families and those affected by AIDS.

The plan’s objective was to integrate HIV prevention and alleviation strategies at all levels and to promote multi-sector collaboration and provide integrated services for identified population groups.

The NASP identified four strategies:

- Improved management to integrate HIV/AIDS responses in all sectors.
- Integration of prevention, care, treatment and impact mitigation for each population group.
- HIV and AIDS related rights protection.
- Monitoring and evaluation coupled with research on HIV prevention and alleviation, emphasizing the importance of supportive public policy and the empowerment of people to protect themselves.

### **(C) (DRAFTED) NATIONAL AIDS STRATEGY 2012-2016**

In 2011, the National AIDS Strategy for 2012-2016 was drafted under broad consultation with government, civil society and the private sector, following a review of the situation and an evaluation of the previous national strategy.

The vision of “getting to zero” and the targets for 2016 were agreed in the NAC meeting on 29 March 2011. Apart from the NASP, the NAC agreed to develop biannual operational plan as well as a national strategic information and monitoring and evaluation plan for 2012-2016 to ensure the operationalization of the national strategy and to track the progress of the national response.

**Table 8: Vision and goals for 2016**

Vision	To Get To Zero New HIV Infections	To Get To Zero Aids-Related Deaths	To Get To Zero Stigma And Discrimination
<b>Goals</b>  (by 2016)	<ul style="list-style-type: none"> <li>▪ New HIV infections reduced by two-thirds</li> <li>▪ Vertical transmission of HIV less than 2%</li> </ul>	<ul style="list-style-type: none"> <li>▪ Equal access to quality treatment, care, support and social protection for all people affected by HIV</li> <li>▪ Reduce AIDS related deaths by half</li> <li>▪ TB deaths among people living with HIV reduced by half</li> </ul>	<ul style="list-style-type: none"> <li>▪ All laws and policies which obstruct equal access to prevention, treatment and care services are revised</li> <li>▪ Human Rights and gender specific needs are addressed in all HIV responses</li> <li>▪ Stigma and discrimination of PLHIV and key affected populations reduced by half</li> </ul>

The five-year National Strategy has two over-arching strategic directions:

- 1) Innovation and change
- 2) Optimization and consolidation



## **INNOVATION AND CHANGE**

The four strategies under innovation and change are as follows:

- Expand rights-based and gender sensitive comprehensive prevention services for populations with the highest rates of HIV transmission.
- Expand the protective social and legal environment essential for HIV prevention and care.
- Localize ownership and response.
- Implement a new generation of strategic information to inform and guide the national response at all levels

The first two strategies under innovation and change will be implemented in the 31 prioritized provinces, aiming at reaching at least 80 per cent of key affected populations, including both Thai and non-Thai, with good quality interventions. The laws and policies that will be reviewed include those hindering adequate access to HIV prevention and care for PWID, sex workers, migrants and young people aged under 18 years.

Dialogue will be fostered among members of the Association of South-East Asian Nations (ASEAN) relating to social change and to assess the implications for HIV and AIDS and develop joint strategic responses.

New biomedical technologies and approaches will be carefully planned in consideration of Good Participatory Practice (GPP). Provider-initiated counselling and testing (PICT) and early treatment for prevention, couple counselling and prevention for discordant couples need to be expanded. This will entail the need for additional resources.

## **OPTIMIZATION AND CONSOLIDATION**

Optimization and consolidation refers to the integration of measures and programmes that are already producing good results into the routine service system, while improving the quality of these interventions along the way. Strategies under the heading of optimization and consolidation include improving quality standards and existing plans so that they are more intensive and integrated.

The main thematic areas are as follows:

- PMTCT
- Prevention among young people
- Condom programming
- Blood safety
- Treatment, care and support
- Care and support for children affected by HIV and AIDS
- Reduction of stigma and discrimination
- Public communication

The biannual operational plan will be developed as the reference for concerned organizations to ensure the budgeting in the regular system. The main areas of action include:

**VCT:** Design VCT services to become proactive and more accessible in the community and workplace for all populations. Use of same-day result tests will be considered for the regular programme. Innovations such as home-testing should also be considered.

**Friendly services:** Services emphasizing STIs and VCT are to be scaled-up and made client-friendly in terms of service quality, convenience, service hours and the attitude of providers. Fostering non-discriminatory, accepting attitudes and respecting human rights is key to making services friendlier. Use of migrant health workers or volunteers attached to the services that have a high volume of migrant clients will be promoted.

**Condom image:** Promoting positive messages and images of condoms for a healthy lifestyle rather than just for disease prevention is highly recommended. This must go hand-in-hand with making condoms more accessible and affordable in all settings: communities, schools, workplaces, entertainment venues, etc. Condoms should be one of the benefits of the universal health coverage scheme so that people can access them for free.

**Gender sensitive interventions:** Tools are needed to help raise awareness on gender sensitivity across programmes. Remedies for gender bias that appear in programmes or interventions need to be developed, and education made available to sexual health promoters and social development workers. Special attention to ending violence against women should be integrated into this effort.

**Public communication:** A large social campaign is needed to foster new social attitudes toward sexuality and gender equality, promote a positive condom image, and encourage respect for the human rights of key affected populations. The campaign will include assertiveness tips for prevention and tips for accessing information and services related to HIV and sexual health as well as sexuality education.

**Parent roles:** Building capacity in the Ministry of Education, MSDHS and civil society organizations will enable these agencies to engage parents and provide parenting skills for communicating with young people for promotion of healthy sexuality in schools, at home, in the community and in workplaces.

**Treatment programme:** It is necessary to harmonize and standardize the treatment protocol and service entitlements for all health insurance schemes, including universal coverage, social security, civil servant medical benefits as well as a health system for migrants to ensure access to good quality treatment.

#### **ENSURING THE RESOURCES FOR HIV PREVENTION**

Advance planning in preparation for the end of Global Fund support in 2014 is needed. The challenge will be to sustain and expand the current prevention efforts and not lose the momentum built up during the past decade. In order to expand the response, new and innovative financing models will be piloted. These will include a “country prevention fund” (AIDS envelope) which could be resourced from various sources, such as the national budget, national health and security office and external donors. Another financing model could be a system in which the government retains its normative functions, but outsources operational activities.

The plan to increase local ownership and funding for an expanded response to HIV includes the following strategies:

- Integrate HIV prevention into local development plans as a routine measure.
- Implement HIV-related joint KPIs for local authorities.
- Establish local partnerships between the authorities, civil society and the private sector.

In priority provinces, the provincial coordinating mechanism will be strengthened to be capable of developing and implementing HIV responses with substantial contribution of their own resources. At the national level, the incentive system for private sector partnerships (ISO, CSR, tax exemptions) will be explored and advocated.

#### **(D) BIOMEDICAL INTERVENTIONS**

Two main actions in the area of biomedical intervention were taken in Thailand over the past two years:

- Consultative meeting among stakeholders
- Research and trials of an AIDS vaccine

#### **CONSULTATIVE MEETING AMONG STAKEHOLDERS**

In December 2010, the DDC and the Thailand NGO Coalition on AIDS (TNCA), with support from the WHO and the Global Advocacy for HIV Prevention (AVAC), convened a consultative meeting between government, civil society and technical specialists on guidelines for implementing a pre-exposure prophylaxis (PrEP).

From this meeting, the following key recommendations for a national policy on PrEP implementation emerged:

- PrEP implementation must occur only as an integral part of a comprehensive HIV prevention package.
- PrEP implementers must take an integrated approach, bringing together related prevention, treatment and care systems and processes, getting buy-in from policy-makers, working with the media, continuing to use and adapt existing tools and programmes, and collaborating actively with community members.
- The rights of affected people, including key groups with high risk-associated behaviour and people living with HIV and AIDS must be considered during any implementation process. More opinions and information need to be collected from gay men, transgender people and other sub-groups of MSM before an implementation strategy is designed.
- A clear, efficient public communication strategy to introduce PrEP to the general public is needed in advance to prevent misunderstandings and misinformation within affected communities and society as whole.

- Thailand must develop and adopt a unified country level mechanism for the implementation of PrEP.
- Realistic funding requirements must be identified and included in any implementation strategy.
- A practical way forward is to begin with a small pilot project examining community systems and social strengthening.

## **RESEARCH AND TRIALS OF AN AIDS VACCINE**

An AIDS vaccine is a biomedical agent that stimulates the immune system of the recipient and is designed to either prevent infection with HIV or prevent progression to AIDS among persons already HIV-positive.

There are two general types of AIDS vaccines:

- Preventive vaccines. This vaccine is for those who are HIV-negative.
- Therapeutic vaccines. This is to control the viral load in persons who are HIV-positive and prevent progression to AIDS.

Both types of vaccines are still in the clinical trial phase. Thus, these biomedical agents are called candidate AIDS vaccines.

There are currently 281 human clinical trials of AIDS vaccines underway around the world. Most are Phase 1 trials (243), Phase 1-2 (18), Phase 2 (17), and Phase 3 (3). An additional 35 proposed vaccine trials are under review.

Thailand conducted its first AIDS vaccine trial in humans in 1994 and as of April 2012 there have been 16 vaccine trials: 14 Phase 1 and Phase 2 trials; and two Phase 3 trials. So far, five trials have been completed, of which three were Phase 1, one was Phase 2 and one was Phase 3.

The Phase 3 trial (RV 144 AIDS Vaccine Trial) currently underway is studying a preventive vaccine, and is a collaborative effort between the DDC of the MoPH, the Faculty of Tropical Medicine of Mahidol University and the Armed Forces Research Institute of Medical Sciences (AFRIMS). The funding for the trial was provided by the United States (US) National Institute for Health and the US Army. The trial is being conducted among 16,402 male and female volunteers in Rayong and Chonburi Provinces. Interim results were announced on 24 September 2009 and indicated that the vaccine was effective in reducing risk of acquiring HIV by a factor of 31.2 per cent, but was not effective in reducing the viral load of HIV after infection.

This finding was the *first time in the in the history of HIV vaccine development that an AIDS vaccine was able to reduce the risk of acquiring infection*, but the findings were insufficient to apply for licensure of the vaccine for general use as a prevention strategy. Nevertheless, the study has provided valuable information.

The research team has appointed four scientific advisory committees comprising experts in AIDS vaccines and immunology to recommend methods to correlate protective immunity and directions for research into development of new, more efficient vaccines.

The four advisory committees are as follows:

- i. Cellular Immunity
- ii. Humoral and Innate Immunity
- iii. Host Genetics
- iv. Animal Models

On 13<sup>th</sup> December 2011 the research team received approval for a RV 305 study to investigate immune system properties as a continuation of RV 144.

Approval of AIDS vaccine trials must pass an independent, ethical review board process and also must be approved by the following:

- The Subcommittee on AIDS Vaccines, which was established by the National AIDS Committee with the principal function to review and screen AIDS vaccine trial proposals to ensure compliance with scientific standards. This technical subcommittee was created at the time of the first AIDS vaccines trials in Thailand in 1994, and has had nine re-appointments up to the present to rotate membership in accordance with the changing context of the epidemic. In 2012, the subcommittee is currently chaired by Dr. Amorn Lilarasami. The secretary of the subcommittee is the Director of the Bureau for AIDS, Tuberculosis and Sexually Transmitted Infections (BATS).
- The Committee for Research in Human Subjects of the MoPH. The Deputy Permanent Secretary of the MoPH serves as chairperson. The office of the secretariat is located in the Medical Services Department. The review and screening of vaccine trial proposals assess conformance with international good clinical practices, in accordance with ethical and technical guidelines. This process ensures that the rights, safety, and welfare of the study subjects are protected. These are principal features of this type of clinical research, which also guarantee the credibility of the data.

## **(E) NATIONAL EVALUATION MECHANISM FOR AIDS RESPONSE**

### **E.1. BACKGROUND**

Thailand has been fighting the HIV and AIDS epidemic for almost three decades now. This epidemic has adversely impacted on the Thai economy, society and livelihoods of the population. Even though Thailand's national AIDS programme has been lauded as a model success story, data from many sources show that gaps remain, which provide channels for renewed spread of HIV, especially among youth and the key affected populations.

Since the beginning of the epidemic in Thailand, the country has invested an enormous amount of resources and manpower to confront the spread of HIV and treat the infected. But the number of PLHIV continues to increase while the budget for prevention, care and treatment is declining. An effective strategy is needed to increase the efficiency and effectiveness of the implementation of prevention and treatment programmes. Measures need to be taken to improve HIV surveillance, monitoring of progress in community and clinical settings, and evaluation of programme achievements to produce empirical evidence of whether the national AIDS programme is on target and proceeding in appropriate ways. There is also a need to assess the coverage of interventions to ensure that the maximum potential outcomes are being achieved and, if not, why not.

The National AIDS Management Center and the Bureau for AIDS, TB and STIs of the DDC of the MOPH recognize the need for a first-rate monitoring and evaluation system for the NAP, from the national level down to the community level. Thus, they are working with nearly 100 people, including people from various organizations, including the NGO Coalition on AIDS, the national network of PLHIV and United Nations agencies, and experts, government staff and staff of educational institutions. A brainstorming session was held between 14 and 16 June 2010 in Cha-Am, Petchaburi Province, which covered the following key issues:

- Identification of the gaps and needs for AIDS M&E from the national to the community levels.
- Prioritization of the evaluation questions to inform guidelines to improve access to effective services for all age groups, genders, and ethnicities in an equitable way without discrimination.

- Propose strategies and a process of implementation and management to create an efficient, technical M&E system comprising the following:
  - A management strategy with adequate support budget to ensure highest quality and credible M&E.
  - A system of applying the findings from the M&E to improve the NAP and plans.

The outcome of this meeting was seven recommendations (built around 14 key questions) for M&E, with a classification of these recommendations into two levels of priority as follows:

**First priority:** Three M&E issues that need immediate attention given their relevance to the strategy and budgeting for implementation of the NAP during the 2012-2016 plan period are as follows:

- National policy and management for an effective NAP.
- Prevention of HIV for KAPs such as sex workers, MSM, PWID, migrant labourers and prisoners.
- Treatment, care and assistance for PLHIV, including both children and adults.

**Second priority:** This includes M&E issues that are addressed after specification of the key concepts and scope of evaluation, including increased clarity of M&E projects, to guarantee that the studies will yield high-quality results that can be applied to implementation in an appropriate way. These include the following:

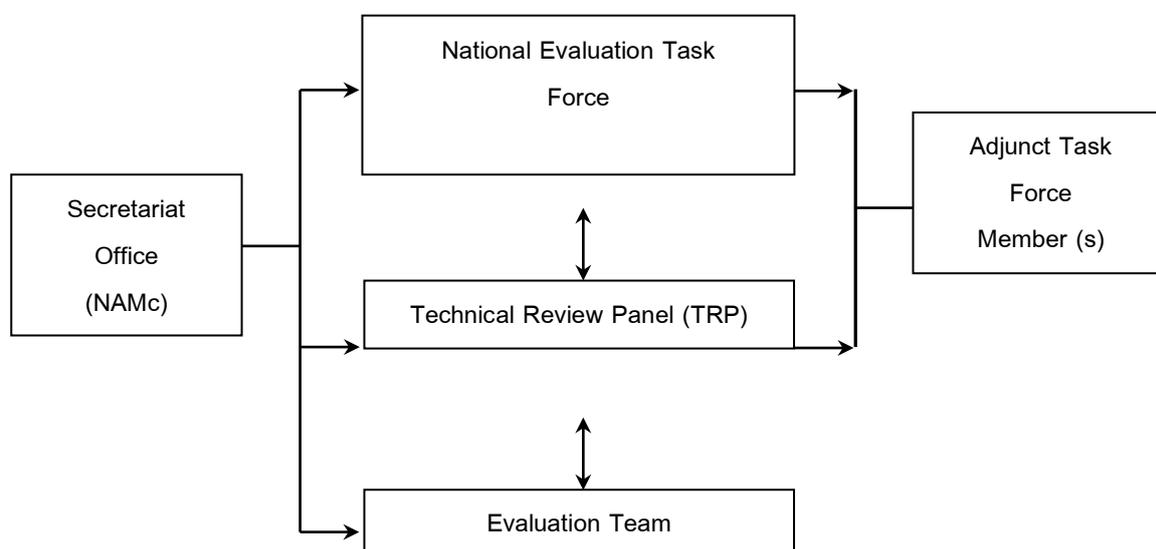
- Prevention of HIV in the general population and particularly among youth.
- Children affected by HIV and AIDS.
- Aversion, stigma and discrimination, including human rights.
- Gender and differences between males and females.

## **E.2. ADVANCING EVALUATION RESEARCH ON AIDS**

The June 2010 brainstorming meeting in Cha-Am produced consensus recommendations regarding AIDS evaluation research in the seven priority areas to generate high quality and applicable findings to improve programmatic interventions. These recommendations were presented to the National AIDS Committee to help define the strategic structure for implementation. In September 2010, the DDC, as the secretariat of the NAC, appointed the National Evaluation Task Force on HIV and AIDS (NETF). The

NETF is comprised of policy makers, health system experts, and representatives from civil society (see Figure 21).

**Figure 21: Structure of national evaluation mechanism**



### **Role of the National Evaluation Task Force**

- Specify the scope of the evaluation of HIV and AIDS prevention and control in Thailand according to the first-priority issues.
- Consider the recommendations of the Technical Review Panel to select agencies to conduct the evaluation on the different issues.
- Monitor progress and outcomes of the evaluation on each issue.
- Synthesize recommendations for strategic management of evaluation of prevention and control of AIDS which is efficient and sustainable, starting from 2011 going forward.
- Appoint task forces as appropriate.

In addition to the functions described above, the NETF is also conducting the following two activities to enhance performance:

- Development of a website for a national evaluation network.
- Development of a database on research and evaluation on various related topics.

The website can be viewed at [www.Thain aids.org](http://www.Thain aids.org)

## **Role of the Technical Review Panel**

The role of the TRP is as follows:

- Analyze external project recommendations and screen these for forwarding to the NETF for selection.
- Advise and provide opinions concerning implementation to the external evaluation projects.
- Monitor, control and evaluate implementation of the external evaluation projects.

The TRP should be comprised of between three and five members and should serve to monitor progress in collaboration with the evaluation team throughout the project duration, in order to share opinions about the methodology and guidelines of implementation, since there may be a need for modification during implementation to resolve problems and obstacles.

## **Role of the secretariat**

The role of the secretariat is as follows:

- Coordinate with the principal members of the NETF, the Adjunct Task Force and the TRP.
- Summarize reflections from the committee members and present these to the NETF for deliberation.
- Conduct support activities to encourage the application of evaluation findings to planning and project development, reducing duplication and increasing Thai researcher capacity.

UNAIDS was the source of funding for the secretariat between September and December 2010. For the period starting in January 2011, the NETF proposed that the secretariat function be institutionalized to produce empirical data for addressing problems relating to prevention and control of AIDS. The functions of the secretariat are thus now considered part of the routine activities of the NAMc, with the aim of serving as an HIV/AIDS Think Tank for the country, with the following duties:

- Build a network among evaluation researchers.
- Control, manage and administer the quality of evaluation of national importance.
- Build capacity in evaluation, and access new technical methods, relating to both content and evaluation methodology.
- Support a culture of utilization of evidence-based decision-making at the policy level.

## **Evaluation research for the period: 2011-2012**

In the past two years, the NETF approved four evaluation research projects with secured funds of 37 million THB as follows:

**Project 1:** National policy and management planning for effective AIDS prevention and control. This project received financial support from the DDC and UNAIDS. The ASEAN Institute for Health Development of Mahidol University is the principal investigator. The preliminary results were presented to the senior management committee of the MoPH and the DDC at the end of 2011. Parts of the findings were incorporated into the five-year national AIDS programme for 2012-2016.

**Project 2:** Prevention of HIV among KAPs: The study funded by the Global Fund the Institute for Population and Social Research of Mahidol University was the principal investigator. Part I was a qualitative research activity focused on process evaluation. While Part II measures impact of HIV intervention at population level. This project also works closely with the Global Fund program review funded by the Global Fund, Geneva.

**Project 3:** This is a situation assessment of vulnerable children in Thailand. The research team is ICF International. Funding is provided by UNICEF. The evaluation is to be conducted over a period of eight months starting in February 2012.

**Project 4:** Evaluation study of HIV counselling and testing and treatment and care and assistance for PLHIV, including both children and adults. This study is at the stage of developing a conceptual framework and research structure under TRP responsibility. Approval was obtained prior to soliciting proposals from applicants to the conduct the evaluation research. Funding for this study comes from the National Health Security Office.

The NETF has been coordinated by NAMc throughout the past year, and this has advanced the evaluation of AIDS projects in Thailand. The findings from these evaluation studies will help indicate how effective the programmes or plans are, how correctly they are being implemented, and how appropriate they are for the challenge. This empirical data will serve as a basis for making improvements in implementation to steer the programmes in the right directions to achieve greater success and cost-effectiveness. It can be said that this approach to evaluation is an innovative strategy of AIDS prevention and control in Thailand.

## **V. COUNTRY PROGRESS TOWARDS THE HLM 2015 TARGETS**

### **TARGET 1: REDUCE SEXUAL TRANSMISSION OF HIV**

#### **1.1. REDUCE SEXUAL TRANSMISSION OF HIV IN THE GENERAL POPULATION AND AMONG THE REPRODUCTIVE AGE POPULATION (MEN AND WOMEN AGED 15-49 YEARS)**

##### **A. HIV PREVENTION AMONG INTIMATE PARTNERS**

An important point in the 2008-2009 progress report was that the 2007-2011 national AIDS programme specified that people in intimate relationships and married couples were key targets in the quest to reduce new infections. Thai society still does not favour use of condoms in intimate relationships and marriage, however, because condoms are associated with STIs, HIV and lack of trust between intimate partners.

##### ***Key national efforts and achievements in 2010 and 2011***

In October 2010, the Department of Health began supporting health outlets to provide voluntary HIV counselling and testing for couples, targeting clients at antenatal clinics and their partners. A model for capacity building and a monitoring system for couples VCT were developed.

The promotion of couples VCT at the ANC clinics has had the following achievements:

- An improved model and guidelines for couples VCT was developed along with a training curriculum and video film. Demonstrations of methods of couples counselling in pilot projects by the DOH and the TUC were conducted in 16 hospitals in five provinces in 2009 and 2010. The results were encouraging in terms of couple participation and yielded sero-status results of discordant and concordant positive couples.
- Training in couples VCT was conducted using the training-of-trainers approach for nurse and counselling staff in 12 health centre zones.
- The monitoring system of couples VCT was improved in 2011 by recording the number of pregnant women and partners who received couples counselling in each month in the routine activity log.

## ***Remaining issues and the steps to address them***

### *Scaling up couples VCT at ANC clinics:*

One challenge faced in the couples VCT programme is that most pregnant women do not attend ANC with their partners. Thus, there is a need for proactive outreach to increase partner participation by mobilization of health volunteers and community peer leaders. In addition, efforts need to be made to reduce the workload of the ANC staff, while maintaining or improving the quality of services and conducting regular clinic inspections.

The DOH plans to expand training in couples counselling, increase production of educational material for staff to use during counselling and motivate more couples to have VCT. Action has already been taken to prepare standards for monitoring and supervision of clinics, to be used by resource persons and responsible authorities of the PCMO and regional health centres.

## **B. HIV PREVENTION IN THE WORKPLACE**

In 2009, the NAC issued the National Guidelines on HIV/AIDS Management in the Workplace, to be applied by all public and private worksites.

### ***Key national efforts and achievements in 2010 and 2011***

The actions and achievements in the period from 2010 to 2011 were as follows:

- The TBCA continued implementing the AIDS-in-the-workplace programme (which began in 2003) to reduce HIV infection among youth working in factories and other worksites, with funding from the Global Fund. Over the past eight years the programme has covered over 2,000 worksites in 56 provinces employing 360,000 labourers.
- The TBCA worked with the Ministry of Labour through the Department of Labour Welfare to evaluate and develop standards for HIV and AIDS management to qualify for AIDS Response Standard Organization (ASO) classification. Fully 8,000 worksites have received the ASO, which helps to promote standard risk behaviour reduction and infection, while reducing prejudice and discrimination against PLHIV. The TBCA has planned to raise the level of ASO to become a recognized standard at the national and regional levels.
- The NAC set up the committee to operationalize the National Guidelines on HIV/AIDS Management in the Workplace. The committee has proposed two subcommittees working for application of the National Guidelines in private and government worksites.

## ***Remaining issues and the steps to address them***

### *Effectiveness of HIV prevention in the workplace:*

One remaining challenge is that there have not been significant changes in condom use behaviour. Greater efforts will be encouraged in the workplace to reduce stigma and to help HIV+ workers to access treatment so that they can continue work. In addition, project implementation will be reviewed to ensure it takes into consideration the gender roles and condom negotiation skills for females, so as to increase condom use among women. A study of factors which affect condom use among male workers under age 25 years when engaging in sex with sex workers will also be conducted to assess why the rate of use is declining among young men.

### *Promotion of the use of the National Guidelines on HIV/AIDS Management in the workplace:*

Promotion of the guidelines has been widely implemented in private worksites through joint efforts by the TBCA and MoL, but implementation among government worksites has not started. The NAMc, together with the Office of Civil Service Commission as the secretariat, will facilitate the functioning of the committee to operationalize the National Guidelines in government worksites, while the MoL and the TBCA will continue implementation of the National Guidelines in private work sites and improve the quality of implementation.

## **C. HIV PREVENTION AMONG WOMEN AFFECTED BY INTIMATE PARTNER VIOLENCE**

Thailand does not have updated data that could be used to respond to intimate partner violence. However, the reporting process has called for the common understanding of definition and the collective efforts to establish a monitoring system regarding this issue.

In 2010, the Office of Women's Affairs and Family Development (OWAFD) under the Ministry of Social Development and Human Security reported that:

- 966 women received services from the Ministry's shelters (physical violence 42.7 per cent, psychological abuse 54.4 per cent, sexual abuse 2.8 per cent);
- 12,554 women facing violence (34 women per day, on average) were assisted by the One Stop Crisis Centre of the Ministry of Public Health (physical violence 74.6 per cent, sexual violence 17.6 per cent, psychological 5.3 per cent, neglected 1.9 per cent, lured for benefits 0.69 per cent).<sup>5</sup>
- 795 women sought counselling and support from key women's NGOs due to violence.

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<sup>5</sup> The figure from OSCC increased from 11,152 women (30.55 women/day) facing violence in 2009.

The 2009 Reproductive Health Survey conducted by the National Statistics Office in 2009, which covered 12 million ever-married women nationwide, found that 365,230 women (2.9 per cent) had experienced intimate partner violence, and such violence was particularly common among young women aged 15-19 years. The survey only covered physical violence among ever-married women, not ever-partnered women.

The data source which mostly correspond to the IPV indicator is the “Violence in Intimate Relationship and Women’s Health” report<sup>6</sup> published in 2003, which was conducted by the Institute of Population and Social Research of Mahidol University and the Foundation for Women, supported by the WHO, which was the first ever survey on violence against women in Thailand. The sample size covered 2,818 women aged 15-49 years in two locations: Bangkok (1,536 respondents) and a province in the upper central area (1,282 respondents). The result shows that 41 per cent of ever-partnered women in Bangkok and 47 per cent of women in the other province had experienced either physical or sexual violence by an intimate partner. In particular, the survey found that 23 per cent of women in Bangkok and 34 per cent of women in the other province had experienced physical violence and 30 per cent of women in Bangkok and 29 per cent of women in the other province had faced sexual violence.

### ***Key national efforts and achievements in 2010 and 2011***

In 2010, Her Royal Highness Princess Bajrakitiyabha of Thailand, as UN Women Goodwill Ambassador, launched the Asia-Pacific Regional Component of the United Nations Secretary-General’s Campaign UNiTE to End Violence against Women (EVAW). The Prime Minister expressed political commitment to end violence against women and girls.

The Women’s Development Plan during of period of the 10<sup>th</sup> National Social and Economic Development Plan (2007-2011) identified targets on ending violence against women and increasing access to healthcare and assistance for all women who experience violence. The MSDHS, MoPH and Ministry of Justice also developed the joint “Strategic Plan and Action Plan in Support of the Protection of Domestic Violence Victims Act (2009-2013) (DV Act), targeting integration of all units involved for the protection of rights and access to healthcare and social support services of women subject to violence and victims of violence.

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<sup>6</sup>Definition of violence against women is almost identical to that of the IPV indicator, while the measurement frequency includes both lifetime violence and past 12 months

In 2010 and 2011, the MSDHS implemented policies and programmes on EAW, including the Joint Programme, “Every Home A Safe Home: Supporting Thailand Towards Effective Implementation of the Protection of the 2007 Domestic Violence Victims Act”, supported by the UN Trust Fund to End Violence Against Women, led by UN Women and participated in by UN Women, UNDP and UNFPA. The Joint Programme designed and piloted a multi-stakeholder coordination mechanism, the inter-agency guidelines on the Domestic Violence Act (DV Act) implementation, a VAW data collection system, training modules for related officials and awareness-raising campaigns, in partnership with various government agencies, including the MoPH in charge of the OSCC in support of violence victims, which aims to enhance the capacity of OSCC staff and the screening and referral systems in partnership with UNFPA. The OWAFFD also entered into a Memorandum of Understanding with 10 government agencies in support of implementation of the Domestic Violence Act.

Government organizations and NGOs also joined hands to raise awareness on EAW amongst service providers, communities, young people, the media and the general public, to overcome barriers of gender stereotypes and discrimination and to change the common misconception that VAW is a private issue. These includes efforts by the Ministry of Justice, Ministry of Education, the Office of the Attorney-General and women’s NGOs working with the communities on the ground (e.g., National Council of Women of Thailand, Foundation of Women, Friends of Women Foundation, Women and Men Progressive Movement Foundation), including in the areas of behavioural change of partners committing violence, who are mostly male.

While efforts to link HIV and VAW are limited, particularly in the intimate partner relationships, in 2010 and 2011, some NGOs, such as the Raks Thai Foundation, started to explore the intersection between HIV and VAW, through working with the Thai Positive Women’s network, supporting positive women in realizing their rights including through an understanding of the CEDAW framework and mechanisms, building their capacity in peer-to-peer support in VAW cases, and promoting partnerships with local government organizations, with support from UN Women.

Under the leadership of Her Royal Highness Princess Bajrakitiyabha, Thailand successfully initiated and facilitated the 2010 adoption by the United Nations General Assembly of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), which makes reference to taking positive measures to address the structural causes of VAW.

In support of the implementation of the DV Act, organizations in the justice sector, e.g. the Office of the Judiciary of the MOJ, the Office of the Attorney-General, the Royal Thai Police, developed guidelines. The inter-agency guidelines were developed through the initiation and coordination of OWAFD, with support from UN Women. The Inter-Governmental Committee on the Prevention and Solution of Domestic Violence had a resolution to develop a National Action Plan on VAW and DV and to review existing gaps of the current DV Act. The database on VAW was developed and set up under the website [www.violence.in.th](http://www.violence.in.th). The OWAFD published a report titled Gender-based Violence Against Women and Girls Indicators with support from the UNDP. The report lists indicators for gathering data and statistics on violence against women and girls. Such data are useful for constant evaluation of progress in this area. A hotline service, shelter and the coordination system of the Operating Centre on EVAW by the MSDHS continue to provide support to women subject to violence.

In 2010, the MoPH issued a policy to set up OSCC in 150 community hospitals nationwide, adding to the existing 783 OSCCs established in 2009. In addition, OSCCs were set up in the four predominantly Muslim southernmost provinces. The first OSCC was opened in 2004.

The women's movement and women's NGOs contribute greatly to the work on EVAW in Thailand. NGOs work in partnership with government agencies in various areas, including policy advocacy, capacity development of officials in the justice and social sectors, social workers, community leaders, NGOs workers, public awareness raising campaigns, working with the media, community mobilization, promoting self-help groups, shelter support, networking amongst NGOs, and research for knowledge generation. National health funding mechanisms, such as the Thai Health Promotion Foundation, has included the topics of healthy sexuality and women's health in its strategic plan since 2006 and has expanded support to various NGO projects on VAW and VAW relating to HIV. VAW was a topic in the NGO Alternative Report to the CEDAW Committee in 2010 with support from UN Women. Furthermore, due to capacity building of members of the positive women's network, more positive women are aware of their rights under CEDAW and have started to collect data and information to include their issues in the NGO Alternative Report.

The wealth of hands-on knowledge on VAW and the intersection of VAW and HIV seem to lie in NGO networks more than in government organizations. Some NGO networks note that OSCC joining the CHOICE forum (Network supporting women with unplanned pregnancies) is an achievement due to the fact that abortion remains illegal in Thailand (apart from some legal abortions for medical reasons). CHOICE provides optional counselling for women who experience sexual violence and have a holistic approach towards solving problems of unplanned pregnancy based on non-judgmental and client-centred principles allowing women to make informed choices. CHOICE also provides mother and baby support.

In 2010 and 2011, the knowledge base in the HIV and VAW intersection was enhanced through a number of research studies, such as research on feminization of HIV and AIDS responses and research on spousal transmission, with support from UN Women.

### ***Remaining issues and next steps to improve responses***

*Lack of understanding and conceptualization of the HIV and VAW intersection and their re-enforceable nature.*

This includes the lack of knowledge, understanding and skills; and lack of understanding of the gender and sexuality lens through which it can be observed that gender power imbalance is the root cause of VAW and intimate partner violence. Furthermore, VAW and gender and sexuality issues have not been considered as a cause or effect of HIV.

The steps that need to be taken include the following:

- Integrate VAW and gender equality into the National AIDS Strategic Plan on the 3<sup>rd</sup> Zero of reduction of stigma and discrimination. In parallel, advocacy should be undertaken on the integration of violence against women living with HIV as part of violence against women work under the National Women's Development Plan and the National Action Plan on VAW, in training on reproductive health rights, gender and sexuality and HIV and in training of government officers working on violence against women and of health providers.
- A social campaign should be implemented to raise awareness on how violence against women is related to HIV and gender equality. Public relations for services of OSCC and on the DV Act is also needed.

*Lack of a systematic database on VAW and intimate partner violence as well as analysis, and thus a lack of evidence-based policies and programming on the HIV and VAW intersection.*

This includes missed data and overlaps amongst databases due to different definitions used, leading to possible multiple counting, and the sensitive issue of protection of confidentiality. Thailand has a national database on violence against women and reproductive health, but HIV is not included in the analysis. Meanwhile, national HIV database still lacks analysis of relationship amongst violence against women, gender & sexuality and HIV.

The steps that need to be taken include the following:

- Conduct a situation survey to compile data on HIV and VAW and conduct qualitative research on the violence faced by women living with HIV to assess the magnitude and severity of the intimate partner violence problem and to provide information for policy decisions. Meanwhile, capacity development and involvement of women living with HIV and women who face violence in the decision making processes, policy making and dialogue processes need to be planned.

*Challenges in the implementation of the DV Act.*

This includes the broad definition of DV in the law, limited number and understanding among officials and the public leading to the under-use of the Act in the protection of victims of violence, and lack of coordination amongst related organizations. Some NGO networks and academics are critical of the imbalance of protecting families over protecting the rights of women in the fine interpretation of implementers, as the Act allows for negotiations between the complainant and the accused.

*Challenges of service providers at OSCC.*

The unclear roles of each unit in multi-sectoral professions and lack of clear guidelines on team procedures affects the referral system and those who need long-term follow-up. For instance, women subject to violence who have started ART but suffer from side effects and/or stigma and concern with confidentiality might lose ART adherence. Migrant women or Thai women who do not have an identification number and who are faced with violence and need ART, are unlikely to have access to the medication.

*Inadequate involvement of positive women in intimate partner violence work, prevention and response.*

HIV positive women are more vulnerable to violence than positive men and negative women. A majority of positive women face sexual violence and are forced on the first sexual relationship; women who learn about their positive status and reveal it are often unable to negotiate safe sex and face unplanned pregnancy and transmission of drug resistant viruses.

Need to strengthen the gender equality mechanism at the national and local levels, including the gender mainstreaming mechanisms in the government (the Chief Gender Equality Officer and the Gender Focal Point System) and to place gender equality at the centre of the national and local planning and budgeting process. The overall objective is the realization of women's human rights.

The steps that need to be taken include the following:

- Strengthen the support system and promote an integrated approach to planning and implementation of HIV/VAW prevention and response, from the legal, service provision, and institutional perspectives, including involvement of local administration organizations and maximizing existing mechanisms in the communities to address the intersection of VAW and HIV. Critical services on VAW should be defined and included in the National Action Plan on VAW.

*Lack of understanding by the public about the root causes of gender inequality and VAW.*

There is a need to engage men in the course of ending violence against women through changing their attitudes and behaviour and reducing the factors inducing violent behaviour.

The steps that need to be taken include the following:

- Strategically plan to engage men and boys in ending violence against women e.g. awareness-raising campaigns and support programmes that focus on men who use violence, aiming to change their behaviour and attitudes to prevent repetitive violence.

## **1.2. REDUCE SEXUAL TRANSMISSION OF HIV AMONG YOUTH**

Youth are an important target for prevention and measures to accelerate services for this group were included in the 2007-2011 national AIDS programme with the aim of reducing new infections by half in 2011. The Department of Health drafted a policy and reproductive health strategy for 2010-2014 to prevent and address problems of teenage pregnancy, HIV and STIs, and to encourage the delivery of youth-friendly health services.

One challenging issue cited in the 2008-2009 progress report was implementation of a sex education curriculum in the absence of a supportive policy or endorsement from senior educational administrators. This lack of support presented a serious obstacle to raising awareness about AIDS and safe sex, to promoting access to condoms and to teaching life skills relating to staying safe and healthy. Another obstacle cited in the report was the legal barrier that prohibits youth under 18 years to access VCT, diagnosis and treatment of STIs, without parental consent.

### ***Key national efforts and achievements in 2010 and 2011***

#### *Enabling policy:*

- In 2011, the reproductive health policy and strategy was implemented in 64 provinces, covering 659 hospitals. It is forecasted that by 2014 every province will have these strategies and programmes in place.
- In 2011, government and civil society agencies implemented HIV programmes for youth, with financial support from UNFPA and the MoPH.
- The DOH, in cooperation with stakeholders, developed policies and strategies for National Reproductive Health 2010-2014 to support prevention and resolution of the problem of unplanned pregnancies among youth, and to provide youth-friendly services in various health outlets, especially hospitals.
- The Office of the Commission for Basic Education developed guidelines for addressing problems of underage pregnancy so that students are not expelled from school and distributed these guidelines to schools throughout the country.
- All schools under the Office of the Commission for Basic Education adopted the “implementation guidelines for prevention, resolution, care and assistance” for students with unplanned pregnancies.

#### *School-based sex education:*

- PATH (Thailand) in collaboration with education and health sectors continued delivering sex education for school-based youth in 2010 and 2011, with grant funding from the Global Fund. As 2011 was the first year of the final three years of the Global Fund supported project, the PATH put more focus on sustainability through establishing a provincial core group and integrating into the Provincial Coordinating Mechanism for HIV as well as mobilizing local resources to maintain school-based sex education.

- The Office of the Commission for Basic Education integrated life skills building into the central curriculum. This includes four components, with compilation, analysis and grouping of educational media, tools and innovations to build these skills, improve internet websites and help teachers to apply the content through learning activities in accordance with the central curriculum for basic education (2008), including guidelines for teachers for evaluating student life skills.
- Based on the Global Fund supported project, a 16-hour curriculum exists but has only been implemented on a limited scale, nine per cent of basic education schools and 28.7 per cent of vocational schools. There were few Local administrative organizations allocating resources for activities on sex education in schools in their localities.

*Youth-friendly services:*

Under the Global Fund supported project, the BATS facilitated the development of youth-friendly services, with the goal of improving the sexual health service system, prevention, care and treatment of HIV/AIDS in ways that are linked and continuous. In 2011, youth-friendly services were set up in 43 provinces with 989 outlets.

*Youth networking:*

The BATS, with funding from the Global Fund, conducted network strengthening of a cadre of peer leaders for prevention of HIV and STI. This effort included exchange of experience among the peer leaders and training of youth counsellors to advise other students their age who are facing problems and help resolve those problems or refer students to appropriate teachers for assistance.

*Parents' communication skills:*

PATH, with the support of Chevron, developed a training programme for parents designed to enable parents to improve their communication skills and communicate more effectively with their teenage children. The training programme also aimed to instil positive attitudes among parents toward sex education. The training programme for parents developed by PATH was adopted by NGOs working on HIV prevention with youth in the community.

## ***Remaining issues and the steps to address them***

### *Delivering sex education:*

Although sexuality education in the schools has greatly expanded, there is still insufficient coverage. Not all youth are able to access accurate information about safe sex and HIV prevention. Sex education has not achieved full coverage nationwide and the amount of education has not reached the standard 30 hours for the academic year. Furthermore, it is not yet possible to evaluate the effectiveness of the sex education programme. In addition, gender sensitivity continues to be a weak component in sex education. Programme expansion and quality control remain major challenges because of a lack of clear policy support and resource allocation from the education sector.

The steps that need to be taken include the following:

- Enact a policy that allows access to VCT for youth under age 18 years without requiring parental consent. There needs to be unlimited access for youth to receive VCT and services that are youth-friendly.
- Advocate for inclusion of sex education into the routine curriculum with at least 16 sessions per academic year, with evaluation of outcomes to help review the strategy to improve quality and effectiveness.
- Build positive attitudes in society about sex education, and create an enabling environment for safe sex.

### *Delivering youth-friendly reproductive health services and delivering HIV VCT:*

The delivery of youth-friendly services has just begun and is facing some obstacles such as geographic coverage, meeting the needs of youth, quality and effectiveness of services and types of services.

The steps that need to be taken include the following:

- Campaigns are needed to create a positive image of VCT and to encourage youth to know their sero-status.
- Support counselling before and after blood testing, especially for vulnerable youth, so that they can learn about their rights and have confidence in confidentiality.
- Expand coverage of youth-friendly services to reach all locations.
- Improve and expand VCT for youth. Include general population youth in this effort, not just MSM, intravenous drug users and sex workers.
- Produce innovative educational materials that meet the needs and preferences of youth, while including the topics that youth need to learn about.

- Create models and processes of implementation which support participation of youth and which build self-capacity.
- Allocate a budget for the implementation of these activities.

### **1.3. REDUCE SEXUAL TRANSMISSION OF HIV AMONG MEN WHO HAVE SEX WITH MEN**

The MSM group was a highly important priority in the 2007-2011 NASP, with the target of reducing new MSM infections by half of the projected total by the end of the plan period. The key issue identified in 2009 UNGASS report was the need for broader coverage and for improving quality of HIV prevention interventions among MSM and TG. This was to be achieved through improving the capacity of staff – government, civil society and volunteers– so that they would be more knowledgeable and understanding about sexual diversity, sexual health and become more skilled in behavioural change communication. In addition, research was needed to identify ways to improve access to services for MSM, especially those who were not yet “out” about their homosexuality, and improving the system of proactive referral to VCT and STI diagnosis and treatment. Of particular importance was the need to help the provincial and local administrative organizations to support policies for MSM and to allocate budgets for services as part of their annual operational plans.

#### ***Key national efforts and achievements in 2010 and 2011***

In 2010 and 2011, Thailand accelerated its delivery of HIV prevention services among MSM and TG. Furthermore, diversified types of HIV prevention interventions were implemented, including targeted efforts on treatment, care and support among MSM and TG. Partnerships with private organizations led to the launch of innovative prevention initiatives using various platforms: social media, mass media and interactive media and events to reach more MSM and TG.

The Comprehensive HIV-Prevention Among MARPs by Promoting Integrated Outreach and Networking (CHAMPION) project, supported by the Global Fund, was implemented in 30 provinces through a combination of prevention interventions and other cross-cutting activities. Interventions included: outreach in schools, sex and non-sex establishments and drop-in centres; referrals; local campaigns on human rights; and stigma and discrimination education. The project supported the establishment and strengthening of community-based organizations and training outreach educators and volunteers. The BATS supported 47 provinces not covered by the CHAMPION project, mainly through condom distribution and support to local initiatives by NGOs for campaigns and awareness-raising.

USAID and TUC partnered with CSOs and the government to develop comprehensive models of packages of services on prevention, treatment and care, including outreach in various venues, internet and drop-in centres, care and support to MSM and TG living with HIV, and HIV Rapid Tests with same-day results. To improve the quality of intervention, civil society organizations were supported to conduct community diagnosis, mapping, size estimations and curriculum development. This was coupled with capacity building support to NGOs and CBOs working in the field of prevention of HIV among MSM and TG through assessments and trainings. The United Nations Development Programme (UNDP) partnered with the BATS to start the process of developing national guidelines for HIV prevention. The TUC consistently supported the government in surveillance and developing manuals and curricula on HIV interventions.

The impact of the “100% Condom Use Programme” helped normalize condom and lubricant distribution and use among MSM, TG and MSW and it has been expanded considerably. The wider geographic reach was coupled with an increase in the number of CBOs (to 36) working for MSM and TG in 30 provinces. Over a thousand people, mostly MSM and TG, were trained in HIV prevention. Through the CHAMPION project alone, close to two million condoms were distributed. In 2010-11, consciousness on the need to improve strategic information resulted in review of lessons-learned on MSM and TG interventions and improving monitoring, evaluation and learning.

Outreach and VCT linkage were strengthened in selected risk sites, including through a mobile clinic of Thai Red Cross AIDS Research Centre in hot zones in Bangkok, hospitals in Chiang Mai, and community-based MSM drop-in centres in Pattaya. Continued training support led to the improvement of the capacities of MSM and TG CBOs. Technical assistance from the government, INGOs and NGOs were made available to CBOs and local health personnel in the provinces to implement MSM and TG programmes, including training of health providers.

### ***Remaining challenges and the steps to address them***

In 2010 and 2011, MSM and TG interventions in Thailand experienced bottlenecks in terms of weak local leadership and poor commitment in many sub-national areas, attributed to low knowledge of local leaders, including some members of PCMs and health professionals. At the same time, low capacity was observed among the MSM and TG community in terms of carrying out policy advocacy to influence commitment among local leaders. Furthermore, it was noted that the local capacity to generate and manage strategic information for policy and planning use for provincial AIDS committees or PCM is weak. Improvements are needed in many areas, including population size estimation, as well as effective use of the findings of programme monitoring.

The quality of services is still uneven, with outreach not clearly linking VCT and STI screening in many areas. This is attributed to low knowledge of workers on VCT and STIs, and weak coordination of NGOs and existing health service providers. Furthermore, the available scaled-up models of HIV prevention of outreach and DiCs are not reaching hidden MSM and TG.

Stigma and discrimination in the public sphere, among family and peers, and self-stigma remain barriers to accessing HIV prevention services for many MSM and TG, especially when stigma and discrimination are encountered in health facilities. Interestingly, facilities such as DiCs can sometimes be stigmatizing venues, as they are perceived by some to be accessed only by gay people and are therefore shunned by MSM in hiding.

It is necessary to improve service coverage to target hidden MSM and TG, particularly youth, which will require scaling up of the use of new platforms such as social media in reaching hidden MSM and TG. This will also require addressing stigma and discrimination related to gender and sexuality, particularly in events and facilities that provide services such as VCT, STI diagnosis, and condoms and lubricant.

It is also necessary to standardize HIV prevention among MSM and TG by developing national guidelines and standard operating procedures. The capacity gap of service providers, especially peer workers and health professionals will need to be addressed through training and retraining. Such training should be strategically linked to the overall organizational development of NGOs and CBOs managing HIV services for MSM and TG. Those implementing the services will need to link outreach to VCT and STI screening, which requires improving the ability of outreach workers to ensure that health facilities are collaborating with the MSM and TG communities.

To be able to address coverage and quality of HIV services for MSM and TG, especially at the ground level, it is necessary to strengthen local coordination, leadership and capacity through PCMs. It is necessary to also provide capacity building to local leadership to enable them to understand gender and sexuality and how better acceptance of MSM and TG leads to improved HIV protection for MSM and TG. Aligned with this, the capacity of local and national policy makers to routinely generate analyze and use information about MSM and TG will need to be strengthened.

At the national level, the national M&E plan for 2012-2016 was recently developed. It calls for aggressive implementation according to the work plan, including increasing understanding and collaboration between various key stakeholders to develop a unified and integrated monitoring system that can be used for programme planning at all levels. This national M&E plan will be a guide for determining the structure, processes and capacities required to improve how data on MSM and TG are generated, analyzed and used for policy and programme implementation.

#### **1.4. REDUCE SEXUAL TRANSMISSION OF HIV AMONG FEMALE SEX WORKERS**

Integrated HIV prevention for key affected populations in Thailand has been and will be supported primarily by funding of the Global Fund, which covers the period between July 2009 and June 2014. This support is helping to expand intensified prevention to 41 provinces, including Bangkok.

Despite efforts over the past two years, the obstacles noted in the 2008-2009 progress report still remain, including the barriers to providing prevention services to non-venue-based FSW, foreign migrant FSW and FSW under age 18. Often, there are also barriers to reaching venue-based FSW as owners of commercial sex establishments do not want prevention staff to contact FSW who are non-Thai or underage and thus, these women are denied essential health services.

There have been repeated calls to treat sex work as simply another form of employment in Thailand so that sex workers can benefit from labour protections and laws as other workers do. The practices of victimizing FSW, subjecting them to harassment, denying them welfare and social insurance, and refusing to address worksite conditions that are sub-standard and unsafe continue. All of which erodes the quality of life and health of FSW.

#### ***Key national efforts and achievements in 2010 and 2011***

##### *Peer-led outreach services:*

Supported by the Global Fund, DiCs were established in 41 provinces and are being managed by civil society organizations. Service standards were set up and followed by NGOs to ensure the standardization of services provided by different DiCs. Together with active and intensive outreach activities conducted by peer educators, staff and volunteers of NGOs, this led to more sex workers being reached and referred to health care services, including STI screening and VCT.

### *Comprehensive condom programme:*

The BATS, supported by UNFPA, initiated the Comprehensive Condom Programme (CCP) with the aim of promoting responsive and sustainable access to condoms and lubricant for all groups of the population, with the ownership and participation of local authorities. Moreover, female condoms were introduced and promoted as an innovative prevention tool, with the support of UNFPA in partnership mainly with the DDC and Health and Opportunity Network. The condom fund for sex workers piloted by SWING proved to be a success and was therefore continued and scaled up.

### *Good quality STI services:*

In accordance with the policy on national coverage of STI clinics, in 2011 coverage reached 26 clinics in 17 provinces. A model of quality assurance, called STI-QUAL, was developed by the BATS with technical support from TUC and UNFPA. The BATS, in collaboration with the 12 Offices of Disease Prevention and Control at the sub-national level, implemented quality assurance of STI clinics on an annual basis to ensure good quality and comprehensiveness of service provision in the clinics.

### *Coverage and improvement of health services:*

- With the support of the Global Fund Round 8 programme for nationwide coverage, HIV prevention and health care promotion services for sex workers were extended to cover 41 provinces. The programme has greatly involved civil society in HIV prevention and access to health care for sex workers.
- Rights and social dimensions were integrated into the HIV prevention and health care programme, in addition to the original focus on health and epidemic control. The government agencies responsible for health service provision became more aware of the importance of having a positive attitude towards sex workers and of providing friendly health services.

### *Sex worker-friendly services:*

Led by the BATS, sensitization, HIV counselling, and a VCT curriculum and guidelines for HIV and STI prevention among sex workers were developed. The training was provided to health service providers in 41 provinces under the Global Fund supported project.

### *Empowering sex workers:*

- Sex workers were also trained and empowered to represent their peers in the Provincial Coordinating Mechanism.
- SWING, supported by UNFPA, implemented the Rights Protection Volunteers for Sex Workers project in Pattaya with the participation of sex worker volunteers, tourist police and the Pattaya Municipality.

### *Building a network for an alliance working on STI and HIV prevention among sex workers:*

The BATS, in collaboration with UNFPA, annually organized a National Seminar on Sex Work, which aimed to enable experience-sharing and sharing of lessons learned, as well as to build an alliance of people working on STI and HIV prevention and care among sex workers. Representatives of government agencies, civil society and sex workers from all over the country participated in the seminars.

### *Local authority involvement and resource mobilization:*

Local Administrative Organizations (LAOs) were involved in responding to the issue of HIV among sex workers. Some provinces were successful in addressing the issue in local policy and planning, with proper allocation from LAOs.

### *Rights, laws and policies:*

- The NAC's sub-committee on promotion and protection of the rights of people living with HIV and AIDS was established in 2011, with representatives from sex worker groups and from NGOs working with sex workers.
- The concept of "sex work is work" was advocated for, together with an attempt to apply occupational health approach to sex work.

### ***Remaining challenges and the steps to address them***

#### *Limited access to knowledge, education and services:*

The percentage of FSW reached by HIV prevention programmes remains low. There are particular challenges in reaching non-Thai and young sex workers. Non-Thai sex workers normally encounter language barriers and difficulties in being illegal migrants, which limit their chances to protect themselves from HIV infection. In addition, non-Thai sex workers and young sex workers are often exploited and are often victims of sexual violence.

The steps that need to be taken include the following:

- HIV prevention intervention should be extended to cover hard-to-reach sex workers i.e. non-Thai, non-venue based and young sex workers.
- Enhance the role and capacity of community health promotion hospitals to provide health care services, including HIV prevention services, to sex workers at the sub-district level.

*Laws and regulations impede access to HIV prevention and health care services by sex workers:*

Sex work is illegal under the anti-prostitution law and sex work is not protected under the labour law. Condoms are often used as evidence for a sex worker to be arrested under the anti-prostitution law and there are occasions when law enforcement officials abuse their authority and inflict human rights violations and violence on sex workers.

The steps that need to be taken include the following:

- Scale up the Rights Protection Volunteers for Sex Workers project, successfully piloted by SWING in other priority sites.
- Enhance the role of NGOs in capacity building for service providers and programme implementers at the local level.

*Regulations for using services under the Universal Coverage Scheme:*

The UC benefits are provided at the local health facility where a patient is registered. This impedes access to health care of sex workers, who are often mobile. Also, un-registered migrants are not eligible to access health care services under any schemes.

*Referral system and coordination:*

There is still no linkage between the HIV sero-surveillance system and the referral system to allow HIV-infected sex workers to access the health care system. Moreover, the coordination between NGOs and government agencies working with sex workers is still limited in some areas and this has caused the referral system to be inefficient and sometimes not function.

The steps that need to be taken include the following:

- Create coordination between the NGOs and government agencies using the Provincial Coordinating Mechanism for improving the referral system, as well as local planning aiming at reaching more sex workers in each province. The local area organizations should be involved in the planning and have budget allocation for HIV prevention and response in relation to sex workers.

### *National data collection and surveillance system:*

The data collection for national surveillance surveys i.e. HSS, IBBS and BED, was conducted in a duplicated manner and on separate occasions. This caused disturbance to both establishment owners and sex workers as they had to go through data collection processes multiple times instead of once.

The steps that need to be taken include the following:

- Integrated BED-IBBS should be introduced to combine the data collection processes. There should be an agreed standard on data collection methods, definitions and time lines among all agencies conducting surveys among sex workers. Furthermore, the linkages between surveillance and referral of HIV+ sex workers to treatment and care services should be established.

### **1.5. REDUCE SEXUAL TRANSMISSION OF HIV AMONG MIGRANTS**

Migrants and mobile populations include migrant workers in Thailand, displaced persons, ethnic minorities and Thais working abroad. This group was included as a target to receive integrated prevention, care and treatment in the 2007-2011 national AIDS programme through intensified outreach and service networking. The gaps and challenges described in the 2008-2009 progress report include the problematic legal status of migrant workers and the system of health insurance coverage and health budgeting for ART. The MoPH health insurance scheme covers only those migrant workers who are registered with the Ministry of Labour, yet there are at least one million migrants working in Thailand who are not registered, some of whom are HIV+ and need treatment.

There is a growing influx of migrants from other countries, including Viet Nam and Bangladesh, who are not being reached with interventions. Migrants in the fishing industry are highly mobile, have high turn-over and are known to engage in high risk behaviours as a lifestyle. This makes reaching them with comprehensive interventions complicated. Furthermore, younger migrants are less familiar with HIV and have low levels of education.

Indicators for migrant workers have been included under Thailand's National Strategic Information and Monitoring and Evaluation Plan for HIV/AIDS 2012-2016. Any monitoring, such as using the IBBS, needs to uphold the rights of migrants and needs to feed into the development and implementation of evidence-based responses.

### ***Key national efforts and achievements in 2010 and 2011***

HIV prevention interventions targeting migrant workers<sup>7</sup> in Thailand have been implemented almost exclusively under the PHAMIT project. PHAMIT is one of four targeted grants under the Comprehensive HIV Prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION) project, which is a Round 8 grant under the Global Fund. The DDC of the MoPH is the Principal Recipient (PR) of CHAMPION, and the Raks Thai Foundation, a local NGO, is the PR for PHAMIT, which is the migrant component. PHAMIT is implemented by the Raks Thai Foundation along with the following NGO partners: AIDS Network Development Foundation (AIDSNET), Foundation for AIDS Rights (FAR), MAP Foundation, Pattanarak Foundation, Social Development Association (SDA), Stella Maris Center Songkla, and World Vision Foundation of Thailand. The project also partners with the Bureau of Health Administration and Provincial Health Offices.

The Round 8 grant started in June 2009, but this is the second stage of the PHAMIT project, which is a scaled-up continuation of the project which started as a Round 2 grant in 2003. PHAMIT now covers the 36 provinces where the greatest numbers of migrant workers are found.

Direct interventions implemented by NGO partners under PHAMIT include: behaviour change communication; condom distribution; and referral for STI diagnosis and treatment and for VCT. Interventions are implemented through trained Migrant Health Workers, volunteer networks, drop-in centres and mobile clinics, direct outreach activities, volunteer networks, campaigns and a variety of media materials produced in migrants' languages and condom boxes. As well as direct interventions, the project aims to make changes in the enabling environment by working with local government officials, employers, the media and Thai communities to improve policies and decrease discrimination; and to improve related policies and programming through increased strategic information, including research, surveillance and monitoring. PHAMIT partners also provide assistance to migrants living with HIV through the Global Fund-supported RCC-Care programme.

Almost all HIV-related interventions for migrants were supported by funding from the Global Fund Round 8 grant, and practically all implementation was by the NGOs under the PHAMIT project. The plan to integrate "migrant friendly services" into public health services as part of the PHAMIT project was stalled by changes in the government and restructuring within the MoPH.

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<sup>7</sup>Not including refugees, displaced populations, or hill tribe / ethnic minorities.



In 2010 and 2011, the MoPH provided health services to documented migrants through the health insurance scheme. There were 719,324 and 829,387 migrants registered with the MoL in 2010 and 2011 respectively. Of these 60.8 per cent were under the MoPH health insurance scheme in 2010 and 69.7 per cent in 2011. PMTCT services are included in the benefits package.

As of the end of 2011, there were 2,785 migrants and non-Thais<sup>8</sup> officially on record as receiving ART. During the flooding of 2011, migrants in the Bangkok metropolitan area who were receiving ART were contacted and provided assistance by the Foundation for AIDS Rights, a partner under the PHAMIT Project, to ensure they maintained adherence throughout the crisis.

### ***Remaining challenges and the steps to address them***

*A policy on MHW has yet to be approved.*

MHW who are trained by hospitals and NGOs under the PHAMIT project provide translation services at hospitals, including assistance with HIV counselling for VCT and the ANC clinics. Currently, some hospitals informally hire MHW while others rely on PHAMIT project partners to hire them. Without a clear policy, however, hospitals are discouraged from utilizing MHW out of fear of breaking the law, and therefore have no incentive to utilize the funds generated from the migrant health insurance to hire MHW.

The steps that need to be taken include the following:

- Continuation of HIV-related services for migrants needs to be planned for when the Global Fund ends its support. This includes incorporating MHW into the health system and making sure that PCMs incorporate migrants into their planning and budgets in partnership with civil society organizations. Cross-border coordination needs to be strengthened to allow migrants on ARV to maintain their treatment regardless of which country they are in.

*Funding sources for prevention need to be secured and hospitals need guidance on how to utilize these funds.*

The shifting of migrants from the health insurance scheme to the social security scheme under the nationality verification system raises concerns because social security lacks a mechanism for funding prevention services. At the same time, the money that is generated for prevention services for migrants is often left unused for its intended purpose and is absorbed to cover general expenses.

The steps that need to be taken include the following:

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<sup>8</sup>Including refugees, displaced populations, or hill tribe / ethnic minorities – Source: NAPHA-Ex

- Benefit packages for both prevention and treatment for migrants under the MoPH health insurance scheme as well as the social security scheme need to be reviewed to meet the same standard as the national health insurance scheme for Thais. An expansion of the coverage to undocumented migrants needs to be considered. Most importantly, the migrant registration policy needs to have a long-range plan, and needs to be implemented in such a way that it promotes the maximum number of migrants to register and purchase health insurance.

*Gaps in ART for migrants:*

In 2011, NGOs identified 3,000 migrants and non-Thai populations in need of ART. In October 2011, the Global Fund announced that it could only provide support for 2,300 cases, and that the Thai government should be responsible for any cases above that number. There are another 700 migrants identified as needing ART by the RCC-Care program, with estimates that there may be an additional 1,000 or more migrants who need ART, but who have not been identified yet.

As the ARV for migrants living with HIV in Thailand is supported by the Global Fund, the generic first-line ARV known as GPO-VIR produced by the Thai GPO cannot be purchased due to the unmet criteria of the Global Fund. Meanwhile, ARV under compulsory licensing for Thai people cannot be used for non-Thai patients. Instead, the BATS must import that particular ARV, which is more expensive.

There are major gaps in coverage of HIV services for migrants under health insurance. While treatment of OI for migrants is covered by both health insurance schemes (by MoPH and Social Security Office), neither scheme covers VCT or ART. Furthermore, there are still gaps in cross-border coordination with neighbouring countries to enable continuation of treatment when migrants living with HIV return home.

The steps that need to be taken include the following:

- There needs to be a clear policy on ART for migrants that stipulates: a domestic funding source including allowing procurement of domestically-produced ARV drugs, and numbers of migrants able to receive treatment, preferably without limits and with clear and reasonable guidelines for eligibility including the new guidelines on initiating ARV at a CD4 count of 350.

## **TARGET 2: REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS**

The HIV surveillance data of the Bureau of Epidemiology show that prevalence of HIV among PWID has remained high over time. Between 2008 and 2009, an important development was the policy recommendation to implement harm reduction and reduce adverse consequences of drug abuse. This recommendation passed technical review through meetings, seminars, and participation of related sectors, including the government, civil society, technical experts and international organizations. The Minister of Health signed off on the recommendation to promote a harm-reduction policy for PWID, including equal care for PWID as provided for other health conditions. Representatives from multiple sectors collaborated to produce recommended measures for reduction of spread of HIV and other diseases among PWID, and advocated for increasing the efficiency of methadone maintenance therapy (MMT), including the provision of MMT as a part of the benefits package under universal health insurance.

### ***Key national efforts and achievements in 2010 and 2011***

#### *Harm reduction policy.*

With full collaboration among concerned organizations including government, civil society, academia and international organizations, a draft policy on harm reduction was completed. This had clear objectives, with targets to reduce HIV infection among PWID through a 10-item comprehensive service package (three service categories: risk minimization; HIV, STI and TB diagnosis and treatment; and mental support and drug rehabilitation) and to help all IDU access all elements of the package in all areas. The policy was proposed for approval in the NAC and the National Narcotic Control Committee in late 2010. The harm reduction policy was approved by the NAC and acknowledged by the National Narcotic Control Committee. Harm reduction was officially added to the accelerated strategy (“five fences”) for prevention Phase 3 (for the period from November 2010 to September 2011) under the Prime Ministerial directive of 306/2010 issued on 18 November 2010 and signed by the Prime Minister (Abhisit Vejjajiva).

The BMA and the New South Wales Health Service Organization of Australia signed a memorandum of understanding on harm reduction for PWID and prevention of AIDS in October 2010 in order to promote collaboration for technical capacity building on harm reduction for IDU in Bangkok.

With support from the World Bank, the harm reduction policy and interventions for PWID in Thailand were reviewed and shared among

stakeholders. Constructive suggestions were made on core programmes for harm reduction including the Needle and Syringe Programme, the Methadone Maintenance Programme, VCT and ART.

*Harm reduction implementation supported by domestic funds.*

The order of the Prime Minister #306/2010 defined harm reduction as one of the optional interventions in the Drug Policy. Accordingly, the Office of Narcotic Control Board (ONCB) implemented the harm reduction program in 10 pilot provinces: Bangkok, Samut Prakan, Chiang Mai, Chiang Rai, Tak, Songkhla, Surat Thani, Yala, Naratiwat and Pattani. The staff from related organizations from the ministries of health, interior and police along with local administrative organizations in the provinces, were orientated and guided to develop work plans for their own provinces. The budget was supported in each province by the ONCB.

*Participation of the 12D network in implementing harm reduction for PWID.*

In 2011, 12 civil society organizations (“12D”) formed a network of people working with drug addiction, and this network played an important role in addressing the overall problems of drug addicts in Thailand, advocated and appealed for clarity of narcotics control policy, and advocated for harm reduction for drug users, especially through clean needle distribution.

*Harm reduction implementation with external funding.*

The CHAMPION project was allocated support from the Global Fund for the period between July 2009 and June 2014. Proactive implementation to increase access and services for PWID was initiated using two models: drop-in centres and deployment of a team of PWID peer volunteers in the community. Distribution of needles and syringes is one core intervention of the implementation and is conducted through 42 sites in 15 provinces in the northern, central and southern regions of the country. Under the CHAMPION Project, the network-scaling method was used to estimate the number of PWID. It was estimated that there were between 40,300 to 97,300 PWID. This data is important for planning interventions for the prevention, care and treatment of HIV/AIDS and for evaluation.

### *Improvement of standards of services for PWID in Bangkok.*

The Department of Health of the BMA, with support from the TUC and BATS, developed a system of PWID care to help all PWID to access health services at PWID clinics regardless of whether they had been enrolled in a treatment programme before or not. The programme was initiated in 20 clinics in Bangkok in 2011.

### *Involvement of the media.*

The WHO supported the 22 people from various media including printed media, broadcasting media on television and radio, and online media for a study visit on harm reduction in Indonesia. The media produced articles on harm reduction and broadcasted these via television and printed them in newspapers.

### *Research and data to improve harm reduction policy and implementation.*

To improve the IBBS for PWID, in view of the constantly evolving practices of injection, the Bureau of Epidemiology and TUC conducted a survey using respondent-driven sampling in 2010 in Bangkok, Chiang Mai and Songkla, in cooperation with local civil society groups and drug users. The data collected through this survey better reflect the situation and conditions of PWID in Thailand.

In view of the increased injection of methamphetamines (or “ice”), a qualitative research study was conducted among users of this drug in Bangkok and Chiang Mai to learn more about the factors, context and practices of injection, including the risk of contracting HIV. The data are to be used to develop a pilot project for HIV prevention among ice addicts.

### *Participation of drug users in addressing the problem of AIDS and drugs.*

Models and plans for services were developed through a management information and service centre in the field that addresses needs of the clients as its first priority by involving drug users, who give opinions and recommendations on how this could be accomplished. Recommendations were extracted from the larger network of PWID in Thailand and from summary points from regional forums to reflect the situation of drug users, and this information will be used to inform plans for addressing AIDS and drugs in concrete ways.

### ***Remaining issues and the next steps to improve responses:***

*Consequences of the interpretation of aspects of the law that do not support needle and syringe programme.*

The Council of State (10<sup>th</sup> Council) has interpreted the law in a way that does not support the use of clean injection equipment as a means of harm reduction for the prevention of HIV. This has caused uncertainty among implementers, especially those in the government, that support harm reduction through clean needle distribution.

*Lack of clear guidelines for implementing harm reduction in Thailand.*

Despite the 2010 policy promoting harm reduction for drug users – a first for Thailand – clear guidelines for implementation have not been produced. Thus, agencies cannot move in the same direction. This is especially a problem in terms of the needle and syringe programme, which conflicts with current law that interprets this as promoting illegal drug use rather than HIV prevention. This impedes the capacity of the programme to fully implement the harm reduction policy, and prevents PWID from carrying clean needles, resulting in the continued sharing and re-use of potentially-infected injection equipment.

*Impact of forcefully implementing the government policy on narcotics control.*

The forceful application of the narcotics control policy causes drug users to move underground, and this makes it more difficult for HIV prevention programmes to access PWID and for PWID to access HIV prevention services. Also, the PWID peer volunteers are a target for law enforcement, risk being arrested during their outreach work, and have their rights violated in other ways. Thus, it is imperative that ways be found to protect the programme workers while doing their duties in the community through working for better understanding with the narcotics control authorities.

*Concerns on sustainability of outreach activity by civil society.*

The proactive outreach services provided by civil society organizations include information centres and services provided by peer PWID volunteers. The budgets for these services come from external sources, and if the external support ends this has implications for the expansion and maintenance of the intervention. It is unclear how much local funding and support will be available to support these interventions in the future.

### *Access to and quality of services.*

Although the National Health Security Office approved the inclusion of methadone maintenance as part of the benefits package in 2009, it was found that the number of recipients of this benefit did not increase much between October 2010 and September 2011. This is mainly a result of the lack of readiness of the service system to meet the needs of PWID. In addition, PWID have high levels of risk for infection with Hepatitis B and C. There is lack of empirical data from national surveillance on how big a problem this is. Diagnosis is not covered in the national insurance plan.

The steps that need to be taken include the following:

- It is necessary to advocate the implementation plan of the subcommittee for support and protection of AIDS rights. This subcommittee has produced a three-year plan with five sub-plans, which include advocacy for harm reduction among PWID as follows: (1) Affirming guidelines for implementing the concepts of harm reduction through a 10-item service package including, especially, use of clean injection equipment; (2) Specifying harm reduction as a policy of the MoPH and developing implementation guidelines for staff, including intensive follow-up; (3) Improving the process of rehabilitation so that it is more efficient; (4) Reviewing the laws for rehabilitation of drug users to advocate for use of harm reduction as one part of the rehabilitation process; and (5) Conducting a review of the situation of stigma and discrimination against IDU and applying the data to inform activity plans for reduction of stigma and protections of rights of PWID to access services.
- Implement the HIV prevention plan for PWID under the NAS for 2012-2016. The NAS for this period was developed through a participatory process with all partners represented in order to analyze gaps and achievements of past implementation to inform new strategies and measures for up-coming implementation.
- Advocate a uniform standard of health. This will help all groups recognize their rights to access services on an equitable basis.

### *Lack of understanding of the concept of harm reduction for PWID, and stigma and discrimination against PWID.*

Implementing harm reduction in Thailand is still considered to be a new activity. Some staff who work with drug users, as well as people in the general community and society still have negative attitudes toward PWID, which leads to lack of access to opportunities.

The steps that need to be taken include the following:

- There should be a campaign to change attitudes so that society views PWID as “patients” who need care and support, rather than as criminals to be prosecuted. As well as modifying viewpoints of all sectors so that they understand the measures for control and treatment of drug use in the same way, there needs to be consideration of the human rights and current living conditions of PWID.
- There should be an effort to demonstrate to the public and to people working with PWID that the harm reduction policy has been effective in many countries around the world.
- There needs to be clarity among implementers in two key areas: (1) Ensure that the system of rehabilitation for drug users is consistent with the nature of the problem, is efficient and is based on human rights; and (2) Promote clarity of the law in the aspect of support for clean injection equipment as essential prevention tools for HIV and other health problems affecting PWID.
- It is necessary to implement a demonstration site for a Comprehensive Harm Reduction service. UN Agency is working with agencies and organizations to plan the implementation of a demonstration site in three provinces: Bangkok, Chiang Mai and Songkla to show the feasibility of comprehensive harm reduction through the 10-component package of services. This will also demonstrate community acceptance of the activity, and can be used as a model for expansion to other sites. In addition, this activity will look at costs of rehabilitation as compared to the cost of harm reduction.

### **TARGET 3: ELIMINATE MOTHER-TO-CHILD TRANSMISSION OF HIV AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS**

#### **3.1. CARE AND SUPPORT FOR MOTHERS WITH HIV AND AIDS**

The PMTCT program of Thailand has achieved a high level of efficiency and coverage in caring for the mothers and children during pregnancy and the post-partum period. The 2008-2009 progress report described progress on accelerated prevention of partners, husbands and wives through the “stay negative” initiative. The report described efforts to reduce unplanned pregnancies among HIV+ women, with involvement of the male partner in multiple dimensions of the process. Husbands were encouraged to participate in couple counselling and HIV testing in order to help make joint decisions with their wives, and, if sero-positive, to develop plans to reduce or avoid problems of disclosure.

### ***Key national efforts and achievements in 2010 and 2011***

Several new policies were adopted and implementation of these policies began in October 2010. These include:

- Provision of highly active anti-retroviral therapy (HAART) to all HIV-infected pregnant women regardless of CD4 count.
- Offer of HIV counselling to partners of HIV-infected pregnant women.
- Routine use of virological testing for early infant diagnosis of HIV-exposed children.

In an effort to improve service coverage and delivery, the Ministry of Public Health has put in place several new initiatives.

- The MoPH, in collaboration with the Thai Red Cross AIDS Research Centre, Siriraj Hospital, and Mahidol University, conducted a financial feasibility study for the implementation of the revised PMTCT guidelines (“Evolution of Interventions to Prevent Mother-to-Child Transmission of HIV: Perspective from Thailand. N. Phanuphak et al., Siriraj Medical Journal, 2011; 63: 20-24).
- The handbook for pregnant women (the pink book) was revised in 2011 to be more comprehensive, and now includes sections about HIV testing of partners and about the use of CD4 testing to determine the most appropriate treatment regimen for HIV-infected pregnant women.
- Global Fund resources are now being used to extend PMTCT services to migrant populations. Previous surveys indicated higher levels of prevalence in this population, and increased coverage is important from both a human rights perspective as well as for reducing the number of new infections in children.
- The NAMc is making a concerted effort to strengthen national monitoring and evaluation efforts related to PMTCT through greater efforts at collecting information related to key indicators and upgrading the current software program used to collect and analyze PMTCT-related data.

### ***Remaining challenges and next steps to improve responses:***

Despite overall high rates of performance in the area of PMTCT and notable achievements undertaken over the past two years, several challenges remain which require continued attention.

*Improvements are needed in couple counselling in ANC clinics.*

An important challenge remains regarding how to improve and expand the model of couples counselling in the ante-natal care clinic settings throughout the country, improve the quality of pre- and post-test counselling, maintain confidentiality, and study the factors that might explain why some pregnant women do not access ANC services.

*Widespread adoption of methods to offer HIV testing to partners of pregnant women is needed.*

While methods have been put in place to better prompt providers into offering HIV testing for partners of pregnant women, mechanisms to ensure widespread adoption of this practice have yet to be identified.

*Stigmatization and discrimination continue to be obstacles to treatment.*

Fear of stigma in hospitals and communities has resulted in some HIV-positive women not returning for ANC care in subsequent pregnancies, or occasional adoption of mixed feeding by HIV-infected new mothers fearful of disclosing their status.

*Incomplete data collection.*

Selected indicators, including testing of partners and CD4 staging of HIV-infected pregnant women, have incomplete data. Mechanisms have been put in place, however, to ensure more complete data reporting on both of these indicators in subsequent reports. Difficulty in obtaining data from private institutions, while a distinct minority of all facilities providing PMTCT services, remains an area of concern.

*A sustainable approach to providing quality PMTCT services is needed for non-registered migrants.*

Financial resources received through the Global Fund for, will likely not be available in the long-term, and local financial resources will be needed with corresponding policy directives to permit service provision to this population.

*Follow up virological testing of HIV-exposed children remains lower than optimal.*

While there has been progress in improving coverage of this important indicator, further improvements in coverage are warranted. The MoPH in collaboration with UNICEF and the Thailand MoPH – US Center for Disease Control and Prevention (TUC) is currently completing an evaluation of the current HIV early infant diagnosis in an effort to further increase coverage and quality of services.

The MoPH is in process of undertaking several key initiatives for PMTCT to strengthen the efficacy of the national response and improve coverage and service quality, particularly for most affected populations. Initiatives underway include:

- Upgrading sub-district health centres to Health Promotion Sub-district Hospitals with PMTCT services, thereby bringing HIV prevention services closer to affected populations. This will result in a significant increase in the number of facilities offering PMTCT services, with the number expected to rise to approximately 9,755, up from 1,316 as reported in the 2010 report.
- Identifying mechanisms to effectively implement the new policy on HIV testing of partners of pregnant women (couples counselling).
- Improving data collection systems related to PMTCT (including national scale-up of couples counselling which was planned to start in April 2012).
- Launching new PMTCT data collection software, PHIMS-3, in 2012, which will collect data on other important indicators including HIV testing of partners of pregnant women and CD4 testing of pregnant women who are HIV positive.
- Investigating financially-sustainable mechanisms that will enable the provision of PMTCT services to migrants.

### **3.2. CARE AND SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS**

Children affected by HIV and AIDS (CABA) include children infected with HIV (primarily as a result of mother-to-child transmission), as well those affected due to morbidity or mortality of family members. The 2008-2009 progress report documented that Thailand does not have a standardized database of children affected by HIV and AIDS. Lack of strategic data on children affected by HIV and AIDS hinders the ability to inform policy and guidelines to address their problems.

In 2011, there were approximately 6,500 children receiving anti-retroviral treatment and the number of children orphaned due to reasons related to HIV and AIDS was 301,865. This constitutes the largest proportion of orphans in Thailand (301,865/853,456).

The survey of the status of children conducted in 2006 (multiple indicator cluster survey - MICS) found that the problems of these children include health, psycho-emotional, and socio-economic challenges that urgently need care, resolution and maintenance for some time to come. There is considerable prejudice and discrimination toward children affected by HIV and AIDS and too little economic support for this vulnerable population.

A significant number of children affected by HIV and AIDS reside in institutional and foster care, sometimes due to death of one or both parents, but more often due to poverty and underlying stigma and discrimination associated with being related to someone with HIV and AIDS. Care for institutionalized CABA may be sub-standard and may violate their rights in some respects. Four government-run institutions include children affected by HIV and AIDS in their total caseload, but several more privately-operated institutions include children affected by HIV and AIDS, with some institutions maintaining caseloads that are almost exclusively children who are HIV-infected.

The Royal Thai Government, notably through the MoPH, MSDHS, and MOE, has instituted various measures that have partially alleviated the burdens faced by children affected by HIV and AIDS and their families. Of note, these include universal free access to health care, including HIV care, free universal primary and secondary school education, and cash transfers for children affected by HIV and AIDS as well as other poor families. Policies such as these have contributed to similar levels of educational achievement for orphans and non-orphans according to most recent MICS data.

### ***Key national efforts and achievements in 2010 and 2011***

The MSDHS has taken on an increasingly prominent role in addressing the needs of children affected by HIV and AIDS over the past two years. The Ministry is a Sub-Recipient of Global Fund financing to advance the social protection agenda. In addition, the ministry has to date supported over 300 children of ethnic minorities get a Thai nationality card, which enables them to gain access to essential services. The ministry has also established 77 Provincial Child Protection Committees to respond to issues of concern affecting children, including for those living with HIV and AIDS.

The Ministry of the Interior has also played an important role in responding to the needs of children affected by HIV and AIDS. In 2011, cash transfers were provided to over 37,000 children affected by HIV and AIDS, and this number is expected to increase to almost 66,000 in 2012.

Significant developments have been initiated during 2010 – 2011 to strengthen the national response for children affected by HIV and AIDS. An important development was Thailand's successful application for funding from the Global Fund for AIDS, Tuberculosis, and Malaria which resulted in 42 million USD over five years to support system strengthening in favour of children affected by HIV and AIDS and other marginalized and vulnerable children living in provinces of high HIV prevalence. Core areas targeted for system strengthening to benefit

these vulnerable populations include the health system, the social protection system, community response, and strategic information. By addressing these various systems concurrently, an important opportunity to further strengthen working partnerships between government and civil society is being taken advantage of.

In the care and treatment arena, two comprehensive paediatric HIV-care models were scaled up nationally. These models, which were developed through the Srinakarind Hospital of KhonKaen University and by the Chiangrai Prachanukroh Hospital in conjunction with AIDS ACCESS Foundation, promote a holistic approach to care, addressing both clinical and psychosocial needs.

Other important developments over the past two years include increased focus on children affected by HIV/AIDS in national documents. The National HIV/AIDS Strategy, National HIV/AIDS Operational Plan, and National HIV/AIDS M&E plan for 2012-2016 all include children affected by HIV and AIDS in national strategies or monitoring frameworks.

### ***Remaining challenges and next steps to improve responses***

Despite the strong foundation laid over the past two years to begin to address the vulnerabilities of children affected by HIV and AIDS and other vulnerable children in provinces of high HIV prevalence, numerous challenges remain.

#### *Lack of data*

A major bottleneck is the lack of basic quantitative or qualitative information about children affected by HIV and AIDS. Accurate information related to numbers affected, service coverage and key challenges facing this population are for the moment largely unavailable. This lack of information makes strategic planning and programming much more complex.

#### *Stigma and discrimination*

Another major challenge in addressing the needs of children affected by HIV and AIDS is the stigma and discrimination faced by this population. Stigma affects service provision from both the demand and supply side of the equation, as it makes affected families reluctant to seek out the support they are entitled to, while simultaneously impinging on service providers' willingness to provide the full complement of services needed by these children.

### *Adolescents living with HIV*

Many children infected at birth are now emerging into adolescence, which comes with challenges related to maintaining requisite levels of treatment adherence, maintenance in regular care, and addressing sexual desires and reproductive health. Many adolescents are experiencing treatment fatigue, and are uncomfortable disclosing their HIV status to prospective partners. Many providers on the other hand, are realizing that they do not have the necessary level of skills and knowledge to adequately address these emerging needs.

### *Holistic care is needed*

Children affected by HIV and AIDS are often viewed solely through a medical lens. A holistic approach to care and support is often lacking in programmes created to address their needs.

Several initiatives are in place to be implemented in the next two years to improve service coverage and quality for CABA. These include:

- Qualitative and quantitative studies to strengthen the evidence base around programming for children affected by HIV and AIDS. These include: 1) a situational analysis focused on children affected by HIV and AIDS including a mapping of challenges faced by this population and services being provided to them, 2) a study on the quality of alternative care, including institutional and foster care, and 3) a possible study on the impact of cash transfers to children in alleviating vulnerability.
- A Multiple Indicator Cluster study, MICS-4, to get more quantitative information on all children in Thailand, including those most marginalized and vulnerable.
- Improving the capacity for monitoring delivery and quality of services to children affected by HIV and AIDS at national and sub-national levels.
- Evaluation of the impact of current social protection measures on children affected by HIV and AIDS and other vulnerable children.
- Strengthening the capacity of local Child Action Groups (CAGs) to effectively program to meet the needs of children affected by HIV/AIDS and other vulnerable children at the local level.
- Development of a model to improve adherence to ARV along with improved positive prevention for adolescents with low adherence in these two domains.

## **TARGET 4: HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ART**

According to the 2002 National Health Security Act, the Universal Coverage scheme was implemented and administered by the National Health Security Office (NHSO). The UC scheme for HIV/AIDS was started in 2006 and has led to the rapidly increased access of ART among Thai national and the ethnic population who are not benefit to the existing medical welfare schemes, including social security schemes, administered by the Social Security Office of the MOL and the Civil Servant Medical Benefit Schemes (CSMBS), administered by the Comptroller General's Department of the Ministry of Finance. Combining of the three major health security benefits, ART and related services have been provided for Thai PLHA for free of charge, and the rapid expansion of the ART coverage was observed.

In 2009, the number of Thai PLHIV who was accessing treatment was estimated to be 200,000 persons. Yet, the challenge in this area is to reach those who are not aware of or deny their sero-positive status so that they can access counselling, diagnosis and treatment in a timely way. Strategies include couple counselling, post-test counselling and sero-status disclosure for children infected by their mothers. In addition, projections indicate that approximately 25 per cent of eligible PLHIV are not accessing the system of care and treatment for opportunistic infections and ART.

### ***Recipients of ART in Thailand in 2010 and 2011***

In 2011, 225,272 PLHIV were receiving ART at 943 ART facilities nationwide, of which 96 per cent are government hospitals. There were 218,762 adults (97.1 per cent) and 6,510 children (2.9 per cent).<sup>9</sup> The overall coverage,<sup>10</sup> according to the Thailand national standard of the ART initiation criteria (CD4 level  $\leq 200$  cells/mm<sup>3</sup>), increased from 72 per cent in 2010 to 77 per cent in 2011. Using the latest WHO guidelines, which specifies ART initiation criteria at CD4 level  $\leq 350$  cells/mm<sup>3</sup>, the ART coverage was 59 per cent in 2010 and 65 per cent in 2011. Coverage of ART among females is significantly higher than among men (82 per cent vs 54 per cent). The number of newly-initiated ART remained stable over the past two years with 35,618 reported in 2011. The number of children receiving ART has declined in recent years. This could be explained by the success of the PMTCT programme nationwide.

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<sup>9</sup> Data sources: Programme-based data from the National Health Security Office, Social Security Office, Civil Servant Medical benefit Fund, Global Fund and estimated private PLHIV from ARV distribution by Thailand governmental Pharmaceutical Organization.

<sup>10</sup> Estimated number of ART needs among adults and children, Asian Epidemic Model and Spectrum for Thailand

The retention of ART at 12 and 24 months after ART initiation has been fairly stable since 2009, at 83 and 80 per cent respectively.<sup>11</sup> The main reasons for less retention at 24 months include death and loss to follow up. The overall death rate in 2010 was 8.8 per cent. This represents a slight increase from 2008 and 2009 when the death rates were 8.2 and 8.3 per cent, respectively. Among those who died during the first 12 months, about 25 per cent died during the first 6 months and all of them had CD4 levels of < 100 cells/mm<sup>3</sup>. The adult death rate is higher than that for children (8.9 per cent vs 4.2 per cent) and the death rate among men is higher than among women (10.3 per cent vs 7.0 per cent). The observed evidence, regarding higher median CD4 levels and a lower percentage of those with CD4 <100 cells/mm<sup>3</sup> at ART initiation, revealed that children had earlier access to ART than adults and women with lower CD4 levels had earlier access to ART than women with higher CD4 levels.

Late diagnosis and/or late referral to care and treatment at an advanced stage of AIDS remain major problems in Thailand. Results from the program monitoring revealed that 50% of newly diagnosed PLHA had the first CD4 level tested within 6 months after diagnosis less than 100/mm<sup>3</sup> and about 60% newly initiated ART when their CD4 level <100 cells/mm<sup>3</sup>. The situations were not improved during 2008-2011.<sup>12</sup>

One of the key actions for successful programme up-scaling is the ART drug management system. In 2011, 3 per cent of ART facilities (18 of 574 surveyed facilities) reported drug stock-out experiences. Most of these occurred during the big floods in Thailand. Although the stock-out period was very short, about half of the patients had to change their ART regimen and/or temporarily stopped ART.<sup>13</sup>

In recent years, an expansion in community care, psychosocial and economic services by civil society was observed. In financial year 2011 there were 383 PLHA group communities with 1,606 peer leaders in all provinces. PLHA access to communities increased from 48,256 in 2009 to 72,569 in 2011.

In conclusion, the ART programme was successfully scaled up in Thailand over the two year period between 2010 and 2011. Furthermore, evidence identified key areas that can be considered for next step planning for the improvement of programme effectiveness towards the reduction of AIDS mortality and improvement of the quality of life.

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<sup>11</sup> National AIDS Programme monitoring system, National Health Security Office, Thailand

<sup>12</sup> National AIDS Programme monitoring system, National Health Security Office, Thailand

<sup>13</sup> Anti-retroviral Facility Survey, Bureau of AIDS and STI, Department of Disease Control, MoPH, Thailand



## ***Key national efforts and achievements in 2010 and 2011***

### *National policy on anti-retroviral treatment:*

During the year 2010, the 2010 National Guidelines on HIV/AIDS Diagnosis and Treatment were developed. Key contents of the guidelines, according to the 2010 WHO recommendations, included 1) early ART initiation with CD4 level  $\leq 350$  cells/mm<sup>3</sup> to improve treatment outcomes, and 2) phasing-out stavudine (d4T) as the recommended first line regimen to minimize size effects.

### *Strengthening effective programme management including a quality improvement system:*

The BATS is a focal point for programme implementation. In 2010 and 2011, efforts were more focused on strengthening programme effectiveness by providing technical support through the development of technical guidelines, designing and piloting innovative intervention models, research and human resource development. The collaborative network included various MoPH departments, TUC, civil society organizations, universities, UN agencies and local organizations.

The RTG has continually played a major role in increasing access to ART services. According to the national UC policy, the NHSO is the major implementing agency to provide treatment services to Thai nationals (indicated by national identification numbers) who are not beneficiaries of the social security schemes or the CSMBS. More than 90 per cent of PLHIV are now receiving ART through the three governmental health security schemes: UC, SSS and CSMBS. Currently there are about 65% of PLHIV registered for ART under the UC. About 5 per cent of PLHIV, including migrants and others not eligible for government health security schemes, are receiving ART under the project supported by the Global Fund, and 5 per cent pay for the ART themselves.

Over the past two years, the cost of programme expansion and improvement of the quality of services, the implementation of national ART programme monitoring and evaluation and laboratory quality assurance, and the strengthening of the PLHIV networking were supported by the NHSO. Regarding the availability of affordable ARV for programme up-scaling, the Thailand Governmental Pharmaceutical Organization produces the generic ARV and maintains the ARV supply system nationwide.

### *Holistic care provided by PLHIV:*

During the past two years, the Thai Network of PLHIV (TNP+) together with the Thai NGO Coalition on AIDS (TNCA), the ACCESS Foundation and Médecins Sans Frontières (Belgium) supported the increase in PLHIV participation through a joint collaboration between PLHIV and hospital staff, who served as “co-service providers”, to establish “Holistic Care Centres”. Peer leaders and volunteers have major roles in delivering comprehensive services and in assisting with follow-up and adherence programmes. Peer leaders and volunteers provide information about ART, counselling, arrange group activities and make home visits to ensure the efficacy of ART and the ability of treated persons to self-care. At the same time, community support of orphans and asocial response for PLHIV were included as components of the Holistic Care Centres. The government supported the TNP+ in their management of the Holistic Care Centres nationwide through funding from the NHSO. As of September 2011, the services of these centres had been accessed by more than 70,564 PLHIV.

### *Strengthening the management information system for programme monitoring:*

The NAP-NHSO management information system has been strengthened over the past two years to facilitate access and utilization of data for programme monitoring. In 2010 and 2011, the NHSO, in collaboration with the BATS, NAMC and TUC, tested a revised MIS and planned to implement in 2012. The revised system include two major components, including 1) improved availability of programme-based data for programme management and administration by the NHSO and key stakeholders, and 2) improved accessibility of key monitoring information to responsible persons at hospitals at the provincial, regional and central levels. The key monitoring information include key performance indicators and related information on programme and service delivery outputs, outcome indicators and early warning indicators of HIVDR (EWI) and mortality related indicators.

### *Implementation of the 2010 National Guidelines on ART:*

The national programme has followed the new guidelines by implementing the following prioritized actions:

- Implemented the d4T phase-out plan through the substitution of d4T with zidovudine (AZT) or tenofovir (TDF ).
- Revised and expanded the benefit package to achieve early initiation of ART, considering PLHIV at high risk of HIV mortality. The revised criteria for ART initiation include:

- ART initiation can be considered for PLHIV with TB infection at any CD4 levels.
- Early ART initiation at CD4  $\leq 350$  cells/mm<sup>3</sup> for PLHIV with the following criteria:
  - Have a history of hepatitis (hepatitis virus B or C).
  - Are older than 50 years old or have an underlying illness relating to diabetes, hypertension or dyslipidemia.
  - Have HIV-associated nephropathy
  - Women with CD4  $\leq 350$  cells/mm<sup>3</sup> during pregnancy.

*Improvement of the quality of service delivery at care facilities:*

- Development of technical guidelines for human resource development: The BATS, in collaboration with technical stakeholders developed technical guidelines on care and ART. The guidelines were distributed and training was conducted. The major technical guidelines developed and distributed in 2010 and 2011 included the 2010 National Guidelines on HIV/AIDS Diagnosis and Treatment, the HIV/AIDS Treatment Literacy, the HIV Self-management Guidelines, the HIV Counselling Handbook, the Standard Operating Procedures for HIV Counselling and Testing, and the Counselling for Prevention with Positive document.
- Performance measurement and quality improvement programme: During the past two years, adult and pediatric HIVQUAL were implemented to facilitate the improvement of service delivery at care facilities. Recently, pediatric HIVQUAL was scaled up to 151 hospitals in 30 provinces. The selected composite key performance indicators that can be used as a standard measurement tool for hospital accreditation are being reviewed.
- Positive prevention to prevent HIV transmission: Expansion of the Positive Prevention measures to the exit care and treatment services, through increasing involvement of PLHA, has been implemented. Guidelines and educational materials were developed and distributed to all hospitals nationwide. Local human resources were trained.

*Innovative model development to enhance outcome effectiveness:*

A number of innovative models were designed and piloted by the BATS, TUC and collaborative partners during this reporting period. Key innovative models include:

- PLHIV self management through building PLHIV capacity on HIV treatment Literacy

- Paediatric disclosure and HIV management: Thirty provincial paediatric HIV care networks were established and the healthcare providers were trained on paediatric HIV diagnosis disclosure and psychosocial support. In addition, training on monitoring and coaching skills was conducted. By the end of 2011, 50 per cent (191 out of 388) community hospitals were able to provide HIV treatment and care for children.
- Mobile population voluntary counselling and training was provided in 46 hospitals to enhance access to VCT and early access to care and treatment among the Thai and non-Thai mobile population and hard to reach populations, including MSM, MSW, FSW, prisoners and youth.

*Implementation of “Emergency Programme Response” during the 2011 Thailand flood crisis:*

During the extensive severe flooding in Thailand, which started in July 2011, the DDC, in collaboration with the NHSO, TNP+, ACCESS, AIDS Foundation and TUC, implemented an emergency programme response to minimize HIV drug resistance (HIVDR), drug interruption and poor adherence during this crisis. Core response components included: (1) expanding free ART at 943 hospitals nationwide to all treated PLHIV, under the UC scheme administered by the NHSO; (2) facilitating increased drug stock while easing restrictions for online approval of second-line and compulsory licensing regimens; (3) risk communication through personal mobile devices and mass-media; (4) active case finding and household drug delivery by the PLHIV network; (5) authorizing special viral-load testing among drug-interrupted PLHIV; and (6) strengthening the quality of HIVDR monitoring systems. Field supervision was conducted to review programme barriers and areas for improvement. Assessment of HIVDR affected by flooding is being reviewed.

*Facilitating access to cheaper and affordable anti-retroviral drugs:*

The Royal Thai Government, through the Thailand GPO, has played a significant role in the production of generic ARV. In 2010 and 2011, lopinavir/retronavir in tablet and syrup form and tenofovir tablets were newly launched. In August 2010, the RTG extended the compulsory licensing of Efavirenz and Kaletra until their patents expire (January 2012 for Efavirenz and December 2016 for Kaletra)<sup>14</sup> in order to ensure access to the common ARV for first and second line regimens at an affordable price.

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<sup>14</sup> UNAIDS (2011, October) 'Medicines Patent Pool helps make anti-retroviral medicines more widely available'

*Strengthening national programme monitoring and the utilization of data for programme improvement:*

A monitoring framework, including a list of key indicators and targets needed to monitor the national programme strategies was developed. In addition, the mechanism for programme monitoring was reviewed and revised. Plans were prepared for piloting the revised mechanism and for building human resource capacity.

***Remaining challenges and next steps to improve responses::***

*Expansion is needed of ART Coverage with CD4 level  $\leq 350$  cells/mm<sup>3</sup>.*

Although the ART programme in Thailand has been scaled-up, the coverage of ART, considering the new recommendations on early access to ART, is still only about two thirds of the total need. The programme feasibility and resource affordability should be considered.

*Effective public health approaches are needed to increase early access to ART.*

About 60 per cent of PLHIV had CD4 levels  $< 100$  cells/mm<sup>3</sup> at the time of initiation, which led to high mortality. Currently, there is no intensive exploration of this problem and its related factors.

*Improvement of ART retention is required in order to decrease the death rate.*

The monitoring data from the past the years revealed no evidence of improvements in the ART retention rate. On the contrary, the death rate showed a stable to slightly increasing trend between 2009 and 2011 (8.2 per cent, 8.3 per cent and 8.9 per cent respectively). These death rates indicate late access to ART and ineffective TB/HIV co-infection management.

It is necessary to increase programme coverage as well as increase early access to ART. The following public health approaches are planned:

- Strengthening of HIV counselling and testing, with improvements to the quality of services and the expansion of new innovative approaches on HCT, including
  - Expansion of Provider Initiated Counselling and Testing in routine services, including STI clinics, TB clinics, etc.
  - Development and implementation of HIV self-testing.

- Piloting and expanding a model of couple counselling services in HIV clinics to increase diagnosis of HIV and determination of discordant couples for effective prevention, care and treatment services.
- A public campaign to increase community awareness on HIV/AIDS prevention and to encourage a positive attitude towards PLHIV.
- Public health advocacy to increase community participation and resource mobilization.
- Expansion of health benefits for early initiation of ART at CD4 < 350 cells/mm<sup>3</sup>.

*All PLHIV in Thailand should have equal benefits.*

There are still discrepancies of treatment protocol between different health security schemes, considering access. The MoPH health insurance programme for migrants does not include ART in the benefit package; meanwhile undocumented migrants cannot join the health insurance programme. There should be equal benefits for all and benefits should all be of the same standard.

To achieve equal and standard benefits across different governmental health security schemes, the integration and harmonization of all health security schemes are needed. Planning steps include:

- Review the existing benefits and revise to ensure equality and standardized packages, in accordance with the national guidelines.
- Review the feasibility of expansion of health benefits for migrant workers and non-Thai PLHIV who are living in Thailand.
- Design appropriate integrated programme management across the different health security schemes, including the reimbursement system, drug supply chains, etc.
- Design an appropriate management information system that can be used for monitoring of the programme management of all schemes, as well as using monitoring data for effective monitoring of programme achievements at all levels.

## TARGET 5: REDUCE TUBERCULOSIS-RELATED DEATHS FOR PEOPLE LIVING WITH HIV AND AIDS

Thailand is currently one of the 22 high TB-burden countries in the world. In 2010 and 2011, the prevalence and incidence rates of all forms of TB were 182 and 137 per 100,000 populations, respectively. In 2010, 77 per cent of TB registered patients were tested and counselled for HIV. HIV prevalence among TB cases is 17 per cent. The treatment success rate among new smear-positive cases was 86 per cent for the cohort of patients registered in 2009.

### *Co-management of TB and HIV treatment:*

TB case-finding, diagnosis and treatment of TB must be revised to meet international and national guidelines. A key indicator for progress in this area is the percentage of HIV-positive TB cases who can access appropriate treatment for their TB and HIV. In Thailand, the best source for this measurement is the data reported by the Bureau of TB/DDC in the MoPH. These reports note the number of TB patients identified as HIV-infected, and among those, how many receive co-trimoxazole and ART. The figures for ART patients are under-reported, however, because TB clinics do not always receive up-to-date information on whether HIV-infected patients referred have actually started ART (and vice-versa).

**Table 9: Co-management of TB and HIV treatment**

Co-management of TB and HIV treatment	2010	2011
Number of persons on ART who began TB treatment	4,092	4,341
Estimated number of incident TB cases in PLHIV	15,694	15,694
% estimated HIV-positive incident TB cases that received treatment for both TB and HIV	26.07	27.7

### *TB assessment for PLHIV*

The percentage of PLHIV who had their TB status assessed and recorded during their last visit demonstrates the level of implementation of the recommendation that PLHIV are screened for TB at diagnosis and at follow-up visits. WHO recommends the use of a simplified screening algorithm for intensified TB case findings that include four clinical symptoms (current cough, fever, weight loss, and night sweats). At present, there is no available source with systematically collected data to measure this indicator. There are two existing monitoring systems that are available, but data does not measure the percentage of adults/children enrolled in HIV care who had their TB status assessed/recorded at last visit.

The existing monitoring systems include:

- TB programme-based data: TB programme-based data provide the number and percentage of screening for TB diagnosis among newly-diagnosed HIV infected persons. The 2011 data revealed that 90.3 per cent of newly-diagnosed HIV cases were screened for TB.
- HIVQUAL-T survey: The HIVQUAL-T survey is a healthcare facility survey that uses cross-sectional data on the percentage of people living with HIV and AIDS receiving care or treatment services at HIV clinics and had a TB-screening at least once during the reporting year. Using a sampling method, HIVQUAL-T surveys reflect figures for patients that hospitals sampled for chart review. There is incomplete data because many hospitals have not fully reported for 2011. With respect to the latter, the number of cases for 2011 was lower than for 2010. In 2011, there were 41,131 samples of adults/children in HIV care and out of this number, and 98.9 per cent had their TB status assessed or recorded at last visit. Using the same method, the coverage percentage for 2010 was 97 per cent. There are several concerns with this figure, namely the extent to which this indicator reveals whether those identified as suspects are investigated further or effectively for TB. Furthermore, for paediatric cases, HIVQUAL only notes those who have been screened in the last six months and not one year as the case for adults.

**Table 10: TB status assessment for PLHIV**

PLHIV who had TB status assessed/recorded at last visit	2010	2011
Reports of PLHIV with TB status assessed/recorded at last treatment	41,255	41,131
Number of PLHIV case records reviewed in the reporting period	42,531	41,601
% adults/children enrolled in HIV care who had their TB status assessed or recorded at last visit	97.0	98.9

### *Infection control policies*

In spite of demonstrable infection control (IC) policies, including TB control, in many large hospitals and healthcare facilities throughout Thailand, there is limited and incomplete data on the percentage or actual number of facilities that have written IC/airborne policies. The Bureau of TB conducts annual facility surveys to review the quality of TB services, including the implementation of infection control measures to prevent risk of transmission of TB. Key contents of the annual survey contain only two of five checklists as indicated by the health sector response guidelines, including proper ventilation of waiting areas and isolation of suspected TB-affected patients.



### *Isoniazid prevention therapy*

At present, national guidance on isoniazid prevention therapy (IPT) recommends considering IPT where feasible. This is particularly the case for children aged under 5 years. The 10<sup>th</sup> Office of Disease Prevention and Control (ODPC 10) in Chiang Mai promotes IPT use, particularly for PLHIV who have undergone TB skin tests (i.e. PPD skin test). There are no national statistics on IPT provision, however.

### **Key national efforts and achievements in 2010 and 2011**

#### *Provider-initiated HIV testing and counselling.*

Provider-initiated HIV testing and counselling of TB patients was integrated into the national guidelines and is being implemented throughout the country. In 2010, 77 per cent of TB patients were tested and counselled for HIV.

#### *Enhancing accessibility to TB care and treatment.*

National efforts during the 2010-2011 reporting period spanned a wide array of areas, ranging from enhancing accessibility of TB diagnosis, care and treatment services to boosting the availability of first and second-line drugs for TB. One critical area that was emphasized was early and higher case detection among vulnerable populations. These populations include PLHIV, migrants, prisoners, the elderly, and children under 5 years of age. For non-Thais not covered under the UC scheme, early and higher case detections as well as care and treatment were supported by the Global Fund. The national TB programme also emphasized early case detection in elderly shelters and approximately 140 prisons. To better guide the process, national guidelines for TB and HIV were developed and distributed nationwide and TB/HIV intensified case finding (ICF) handbooks were distributed to all healthcare facilities. At present, a third version is being revised. Funding from the NHSO ensured support for TB activities at the regional, provincial, and district levels. A draft training curriculum for providing ART to TB/HIV-infected patients was developed.

There has been a greater commitment to coordination and oversight from the MoPH, with designation of “Mr/Ms TB” at all hospitals and provisional health offices. In addition, TB monitoring has been integrated into regular health inspector checklists.

In 2010, the protocol for Thailand's second national TB prevalence survey was approved by WHO. In 2011, the budget for the survey was approved by the Global Fund. In early 2012, the Ethical Review Committee at the Ministry of Public Health approved the protocol. The national TB prevalence survey is being launched in 2012.

*Procurement of first and second line drugs.*

Another key national effort that took place during the reporting period was the procurement and supply of first and second line medication for TB. This was done by the NHSO through the GPO.

*Non-Family DOT providers.*

Another national effort undertaken in 2010 and 2011 was to increase the proportion of community-based non-family directly observed treatment short course providers (e.g. village health volunteers, community health volunteers, neighbours) to provide quality DOT. There is still more work to be done in this area and the national TB programme will seek to integrate non-family DOT into its ongoing TB care and treatment services.

***Remaining challenges and next steps to improve responses:***

*Need for a national policy on IPT.*

There is still no national consensus on the provision of isoniazid preventative therapy. A comprehensive review of IPT program effectiveness is currently being considered.

*Need for systematic data collection on TB infection control.*

Infection control is a part of the "3 I" strategy in controlling the TB and HIV epidemics (together with intensified TB case finding and isoniazid preventative therapy). At present, there is no systematic data collection on TB infection control in healthcare facilities. This remains a critical step in improving the quality of DOT.

*Need for improved quality of care for TB services in private healthcare facilities.*

One key next step is to ensure that TB practices and services provided in private healthcare settings are in line with national and international guidelines. There is need for effective monitoring and evaluation (namely data collection) on TB and HIV care/treatment in private healthcare settings. This is particularly the case in Bangkok, which has a sizeable number of private hospitals and clinics.

*Need for strengthening of HIV and TB care and treatment services and strengthening of integrated activities.*

There is need for improved referral linkages for ART-initiation in HIV-associated TB during TB treatment. At present, there is no available source with systematically collected data to measure the percentage of adults and children enrolled in HIV care who had their TB status assessed and recorded during their last visit. There is also need for further strengthening of TB/HIV integrated activities, particularly revitalization of the national TB/HIV committee. Such activities include intensified case-finding among PLHIV.

*Need for improvement of TB screening of PLHIV and HIV screening for TB patients.*

There is a critical need to improve screening for TB among PLHIV. TB screening within HIV clinics is high but should become standardized. Thus, one key step is to standardize TB screening in HIV clinics and link suspect cases to care and treatment. Similarly, there should be an increase of HIV testing and counselling for patients that are newly diagnosed with TB. A key step in doing so is through provider-initiated counselling and testing.

There are several efforts being made to improve data integration:

- Efforts to build a single data hub to link multiple electronic systems, particularly systems that can report on cases of multi-drug resistant TB (MDR-TB).
- Operational research related to the effectiveness of a standard TB-infection control package. This is a two-year study that is being conducted both in Thailand and Viet Nam.
- Two major surveys are being implemented in 2012. One is the national TB prevalence survey, which will sample nearly 90,000 cases and will shed light on the burden of TB in Thailand. The second survey is the national drug resistance survey, which will provide data on MDR-TB and XDR-TB. The results of this survey will coincide with the operationalization of the five-year plan for multi-drug resistant TB.
- A national TB programme review was last completed in 2007. A new one will be implemented to address programmatic gaps.

## TARGET 6: REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE IN LOW-AND MIDDLE-INCOME COUNTRIES

To measure expenditure on HIV and AIDS, the Thai Working Group for the National AIDS Spending Assessment used the same method as in the previous report with the application of National Health Accounts [OECD System of Health Account, version 1.0: 2000]. Secondary data on actual expenditure on HIV and AIDS was compiled, where available, from relevant financing agents. Where there was no ready reference secondary data on spending on HIV and 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 relying on epidemiological data). This study (the National AIDS Spending Assessment) covered only spending by government, non-profit and international resources. It deliberately excluded household spending on HIV and AIDS, as there is no any national household survey dataset capturing household spending specifically on HIV and AIDS. In the context of universal coverage, household spending on HIV and AIDS is likely to be extremely low.

### *Expenditure between 2010 and 2011*

The National AIDS Spending Assessment found that total expenditure on HIV and AIDS programmes totalled 7,733 million Thai Baht (approximately USD 257.8 million) in 2010 and 9,922 million THB (approximately USD 330.7 million) in 2011. These figures were 0.08 per cent and 0.09 per cent of the Gross Domestic Product (GDP) in 2010 and 2011, respectively, and 2.0 per cent and 2.4 per cent of all health expenditures in 2010 and 2011, respectively.

The marked increase of AIDS expenditure in 2011 was in the category of care and treatment. The amount of spending for care and treatment increased from 5,676 million THB (approximately USD 186.7 million) in 2010 to 7,261 million THB (approximately USD 237.2 million) in 2011.

**Table 11: Thailand AIDS spending by function, 2008-2011**

AIDS spending categories	2008	2009	2010	2011
	millions of THB			
1. Prevention	1,500	987	1,015	1,334
2. Care and treatment	4,560	5,483	5,676	7,261
3. Orphans and vulnerable children (OVC)	50	52	24	24
4. Program management and administration	397	250	195	320
5. Incentives human resources	44	208	147	207
6. Social protection and social services excluding OVC	219	171	224	224
7. Enabling environment and community	2	8	124	169
8. Research excluding operational research	156	49	330	383
<b>Total</b>	<b>6,928</b>	<b>7,208</b>	<b>7,733</b>	<b>9,922</b>

The proportion of spending for children affected by HIV/AIDS, excluding social protection and social services, has never been more than 1 per cent. But between 2012 and 2014, the funding from the Global Fund will be a spearhead for the country to strengthen the integrated service system for health, social protection and community and ensure sustained financial support for an ongoing programme of care and treatment for children affected by HIV and AIDS. Spending on the enabling environment, which has been indicated as one key factor to achieve the zero stigma and discrimination goal in the National AIDS Strategy for 2012-2016, accounted for 1.6 per cent and 1.7 per cent of total HIV/AIDS spending in 2010 and 2011, respectively.

**Table 12: Thailand AIDS spending by function, 2010 and 2011, current year price and percentage**

AIDS spending categories	2010		2011	
	mill. THB	%	mill.	%
1. Prevention	1,015	13.1	1,334	13.4
2. Care and treatment	5,676	73.4	7,261	73.1
3. Orphans and vulnerable children (OVC)	24	0.3	24	0.3
4. Program management and administration	195	2.5	320	3.2
5. Incentives human resources	147	1.9	207	2.1
6. Social protection and social services excluding	224	2.9	224	2.3
7. Enabling environment and community	124	1.6	169	1.7
8. Research excluding operational research	330	4.3	383	3.9
<b>Total</b>	<b>7,733</b>	<b>100.0</b>	<b>9,922</b>	<b>100.0</b>

In both 2010 and 2011, a sizeable percentage (85-86 per cent) of expenditures came from domestic sources. The government budget, through the National Health Security Office (NHSO), provided for a significant portion of HIV and AIDS spending, largely focused on care and treatment. With regard to AIDS-spending categories, care and treatment accounted for 73 per cent of overall HIV-related spending. Prevention accounted for 13 per cent of overall HIV-related spending for both years.

A significant proportion of funding for prevention came from international sources (47.8 per cent in 2010 and 44.3 per cent for in 2011), of which the Global Fund provided 90 per cent in 2010 and 93 per cent in 2011.

The expenditure profile of donor resources differed significantly to that of domestic resources. Domestic resources concentrated most on care and treatment (84.3 per cent and 83.9 per cent in 2010 and 2011, respectively), while donor resources were spread throughout the eight major spending items. In 2011, 41.6 per cent of donor spending was on prevention, 23.6 per cent

was on research excluding operational research, 12.0 per cent was on programme management and administration strengthening, and 8.9 per cent was on care and treatment.

Among the domestic sources of finance, the NHSO (responsible for the UC scheme) provided the major share of funding, 48.8 per cent in 2010 and 52.9 per cent in 2011. The Civil Servant Medical Benefit Scheme and Social Health Insurance had a share of 15.1 per cent and 10.4 per cent, respectively, in 2010, and 12.3 per cent and 10.4 per cent in 2011.

Thai Red Cross as a non-profit institution contributed a significant proportion of funding for the blood safety programme and contributed 16.8 per cent of prevention funding in 2010 and 20.6 per cent in 2011.

**Table 13a: Thailand AIDS spending by functions and source, 2010 and 2011**

AIDS spending categories	2010			2011		
	Total mill. THB	Domestic sources (%)	International sources (%)	Total mill. THB	Domestic sources (%)	International sources (%)
1. Prevention	1,015	52.2	47.8	1,334	55.7	44.3
2. Care and treatment	5,676	97.8	2.2	7,261	98.2	1.8
3. Orphans and vulnerable	24	15.8	84.2	24	0.4	99.6
4. Program management	195	43.1	56.9	320	46.5	53.5
5. Incentives human	147	62.9	37.1	207	58.3	41.7
6. Social protection and	224	100.0	0.0	224	100.0	0.0
7. Enabling environment	124	53.2	46.8	169	49.4	50.6
8. Research excluding	330	10.9	89.1	383	12.3	87.7
<b>Total</b>	<b>7,733</b>	<b>85.2</b>	<b>14.8</b>	<b>9,922</b>	<b>85.7</b>	<b>14.3</b>

**Table 13b: Percentage of Thailand AIDS spending by source and functions, 2010 and 2011**

AIDS spending categories	2010			2011		
	Total mill. THB	Domestic sources (%)	International sources (%)	Total mill. THB	Domestic sources (%)	International sources (%)
1. Prevention	13.1	8.0	42.4	13.4	8.8	41.6
2. Care and treatment	73.4	84.3	10.7	73.1	83.9	8.9
3. Orphans and vulnerable	0.3	0.1	1.7	0.3	0.0	1.7
4. Program management	2.5	1.3	9.7	3.2	1.8	12.1
5. Incentives human	1.9	1.4	4.8	2.1	1.4	6.1
6. Social protection and	2.9	3.4	0.0	2.3	2.6	0.0
7. Enabling environment	1.6	1.0	5.1	1.7	0.9	6.0
8. Research excluding	4.3	0.6	25.6	3.9	0.6	23.6
<b>Total per cent</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
<b>Total Million Thai Bath</b>	<b>7,733</b>	<b>6,588</b>	<b>1,145</b>	<b>9,922</b>	<b>8,499</b>	<b>1,423</b>

### ***Remaining challenges and next steps to improve responses:***

Thailand has recognized the need to ensure sustainable domestic funding for HIV prevention activities, particularly to fund the continuation of activities already initiated with Global Fund support. Establishment of an HIV prevention fund has been indicated as a priority area in the National AIDS Strategy for 2012-2016.

Another key strategy defined in the NAS is to advocate for localizing ownership and funding of the expansion of responses and of the strengthening local capacity to ensure good quality services.

A further key strategy of the NAS for 2012-2016 is the strengthening of the use of strategic information to inform and guide the national response. The national strategic information and M&E plan was developed in parallel with the NAS with a clear and detailed plan and costing. The plan can be used to call for support from the country.

### **TARGET 7: MOBILIZE CRITICAL ENABLERS AND SYNERGIES AMONG DEVELOPMENT SECTORS**

#### **7.1. COOPERATION AND SYNERGIES**

##### **7.1.1 Cooperation within and between governments**

In 2010 and 2011, the political sector gave importance and support to the implementation of the NASP, by virtue of the cabinet resolution approving guidelines for inter-ministerial integration of the AIDS strategy, and budget support for free HIV VCT and ART for full coverage.

In 2010, a review of progress of the NASP for 2007-2010 was conducted and the prevention of the spread of HIV and AIDS was specified as one of nine national development strategies to be integrated among ministries. Based on the NASP, joint key performance indicators for HIV prevention were developed and used as a tool for relating ministries to develop a joint work plan.

In addition, the prime minister chaired meetings of the NAC and was a presenter at national campaigns, and welcomed recommendations to establish an AIDS Prevention Fund as part of the next National AIDS Strategy. Furthermore, the Bangkok Metropolitan Administration signed a Memorandum of Understanding between Thailand and Australia for collaboration in harm reduction for PWID in Bangkok.

### **7.1.2. Cooperation between civil society organizations and with government and UN agencies**

Civil society groups in Thailand have participated quite actively in prevention and control of AIDS since the beginning of the epidemic. In 2010- and 2011 there were increased opportunities of civil society to participate in the national AIDS programme through sharing its viewpoint on policies and strategies for AIDS prevention, care and treatment. Many of the components of today's national AIDS programme arose from the advocacy efforts of civil society, in particular, the endorsement of the NAC and the National Narcotic Control Committee of the harm reduction strategy as an optional strategy in the National Narcotic Policy. In addition, civil society participated in or had representation in the strategy formulation for prevention and control of AIDS from the level of the NAC to the Committee for Inter-country Collaboration, the Task Force on Strategic Proposals, and the Task Force on National M&E. In sum, civil society has been increasingly represented on the various national committees of the national AIDS programme.

In 2010 and 2011, civil society organizations implemented campaigns and movements in the area of protection of the human rights of PLHIV through the activities of 15 networks under the Thai NGO Coalition on AIDS. National and international NGOs and partners from the UN worked with the Bureau of AIDS of the DDC of the MoPH to conduct a campaign on "sex rights, AIDS rights and human rights" on World AIDS Day, and continued these activities, including a national poll to assess views on sex rights. There was support for changes in the guidance of the Thai Medical Council so as not to require parental consent for youth VCT.

In 2011, the Foundation for SOGI Rights and Justice was formed, and involved those with diverse sexual lifestyles, technical experts on gender studies, and human rights experts. The Thai Katoey Friends Network was successful in appealing to the Ministry of Defence to change its classification of transgender from "mental defect" to "sexual orientation different from sex at birth".

Under Article 30 of the Thai Constitution, it is specified that there must be no discrimination against persons based on ethnicity, place of origin, gender, age, language, or religion. Furthermore, a master plan for human rights has been developed that details support for and protection of rights and freedoms. But, until recently, there was nothing in place to protect the rights of PLHIV. In recent years there has been visible progress in this area. The NASP for 2007-2011 specified that protection of AIDS rights was part of the implementation strategy and in 2010, a subcommittee for the "Support and Protection of AIDS Rights" was established under the NAC resolution.

### **7.1.3. Coordinated efforts by UN agencies**

With the aim of facilitating synergies and maximize the UN contribution to Thailand, the UN agencies involved in HIV and AIDS prevention and treatment in Thailand identified a number of Joint Results for 2010-2011. The UNAIDS country office acted as the facilitating body to achieve the joint results, while individual UN agencies implemented activities according to their specific mandates. In 2010 and 2011, these agencies implemented numerous coordinated actions. For example, UNAIDS, UNODC, WHO and World Bank acted jointly to advocate for the harm reduction policy and for improving implementation through evidence-based decision making and policies. Other examples of coordinated actions include those taken by UNICEF, UNFPA, WHO and UNHCR in the area of PMTCT, and a joint UN programme (UNDP, UNAIDS, UNFPA and UNICEF) targeting prevention of stigma and discrimination and protection of the rights of PLHIV.

### **7.1.4. Synergies in HIV prevention**

Implementation of prevention programmes in the past two years involved providing information, knowledge, and communicating about HIV for the general population through various channels, and especially focus groups, such as youth and key affected populations, including sex workers, MSM, PWID, prisoners and migrants, largely with support from the Global Fund. The communication includes information on sex education, and reproductive health, gender, and sexuality. The result has been increased access to prevention services. There has also been some improvement towards encouraging provinces to take over responsibilities for the national AIDS strategies in their locations.

### **7.1.5. Synergies in treatment, care and support**

The advocacy of civil society in the area of care and treatment has resulted in considerable progress in terms of comprehensive coverage of treatment and care services. In the past two years, the government allocated a large budget through the National Health Security Office which significantly increased coverage and access to care and treatment. Furthermore, the country now has an implementation plan being supported by Round 10 of the Global Fund, and an implementation plan of the MSDHS for the assistance of children affected by HIV/AIDS.

Other areas of progress include: (1) development and expansion of paediatric treatment, positive prevention, and the development of models of care and treatment through self-management; (2) development of a progress-monitoring information system for support of the national AIDS programme database, including HIVQual, STI-Qual, and EWI tools, including capacity building of staff in the use of the data; (3) planning for improvement and expansion of counselling services for hard-to-reach and vulnerable populations, and the general population; and (4) coordination with civil society groups and the community to achieve greater access to services by PLHIV and increased public welfare assistance for PLHIV.

In 2011, the BATS, in collaboration with other government agencies and civil society organizations, with grant support from the NHSO, launched a project to improve VCT for PLHIV across the continuum, from those who are asymptomatic to those receiving ART. In addition, the DDC and the ACCESS Foundation, with the Global Fund grant, began implementation of a project on care for vulnerable children, including children infected and affected by HIV and AIDS in high HIV prevalence areas. Through this project, the three systems of health, social protection and community care will be strengthened and integrated to provide holistic care for vulnerable children and children affected by HIV and AIDS. Furthermore, under a NAPHA extension project by the BATS/DDC, the Global Fund supported ART for 2,700 migrants living with HIV.

Thus, there has been great progress in the provision of treatment and care. If it were to rate progress, civil society groups would assign a value of eight points out of ten. The Thai policy provides virtually complete coverage for most groups, there is increased access to ART, and there has been a significant decline in AIDS mortality.

## **7.2. CHALLENGES AND NEXT STEPS**

### **7.2.1. Obstacles to the participation of civil society**

There are some obstacles to civil society participation in policy and programme development, such as the short notice regarding meetings; the large volume of background printed material for meetings, much of which is in English; and the lack of data or clear understanding of some aspects. In addition to the need to address these shortcomings, civil society groups feel that there is a need for improvement in the system of technical assistance for civil society. The government has not increased the allocation for civil society; it remains at 50 million THB per year. It is necessary to provide an adequate budget for civil society organizations, as this would increase civil society participation in a meaningful way.

### **7.2.2. Limited political support and leadership**

Overall, if civil society were to rate the progress of the national AIDS programme in the past two years, civil society would give a grade one point lower than in the previous assessment. This is because although government leadership in 2010 and 2011 gave importance to HIV/AIDS as evidenced by the participation in NAC meetings and although the prime minister (Abhisit Vejjajiva) was active by chairing the NAC, no policies emerged from his government that concretely advanced the country toward the goal of “Getting to Zero”. In fact, some policies and actions serve as obstacles to the “Getting to Zero” goal. One example of a government action that poses an obstacle to treatment and care is the signing of free trade agreements with the European Community and the USA that have conditions attached regarding the price of anti-retroviral drugs, and the expanded TRIPS agreement. Furthermore, the government has shown no progress in taking over funding responsibility for the programme, and most of the prevention budget still comes from external sources, principally the Global Fund. From the past government to the present, it is still not clear who is going to provide the national level leadership to advance the NAP. Furthermore, there has been insufficient implementation of actions to clearly advance the prevention, care and treatment agenda.

### **7.2.3. Inappropriate laws, policies and regulations**

Laws, policies and regulations exist that pose obstacles to access to prevention, care and treatment services. For example, the Anti-Prostitution Act of 1996 (Articles 5, 6, and 7) criminalizes selling sex, punishable by fines and/or imprisonment, and fear of prosecution makes it difficult for sex workers to access information and services for HIV prevention and treatment of HIV and AIDS.

Likewise, the law regarding commercial sex establishments of 2004 does not specify the status of persons working in those establishments, and this vagueness denies workers in these establishments their labour rights. Furthermore, this law gives establishment owners and managers the power to force workers to engage in compulsory blood screening and disclose their results.

Also, there is compulsory or un-informed HIV screening of job applicants and university applicants, both government and private sector. No aspect of the law protects workers and students from this violation of their human rights or imposes penalties on employers for doing this.

Another policy that serves as an obstacle to prevention, care and treatment is the interpretation of the Council of State that the distribution of clean needles promotes illegal drug use and is therefore punishable by criminal law. This reduces access of PWID to clean injection equipment and thus restricts their ability to prevent infection with HIV. Although a harm reduction policy passed as a resolution of the NAC, this cannot be implemented as the distribution of clean injection equipment violates the law, as interpreted by the Council of State.

#### **7.2.4. Obstacles to prevention of HIV transmission**

Stigma associated with sex outside of marriage and discrimination against sex workers, MSM and TG hinders access to services that aim to prevent HIV transmission. Local communities and health workers need to be more supportive of prevention activities, including having more positive attitudes. Acceptance is an important factor, which impacts on the individual's ability to manage and negotiate safe sex, and ensure freedom from sexual violence.

The NAS has specified certain groups of the population as most-at-risk of HIV infection. The view of civil society is that specifying certain groups as "high risk" is a form of stigmatizing and discrimination and does not solve the problem of AIDS since the root cause of the problem is linked to socio-cultural factors, not to health or epidemic spread alone.

Integration of prevention actions into the routine services at the provincial level needs improvement, if there is to be successful sustainability of the work.

#### **7.2.5. Obstacles to the provision of care, treatment and assistance**

Although the country has a policy for care and treatment which has achieved good coverage, there is a need to review certain aspects. There remain challenges regarding the integration of clinical services such as ANC and ART and TB treatment. In addition, there is a need to find ways to provide treatment for foreign migrant workers. There needs to be improvement in client-friendly services in hospitals, including a better referral system between civil society and the government.

Another challenge is the TB mortality rate among PLHIV, which is still high. There is a need to look at harm reduction for PLHIV who are TB-infected. A further challenge is producing a database that describes the scale and scope of the problem. Also, the coordination across sectors is not yet efficient. Furthermore, factors such as stigma and discrimination by health care staff towards PLHIV and the lack of skills among some staff, impede progress in this area. There is drug

resistance to the 1<sup>st</sup> line ART regimens, so another challenge is to maintain the efficiency of treatment using the 1st line regimen, and prevent further drug resistance. There is also a need to improve the quality of services that are not yet up to standard.

Social stigma and discrimination against PLHIV is a significant obstacle to treatment and care for these people. There is a need for a social environment that enables protection of sexual rights, reproductive health rights, and gender equality to reduce stigma and discrimination against persons seeking health care for treatment or prevention of HIV and AIDS.

## **VI. PROGRESS OF BEST PRACTICE CASES**

This section describes the progress of the best practice cases that were listed in the 2010 country progress report. The best practice cases include both government and civil society projects. The projects have different characteristics, strengths and weaknesses. A strength of the civil society projects is innovation in model development and tools and intensive implementation. These face weaknesses in terms of the capacity to scale up, however. A strength of government projects is that they can often cover a wider area, but this strength becomes a weakness when there are shortcomings in implementation as the shortcomings become magnified.

The principal implementing agencies submitted three sets of data as follows: implementation progress during 2010-11; project expansion as well as factors that enable expansion; and problems and obstacles to implementation including in case of termination of the project. The information in this report focuses on the conditions for sustainability of the interventions.

### **REAL LIFE PROJECT**

The AIDS Network Foundation branch in northern Thailand (AIDSNet-North) works with partners to improve the quality of life of PLHIV using a participatory process and learning from actual life experiences.

The Real Life project began in 2004. The project promotes rights awareness, critical thought and decision-making for managing the reproductive health of PLHIV and their partners, among both discordant and concordant couples. The project also builds capacity and skills in communication for PLHIV peer leaders. The project has been able to assist over 5,000 PLHIV and has resulted in increased awareness, safer behaviour and has improved access to needed health services.

In 2010 and 2011, the project expanded its implementation area from eight provinces in the north to 20 provinces including the lower north and northeast regions. In addition, the project expanded the target population from PLHIV peer leaders to community peer leaders, adding community-based counselling in the process. The project has modified the process of implementation so that it is consistent with the lifestyle of the community. AIDSNet-North is now arranging linkages with the government in the area of services and budget support, especially from the NHSO.

## **VOICES AND CHOICES PROJECT**

The Voices and Choices project was implemented by the Raks Thai Foundation (Raks Thai) until 2009, and focused on HIV+ women. The project aimed to build capacity and empower women so that they can make beneficial changes in their lives. The participants in the project gained knowledge and understanding about sexual health and reproductive health rights. They also became better able to express their needs to their partners, staff and other related persons and also gained skills in sex communication, so as to be able to negotiate for safe sex. The project used a process of exchange among participants to get at the root of their problems, and used a peer support process to work out solutions that are appropriate and consistent with the context of each individual. The project involved over 3,000 persons – both PLHIV and others – in its activities. Peer leaders in the women’s network were also able to involve their male partners to help improve awareness among male partners of positive women.

Even though the formal Voices and Choices project ended in 2009, the concepts and methods of the project were sustained. In 2010 and 2011, the project broadened the focus to include groups in the community, hospitals and regional networks. There will be continued advancement and expansion of the approach over time with a clear focus on promotion of sexual health and reproductive health of women living with HIV. There are linkages with the government and private sectors and other Civil Society agencies to sustain the efforts of the peer group.

Some of the peer positive women were selected by the Department of Health to serve as resource persons in the expanded training for development of models of reproductive health for PLHIV. The aim is to increase access to services for positive women, and to encourage them to air their opinions in order to improve services of hospitals so that they meet the needs of female PLHIV. These women assist ANC services in 13 hospitals in 12 provinces, and actively participated in the development of the National AIDS Strategy for 2012-16.

## **PREVENTION OF HIV AMONG PREGNANT WOMEN: COUPLES ANC**

The Couples ANC project is implemented by the Reproductive Health Division of the Department of Health with partners and the Faculty of Nursing of Burapha University. The project promotes a model of ANC that enables seronegative pregnant women to stay negative through increasing partner involvement in counselling. The pilot model of this approach to ANC was tested in six health promotion hospitals, and then expanded to regional, provincial and district hospitals between 2007 and 2011.

In 2010 and 2011, the project approach was integrated into the routine service system. The MoPH announced couples ANC as a policy for one approach of prevention of mother-to-child transmission of HIV. This gave MoPH outlets a mandate to provide pre- and post-test HIV counselling for couples while maintaining confidentiality. In addition, indicators were developed for hospitals to meet the standards of the Sai Yai Rak initiative, which requires the involvement of at least 20 per cent of the husbands/partners or relatives in a parent-training curriculum with the pregnant women.

The government is the “owner” of the project approach. This is beneficial in terms of the capacity to expand the model and institutionalize the approach. The need for oversight and ensuring expertise of the staff is still a challenge for the continuation of this strategy at a high quality level, however.

### **THE TEEN PATH PROJECT**

The Teen PATH project is being implemented by PATH (Thailand) with the involvement of the Ministry of Education. The focus is on delivering sex education and prevention of HIV among school-based youth. The project approach is a system of comprehensive sexuality education (CSE), which requires policy support from educational institutions and teachers to serve as leaders of change to help promote sexual health among Thai youth.

Ten implementing partners have been working with PATH since the outset to create model school programmes of CSE, which can be expanded to cover all grade levels, from primary through to university-level, ultimately becoming a permanent feature of the core curriculum. A network of teachers has been created among those trained in CSE and youth development. There is a team of technical experts in CSE in the field who are model implementers of the CSE curriculum for youth at different levels. And project youth groups work for improved understanding of AIDS and CSE in the schools and the community through a network of peer educators. These peers have been accepted by partner networks in the locality, and they collaborate to mobilize local resources to support CSE.

At the end of the 8th year of the project (2010), and the final year of Global Fund support for this effort, PATH attempted to modify the structures and strategy of implementation to advance implementation at the provincial level, build capacity for expansion while maintaining quality, and mobilizing local resources to hand over responsibility of support from the Global Fund to domestic sources. In the 8<sup>th</sup> year, PATH also worked to identify focal points and CSE task forces in 43 target provinces through linkages with the Provincial Coordinating Mechanism.



In 2010 and 2011, PATH was able to promote continuation of the expansion of CSE in schools and to mobilize funds to strengthen these activities. This involved a process of building communication skills among parents and their adolescent children to reduce conflict and promote more conversation and understanding about safe sex. Through this approach, it is hoped that parents will acquire sustained skills and positive attitudes about sex in order to promote the sexual health of adolescents in their communities.

The winding down of Global Fund support for this project has resulted in the shortening or diminished intensity of some of the project interventions in the field. Nevertheless, PATH has been able to continue project activities through mobilizing support from other agencies, such as the MoPH, the NHSO, the MSDHS and local administrative organizations. In addition, PATH has continued to lobby the Ministry of Education to include CSE in the core curriculum of the country. Increasingly, the provinces are taking greater ownership of this issue in support of CSE for youth with PATH serving as a technical mentor. The strength of the various project networks should help to keep the interventions going.

Results of monitoring and evaluation to learn about progress and factors behind success or failure of implementation are included in the Teen PATH 9<sup>th</sup> year report (March 2015). These findings can be used to adjust strategies for the final three years, and for policy communication, which is a key factor in ongoing government support for the project approach.

### **THE NAPHA EXTENSION PROJECT FOR MEKONG RIVER BORDER AREAS**

This NAPHA Extension Project for Mekong River Border Areas is implemented by Chiang Saen Hospital in Chiang Rai Province with a focus on extending ART for people in areas bordering on the Mekong River. Intended beneficiaries include labourers, persons from border communities, cross-border migrants, undocumented persons and others without health insurance coverage. All recipients of ART experience improved health, were able to pursue a normal life in the community, came together in PLHIV support groups, and conducted prevention activities continuously over time.

During 2010 and 2011, it was found that of 99 PLHIV seen by Chiang Saen Hospital, 17 were referred to hospitals in Lao PDR, four were referred to Burmese hospitals, four were referred to other Thai hospitals, and 18 were transferred for coverage under the National Health Insurance scheme. The remaining 56 PLHIV were cared for through the NAPHA extension project. Some patients showed early signs of drug resistance and side effects of ART.

This complicated the therapeutic requirements, including increased costs to the patients and the hospital after discontinuation of external assistance. There are efforts to mobilize funds among the PLHIV network, local agencies or private groups.

Despite the financial challenges, the hospital is continuing to provide care for these PLHIV, often by arranging non-Thais to be repatriated to hospitals in their home country for ongoing treatment. There is a strong network of PLHIV in the locality, which received support from Norwegian Church Aid, which helped the Chiang Saen hospital over a 16-year period between 1992 and 2008. The Population and Community Development Association has also provided socio-economic support, and the International Organization for Migration has supported the development of a cadre of migrant health workers to provide a link between the migrants and Thai resources. A multi-disciplinary team helps build technical capacity and conducts learning-exchange forums every one to two months.

### **THE PHAMIT PROJECT**

The PHAMIT project is being implemented by the Raks Thai Foundation with other NGOs, with an emphasis on increasing use of condoms for prevention of HIV, and reproductive health promotion among the population of migrant workers, their families and other populations connected to the migrant workers who came to Thailand from Lao PDR, Myanmar and Cambodia. Many of these migrant workers work in the fisheries industry.

The project integrates a comprehensive set of interventions through a flexible process that allows adjustment to the local environment and context. Outreach and community-based services are implemented for the migrant worker communities. The project uses a variety of communication strategies, distributes condoms, and refers migrant workers to client-friendly reproductive health services at drop-in centres. The migrant workers can access information about services, meet friends and participate in learning activities in these centres, which are easily accessible and are considered a “safe space” for the migrant workers. Through regular participation, the migrant workers acquire a sense of community ownership of the drop-in centres. The centres are also a site for primary contact and referral for STI case management and maternal and child health care services. Staff and volunteers of the centres follow-up on the outcomes of treatment.

In 2010 and 2011, the project held fast to its mission to protect the human rights of migrant workers and provide uninterrupted HIV prevention services. Over the past two years, the project has reached 228,786 persons working in 124 districts of 36 provinces, including the 19 coastal and 17 inland provinces that have the largest numbers of migrant workers. The project has provided VCT to 3,976 migrant workers, STI services to 2,235 migrant workers, and has distributed 2,586,829 condoms through various service outlets.

Summary of achievements of the PHAMIT Project in 2010 and 2011:

- Over 2.5 million condoms distributed to migrants.
- 228,786 migrants reached with HIV behaviour change communication
- 4,270 migrants provided with referrals for VCT and 2,500 for STI diagnosis and treatment (regardless of registration status).

The project faces challenges in promoting equality of access to health and equal rights. The project has found cases of discrimination in service provision and negative prejudice among some Thais towards migrant workers. It remains a challenge to instil the value of viewing needy people solely as fellow humans, without regard for nationality or status. Raks Thai is determined to promote change in the degree of collaboration between the government, employers, NGOs and health service providers in order to ensure easy access to health and special services, and improve clarity of the strategies to ensure health insurance coverage for the migrant worker population.

### **INTEGRATED PSYCHO-SOCIAL, CLINICAL CARE AND TREATMENT**

This project is implemented by the “We Understand” group, which is a network of persons working with children and youth living with HIV, including staff from NGOs and the government. The group includes artists, media professionals and volunteers. They work with a diverse array of partners and organizations to develop models of implementing psycho-social interventions through art, and to integrate these psycho-social interventions with care and clinical treatment.

There are 12 groups of youth volunteers with 200 members. They play an important role in supporting implementation of services for more than 1,000 HIV+ youth. The project also involves facilitating follow-up care and treatment and building the capacity of family members to continue the support interventions. The goal is to reduce the impact of AIDS in HIV+ children and youth, through helping youth have good mental health, to understand themselves, exchange thoughts and experience with peers and increase their

self-esteem. The beneficiaries experience internal development, have reduced stress and improved concentration, and they are able to explore options to resolve their own problems. The experiences and lessons learned from the project have been summarized in a publication and DVD that has been disseminated in conjunction with the learning curriculum for interested persons.

In 2010 and 2011, the volunteer youth groups fanned out to cover many provinces, especially in the northern region. There was also an expansion of activities to include youth affected by AIDS and general population youth in addition to the HIV+ children and youth. Over the past two years, the youth volunteers have worked with health service providers in conducting activities for children in the clinic setting, conducting home visits, arranging learning camps during school term breaks, developing media and conducting community and school campaigns, establishing a fund using seed money from donations, and conducting resource mobilization through promotion of the art products of the children, with support from the business sector.

The project has had success in directly improving the quality of life of children and youth living with HIV. They acquired greater self-esteem, participated in helping other HIV+ children live normally in the community, and have improved health. The success of this project has stimulated interest among other agencies to take on some of the activities and expand coverage, with support from outside sources.

## VII. SUPPORT FROM DEVELOPMENT PARTNERS

### (A) KEY SUPPORT FROM INTERNATIONAL DEVELOPMENT PARTNERS IN 2010 AND 2011

In 2010 and 2011, the contribution from international development partners to Thailand was provided in four key areas: firstly, in scaling-up HIV prevention efforts (mainly the Global Fund); secondly, in providing technical and financial support for developing innovative models or replicating models that can be adopted nationwide as well as supporting models to improve the effectiveness of the national response (bilateral donors and UN agencies); thirdly, making available key strategic information, strengthening the M&E structure and the use of data for improving strategic planning and programme implementation; and fourthly, support for policy, advocacy and strategic planning and management at the national and sub-national levels through evidence-based decision making and planning.

The funding from international development partners contributed about 15 and 14 percent of total AIDS spending in 2010 and 2011 respectively (1,145 million THB in 2010 and 1,422 million THB in 2011), an increase from 7 percent in 2009. The majority of the contribution from international development partners (42 percent in 2010 and 2011) went to prevention. This represented a significant increase from 29 percent in 2009. The main contribution in this area was from the Global Fund, with complementary technical assistance from bilateral and UN agencies. The support provided by each key development partner in 2010 and 2011 is illustrated in Table 12.

#### THE GLOBAL FUND

In July 2009, Thailand signed a contract with the Global Fund to implement HIV prevention actions targeting key affected populations (FSW, MSM, MSW, TG, PWID and prisoners) and migrant workers. In 2010, the financial contribution of the Global Fund was 829 million THB; this increased to 1,083 million THB in 2011. The period of 2010-2011 is the first two years of implementation of Global Fund supported actions targeting KAPs and migrant workers. Prior to this, the Global fund supported the implementation of actions in the areas of HIV prevention for youth and provision of AIDS treatment to migrants and minorities for five years.

The Global Fund operates through three principal recipients (PR): the Department of Disease Control, Population Services International-Thailand (PSI), and the Raks Thai Foundation. Six government organizations have received support from the Global Fund, with the remainder (majority) of Global Fund contributions going to 51 NGOs and CBOs.

In late 2011, Thailand was successful in securing Global Fund Round 10 funding for Phase II of the KAP HIV prevention programmes, including a single stream funding (SSF) for PR-DDC. The Phase II and SSF contracts were signed in October 2011.

### **BILATERAL PARTNERS-US CDC GLOBAL AIDS PROGRAMME AND USAID**

The United States Center for Disease Control and Prevention Global AIDS programme provided support to number of government organizations at the central and provincial levels. The CDC provides comprehensive and intensive technical support, including programme design, system strengthening, support during implementation and comprehensive monitoring and evaluation. Each step is provided with mentorship from in-house staff as well as embedded additional staff to main partners or at points of services. In 2010 and 2011, a number of projects were completed and scaling-up was begun, including 1) integrated HIV prevention targeting MSM, with a computerized monitoring system and continuum of treatment and care for MSM positives; 2) HIV prevention in a closed setting, 3) tools, manual and training related to couples counselling, paediatric HIV disclosure and facility-based prevention with positives, 4) the enhanced PMTCT programme monitoring system (PHIMS and PHOMS) with data use for programme improvement, with Training of Trainers.

Projects that are in the stage of integration into the national system include the community-based paediatric HIV quality care network; the HIVQUAL, laboratory EQA and IQC for STIs, TB, OI, HIV testing, QI of SI programme and HIV counselling and testing. The CDC also continued its critical role in providing technical assistance and building local partners' capacity to undertake high quality surveillance (HIV and TB) and surveys of KAPs and the national treatment and care monitoring system. Assistance included enhancing the analysis system to facilitate using data for improving implementation, and conducting evaluation studies (such as evaluation of KAP and prisoner HIV prevention actions and evaluation of the cost effectiveness of TB programmes) and observational studies identifying the risks of TB mortality. The CDC Global AIDS programme contributed between USD4.5 and 5.3million annually in 2010 and 2011.

The USAID Regional Development Mission, Asia, provided technical assistance in 2010 and 2011, in collaboration with implementing partners: the Bangkok Metropolitan Administration, the Ministry of Public Health and international NGOs (FHI360, Pact, PSI and RTI). USAID's Thailand activities aimed to reduce transmission among KAPs, particularly among MSM and TG. USAID's technical assistance-based approach focuses on synthesizing data from HIV KAP intervention models, documenting lessons learned, evaluating the models and leveraging scale-up, which includes provision of technical assistance for quality



assurance to the donors such as the Global Fund and to the MoPH and Thai provincial health offices. In 2010 and 2011, USAID provided USD 1 million for HIV prevention and USD 700,000 for TB prevention annually. Support from USAID also included the provision of 1,301,678 male condoms, 15,321 female condoms and 739,210 sachets of lubricant. These were distributed through peer prevention outreach to 233 outlets. HIV prevention actions reached 12,087 MSM, including positive prevention interventions. To achieve these results, technical assistance was provided to the Rainbow Sky Association of Thailand (RSAT) and its sub-recipients of the Global Fund. USAID also supported the HIV Rapid Test with same day results demonstration project for MSM in three hotspots: Bangkok, Chiang Mai and Pattaya in May 2011, aimed at improving the uptake of testing among MSM. This involved integrating HIV rapid test services in the three provinces through three different service delivery models including mobile clinics, community public hospitals and community-based MSM drop-in centres. To date, 302 MSM have been tested using rapid tests with same day results and training has been provided to community and facility-based care providers. USAID also supported home and community-based care models for MSM-PLHIV through strengthening the referral system from facilities to communities, increased access to psychosocial support and improved access to care and support services for positive MSM at drop-in centres. USAID supported the national TB programme through assisting an evaluation of TB infection control practices in hospital settings in Mae Sot and built the capacity of infection control staff in six provinces.

## **UN AGENCIES**

UN agencies have supported numerous activities towards achieving HIV and AIDS prevention and care targets. To facilitate synergies and maximize the UN contribution to Thailand, Joint Results for 2010-2011 were identified. Higher level results (targets) included reducing sexual transmission of HIV, protecting drug users from becoming infected with HIV and removal of punitive laws, policies, practices, stigma and discrimination. Cross cutting themes included strengthened programming targeting young people among most affected populations, ending gender-based violence, and partnerships at all levels with civil society and key affected populations.

The UNAIDS country office is the facilitating body to achieve the joint results, while individual UN agencies implement activities according to their specific mandates. The UN contributed 42.6 million THB in 2010 and 43.8 million THB in 2011.

**Key actions by UN agencies in 2010 and 2011 are described below:**

*Target: Reduce sexual transmission of HIV among sex workers and MSM.*

The UNFPA supported activities to increase the coverage and quality of reproductive health and HIV prevention services for male and female sex workers, and to build the capacity of technical staff, and supported forums for policy and advocacy dialogue and for sharing of good practices. The ILO supported the development of a standardized training package on HIV prevention and sexual health, and skills to reach out to MSM clients. The ILO also increased the supply of condom and water-based lubricants in five sex work venues in Bangkok. The UNDP supported the development of national guidelines of HIV prevention among MSM and TG. UNESCO supported a study on health seeking behaviour among MSM and TG; and developed peer education, communication and advocacy materials and media. The UN joint team supported a multi-city scan on HIV and MSM.

*Target: HIV prevention among youth.*

UNICEF sponsored a formal review and documentation of HIV prevention among street children, particularly migrant and stateless children, and supported a project and evaluation of HIV prevention among religious and cultural minorities in the far south. UNFPA supported the development of comprehensive reproductive and HIV prevention services for youths, youth friendly STI/HIV testing and treatment services and Quality Assurance. The UNFPA, in collaboration with Department of Disease Control, established a national technical working group on the comprehensive condom programme to develop a national plan and strategies to reposition the condom programme. The UNHCR supported comprehensive HIV prevention, including an HIV counselling and testing programme targeting Myanmar displaced persons in five temporary shelters, and the World Bank support a study tour to the AVAHAR programme in Bangalore.

*Target: Reduce transmission of HIV among people who inject drugs.*

UNAIDS, UNODC, WHO and World Bank acted jointly to advocate for the harm reduction policy and for improving implementation through evidence-based decision making and policies. The World Bank supported assessments related to MMT and harm reduction programmes to facilitate a change of policy and to improve the quality of services. WHO sponsored a harm reduction study tour for Thai media to Indonesia. A technical working group on harm reduction was established.

*Target: Eliminate mother-to-child transmission and substantially reduce AIDS related maternal deaths.*

UNICEF, UNFPA, WHO and UNHCR took a number of actions in this area in 2010 and 2011. UNICEF supported a national evaluation of the HIV early infant diagnosis programme and an assessment of the use of the information gathered, and supported the use of communication technology to improve HIV-related outcomes. UNFPA pursued programme development related to male involvement through couple counselling and testing at ANC clinics with human rights-based services of reproductive health and family planning for PLHIV. At the end of this programme, the DOH expanded it to all 12 DDC regions. UNHCR continued the PMTCT program in two shelters. Increased uptake was observed when community mobilization activities were implemented through targeted health education to sensitize community leaders.

*Target: Improve treatment and care, including social support.*

UNICEF supported a successful advocacy and resource leveraging effort, which resulted in Thailand obtaining funding of USD 42 million under Global Fund Round 10. UNICEF also supported the development of a comprehensive HIV paediatric care model and planned for expansion of this model nationwide. UNHCR, in collaboration with the NAPHA program (through the Global Fund) provided ART to 74 displaced persons. A number of activities were supported by UNICEF, UNAIDS, UNDP, WHO and ILO to facilitate policy dialogue, dissemination, exchange of knowledge and experiences on treatment and care for the migrant population, promote strategies to enhance ART adherence, provide national training on HIV sensitive social protection, and document best practices in paediatric HIV care, support and treatment by linking healthcare facilities and communities and discussion forums on social protection, in partnership with relevant line ministries.

*Target: Reduce TB deaths and TB/HIV.*

WHO supported the development of the Multi-Drug Resistant TB plan for 2012-2016. The MDR TB plan aimed at boosting efforts to promote TB screening and treatment among PLHIV. WHO was an integral part of policy dialogue/preparations for GF Round 10, which included emphasis on TB programming. In 2011, WHO supported the National TB Programme managers meeting for the South East Asia Region, which was held in Bangkok in December. The meeting provided a broad overview of TB programmes, including those targeting PLHIV.

*Target: Defend the human rights of PLHIV, and end stigma and discrimination, violence and gender inequality.*

A joint UN programme (UNDP, UNAIDS, UNFPA and UNICEF) targeted prevention of stigma and discrimination and protection of the rights of PLHIV in seven provinces. The project set up AIDS rights protection centres and an AIDS Right Committee. Training was provided to committees and core team educators representing KAP groups and PLHIV networks. UNFPA supported a survey to assess violence against sex workers and use the results for designing rights protection activities through volunteer sex workers.

*Target: Strengthen national and sub-national strategic planning and management.*

In 2011, all UN agencies participated in and supported the development of the new National AIDS Strategic Plan 2012-2016 to ensure evidence-based and strategic decision-making and prioritization. To achieve the expected results, the World Bank supported results-based training to focal points before the process started, while UNICEF, UNFPA, UNAIDS and WHO supported consultations to reach national consensus on the proposed national strategies and operational plan. UN agencies supported number of studies including evaluation studies; evaluation mapping and other assessments. For example, UNAIDS supported a feasibility study for the implementation of an “area based M&E system” in three provinces, the development of routine integrated programme monitoring targeting KAP and an HIV prevention curriculum.

*Target: Support research into new prevention and treatment technologies.*

In 2010 WHO supported a laboratory workshop on HIV drug resistance to strengthen capacity related to genotyping assay for HIV drug resistance and a stakeholder workshop on pre-exposure prophylaxis.

**Table 14: Summary of support from Thailand's development partners by key thematic areas, 2010-2011**

Key thematic area	GFATM	Bilateral		UN agencies									
		TUC	USAID	ILO	UNFPA	UNICEF	UNDP	UNESCO	UNODC	UNHCR	UNAIDS	WHO	World Bank
<b>Reduce sexual transmission of HIV</b>													
<i>Youth and general population</i>	•	•			•	•		•		•	•	•	
<i>Sex workers (male and female)</i>	•	•		•	•			•		•	•	•	•
<i>Men who have sex with men and Transgender</i>	•	•	•	•			•	•			•	•	•
<i>Prisoners</i>	•	•									•		
<i>Displaced persons</i>										•			
<b>Reduce transmission of HIV among people who inject drugs</b>	•	•							•		•	•	•
<b>Eliminated mother-to-child transmission and substantially reduce AIDS related maternal deaths</b>		•			•	•				•		•	
<b>Treatment and Care including social support</b>												•	
<i>Thais</i>		•	•	•		•							
<i>Non-Thais and displaced persons</i>	•	•	•	•		•				•	•		
<b>TB/HIV</b>	•	•	•									•	
<b>Human right, stigma and discrimination including violence and gender equality</b>	•	•	•		•	•	•				•		
<b>Management, strengthening national and sub-national strategic planning</b>	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>Strategic information including monitoring and evaluation</b>	•	•	•	•	•	•	•	•	•	•	•	•	•
<b>Laboratory</b>		•										•	
<b>New prevention technologies (for example: PrEP)</b>		•										•	
<b>South to South and regional and global sharing experiences</b>	•	•	•	•	•	•	•	•	•	•	•	•	•

**(B) PROPOSED ACTIONS TO BE TAKEN BY INTERNATIONAL DEVELOPMENT PARTNERS TO ENSURE ACHIEVEMENT OF TARGETS IN 2012-2013**

The Global Fund is providing continued support until the end of 2013 in addressing HIV prevention targeting KAPs and youth, and providing care and support to children affected by HIV and AIDS. The US Government in collaboration with its implementing partners, the Bangkok Metropolitan Administration, FHI 360, Pact, Inc., and the Thailand Ministry of Public Health, will continue to build capacity, strengthen health systems, support country ownership and enhance government coordination. These development partners emphasize building model programmes for most-at-risk populations, quality systems and strategic information. Focusing on providing technical assistance (TA) and capacity building for government and civil society, they are introducing and evaluating innovative, science-based programmes, and facilitating integration of these into routine systems. They target areas where people remain at risk, coverage is low and systems require improvement. Numerous US Government-supported programmes have been adopted for scale-up by the Thai Government and the Global Fund, demonstrating the effectiveness of this strategy.

Three key joint UN actions are planned for 2012-2013. First, high impact prevention will be scaled-up in prioritized provinces. UN agencies will work with local partners to develop standard tools and mechanisms including QA and QC for high impact prevention programmes. Second, evidence-based decision making will be established for legal and policy changes for HIV prevention among injecting drug users. Third, demonstration sites for comprehensive harm reduction will be developed, implemented and documented; and a national consensus and action framework will be established on protective working environments conducive to access to HIV and STI services for all sex workers. In addition three activities are planned in the area of monitoring and evaluation. The tools and methods for impact evaluation of HIV prevention efforts will be developed, monitoring tools for HIV related stigma and discrimination will be developed and a baseline established, and evidence-based policy and programme recommendations will be developed for prevention programmes for young MSM, TG, sex workers and PWID. These areas of support do not include the planned actions of individual UN agencies in 2012 and 2013.

## VIII. MONITORING AND EVALUATION

The Thailand National AIDS Strategy 2012-16 put emphases on strategic information (SI) as one out of five key strategies. M&E is critical part of SI. Thailand pursues increased availability and accessibility of high quality essential data that can support evidence-based planning and inform decision-making effective HIV/AIDS responses.

In 2010, a new national M&E plan was developed for prevention of new infections among KAPs, through gaining the cooperation of the target populations and implementers, and with support from the Global Fund. In 2011, a new national AIDS strategic plan was developed for 2012-16 which included an M&E component as one the three core priorities of the plan. This was part of a comprehensive and consolidated effort to systematically plan for a new generation of strategic information and M&E for the national AIDS response, while strengthening the system's capacity, quality and responsiveness. The SI and M&E plan measures progress towards achieving national goals and objectives, including towards reaching "the three zeros": zero new infections, zero AIDS deaths and zero discrimination, in an effective, efficient and timely manner.

Thailand has attempted to develop a unified system for monitoring and evaluation programmes on prevention and control of AIDS. A clear structure for M&E has been defined and there is now a Task Force for M&E at the national level and the system at the provincial level has been strengthened to maximize utility of the data.

In the past two years, Thailand has mobilized agencies, plans and budget for M&E at the national level and there have been efforts to institutionalize M&E and surveillance efficiently, but there are shortcomings in the areas of staff capacity, amount of budget and management. There is still a need for technical support and funding from international donors.

### **(A) ACHIEVEMENTS IN M&E IN 2010 AND 2011**

Through partnership and collaboration between government organizations (health and non-health), civil society organizations and academics, several important results were achieved during the reporting period (2010 and 2011). These are summarized below.

- **Partnership to plan, coordinate and manage the M&E system**

At the national level, joint Key Performance Indicators were developed and were committed to by line ministries for collective and synergistic efforts towards achieving the national HIV/AIDS response goals.

Good progress was made at the provincial level, through establishing the provincial coordinating mechanism in 59 provinces, which serve as bodies to coordinate key stakeholders to design for data needs, collect data from the various partners and use data for planning and improvement of programmes. In addition, the NAMC initiated a pilot project “an area based M&E system” in three provinces. The lessons learned from this project will guide implementation in priority provinces starting in 2012.

- **National multi-sectoral strategic information and M&E plan and costed work plan**

In early 2010, Thailand developed a national M&E plan on HIV prevention targeting key affected populations for 2010-2011. Thailand also conducted the M&E system strengthening assessment (MESS assessment), which was completed in September 2011. The national M&E plan for HIV prevention among KAPs and recommendations from the MESS were used as a basis for developing key SI and M&E strategies and a costed SI and M&E plan for 2012-2016.

The SI and M&E plan for 2012-2016 consists of three parts. The first is a set of core indicators that are designed to measure the progress of the National AIDS Strategy. The second is a work plan that is designed to systematically measure against core indicators, perform regular monitoring of national response, generate additional strategic data that critical to decision making and also address needed system strengthening. The third is resource estimation for implementing the priority SI and M&E work plan.

The SI and M&E plan 2012-16 is the first national effort to mainstream a work plan for SI and M&E activities. It is imperative that key stakeholders understand its importance and incorporate M&E activities into their work plans, with a strong link to joint KPIs.

- **Routine HIV programme monitoring**

A numbers of new developments and enhanced existing routine programme monitoring systems were seen during the reporting period. There include:

- A community based monitoring system. A MSM programme monitoring system was developed. This system was used for almost two years by NGOs and CBOs working with MSM and implementing HIV prevention programmes. This monitoring system was provided to the NGOs and CBOs along with a capacity building package to enable staff to clearly understand indicator definitions, operation of the system and how to use data for programme improvement. Through PSI, an IDU monitoring system using Unique Identifier Codes (UIC) and a monitoring system for migrant HIV prevention were successfully implemented.
- The pilot phase of a monitoring system for an HIV prevention programme at prisons was completed in five sites. The Department of Corrections plans to expand the programme to 32 sites with funding from the Global Fund.
- A computerized STI reporting system was developed and implemented in 17 specialized STI clinics and its coverage will be expanded to 31 provinces in next two years.
- A strengthening PMTCT programme monitoring system has shown progress. PHIM version 3 was revised according to the 2010 national guidelines and better capture key PMTCT programme service outputs, including couples counselling and ability to disaggregate by sub-populations.
- A modified NAP database and system is in progress and will serve as a unified care and treatment monitoring system for all insurance schemes. It includes expanded standard indicators and definitions; enhanced analysis functions to better use data for programme performance management. The system will be further developed to increase utility and access of NAP data, particularly at the facility and provincial levels.
- It was envisioned to create a routine integrated HIV information system (RIHIS) which could provide a holistic picture of prevention (community and facility based), care, treatment and social support. In 2010 and 2011, the NAMc developed a RIHIS system, manual and curriculum and trained staff at the regional, provincial levels, including civil society groups, particularly those working on HIV prevention.

- **Surveys and Surveillance**

In 2010 the Bureau of Epidemiology (BoE) expanded the coverage of the IBBS among MSM from three to 12 provinces. The BoE also initiated an IBBS among PWID using the RDS method, to understand the epidemic among PWID and conducted an IBBS among migrant workers in 10 provinces.

Under the Global Fund grant, the IBBS for FSW, MSM, PWID and migrant workers was conducted in 2010 and considered to be baseline for monitoring the HIV prevalence and behaviour every two years.

- **Evaluation, special studies and research**

Thailand successfully implemented several evaluations and research studies in 2010 and 2011. These are summarized below.

- The Network Scale-Up method was applied to estimate the size of the KAPs. Thailand continued this effort by establishing a technical working group to undertake synthesis and verify findings, and provided recommendations on KAP size estimation for each population at the end of 2011. This information is critical to programme planning and the national response programme.
- Evaluation mapping was conducted in 2010 and provided critical inputs to setting the national evaluation agenda for HIV/AIDS.
- In mid 2010, a national evaluation agenda for HIV/AIDS was developed and seven priority evaluation questions were proposed through a national consensus workshop. In 2011, Thailand established a National Evaluation Task Force as a national mechanism to manage the implementation of evaluations, ensure technical quality and data use for decision making. As of December 2011, five evaluations had been put in place with secured funding of USD 1.2 million.

- **Data use for decision making and improving programme implementation**

A number of data use tools were developed to promote effective use of facility based data on treatment and care, HCT and STI programmes, namely HIVQUAL, HCTQUAL, STIQUAL and the paediatric quality care model. With support from the NHSO, BATS has built capacity for relevant staff to implement these tools nationwide. Community based implementing agencies are in the early phase in developing a data use model for frontline staff, such as outreach workers and peer educators.

## **(B) CHALLENGES IN THE IMPLEMENTATION OF A COMPREHENSIVE M&E SYSTEM and PLANNED REMEDIAL ACTIONS**

The recommended spending on M&E as a proportion of total AIDS expenditure is between 5 and 7 per cent, in order to ensure a functional M&E system. In recent years M&E has been recognized as a critical component that Thailand needs to pay greater attention and extensive efforts. However, a NASA report revealed that in 2008 and 2009, investment in M&E was less than one percent of total AIDS expenditure. During the reporting period (2010-2011) there was very little improvement in country investment on M&E. Strong leadership from health and non-health government organizations and individual as well institutional capacity is a critical challenge that Thailand faces in the implementation of a comprehensive M&E system.

**Table 15: Investment in M&E and basic research in Thailand, 2008-2011**

Expenditures	2008		2009		2010		2011	
	mil. THB	%						
Total AIDS expenditure	6,928		7,208		7,733		9,922	
M&E	50	0.7	67	0.9	69	0.9	131	1.3
Basic Research (excluding operational research)	156	2.3	49	0.7	324	4.2	377	3.8

A high priority in the coming years is to implement SI and M&E activities according to the 2012-2016 plan. Thailand should also be more strategic on investment in high priority SI and M&E activities. Recommended actions are described below.

- Support SI and M&E of activities related to reducing new infections, reducing deaths, promoting counselling and testing, upholding human rights, reducing stigma and discrimination, and raising awareness of gender-based issues including gender-based violence.
- Give priority to strengthening routine integrated HIV information systems among KAPs.
- Enhance existing surveys and surveillance systems and develop new tools to measure changes in attitudes related to stigma and discrimination.
- Improve the availability and quality of HIV evaluation, economic studies and research as part of an integrated package of new generation strategic information.

- Strengthen key organizations that will implement SI activities and the M&E system in order to build a holistic picture of the epidemic and response at the national and sub-national levels.
- Support data use for decision making through development and implementation of data use tools such as HIVQUAL, STIQUAL, HCTQUAL and others to link data with service and programme performance, and to generate “localized” strategic information in the 31 priority provinces.
- Recruit additional technical SI and M&E staff and/or embed M&E technical officers in key organizations.
- Strengthen human and institutional capacity through formal and on-the-job SI and M&E training to bring about more effective and efficient implementation according to the national SI and M&E plan.



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