The information, conclusions and recommendations contained herein are those of the Review Team and do not necessarily reflect the views of the Agencies or Institutions who delegated staff to this Review.
The review team members would like to express their gratitude to the staff of the AIDS cluster and the Center for AIDS Prevention and Problem Alleviation Administration of the Bureau of AIDS, TB and STI, for the organization and the logistics of the review. We are grateful to all persons we met for their time, their availability and for the sharing of the information.

“We are living in the AIDS era. There is no doubt that history will record our response. There is no time for complacency; no time to rest on our laurels. It would be a crime to let HIV continue to spread, while we already know how to interrupt it. It would be an even greater crime to let people suffer from AIDS, without access to treatment, while effective medicine is readily available”.

His Excellency Thaksin Shinawatra, Prime Minister of Thailand at the Opening Ceremony of the XV International AIDS Conference, Bangkok, 11 July 2004.
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<td>AIDS</td>
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<td>ANC</td>
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1 Executive Summary

An International Review Team commissioned jointly by the Ministry of Public Health (MoPH) of the Royal Thai Government and the World Health Organization (WHO) conducted an assessment of the performances of the national health sector response to HIV/AIDS. It found that one of the important features of this response was to have succeeded in scaling up initial projects which were geographically limited and narrowly focused to the level of national initiatives which benefited from strong political commitment, dynamic management, dedicated human resources, multiple alliances between formal and non-formal sectors, significant funding and prominent role played by an ever-growing number and diversity of non-governmental and community-based organizations. Building on an initial emphasis on prevention, access to antiretroviral therapy is now expanding with great rapidity. The team concluded that the national goal of treating 80,000 persons by the end of 2005 was achievable.

The first case of AIDS in Thailand was diagnosed in 1984. Since its inception in 1987 the National AIDS Control Programme (NACP) has achieved great strides, accumulated a vast experience and served as a source of learning and inspiration to a large and growing number of countries around the world.

The combined prevention and care response has generated considerable dividends: the spread of HIV has slowed significantly in most communities; behaviors have responded well to aggressive information, education and access to services, condoms and support; although persisting, the stigma initially attached to HIV/AIDS is gradually receding and the public discourse around sexuality and sexual health more open.

Thailand has already lost more than 551,000 of its young people to AIDS. Every life that can be saved through appropriate treatment among the 540,000 people who currently live with HIV infection in the country counts. The expanding access to antiretroviral medicines and the mobilization of financial and human resources on a large and growing scale, both in the formal sector and within civil society, are considerably beneficial to people living with HIV as well as their families, communities and the Nation as a whole. The prevention of perinatal transmission of HIV is now being implemented with great success throughout the country.

HIV transmission fell rapidly in the 1990s as a result of the strong focus on prevention. It has been estimated that over 5.7 million HIV infections have been averted thus far through effective prevention. In spite of these efforts, however, in 2004, about 17,000 people in Thailand were newly
infected with HIV. Although this figure is lower than in previous years, there are signs that the HIV epidemic is threatening to rebound:

- The annual number of new infections is no longer declining as rapidly as it did in the last decade;
- One-third to half of the new HIV infections this year will be among women who are in a stable relationship who will become infected sexually by their spouse or regular partner;
- Adolescent boys and girls engage more frequently in risk behaviors which expose them to HIV infection than their peers a few years ago;
- The achievements of the 100% condom programme are being challenged by an insufficient outreach effort to sex workers (SW), the changing profile of sex work in Thailand, and inadequate condom supplies;
- There are signs of increased risk of HIV infection among men having sex with men (MSM), transgender, and other marginalized populations, including minorities, immigrants and their dependents, prisoners and drug users;
- There is a rise in certain sexually transmitted infections (STI) as a result of relocating diagnosis and treatment clinics to hospitals which sex workers are reluctant to attend, lowering adherence to safer sex practices, and insufficient supplies of condoms.

The International Review team presented a series of findings and recommendations as well as specific suggestions for further consideration and action to the Ministry of Public Health, Thailand. These were divided into five major programme areas: (1) status and trends of the HIV and related epidemics (2) policy, structures and programmes (3) prevention (4) care and treatment and (5) monitoring and evaluation (M&E).

**Moving forward**

In two decades of innovations and hard work, Thailand has accomplished great progress towards bringing the spread of HIV under control and mitigating its impact on individuals infected and affected by the epidemic. No praise is enough for those who, over the years, have devoted and often sacrificed their personal and professional life to this powerful movement which has mobilized people, communities and the nation as a whole. Today, the results of this effort speak for themselves in terms of both the number of HIV infections averted through well targeted prevention and years of healthy life saved by making treatment increasingly available. Importantly, these results have created a sense of confidence, both within Thailand and abroad, that the HIV/AIDS epidemic can be overcome when leadership, science, social mobilization and resources are brought to bear all at once.
The national response to HIV is now confronting several changed realities to which it must rapidly adjust:

- There are clear signs that the epidemic is pursuing its course, unabated, in communities such as some sex work populations that have not been or are no longer being reached by prevention approaches suited to their needs. It threatens to regain momentum in other communities, where complacency has set in - among young people in particular. It appears to be on the rise in other populations such as MSM and it has become harder to track in communities driven underground such as injecting drug users (IDUs).

- The urgent scaling up of access to treatment, while essential, is overshadowing the critical importance of enhancing prevention simultaneously with care.

- There is a general feeling that the response to HIV has moved from a people centered approach to a patient centered approach, drifting away from the mobilization of forces within society that can be marshaled to prevent HIV spread to a more clinical focus on HIV infection once it has set in.

The current and planned investments in care are highly commendable and should be further expanded to best respond to the growing demand. This investment in health and survival makes sense in both human and economic terms. Yet, the movement which has led to behavior change and the gradual although incomplete decline of stigma attached to HIV needs to be revitalized. Every HIV infection prevented alleviates much suffering and is a source of savings on future costly medical interventions.

There are great opportunities to revitalize the response to the epidemic in the current context of Thailand:

- Under the leadership of Government, the expressed national commitment to this developmental priority should return HIV to the center of the public debate.

- The political and administrative decentralization under way should bring HIV work closer to the people, with a systematic capacity building on local level while the Center retains key enabling, supervisory and research functions and operates monitoring and early warning systems needed to detect any breakdown in services as the devolution of responsibilities to the periphery unfolds.

- The health reform should specifically take HIV into account and ensure that both prevention and access to care are equally accessible by all, regardless of their economic or legal status, and free of cost or fully covered by existing user fees when they can be afforded by those seeking services.

- Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement
schemes, local production, pressure on domestic and international prices and where necessary the application of safeguards embodied in international trade agreements.

- Prevention and social support need to be more prominent and be closely linked to care as access to treatment further expands according to existing plans.
- A reinforced focus of prevention should be on young people and on people who are married to, or in a sustained relationship with, HIV-infected partners.
- Prevention strategies must adapt to the evolving patterns of HIV risk behaviors and situations such as those inherent to sex work involving women, men and their clients, men having sex with men, drug users and minority groups such as border populations, as well as legal and illegal migrants both for their own sake and the sake of the public health of the nation.
- The use of knowledge acquired through research should be systematically applied to developing HIV/AIDS policies and strategies which, in turn, should inform the research agenda, particularly in the field of social, behavioral, health system and intervention-based research.
- Civil society, in particular non-governmental and community based organizations, need to be more effectively supported and financed from national and local sources, and local authorities should be strongly encouraged and rapidly given the capacity to do so.
- The response to HIV should work further towards incorporating human rights principles enshrined in the National Constitution and judicial provisions, mechanisms and instruments should be put in place to achieve this goal.

Granted high level of political commitment in Thailand, the exemplary capacities of the staff of the health service and the readiness of civil society these opportunities can serve as a stepping stone to carry forward a people-centered response to the epidemic and current challenges can be met with confidence.
INTRODUCTION

The Thailand National AIDS Control Programme is approaching its 20th birthday. Since its inception in 1987 it has achieved great strides, has accumulated a vast experience and has served as a source of learning and inspiration to a large and growing number of countries around the world. One of its unique features is to have succeeded in scaling up its response to HIV/AIDS from initial projects which were geographically limited and narrowly focused to national initiatives which benefited from strong political commitment, dynamic management, dedicated human resources, multiple alliances between formal and non-formal sectors, significant funding and prominent role played by an ever-growing number and diversity of non governmental organizations (NGOs) and communities based organizations (CBOs). This response has generated considerable dividends: over time, its impact on the spread of HIV within and from different communities became increasingly felt and in many cases measurable; behaviors responded well to aggressive information, education and access to services, commodities and support; the stigma initially attached HIV/AIDS began to recede and the public discourse around sexuality and sexual health gradually opened. By the late-1990s, there were clear signs that, granted a full-fledged access to the newly available antiretroviral treatment combined with a sustained or growing HIV/AIDS prevention efforts, the weakening epidemics could be brought under firm control and their impact considerably reduced in a foreseeable future.

As in any other country, the HIV/AIDS situation in Thailand has been and continues to be influenced by the political, economic and social context in which it evolves. The introductory chapter of the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand, 2002-2006 (part of which is adapted from the Ninth National Economic and Social Development Plan), projects the vision of a nation undergoing a cultural, social, political and economic transformation which creates new vulnerabilities and new opportunities with regards to HIV/AIDS. Three elements of this narrative are particularly relevant to this review: (1) the need to avoid complacency in the face of continued spread and predictable impact of HIV; (2) the reference to specific societal factors deemed to undermine community cohesiveness and capacity and exacerbate poverty and ill-health; and (3) the structural transformation which, in line with the 1997 Constitution, provides for the transfer of authority and resources from central to local political and administrative levels. The 2002-2006 National HIV/AIDS Plan spells out goals, targets and strategies which emphasize the participation of individuals, families and communities in HIV/AIDS prevention and alleviation; the support to be extended to them by health and social welfare services; the development of knowledge and research; international cooperation; and integrated management of HIV/AIDS prevention and care. The present review report will be guided by these key programme elements intended to translate the “holistic, people-centered development approach” of the Ninth National and Economic Development Plan into coordinated and sustained HIV/AIDS-related action.
The 1997 Constitution contains several provisions highly relevant to HIV/AIDS with regards to the protection of human dignity, rights and liberty, equality of men and women, non-discrimination, the right to protect one’s reputation and privacy. As importantly, it establishes health as a human right to be protected by the State. Followed a heath care reform which, among other measures, created equal entitlements to health under a Universal Coverage Scheme (UCS) through a combination of three insurance and cost-recovery systems. Started in 2002, the UCS provides for access by any Thai citizen to comprehensive care against an out-of-pocket payment of a 30-Baht fee per visit. As antiretroviral therapy (ART) was being introduced and promptly scaled up in Thailand, the capacity of the new scheme to cover the cost of quality ART in an equitable, comprehensive and sustainable fashion began to raise serious doubts.

In summary, the National HIV/AIDS Programme is currently undergoing a dual transition: a political/administrative decentralization and a health system reform. Either or both can create new opportunities for greater impact on HIV/AIDS or generate complexities and gaps which may affect the coverage and quality of prevention and care.

Against this backdrop, the Royal Government of Thailand sought the cooperation of the World Health Organization in order to conduct an independent, external review of the progress achieved and constraints experienced by the health sector response to HIV/AIDS in the country. Such review took place in 1990 and again in 1991. Since that time, numerous internal assessments, operational, technical and managerial guidelines as well as formal and informal meeting reports and research papers have been published on a wide variety of topics related to HIV/AIDS in Thailand.

The present review drew a large amount of quality information from these documents, in particular from those produced since the launching of the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand, 2002-2006. This information was complemented by findings from face-to-face exchanges of views with People living with HIV and other key actors in the response to HIV/AIDS and by visits to institutions and community-based projects both in Bangkok and in four regions of the country. While the review was not designed so as to include systematic primary data collection during site visits, it provided multiple opportunities for reviewers to appraise and complement the information on record and build their conclusions and recommendations on the strongest available evidence.

It is hoped that the conclusions and recommendations arising from the present review will both help learn from the ongoing national health-sector response to HIV/AIDS and inform the next National HIV/AIDS Plan, covering the period 2007-2011, now under preparation.
3 THE STATUS AND TRENDS OF THE HIV AND RELATED EPIDEMICS

Thailand is among the few countries in the world to have turned around a rapidly escalating generalised epidemic. The first AIDS case was reported in 1984. Initially concentrated in IDUs, the epidemic spread among female sex workers and their clients, and from there to widespread heterosexual transmission within the general population. The multisectoral response was rapid and effective, however, and overall HIV transmission has dramatically declined. Among pregnant women, HIV prevalence peaked in the mid-1990s with a national median at 2.3% in 1995 declining progressively to 1% in 2004. Reported AIDS cases in men and women peaked in the late-1990s before consistently declining. According to the Thai Working Group on HIV/AIDS Projection, the number of new HIV infections was estimated at 17,000 in 2004 compared to an estimated 143,000 new infections in 1991. It has been estimated that over 5.7 million HIV infections have been averted thus far through effective prevention.

The Thai Working Group on HIV/AIDS Projection also estimates the cumulative number of people infected with HIV in Thailand since the beginning of the epidemic until 2005 at 1,092,327, including 551,505 who died and 540,822 currently living with HIV or AIDS. As of June 2005, 362,768 AIDS or symptomatic cases have been reported to the MoPH including 86,923 death cases. The actual number of children affected by HIV/AIDS is unknown. However it is estimated that there are currently over 500,000 (that is, one or more parents are HIV positive or living or have died of AIDS) including some 380,000 children who have lost at least one parent to AIDS, and, 30,000 double orphans (children who have lost both parents to AIDS). The incidence of orphans is expected to fall significantly due to increased access of parents to ARVs.

Among female direct and indirect sex workers, male sex workers, male conscripts and males attending STI clinics, HIV sero-surveillance showed a constant and progressive decline in HIV prevalence since the mid-1990s. However, HIV prevalence among IDUs in treatment centers has gradually increased to exceed 50%. Limited surveys among MSM point to increasing transmission with a prevalence of 17.3% measured in 2003 in Bangkok. In addition, there are consistent reports of increases in risk behaviours that might affect patterns of transmission and dynamics of the epidemic. A shift from direct to indirect sex work, as well as to sex work outside establishments, both incompletely reached by prevention programmes, have been documented. As a consequence, definitions and strategies for direct and indirect sex workers vary over time and across sites. A recent rise in STIs was reported following closure of STI clinics. STI care is increasingly integrated into primary care units (PCU), raising questions about the quality of prevention interventions and reliability of STI reporting as an early warning system for sexual transmission. The use of condoms with sex workers reported by male conscripts and factory workers has remained stable at around 60% since 1995, whereas female direct sex workers continue to report over 90% condom use.
These differences in reported rates may indicate lower condom use in less easy to reach groups of indirect sex workers and may also reflect some reporting bias.

Apart from high risk behaviours, HIV transmission among spouses of HIV-infected men is expected to account for 30% to 50% of new infections in Thailand this year, according to the Asian Epidemic Model. Behavioural data show that young people engage more often and earlier in sex whereas their use of condoms remains low despite slight increases in recent years. Mother-to-child transmission has been dramatically reduced due to universal access to ARV prophylaxis. In 2001-2002, national perinatal HIV outcome monitoring identified that 5.4% children born to HIV+ mothers have been HIV infected and 3.0% died before being tested for HIV.

Thailand has implemented since early in its epidemic an exemplary surveillance system; based on HIV sentinel sero-surveillance and behavioural surveys, national STI and AIDS case reporting, it is complemented since 2004 by HIV incidence surveillance using new diagnostic methods. HIV serosurveillance is conducted every year in each province targeting 8 populations: pregnant women attending ANC, direct and indirect female sex workers, male sex workers, injecting drug users, blood donors, males attending STI clinics and military recruits. Behavioural surveys are conducted every year in 2 provinces per region targeting male and female students, male and female factory workers, military recruits, women attending ANC and since 2004, the general population. These invaluable sources of information appear to be incompletely disseminated and utilized in identifying needs and planning the response at different levels. Despite worrisome trends, surveillance among IDUs is not systematically conducted in all provinces and no data are available outside rehabilitation centers. Data on sex workers are incomplete outside establishments. Sparse information is available concerning MSM and male prisoners.

Although it is unlikely that the spread of HIV in Thailand will ever rise again to the levels observed in the mid-1990s, there are signs that the country may be at risk of a rebounding epidemic:

- The annual number of new infections is no longer declining as rapidly as it did in the last decade;
- One-third to one-half of the new HIV infections this year will be among women who are in a stable relationship who will become infected sexually by their spouse or regular partner;
- Adolescent boys and girls engage more frequently in risk behaviors which expose them to HIV infection than their peers a few years ago;
- The achievements of the 100% condom programme are being challenged by an insufficient outreach efforts to sex workers, the changing profile of sex work in Thailand, and inadequate condom supplies;
• There are signs of increased risk of HIV infection among men having sex with men, transgender, and other marginalized populations, including minorities, immigrants and their dependents, prisoners and drug users;

• There is a rise in certain sexually transmitted infections as a result of relocating diagnosis and treatment clinics to hospitals which sex workers are reluctant to attend, lowering adherence to safer sex practices, and insufficient supplies of condoms.

❖ Recommendations

1. HIV surveillance should be strengthened by identifying the gaps in information on current patterns of HIV transmission in IDUs, MSM, sex workers outside establishments, prisoners and other vulnerable population (migrants, mobile populations), while upholding ethics and human rights;

2. Bureau of AIDS, TB and STIs (BATS) support to standardize STI surveillance is needed to maintain an early warning system for increasing sexual transmission;

3. The information produced by the surveillance system on the pattern of HIV transmission needs to be more systematically shared and used in driving a comprehensive multisectoral response appropriate to Thailand’s epidemiological transition; and

4. The development of human capacity at hospital and provincial levels is a critical need to increase the quality of surveillance.
4  **POLICY, STRUCTURES AND PROGRAMMES**

4.1  **Budget and Finances**

Total government funding for the AIDS programme increased from 1.44 to 1.6 billion Baht during the period 1999 to 2005. The largest share of the AIDS budget in 2005 (75%) financed treatment and care, including ARV and drugs for OI, HIV testing and social welfare for people living with HIV/AIDS (PHIVs). Programmes to prevent the spread of epidemic accounted for only 15% of the budget, covering public information, condom promotion (including condom supply), prevention of mother–to-child transmission (excluding ARVs) and other community prevention activities. An additional 70 million was distributed to NGOs for community level AIDS prevention and care activities. Grant funding for NGOs remained constant from 2001 to 2005, although it is anticipated that the grants for NGOs may be reduced to 50 million Baht in 2006. However, the perception of many NGOs is that the level of funding to NGOs has consistently reduced in recent years and that funding doesn’t always reach NGOs, PHIV groups and other community based organisations. The slow disbursement of funds from national to provincial to district level is also of concern.

Twelve other ministries apart from Ministry of Public Health received funding according to their workplans. In the last few years, the amount of funds allocated to each ministry was mostly at a constant amount except for the Ministry of Interior where its AIDS budget increased from 31 million in 2002 to 67 million in 2005 for their work on empowerment of families and communities. In addition, 50 million Baht is distributed annually from BATS to other ministries for prevention activities. The Global Fund for AIDS, TB and Malaria (GFATM) is also providing some USD 192 million over a five year period (2003-2007) for HIV/AIDS activities.

Apart from GFATM there are many additional external agencies also funding different programmes and this information is difficult to compile in one place. It is important that research be strengthened to provide more information on the situation of international funding of HIV/AIDS activities in Thailand, on domestic expenditures and on the prioritisation of specific programmes such as prevention in terms of overall financial allocations. The National AIDS Account (NAA) started in 1994 in partnership between the National Economic and Social Development Board (NESDB) and the International Health Policy Program (IHPP). For the period 2000 to 2003, it tracked the total HIV/AIDS expenditures from multisectoral public, private, household and external sources, based on secondary data or if not available on price/quantity estimates. The total expenditures on HIV/AIDS for 2003 was estimated at 4,479 million Baht increasing from 3,141 million Baht in 2000. In 2003, the public sector accounted for 60% of the total expenditures and households for 21%. This important contribution of households was in part due to the ART regimens “not covered by the
The national scheme” including 2\textsuperscript{nd} line regimen. The 2 main components were ART (45.6\%) and treatment for OI (32.8\%). The NAA concluded on the need for additional investments in HIV prevention services. Thailand is in the process to support other countries in the Region to develop NAA. Information on economic evaluation, such as cost-effectiveness of programmes, is not available for most interventions (except ART 1\textsuperscript{st} line regimen) and more research in this area is urgently needed.

4.2 Effect of Health Care Reform

Health care reform was long recognized as essential to the transformation of Thailand’s health service system to enable equal coverage of the entire population. The promulgation of the 1997 constitution brought the necessary changes in the socio-political infrastructure for this to take place. As a consequence, with the election of the current government in 2001, the promotion of Thai citizens’ rights to access basic health services and the popular “30 Baht scheme” policy became a priority. Public sector reform, decentralization of central authority and the restructuring of the Ministry of Public Health has been undertaken in accordance with the constitutional mandate with important consequences for the HIV/AIDS response at the national, provincial and local levels.

4.2.1 Decentralization

Decentralization presents a great opportunity to bring HIV programmes closer to people but also brings a risk that the response may become fragmented. While the results of decentralization may be greater ownership of programmes, more locally adapted responses and greater accountability, local capacity has to be ready to take over key responsibilities, including funding, resources, priority awarded to HIV relative to other issues, coordination of local initiatives, and linkages between HIV and other local priorities.

With decentralization, provinces will assume an increased responsibility for management of the HIV/AIDS response. While some provinces have already developed the necessary structures and skills to cope with this change, there is a concern that many provinces do not have the required capacity to do so and are not fully prepared to fulfill their new roles. Some provincial and district health authorities have demonstrated their capacity to manage change. However there is unclear commitment from some Governors and local authorities; many Provincial AIDS Committees are well established but weak in actual implementation; there is a lack of clarity about funding from provincial level as national funding declines; competencies and human resources are limited, with many officials having to perform multiple tasks. It remains to be seen whether HIV/AIDS networks at the regional and provincial level will be able to sustain their activities and continue to play a crucial role in coordinating and cooperating in the HIV/AIDS prevention and control program.
One of the key steps to ensure that decentralization does not weaken the HIV/AIDS response is to maintain the high profile of HIV on the national agenda and secure the engagement of all sectors of government, nationally and locally. The National AIDS Committee (NAC) has a key role in achieving this, but its visibility, credibility and efficiency requires high-level political commitment, including the Prime Minister’s personal involvement in chairing the committee, thereby encouraging high-level participation from all ministries.

In addition, there will need to be a repositioning of BATS in its role as the central structure in the management of the response. Decentralization will most likely result in a weakening of the capacity of the Bureau, through limited human resources, a declining budget, and increasing reporting burden for BATS. However, it is important that BATS be supplied with the necessary means to ensure that it is equipped to fulfill its redefined role, including norm setting, monitoring and surveillance (early warning), epidemiological and operational research, strengthening local capacity (training and supportive visits) and ensuring close linkages between policy, programme and research.

Based on this scenario, the role of BATS will change to that of a facilitator which will enable sharing of its experience and knowledge among regional, provincial and local authorities. BATS’ existing role of directing strategic themes may not be compatible with envisaged processes conducted at the provincial level. However, regional and provincial health administrators will still need BATS to provide governors with standard guidelines and indicators for technical procedures covering allocation of budget for AIDS at the provincial and district levels. These would enable provincial health authorities to request appropriate allocation of provincial and local government budgets.

Under the restructuring process, the Ministry of Public Health has shifted its mission from being the main health care provider to the role of national health strategic implementation. Consequently, the Department of Disease Control (DDC) has had to change its role from that of vertical program manager to the new mission of strategic manager, through technical leadership. The role and function of national, regional, provincial and local level government agencies in HIV/AIDS management and care has been adjusted to meet the new mission. At the same time the National Health Security Office’s policy of making health care accessible to the Thai population has also resulted in restructuring and functional reorientation of the health care system which has affected its effectiveness.

4.2.2 The 30 Baht Scheme and Health Service Restructuring

From 2002 the Health Security Office was appointed as collective purchaser of health services covering more than 40 million constituents. As a result, by 2004 the accessibility to care for Thais
increased from around 75 percent to 95 percent. The per capita budget allocation increased from 700 Baht in 2001 to 1,396 Baht in 2005, and will rise further to 1,650 Baht in 2006. The budget for National Health Security includes services for the individual and families covering disease prevention, health promotion, therapeutic care and rehabilitation. The service purchasing criterion is designed to be an incentive for the health care provider to deliver service with quality, efficiency and equity. Budget is allocated to Primary Care Units (PCU) for the areas of prevention and care, ambulatory care, in-patient care, emergency care and catastrophic illness. The purchasing criteria under the scheme are under development and an increasing number of health services are being included. While the National Health Security Office is revising guidelines for care and financing, accompanying changes in management might adversely impact on some vertical programs such as HIV/AIDS as these are integrated into the health care system.

The challenges which the reform process have posed to the health care system may be best exemplified in relation to the TB and STI prevention and control program which was integrated into the changing infrastructure over the last few years (see Annex).

4.2.2.1 Resource Allocation and the 30 Baht Scheme

The payment mechanism of the 30 Baht scheme encourages hospitals to reduce treatment costs, with potential implications for the quality of care. The current capitation fee is 1396 Baht with a patient contribution of 30 Baht per consultation. Of this, 210 Baht is supposed to be dedicated to prevention budgets. Due to cost of treatment over-runs, the funds allocated for prevention are often used by health care facilities for care and cure instead.

The allocation of prevention funds to district level assumes that information, education, communication (IEC) materials can be developed at local health care facility level. However, there are major economies of scale in the production of IEC materials and it is not financially viable to develop and print a small number of copies of a poster at hospital level. Posters, leaflets and radio spots on CD for community radio require a central level budget and production in large-scale print runs.

In capitation systems, careful strategic planning is necessary to ensure the health needs of the population are met. Examples of potential gaps include interruptions and shortages in the supply of condoms for sex workers, shortages of funds for community based programmes such as village health worker and support to people living with AIDS and their families including affected children.
4.2.2.2 Registration and Social Exclusion

Hospital reimbursement takes place only for people registered in a locality. Some catchment areas include large numbers of unregistered migrant workers. Internal migrants are often reluctant to register locally. International migrants may sometimes not be allowed to. In these cases, hospitals are forced into out-of-pocket expenditures and partial coverage of these deprived populations.

4.3 Human Rights

Ever since its inception, the NACP incorporated human rights principles of non-discrimination, equality and protection of dignity in its plans and guidelines. As a result of ignorance, fear and stigma, however, instances of discrimination against PHIV on the workplace, at school and within health facilities were reported by community based organizations and the media. The 1997 Constitution, the Health Security Act (2002) and the State’s Information Act (1997) embody provisions for protection of human rights and dignity, in particular against discrimination. More recently, the Ministry of Labour produced a Code of Practice on the Prevention and Management of HIV/AIDS in the Establishment (January 2005) applying to all employers and employees, including job applicants in the public and private sectors, in all types of establishment both formal and informal. The document encourages all such establishments to develop appropriate policy and plans of action on a voluntary basis. To contribute to the adoption and implementation of sound policies and practices on HIV/AIDS in the workplace, the Thai Business Coalition on AIDS (TBCA) issued the AIDS-response Standard Organization (ASO), an instrument applied to the assessment of compliance of establishments with key principles laid out in the Code of Practice. Although not mentioning HIV/AIDS specifically, the Penal Code contains provisions concerning privacy and libel. The Medical Council’s Regulation on Professional Medical Ethics (1983) contains clauses on the protection of confidentiality in the relationship between individuals and care providers, complemented by specific Guidelines on AIDS for Medical Doctors (2002).

In the course of the review, the Review Team sought from governmental and non-governmental organizations information on any knowledge they would have of cases of human rights violations related to HIV/AIDS. The Team was told that the frequency of such violations—in particular discrimination on the basis of HIV status—had been high in the early stage of the epidemic but had gradually declined as a result of information and education. The Center for AIDS Rights (CAR), an NGO focused on the promotion of human rights through information and capacity building sees the role of PHIV not only as promoters of human rights in the context of HIV/AIDS but also in relation to any violation that may occur within their community.
A recent study (Sringernyuang L, Thaweesit S, Nakapiew S, personal communication, 2005) reviewed the situation of HIV-AIDS related discrimination in Bangkok. The study concluded that human rights violations continued to occur in the health care setting, in particular with regards to such practices as refusal to treat or different treatment on grounds of HIV/AIDS status; testing without knowledge and breaches of confidentiality.

In recent years, there have been documented instances of discrimination on the basis of HIV status in settings outside the health sector. Children with HIV were denied entry to primary school, employees were summarily dismissed, HIV tests were performed at the request of prospective employers on job applicants. These instances were resolved through negotiations, occasionally supported by NGOs, but no case has thus far been brought to court.

Overall, NGOs felt that in Thailand, HIV-related human rights policies and guidelines were sound but lacked explicit legal backing and were not uniformly understood and practiced at the local level.

### 4.4 NGOs, CBOs and PHIVs.

Since the mid 1990s there has been significant growth in the number of NGOs and CBOs (including people living with HIV/AIDS groups). At present there are over 500 NGOs working in HIV/AIDS and over 800 PHIV groups. These organizations have established strong networks at the regional and national level, with representation on key bodies responsible for policy and planning.

Initially most NGOs were engaged in prevention however their role evolved naturally towards care and support and, until recently, the activities of most NGOs have generally included a combination of prevention, care and support. At present, however, it appears that NGOs are less engaged in prevention, with an increased shift towards care. The reasons for this shift are complex, but are mainly because (1) care is time consuming but more urgent and visibly rewarding; (2) available external funding is increasingly targeted to care and support (3) concerns that the overall amount of national money available to NGOs has been reduced; and (4) recent changes in disbursement of funds from the MOPH, with monthly financial reporting, imposes an excessive burden. Given this situation, preventive work, which is generally seen as a more flexible, though still important, activity, is the first to be dropped.

A further trend, seen particularly among NGOs working with young people, is for the evolution of more comprehensive approaches, addressing other issues in addition to HIV/AIDS. This appears to be generally consistent with the particular social and economic context, for example in areas where drug use is high demand reduction may be a priority, and similarly where unemployment is a priority among young people, the main focus may be on occupational development, rather than directly on...
HIV/AIDS. In Muslim communities in the far South, currently affected by civil unrest, HIV/AIDS life skills education for young people may need to be combined with skills on conflict resolution. This is a good and natural progression and can help ensure sustainability of HIV/AIDS responses.

NGOs, CBOs and the PHIV network are in an ideal position to reach the most hard to reach, vulnerable groups (IDU, MSM, migrants, non-registered populations, youth, street-based sex workers and discordant couples) but require flexibility in funding “tailored” technical support (including targeted IEC materials) and “light” reporting to allow for innovative approaches to these vulnerable groups.

4.5 Private Sector

With a few notable exceptions, the private sector has been slow to become engaged in HIV/AIDS. Despite the relative prosperity of some companies and individuals, Thailand has not yet seen the emergence of generous wealthy private sector donors such as those in Western countries. The Thai business ‘consciuosness’ on donating funds is different and may require a different approach. Nevertheless, many companies and individuals have contributed to the HIV response. The TBCA has been an important catalyst in mobilizing the involvement of the private sector, and development of AIDS in the workplace initiatives, including promotion of HIV standards among employers. The private health sector, has also recently become engaged, in cooperation with the Ministry of Labour (MOL), TBCA and ILO, in development of health care coverage for workers and the AIDS Standards organization (ASO).

Private hospitals supply a significant number of PHIV with treatment and care but there remain concerns about the comprehensiveness of service supplied by some of these hospitals.

4.6 Other Government Agencies

For sectors outside health, government agencies such as Ministry of Labour, Ministry of Education, Ministry of Defence, and Ministry of Social Welfare (now the Ministry of Social Development and Human Security) were initially not engaged in the HIV/AIDS response. However, all became engaged when funds were allocated from the Prime Minister’s office but have been less forthcoming in providing funding from their own budgets and developing specific HIV/AIDS strategies and work plans as an integral part of their ministry’s work. Now these ministries appear to be largely dependent on the limited funding available from BATS. Despite these constraints, some agencies appear highly committed, and there are examples of useful contributions, such as the MOL’s promotion of the Code of Practice for HIV in the workplace.
One important issue which needs to be addressed is the inconsistency of policies between different ministries. This is particularly relevant in the area of the law. For example the use of condoms by police as evidence of commercial sex is at odds with the condom promotion by MOPH for sex workers. Information from consultations suggests that this practice may also discourage condom use for prevention amongst young people as well as restrict the condom distribution activities of outreach workers. Inconsistencies can also be seen in the area of administration, such as in the Ministry of Finance’s use of a monthly disbursement system for release of small grants payment to NGOs and community organizations, which greatly increases the administrative burden on both recipients and the MOPH.

International Cooperation

Many international agencies have cooperated with Thailand in the HIV/AIDS response. These include organizations within the UN system, the Global Fund for AIDS, TB and Malaria (GFATM), bilateral agencies, research institutes and INGOs. The technical and financial support from these agencies has made an important contribution. However differences in administrative requirements, such as reporting formats, have presented challenges. The reporting requirements of GFATM, in particular, were reported as being a heavy burden.

Many international donors have reduced bilateral funding support to Thailand in recent years and these funds are increasingly targeted at treatment and care rather than prevention. Moreover funds for prevention activities from international donors in some cases may not be available for NGOs that do not commit themselves to the ABC concept (Abstinence, Be faithful, use Condoms). This is part of a pattern which has seen HIV/AIDS work in Thailand being increasingly influenced by international political agendas.

In addition to traditional questions of sustainability, changing political agendas within Thailand have recently increased ambiguities around the role of international resources. The picture has been further complicated by decentralization, which raises questions about how international cooperation will function.

Thailand is now also playing an important international role in the global HIV/AIDS response. Based on the valuable experience and lessons learned from her HIV/AIDS programme, Thailand has contributed in some key areas, including:

- Sharing its HIV/AIDS experience with others through South-South cooperation such as workshops and study visits, technical support in developing NAA in neighbouring countries;
- Commitment of US$ 1million for 5 consecutive years to GFATM;
- Extension of direct bilateral assistance to neighboring countries.
However, the view that Thailand is a success story has led to a certain level of complacency in the response to HIV/AIDS.

### 4.7 Knowledge Management

As a result of the HIV/AIDS response there is now a huge body of knowledge and expertise in Thailand. It is important that there are structures in place to enable sharing of this knowledge and expertise, in order to promote coordination, learning and development of more effective approaches. Regional-level lessons-learned forums have been held on an ad hoc basis, for example in the Upper North and Region 5 in the Northeast. In addition the national bi-annual AIDS Seminar provides an important platform for sharing of knowledge. However, in order to ensure the maximum benefit is derived from such forums it is important that civil society and Government agencies participate as equal partners in planning and organization of forums - owing to a feeling that the content of this year’s National Seminar was over-driven by specific agendas, civil society is planning an additional forum in November 2005.

**Recommendations**

1. The place of HIV/AIDS within the national agenda needs to be strengthened by revitalizing the role of the NAC and ensuring that it receives once again continuously attention by its chair, the Prime Minister so as to generate the highest level of interest and commitment by its members;

2. Mechanisms need to be put in place to ensure total government HIV/AIDS budgets remain at least at current levels during the process of decentralization;

3. Resource mobilisation should be planned to ensure stable long-term funding for NGOs who are increasingly dependent on support from large donors such as the Global Fund for their work;

4. Other ministries need to budget for HIV related activities independently of MoPH budgets and incorporate a specific HIV/AIDS component as an integral part of their ministries’ own strategies and work plans;

5. Once the process of the NAA finalized and standardized, the NAA should be integrated into the NAP;

6. Coordination between Ministries and Departments should be improved to ensure consistency of policies, in particular those relating to access to preventive measures, such as condoms;

7. Interest should be stimulated together with the building of competency at the provincial level and below: build the evidence, advocate for more engagement at local levels, revitalize Provincial HIV/AIDS Committees, support NGO/CBO networks, build their capacity in advocacy and service delivery;
8. On the basis of existing management-information systems, an early warning system should be developed to detect failures in essential services as responsibilities and resources are being decentralized;

9. The formulation of the next 5-year plan and related budgets should ensure to support:
   a. The technical and monitoring functions of BATS,
   b. The leadership and managerial function of Provincial teams,
   c. The capacity development of NGOs/CBOs;

10. NGOs, CBOs support should be reinforced particularly for those who are able to reach populations living on the margin of society (substance users, MSM, illegal immigrants) whose HIV/STI/TB prevention and care needs must be met for the sake of their own health and that of the general public as a whole;

11. Forums for sharing and exchange among partners at all levels should be promoted to enable learning, more effective monitoring, accountability and transparency;

12. An inventory of non-government sources of funding for HIV/AIDS related activities in Thailand should be established;

13. There should be a stronger linkage between economic analysis of costs and cost-effectiveness and strategic prioritisation at national level and programme implementation at local level; and

14. A financial monitoring system is needed to determine actual expenditures by priority area and whether hospitals are conforming to government guidelines on allocation of funds (for example to prevention).
5 MAINTAINING CONTROL OF THE EPIDEMIC – HIV PREVENTION PRIORITIES

Thailand’s HIV epidemic has changed significantly in recent years with progressively lower levels of transmission affecting more diverse population groups (see Annex 4 for more detail on status and gaps in prevention efforts). New strategies are needed to better reach these groups with effective prevention.

While new approaches are needed, it is critical that Thailand maintain the highly effective interventions that rapidly contained HIV spread in commercial sex early in its epidemic. Yet Thailand’s STI clinics and 100% condom use programme are in jeopardy. In fact, regional teams documented that the 100% condom use is in a state of collapse in many areas leaving sex workers without access to condoms or STI services. In Chonburi province, for example, the Pattaya clinic is the only STI clinic remaining out of 11 two years ago, and it is struggling to maintain basic outreach and clinical services for an estimated population of 14,000 female and male sex workers.

Condom supply to the regions has been cut to 25% of previous levels in some areas visited. According to persons interviewed including sex workers, interventions with sex workers are no longer able to provide adequate supplies. Other vulnerable population are not yet covered by the 100% condoms programme. Condoms are generally not provided to people living with HIV/AIDS despite ongoing risk of transmission to regular partners.

One of the most worrisome consequences of recent changes is the loss of an ‘early warning system’ to detect increasing HIV and STI transmission trends. Until recently, reliable reporting from all provinces through the STI clinic network permitted Thailand to monitor the progress of its epidemic and fine-tune its response. Regional visits documented that, while surveillance activities continue under new structures, data are no longer reliable due to collapse of regular outreach work to sex establishments.

Despite these data limitations, the review team found evidence that STI and HIV transmission may be on the rebound in several areas. For example, HIV prevalence among military recruits and indirect sex workers in Region 3 doubled last year. On a national level, increases in STIs are being seen for the first time in over 15 years even though fewer STI clinics are reporting (see Annex 5).

Health reforms have also had a dramatic impact on the implementation of public health interventions for HIV, STI and TB programmes. While some services – such as prevention of mother to child transmission (PMTCT) and ART – appear to be well implemented under decentralized health services, other programmes are clearly threatened. Decreasing levels of funding and access issues raise questions about survival of key prevention and disease control programmes during this transition.
5.1 Sustaining proven interventions with sex workers and their clients

Sex work has changed over the years and more sex workers are working in less easy to reach ‘indirect’ settings including bars, karaoke and massage parlours. There is also a reported increase in male and transgender sex work that is not being adequately reached by current interventions. New patterns of commercial sex warrant new strategies to ensure maximum reach and impact of prevention efforts. Appropriate interventions to reach sex workers in different settings – such as indirect and male sex work – include peer-based outreach, provision of condoms and non-judgmental clinical services.

Field visits confirmed that a number of changes related to recent health reforms weaken Thailand’s ability to control HIV and STI transmission among sex workers and their clients. These include:
- Fewer STI clinics and a weakening of services (staff shortages, low priority to providing services for sex workers, new and inexperienced staff);
- A large reduction in outreach visits to sex work sites for condom promotion and prevention work;
- Decreased condom supply at national level has limited distribution to sex work settings. Several provinces report receiving only 25% of requested number of condoms;
- Relaxation of condom promotion efforts targeted to clients and potential clients of sex workers;
- General weakening of the monitoring and surveillance system that has been key in informing the MoPH about trends in condom use and STI among sex workers. It will be very difficult to interpret trends as a result of a decrease in sites reporting and turnover of trained staff.

There also appears to be less focus on clients and potential clients of sex workers than previously. The armed forces reported stagnant and insufficient budgets for HIV prevention work despite trends towards more commercial and casual partners reported by military recruits (see Annex 4). Another cause for concern is decreasing support and collaboration of law enforcement for HIV prevention among sex workers. For example, it has been widely reported that sex workers, MSM and even young people who are found carrying condoms are fined or charged by the police. As a result, condoms are reportedly not found at certain entertainment sites and it is likely that many indirect sex workers do not carry condoms with them.

5.2 Extending HIV prevention to drug users

Drug use including alcohol and methamphetamine can impair judgment and increase high-risk behaviour. In addition, HIV can spread extremely fast through networks of injecting drug users as a result of sharing injection equipment. In Thailand, HIV prevalence among IDUs increased from 2%
to 43% in one year (1987-1988). Since then, HIV prevalence has fluctuated with about half of injecting drug users in contact with treatment services testing positive.

It is unclear what impact Thailand’s war on drugs is having on overall drug use and drug injecting. Disrupted surveillance and restricted access to prevention services have made it difficult to determine the impact on HIV and effectiveness of current prevention efforts. Even with an overall decrease in drug use, which is difficult to verify, it is likely that remaining and new drug users will engage in riskier behaviours to avoid detection and will be reluctant to access drug treatment and HIV prevention services.

HIV prevention among injecting drug users has been largely lost in Thailand’s overall response to drug use. National efforts focusing largely on supply and demand reduction have not been matched by interventions to reduce drug-related harm, despite strong international evidence of their effectiveness. The real danger of such an unbalanced strategy is that drug users will be driven underground, away from prevention and treatment services, facilitating HIV spread both within drug using populations and through sexual partners to other sectors of the population.

Therefore, Thailand should act quickly to scale up outreach and related harm reduction programmes particularly in urban areas where drug supply and use is most likely to continue. Such interventions have been shown to reduce risk of HIV transmission and do not result in more people using drugs. In addition, because of high HIV prevalence rates for nearly two decades, drug users also need HIV-related services including voluntary counselling and testing (VCT), care, support and ART, yet little has been done to address specific challenges of providing these services.

5.3 Reaching men who have sex with men

MSM are a diverse group that may include up to 5-10% of males in Thailand. According to MOPH surveillance, the number of male sex workers increased from 4,132 in 2000 to 4,460 in 2004, most of them found mainly in gay bars, karaoke and on the street. In 2003, research conducted by Thailand MOPH-U.S.CDC Collaboration (TUC) found that HIV prevalence among MSM in Bangkok was 17.3%; a follow-up study is expected in 2005.

Since many MSM sell or buy sex and may also have sex with women, the potential for HIV transmission both within and beyond MSM networks is high. In 1997, HIV prevalence among male sex workers checked in Chiang Mai, Chonburi and Phuket was about 21% (BATS report). Marginalization and discrimination inhibit HIV prevention with MSM. As with indirect sex workers and IDUs, MSM without access to HIV services are most vulnerable to HIV. Male and transgender sex workers have special HIV prevention needs due to high visibility and stigma.

Peer outreach can help identify new venues (such as bars, saunas and street locations) and extend prevention efforts to better reach MSM networks. Better access to clinical services, adapting proven
models used with female sex workers, would further strengthen HIV and STI prevention in this group. In addition, it should be recognized that men in prison frequently have sex with other men and should have ready access to prevention information and condoms.

5.4 Accessing migrant and mobile populations

Migrant and mobile populations are highly vulnerable to HIV yet frequently have poor access to HIV-related services. Migrants, such as seafarers, construction and factory workers, generally live under conditions of difficult jobs, low wages, poor housing and sanitation, low literacy and lack of access to education. Limited access to health information and services including condoms, as well as culture and language barriers, increase vulnerability. Health risks include very low condom use with sex workers, drug use, alcohol consumption, accidents and injuries. As a result, HIV prevalence among migrants is frequently higher than among Thai nationals living in the same area.

Most interventions with migrants are conducted by NGOs in partnership with MOPH, and funded by the Global Fund and other international organizations. Existing interventions largely target seafarers in the South and East. Gaps remain among other migrant populations working as construction and factory workers.

Policies that impede access should be reviewed. Registration poses clear problems of access to public services for migrant workers, and may also affect to some extent the urban poor, indigenous hill tribe peoples, and others; the same factors that exclude them from recognition by the Thai government may also make them vulnerable to HIV infection. Prevention programmes for migrants should address their specific HIV prevention and treatment needs, and be scaled up to fill existing coverage gaps.

5.5 Behaviour change among young people

Young people account for an increasing proportion of new HIV and STI infections. Recent surveillance assessing risk behaviors to HIV infections show that Thai youth continue to engage in HIV risk behaviours. These include a higher proportion of sexual experiences, high rates of unprotected sexual intercourse, and, among sexually active youth, low rates of consistent condom use with both steady and casual partners. Modern technology such as mobile phones, internet, video and other media have opened up many new channels for exposure of young people in Thailand to information about sex, as well as increased opportunities for sexual experience.

Young people in Thailand especially vulnerable to HIV/AIDS include street children, MSM and transgender, young people from ethnic minorities, mobile and border populations, drug users, young people living with HIV, young people from slum communities, and those in remote rural communities.
Issues identified by young people themselves include increased access to information about HIV/AIDS, especially that which is consistent with their needs, and in forms, including language and style, which are easily accessible to young people. Young people also want to acquire life skills to protect themselves from infection with HIV, or to help them to live better with HIV. Further, young people also want access to services, such as counselling which is friendly to young people, and condoms.

Prevention models among youth have been piloted and scaled up nationwide by Ministry of Health, Ministry of Education and PATH. While the educational system should urgently strengthen efforts to build appropriate life skills among students, attention is also needed among especially vulnerable young people who are at risk of adopting high-risk sexual or drug-using practices. There are some good examples of effective models for peer-based HIV/AIDS prevention and care activities for young people, however these need to be scaled up in order to access vulnerable populations.

5.6 Reducing transmission to regular partners

Transmission to regular partners is a growing concern as Thailand’s epidemic ages. Since HIV transmission in commercial sex settings has been so effectively controlled, an increasing proportion of infections are found among regular partners of men and women previously infected. Awareness of HIV status is generally low in regular relationships as is condom use.

Several areas of intervention should be strengthened. These include reinforcing HIV prevention in sexual and reproductive health services, promotion of HIV testing and counselling for couple, support for disclosure, risk reduction counselling both for those who test HIV-positive and those who test negative. ‘Positive prevention’ refers to specific prevention support to PLHA that should be a part of every contact with health services.

Prevention efforts should also be maintained and strengthened in diverse occupational settings. For example, military HIV prevention budgets are currently low and stagnant, limiting possibilities for promoting prevention among men who frequently have commercial and casual as well as regular partners. Workplace programmes in general should be strengthened to reinforce prevention both within and outside regular relationships.

5.7 Bringing together the prevention package

Despite impressive achievements in the past, Thailand should avoid set ideas about its HIV epidemic and complacency in its response. An evolving epidemic with multiple potential foci presents new challenges and calls for vigilance and flexibility in response. Prevention efforts should maintain and improve what has worked in the past while introducing, evaluating and adapting appropriate new approaches to identify and intervene in populations where risk of infection is high.
For populations at risk, effective interventions combine peer-based outreach with non-judgmental services for HIV prevention, care, support and treatment, as well as development of appropriate IEC material for each group. Scale-up of such interventions has the potential of reaping significant public health benefits that far outweigh the costs of programme implementation. The millions of HIV infections averted in Thailand as a result of earlier interventions is ample testimony to the effectiveness of such approaches.

**Recommendations**

1. A focus on HIV/AIDS should be a component of Healthy Thailand policy to boost awareness of HIV, which has decreased in recent years;
2. Thailand should ensure that key components of its successful public health response to HIV (such as STI clinic network and sex work interventions) are not weakened by current changes in the health sector;
3. Better size estimations and mapping of most-at-risk populations should be carried out to facilitate planning, scale-up and monitoring of interventions;
4. Interventions to reach indirect sex workers working in bars, karaoke, massage parlours, etc. and outside establishments should be extended and strengthened;
5. Increased support should be provided to build the capacity of NGOs to scale up outreach and prevention programmes with sex workers, MSM, drug users, migrant populations and others who are unlikely to access health services on their own;
6. Condom availability should be ensured for sex workers, IDU, MSM, young people, migrant populations and people living with HIV;
7. MOPH should work with the National Bureau of Police to increase support of prevention work particularly with female and male sex workers and IDUs; Interference with condom promotion, efforts such as using condom possession as evidence of prostitution, should stop;
8. Thailand should set clear policies on the importance of harm reduction interventions in reducing HIV transmission among drug users;
9. Successful pilots, especially outreach and methadone maintenance therapy, should be scaled up with initial focus on urban areas where continued IDU is most likely;
10. HIV-related services such as VCT, care and ART should be strengthened and access to these services by most-at-risk populations ensured. Positive prevention should be fully integrated into all care, support and treatment services; and
11. Drug hazard, sex and HIV/AIDS education should be included in the core curriculum in schools and promoted among youth out of school. To support this, the Ministry of Education should build teacher capacity at all Rachaphat universities and ensure nationwide implementation.

(see Annex 4 for more detail recommendations for strengthening prevention efforts)
6 accessibility to services

6.1 Thailand’s national STI control programme

Effective STI services were a key element in the early and rapid success of Thailand’s response to HIV and remain important today. High rates of curable STI such as gonorrhea, syphilis and chancroid acted as potent cofactors that facilitated HIV transmission between sex workers and their clients, and clients in turn efficiently transmitted infection to their regular partners. Rapid control of these STIs thus had impact on HIV transmission above efforts to increase condom use. As a result of these combined efforts, chancroid disappeared from Thailand as an endemic disease and STI incidence overall decreased by over 90% in the 1990s. Ongoing surveillance and control activities have helped maintain these low rates until recently when the first increases in STI rates in 15 years were reported from some provinces.

STI services directly support the 100% Condom Policy by providing regular examinations and treatment for sex workers. Monitoring of infection rates among sex workers and STI patients provides direct evidence of 100% CUP implementation; high STI rates from specific sex work establishments signals poor compliance.

On a provincial and national scale, rapid reductions in STI rates provided the earliest evidence of success of the interventions. Similarly, a strong national network of STI clinics reporting regularly from all provinces provides an early warning system for a possible resurgence of sexual HIV transmission due to intervention weakness or behavioural change.

STI services have been impacted by health reforms in a number of ways. There are fewer STI clinics and reportedly less outreach activities to promote prevention among sex workers. Policies such as early retirement and a 5% layoff resulted in loss of experienced staff, undermined motivation and weakened services. STI reporting from provinces has declined from 76 provinces in 2002 to 53 in 2004.

Under the new hospital-based STI services in many provinces, important activities to control STI and HIV among sex workers in their workplaces have been seriously compromised. Most STI clinics under the new system are not full function institutions, frequently lacking outreach, partner notification and counselling services. Sex workers are reportedly less likely to use the new services because of negative attitudes of other patients and hospital staff and inadequate provision for outreach. Lack of an established relationship as previously existed between sex workers and STI clinic staff is a key factor.
Under the new system, STI services are often low priority in the hospital. STI clusters, DDC centers and Provincial Health Offices have no authority to push the hospitals to improve the STI services at the hospitals due to the different administrative line.

### 6.2 PMTCT plus

The first paediatric AIDS case of mother to child HIV transmission was reported in 1988. By 1990s, 2.3 percent of pregnant women were HIV infected and it is estimated that between 8,000 to 10,000 HIV mothers were giving birth per year at the beginning of the 1990's.

Initially, the Ministry of Public Health provided formula feeding to all HIV infected mothers and provided education to avoid breast feeding, while the Thai Red Cross implemented a program for the prevention of mother to child HIV with the use of zidovudine and support the provincial hospital to provide PMTCT service.

Since 1999, after the successful field trial of the combination zidovudine nevirapine in north-eastern and Bangkok region, the Department of Health (DOH), Ministry of Public Health, launched the country wide program to cover the PMTCT over the entire ante-natal care (ANC) clinics (see Annex 6 - components of the PMTCT).

Thailand’s policy of offering HIV testing as a routine part of antenatal care has allowed nearly all women receiving antenatal care to learn their HIV status before giving birth. However PMTCT coverage is still at 89%, meaning that at least 11% of women in Thailand did not enter the programme or choose to opt out. Around 12 percent of HIV-seropositive women giving birth did not have antenatal care. Offering rapid HIV testing around the time of delivery provided HIV testing to 71 percent of women who did not receive antenatal care. Women with positive test results could learn their serostatus in time for interventions to reduce mother-to-child transmission risk.

Perinatal HIV Implementation Monitoring Systems (PHIMS) was launched since October 2000 to enable the provincial and national level to monitor and evaluate the ongoing program. The PHIMS was applied in every hospitals and yielded effective indicators for monitoring the program. It is completed by the Perinatal HIV Outcome Monitoring System in place in 6 sentinel provinces to document the HIV status of all babies born from HIV+ mother.

During the review field visits in provincial hospitals, it was found that the supply chain for ARV and formula milk were sometimes discontinued and that practitioners had to mobilize other resources for substitution.

Currently, the DOH has extended the service to cover the medical care for mothers, their spouses and children, so called PMTCT plus. However, the PMTCT plus has still been separated from care and treatment for PHIVs in most of the hospitals as a result of the division of responsibilities.
between the DDC and DOH. In 2006, it is planned that the programme will be administrated under the 30 Baht scheme and this will resolve the managerial issues of the programme.

6.3 VCT

The first VCT service was established in 1991 in Chiangmai province with the support of the Thai-Australia Northern AIDS Prevention and Care Program and Communicable Disease Control Region 10. It was followed by the opening of an anonymous clinic by the Thai Red Cross in Bangkok. These VCT settings were designed to serve preventive measures to the general population. Subsequently, the Ministry of Public health promoted the development of anonymous clinics in public hospitals throughout the country. However, the hospital’s anonymous clinic could often not be sustained. Although there were a number of trainings organized for nurse counselors, the hospitals could not keep the nurses working only on VCT due to the workload. Also, the increasing demands for VCT created heavy workload, burn out and resignation of staff. HIV/AIDS counselling and voluntary counselling and testing (VCT) are now available at approximately 1,000 hospitals and clinics across the country. These services can be delivered in specific HIV counselling units or are integrated in outpatients department (OPD) or in general health counselling unit. All prenatal care units also deliver VCT. Thailand has a comprehensive and extensive network of voluntary counselling services staffed by trained counsellors and supported by extensive referral networks. Psychosocial support is provided by mental health professionals linked to psychiatric hospitals, counsellors working in government regional, general, community and private hospitals, health centers and by partners in non-governmental and community-based organizations. VCT accounted for 2 percent of the total HIV/AIDS expenditure among MoPH budget in 2003.

The review team noted that VCT services in hospitals are constrained by the shortage of manpower and inadequate training of staff. The referral system for psychological support is often not operational. Most of the practitioners count VCT as a diagnostic test rather than an opportunity to promote prevention. VCT is charged (under 30 Baht scheme if prescribed by a doctor, at higher cost if self-referral for VCT) and conducted without anonymity. Counselling services are delivered individually or in group.

With the maturing of the HIV epidemic, there is a need to support workers including counsellors to enable them to cope with excessive workloads and burnout. There is a need to roll out adherence counsellor training to support scaling up of ART and to scale up implementation of evidence based psycho-social care interventions to vulnerable populations including IDUs, MSM, mobile populations, children and adolescents. It is critical that VCT policy and legislative gaps are quickly clarified and addressed.
6.4 HIV/AIDS care

The review team was made aware of a "3 by 5" (3 million people on ART by 2005 initiative) evaluation conducted in the second half of 2004. The following section of the review report include their key observations.

6.4.1 Status

Exceptional progress has been made by the Royal Thai Government (RTG) in scaling up access to treatment in Thailand, achieving the national treatment target of delivering antiretroviral treatment (ART) to more than 50% of those in need within 2001 to 2004. As of February 2005, some 60,000 PHIVs in Thailand had received ART. Expanding ART coverage has been achieved rapidly through high political commitment and harnessing the full potential of the strong public health system. Subsequently, in July 2004, the RTG declared its commitment towards the ultimate goal of universal access to ART

A one-stage approach to ART with first-line therapy regimen for adults and children, fully subsidized by the RTG, as well as a comprehensive approach to the epidemic where care and treatment are linked with prevention have been adopted. The service delivery model for HIV/AIDS care and ART is through the public health care system involving the different levels up to district hospitals. Expansion to private hospitals started only recently.

The procurement and supply management component of the national ART scale-up strategy has been well planned. Only in 2005, a shortage of efavirenz occurred during a short period, partly solved by an urgent redistribution of stocks available in the treatment units. A strong HIV, CD4 and viral load laboratory network has been developed (see Annex 7 - ARV, other drugs and reagents)

In collaboration with the government and independently, the Thai PHIV movement and community sector have played a key role in scaling-up treatment access. A nationwide programme to increase access to the prevention and treatment of opportunistic infections (OIs) has provided a basis for treatment literacy and education for antiretrovirals (ARVs) and the establishment of comprehensive and continuous care (CCC) centers operated by PHIV volunteers and supported by health care workers in 129 district hospitals covering 10 000 clients on ART.

The IHHP conducted a cost effectiveness analysis of the NAPHA program. This model did not include the cost for 2nd line regimen. In 2004, ART cost effectiveness was estimated at 592 US$ per life year saved and at 614 US$ per year of orphanhood prevented.

The ARVs are presently supported through different funding mechanisms, including NAPHA, Global Fund to Fight AIDS, TB and Malaria (GFATM), Social Security Scheme (SSS) and PMTCT-Care. Integration of the HIV/AIDS care into the government 30 Baht scheme will soon be implemented. The scheme will support second-line treatment regimens.
The total health expenditure on HIV/AIDS increased from 2996 million Baht in 2000 (US$ 74.4 million) to 4188 million Baht in 2003 (US$ 101.3 million). The largest increase in spending during this period came from the ART programme (which more than tripled in spending) and from outpatient care. In response, the share of total AIDS expenditure going to ART increased from 20.3% in 2000 to 50.1% in 2003. Jointly, ART and OI treatment account for 85.1% of total AIDS spending.

Modelling indicates that under the MOPH guidelines in 2004, the cost of the ART programme alone is expected to reach US$ 74 million in 2010, which will double the current expenditure of all HIV/AIDS programmes. (see Annex 8 - Projected Cost of Scaling-up of ART.) Of importance, the share of ART drug costs accounts for more than 85% of the total cost of the ART programme. The ART programme expenditure in percentage of the National Health Budget is expected to increase from 6.1% in 2004 to 10.2% in 2010. Considering that a large proportion of those on first-line therapy will eventually need second line therapy, expenditures of second line may then start to account for more than one-half of the total spending. By 2020, second line therapy for one quarter of all patients will be absorbing three quarters of the treatment budget and the cost of ART with second line regimens could reach US$ 500 million per year.

6.4.2 Analysis and observations

The rapid expansion of the ART programme for the past 3 years has created a substantial additional workload on health professionals and administration of the universal coverage scheme. Staff are overstretched and it may lead to burn out.

The ART programme is only monitoring two indicators. The selection of a national set of indicator consistent with international recommendations could assist in cross-country comparisons and sharing of best practices. The introduction of cohort analysis, as done with TB, should be considered. With metabolic side-effects of ART often reported, data on treatment adherence should be monitored, particularly considering that poor adherence to first line therapy will speed the development of resistance.

The lack of appropriate paediatric formulations is of major constraint. Paediatric ART guidelines and the PMTCT guidelines also need revision in light of recent scientific knowledge. Children with HIV also face difficulties in relation to adherence, as carers are often ill or aged, and unable to provide adequate supervision to ensure ARVs are taken at the correct dosage or time.

ART should be used to increase the uptake for prevention activities and several opportunities are opening up for accelerating prevention. These include concentrating on “prevention for positives” by specifically targeting condom promotion to those on ART (especially important to reduce onward
transmission of any resistant virus that may emerge during therapy); and the promotion of harm reduction interventions as an entry point to HIV/AIDS care and treatment.

There are no specific data available with regards to enrolment of high-risk behaviour groups/hard-to-reach groups such as injecting drug users (IDUs), sex workers, prisoners and migrants to NAPHA. The review team noted that in some sites active drug users are not included into NAPHA. However, sex workers are generally enrolled in NAPHA without any discrimination and pilot project for prisoners are initiated. HIV-positive migrants find it difficult to enrol into HIV prevention and ARV treatment programmes because of language issues, their mobility and lack of legal status in the country. Efforts are made to incorporate the 30 Baht scheme to them and to develop specific communication materials for HIV prevention by the MOPH. Those who are not registered with the national health system also include the poor in urban centres and indigenous hill tribe peoples. The government should ensure an enabling environment for preventing HIV infection and providing care and treatment to these vulnerable groups / hard to reach groups.

Although efforts are under-way to ensure the long term sustainability of ARV, e.g. with the development of a scheme of cost sharing with government, HIV/AIDS projections and economic modelling indicate rapid increasing cost of ART, mostly associated with the cost of second line therapy. While it is clear that the financial needs for firsts and second line, even third line ARV regimen, require aggressive measures to reduce costs, there is need to further study the feasibility and impact of introducing these regimens and to look at mechanisms to reduce costs.

6.5 **TB and HIV**

It is estimated that 10-25% of TB patients are co-infected with HIV and that TB morbidity in HIV individuals is around 20-40%. TB/HIV co-infection results in an increased TB mortality rate and a decreased TB success rate. Treatment success rate (72% in 2002 cohort) is still below the Global DOTS target of 85%, suggesting some difficulties with its implementation. TB case finding has improve these past few years. However, with the TB case management at hospital level, DOTS implementation is encountering difficulties.

The review team noted that TB/HIV is widely recognized as a public health problem and that there is a good knowledge and analysis of the TB/HIV situation at national level. TB and HIV programmes are now structurally integrated at national and regional levels. The TB/HIV integrated strategy prepared aims at the delivery of an integrated TB/HIV package in all health services settings to follow international guidance. TB/HIV activities have been initiated at national level and are now expanding to the provincial and district level.
TB program’s budget has been devolved and is currently implemented as a part of 30 Baht scheme. Consequently, TB patients have to pay 30 Baht for each visit. Also, the supervision mandated through the former vertical program disappeared and the purchase of TB drugs, case finding, DOTS implementation and follow up of TB cases is difficult to sustain. The Central, Provincial and community hospitals are often overloaded due to the increasing demand in medical services resulting from the universal coverage policy. Consequently, the fundamental activities of TB control are not always implemented.

The review team noted that TB and HIV have been very well integrated in the small district hospitals where the same service manages both TB and HIV. In tertiary hospital, services are most of time jointly delivered with referral of patients between the two. TB patients were not offered HIV VCT in all the centers visited during the review team field visits.

Groups of PHIVs, NGOs and CBOs are supporting the implementation of TB/HIV activities. Additional analysis of TB HIV can be consulted in annex (see Annex 9 on TB/HIV status).

**Recommendations**

**STI services**

1. STI and reproductive health services should be extended to specific populations at risk (sex workers, MSM, young people with STI or sexual concerns) and access to services ensured as the health system undergoes reform;

2. DDC (BATS and 12 Regional STI clinics) should have a clear role in directly supporting STI services at provincial level to maintain key outreach, monitoring and surveillance functions of the previous successful programme. DDC-supported STI clinics in each region or province could serve as learning sites to support decentralized STI services at community hospital level and maintain standardized STI management;

3. Appropriate mechanisms and budget should be developed to maintain outreach activities to sex workers in each province. Primary care units (PCU) should be involved to ensure that outreach to populations at risk in their catchment areas is carried out as an integral component of its STI prevention and treatment work. Outreach should be extended in collaboration with NGOs to better reach indirect and male sex workers;

4. BATS should develop plans to transfer skills from experienced STI clinic staff to new staff providing decentralized STI services at hospitals and PCU through training and supervision at regional and provincial level; and

5. BATS should build its capacity to provide leadership in HIV/AIDS prevention and better technical support to provinces and other ministries.
PMTCT plus
1. HIV/AIDS care and treatment and PMTCT should be streamlined with a unified framework of technical support and an effective supply chain;
2. The informed consent of pregnant women to counselling and HIV testing and pre and post test counselling should be systematically ensured; and
3. An evaluation of the profile of pregnant women not reached by the PMTCT programme should be conducted with a special attention on migrants and mobile populations.

VCT
1. A clear national policy of VCT should be strengthened in line with Thailand’s national guideline for protection of individuals and privacy and complying with the promotion of free and anonymous access to VCT;
2. VCT should be encouraged and promoted as a service for the general population, not only restricted to population at risks or symptomatic clients with HIV infection;
3. VCT services should be strengthened through capacity building and support so that there will be sufficient counsellors to provide service in every health care setting responsible for HIV/AIDS, TB and STI care;
4. VCT for mobile and hard to reach populations has to be specially developed to overcome the communication and social barriers; and
5. Under the 30 Baht scheme, VCT should include provision of condoms and for those clients testing positive, a systematic clinical examination and CD4 count.

Care
1. Health benefit scheme should be harmonized in order to optimize resource use and unify the benefit package among the collective health care purchasers (30 Baht scheme, CSMBS and SSS);
2. HIV/AIDS care and treatment functions should be delegated to the primary health care infrastructure so as to reach PHIVs in their community and alleviate the burden of tertiary hospitals; and
3. Employment opportunities and income generating activities should be developed for PHIVs in care.

Antiretroviral treatment
1. ART programme should be expanded towards universal access as planned. Strict attention should be given to regular adjustments of treatment and monitoring strategies in particular with second line and salvage treatment regimens in the near future;
2. Staff and managerial capacity at the National AIDS Programme for the ART programme should be strengthened at all levels in particular for M&E. The proportion of resources allocated to staff (e.g. short-term consultants, temporary staff) should be increased during the initial rapid expansion of the ART programme;
3. The coordination and management between PMTCT-Care and NAPHA programme should be streamlined at all levels;
4. Access to ARV paediatric formulation needs to be developed as an urgent priority;
5. Efforts are needed to increase access to ART for high-risk groups such as sex workers, MSM, migrant workers and IDUs with promotion of enabling services such as harm reduction both in communities and within closed settings;
6. The human resource development component of the ART programme in particular at district and sub-district levels should be further strengthened. This could be complemented by a mentoring system;
7. Monitoring and reporting tools need to be standardised for all public sector ART programmes with the introduction of cohort analysis;
8. Research should be undertaken to explore the feasibility and impact of cost sharing and co-payment by patients and local government; and
9. Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement schemes, local production, pressure on domestic and international prices and where necessary the application of safeguards embodied in international trade agreements.

TB and HIV
1. The budget for TB drugs should come from a central allocation rather than from the 30 Baht scheme, as it is established for ART. This would provide incentive for practitioners in hospital to provide proper care to TB and AIDS clients; and
2. TB case finding and VCT should be recognized as preventive measures and included in the 30 Baht scheme’s benefit package free of charge so that the budget allocations can be mobilized to support these activities.
7 Monitoring and Evaluation System

The national allocation of resources for surveillance and monitoring of the AIDS epidemic and responses is less than 1% of the total government HIV/AIDS budget. The M&E systems include two main components: firstly a series of statistical data collection instruments that are used partly for management and partly for reporting purpose, and a management based system that consists mostly of meetings between stakeholders and different levels of the system to review changes in the situation and programme management. One result of decentralization is that there has been some fragmentation of national statistical reporting systems and an increased emphasis on local management information systems often based on meetings between stakeholders.

7.1 Systems in place

Several key HIV-STI-TB statistical monitoring systems have been in operation for some years, with varied coverage of the population. The AIDS case reporting system is very well developed but under-reports the total number of cases as in any case reporting system. The information is used at local and national levels to monitor the evolution of the epidemics. Sero and behavioural surveillance through sentinel sites has been effective for two decades but there is some concern that shifts in responsibilities from provincial level to hospital units may affect coverage. There are currently eight databases on HIV/AIDS, STI and TB surveillance under the management of the Ministry of Public Health and other Ministries. There are some overlaps between these databases. Coordination between agencies and rationalization (by government requiring all agencies to use the same software) of information into a single database would improve access to information, make it easier to obtain the ‘big picture’ on the epidemic and also to use the monitoring systems to obtain information on outcomes and impacts.

Local level programme and operational management information systems are less developed, as is monitoring of coverage of prevention and community-based programmes such as community based care and support, voluntary counselling and testing, condom distribution and interruptions in supply to sex workers and IEC activities.

Monitoring of coverage of treatment with ARVs, especially PMTCT is virtually complete. HIV drug resistance surveillance has been established this year, with a first survey among new HIV+ sex workers in 24 sentinel sites. Information on migrant population is limited similar to the coverage of services; this is important as there are some indications that HIV is higher in migrant populations.
Outputs of other government sectors (such as education), the Global Fund, and other international and NGO activities cannot be traced in the National AIDS Control Programme monitoring system, making it impossible to obtain an aggregate picture of the collective response.

Health reform and decentralization are already having significant effects on the monitoring system. As monitoring systems continue to adapt to local situations and priorities, reporting on national level indicators is increasingly fragmented. Some health facilities have stopped submitting data on indicators such as number of commercial sex establishment census, estimated numbers of sex workers, and STI case reports. At the same time, decentralization of decision-making has resulted in an increased importance of local HIV-AIDS Committees, and an increased demand for feedback and programme management information.

MoPH officials indicated that the quality of HIV/AIDS data is declining. Development of effective strategies for groups such as youths, IDUs, MSM, mobile populations and ethnic minorities is constrained by lack of information. “Second generation” surveillance systems to capture the changing dynamics of the epidemic and facilitate responsive planning are under development.

### 7.2 Development of one integrated national M&E system

There is an urgent need for a national multi-sectoral M&E framework. At present, even the core indicators have not yet been agreed upon, but it is important that this be a short list, and that the government resists international pressures to proliferate the numbers of indicators. A unified system extending from national to provincial levels is needed. Without this, the big picture of the national situation and collective response will not be available to decision makers.

Thailand is producing a large amount of high quality surveillance information and research. The main sources of data in Thailand include HIV-AIDS-STI case reporting and sentinel surveillance systems, behavioural surveillance, routine programme management information, quality assurance assessment, qualitative research and ethnographic research. An analytical process of validation of these disparate sources by triangulation, and of integration and synthesis of information is needed to support evaluation of programme effectiveness. This will help decision-makers to identify and prioritise the most effective programmes and enhance the impact of the AIDS programme. A central body to coordinate data collection from all partners, undertake capacity development and synthesise the information is required to achieve this goal.
The HIV epidemic in Thailand is changing and evolving and the health system is also changing. To continue to be useful, the M&E system has to change from series of vertical systems to a single integrated and multi-sectoral system.

7.3 Knowledge management and research

The strategy to mobilize research capacity as wisdom of National AIDS Plan was explicitly expressed in 1996 with a budget allocated to the research plan. In addition, the Ministry of Public Health has implicitly allocated some part of medical care budget to support the collaboration of clinical trial networks. All these investments may still be too modest contribution to research. Nevertheless, there has been a growing community of researchers in multi-disciplinary areas to attain knowledge for AIDS solutions, including vaccine development. Research results have been integrated in the development of policy; e.g. the launch of the national PMTCT programme following the results of clinical trials. The major driving force has come from foreign or international donors. Thus, many of researchers had to compromise with initiative demand of those donors.

Situation analysis and knowledge to keep pace with the rapidly evolving epidemic and cope with the emerging problems need further support. Critically, the risk behavior of different communities needs to be analysed to develop improved programmes. Future operational research should address maximizing the opportunities for ART implementation presented by the 30 Baht scheme which has considerably increased access to health care in the country. At the same time, challenges posed during the on-going transitional adjustments concurrent with health sector reform need to be addressed. Areas for future operational research that were identified during the review were:

- Evaluation of ART implementation through the contracting units for primary care (CUP),
- Evaluation of the processes and outcomes of ART implemented through partnerships, including joint HIV-TB interventions undertaken through collaboration with the national TB programme and in academic institutions,
- Long term financial sustainability of ART and the whole AIDS programme focusing on: 1) future increasing trend of ART expenditure (per PLHA and as % of current health expenditure), reduction of OI treatment, and further reduction in prevention expenditure, and 2) streamlining programme (CSMBS, SSS and NAPHA), standardised treatment regimen and cost sharing by concerned parties on training of human resources or adequate budget,
- In-depth analysis of data at national and sub-national levels for a better understanding of HIV/AIDS trends and impact of the epidemics,
- Development of improved mechanisms to ensure treatment observation, patient transfers and referrals in order to improve outcomes.
**Recommendations**

1. With decentralisation, local authorities have increasing responsibilities. Capacity development in use of information for decision making is urgently needed;

2. The NAP should develop a knowledge management strategy and a research management plan integrating the activities of the different agencies involved, enabling the identification of crucial gaps and facilitating the dissemination of the information needed by programme managers and policy makers;

3. The DDC, the BATS and the regional offices of Disease Prevention and Control should focus on programme-related and technical issues;

4. Validation of information by triangulation, and synthesis and analysis is needed to provide better information to policy makers;

5. HIV drug resistance surveillance should be urgently strengthened, targeting new HIV cases and patients on ART;

6. A single national M&E system is needed. This requires development of a national integrated M&E plan, a central coordinating body for HIV/AIDS-STIs and TB and that government issues a requirement that all involved agencies use the same database system. (Use of DevInfo software, recommended as the new standard for all UN agencies by Kofi Anan last year, should be considered seriously.);

7. The AIDS cluster should continue to collaborate with universities and institutions focusing on programme-oriented operational research; and

8. Efforts are needed to simultaneously strengthen the research capability of HIV/AIDS and public health personnel at both central and provincial level, in collaboration with research departments at universities.
8 MOVING FORWARD

In two decades of innovations and hard work, Thailand has accomplished great progress towards bringing the spread of HIV under control and mitigating its impact on individuals infected and affected by the epidemic. No praise is enough for those who, over the years, have devoted and often sacrificed their personal and professional life to this powerful movement which has mobilized people, communities and the nation as a whole. Today, the results of this effort speak for themselves in terms of both the number of HIV infections averted through well targeted prevention and years of healthy life saved by making treatment increasingly available. Importantly, these results have created a sense of confidence, both within Thailand and abroad, that the HIV/AIDS epidemic can be overcome when leadership, science, social mobilization and resources are brought to bear all at once.

The national response to HIV is now confronting several realities to which it must rapidly adjust:

- There are clear signs that the epidemic is pursuing its course, unabated, in communities such as some sex worker populations that have not been, or are no longer being, reached by prevention approaches suited to their needs. It threatens to regain momentum in other communities, where complacency has set in—among young people in particular. It appears to be on the rise in other populations such as men who have sex with men and it has become harder to track in communities driven underground such as Injecting Drug Users.
- The urgent scaling up of access to treatment, while essential, is overshadowing the critical importance of enhancing prevention simultaneously with care.
- There is a general feeling that the response to HIV has moved from a people centered approach to a patient centered approach, drifting away from the mobilization of forces within society that can be marshalled to prevent HIV spread to a more clinical focus on HIV infection once it has set in.

The current and planned investments in care are highly commendable and should be further expanded to best respond to the growing demand. This investment in health and survival makes sense in both human and economic terms. Yet, the movement which has led to behavior change and the gradual although incomplete decline of stigma attached to HIV needs to be revitalized. Every HIV infection prevented alleviates much suffering and is a source of savings on future costly medical interventions.

There are great opportunities to revitalize the response to the epidemic in the current context of Thailand:

- Under the leadership of Government, the expressed national commitment to this developmental priority should return HIV to the center of the public debate.
• The political and administrative decentralization under way should bring HIV work closer to the people, with a systematic capacity building on local level while the Center retains key enabling, supervisory and research functions and operates monitoring and early warning systems needed to detect any breakdown in services as the devolution of responsibilities to the periphery unfolds.

• The health reform should specifically take HIV into account and ensure that both prevention and access to care are equally accessible by all, regardless of their economic or legal status, and free of cost or fully covered by existing user fees when they can be afforded by those seeking services.

• Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement schemes, local production, pressure on domestic and international prices and where necessary the application of safeguards embodied in international trade agreements.

• Prevention and social support need to be more prominent and be closely linked to care as access to treatment further expands according to existing plans.

• A reinforced focus of prevention should be on young people and on people who are married to, or in a sustained relationship with, HIV-infected partners.

• Prevention strategies must adapt to the evolving patterns of HIV risk behaviors and situations such as those inherent to sex work involving women, men and their clients, men having sex with men, drug users and minority groups such as border populations, as well as legal and illegal migrants both for their own sake and the sake of the public health of the nation.

• The use of knowledge acquired through research should be systematically applied to developing HIV/AIDS policies and strategies which, in turn, should inform the research agenda, particularly in the field of social, behavioral, health system and intervention-based research.

• Civil society, in particular non-governmental and community based organizations, need to be more effectively supported and financed from national and local sources, and local authorities should be strongly encouraged and rapidly given the capacity to do so.

• The response to HIV should work further towards incorporating human rights principles enshrined in the National Constitution and judicial provisions, mechanisms and instruments should be put in place to achieve this goal.

Granted high level of political commitment in Thailand, the exemplary capacities of the staff of the health service and the readiness of civil society these opportunities can serve as a stepping stone to carry forward a people-centered response to the epidemic and current challenges can be met with confidence.
9 ANNEX 1: REVIEW TEAM MEMBERS AND FACILITATORS

Review team members

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TB/HIV task force, Department of HIV/AIDS, WHO Geneva

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- Ms Lisa Kuntamala,
- Ms Parita kuiketatkul,
- Ms Vipa Pawanaporn,
- Ms Bussaba Tantisak,
- Ms Panatda Khaosa-ard,
- Ms Parichat Chancharas,
- Mr Surasak Thanaisawanyangoon,
- Ms Somchit Leknimit,
- Ms Chitra Onnom,
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- Ms Panipak Thongchang,
- Ms Naporn Hantrakoon,
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10 ANNEX 2: LIST OF INSTITUTIONS AND PERSONS MET

The list of persons met is not exhaustive and limited to the main speakers during the visits conducted in the institutions. The review team members would like to thank all the persons who participate and who are not quoted in this list.

Bangkok

- **BATS**
  - Department of Disease Control
    - Dr. Phetsri Sirinirund
    - Dr. Daranee Viriyakitja
- **AIDS cluster, BATS**
  - Dr. Sanchai Chasombat
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- **Bureau of Strategy and Planning**
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  - Ms. Rossukon Kangvallert
- **Bumrasnaradura Institute**
  - Dr. Atchara Choaavananich, Director
  - Mrs. Yaowarat Inthong
- **International Health Policy Program**
  - Dr. Viroj Tangcharoenphantsad, Director
- **National Health Security Office**
  - Dr. Taworn Sakonphanit
- **Samutpakarn Hospital**
  - Mr. Supoj Thungserisub
  - Dr. Kovith Yongvanichit
- **SamutSakorn Provincial Health Office**
  - cop. Rasri Satayawirut
- **Office of the Permanent Secretary for Ministry of Labour and Social Welfare**
  - Mr. Akrapol Wanaphuti
- **Department of Employment, Ministry of Labour and Social Welfare**
  - Ms. Duangmon Booranalit
- **Department of Skill Development, Ministry of Labour and Social Welfare**
  - Ms. Pundharika Samiti
- **Social Security Office, Ministry of Labour and Social Welfare**
  - Ms. Kanjana Dhewasilchaikul
- **Office of Permanent Secretary for Education Ministry of Education**
  - Ms. Manthana Sungkit
- **Ministry of Defence**
  - Major. Smith Wattanathankam
  - Dr. Praphan Phanuphak, Director
- **East West Center**
  - Dr. Wiwat Peerapatanaokorn
- **Bangkwang Central Prison**
  - Dr. Manop Srisuphanthavorn, Director of Medical Division
- **Mercy Center**
  - Ms. Usanee Janneong
  - Mr. John Mactaggart
- **Bangkraui Hospital**
  - Ms. Prane Kreethapirom
- **MSF – Belgium**
  - Mr. Ian Naewbanij
- **Thailand MOPH – U.S. CDC Collaboration**
  - Dr. Jordan Tappero, Executive Director
- **Rainbow Sky**
  - Dr. Frits Van Griensven
  - Mr. Rapeepun Jommaroen, Assistant to secretary-general
- **Heath Promotion Center**
  - Mr. Salantorn Eiamsuontorn
- **Population & Community Development Association**
  - Senator Mechai Viravaidya
  - Mr. Praween Payapvipapong
- TBCA Dr. Anthony Pramualratna
- Access foundation, Path Ms. Phakamas Ardphoom
- PWLA Network Mr. Chalermchai Phueanbuaphan
- Duang Prateep Foundation Ms. Nittaya Prompochuanboon
- Swing Group Ms. Wassana Warint

Region 3

- Regional Office of Disease Prevention and Control Dr. Prasong Pagehavoenpol
- Chonburi Provincial health office Mrs. Yupin shinsa-nguankeit
- Sattahio kg 10 Hospital Mrs. Ruchanee Tarasuntisur
- Camillion Center Office Dr. Apinya Vongkeew
- Sex entertainment place, Pattaya city Dr. Ramase Amphaidis
- Ruam-Kra-Ton-Club Team Mrs. Nanemon Kotcharin
- Rayong Provincial Health Office Ms. Phantira Jitman
- Ban chay district Hospital Ms. Kanjana Tongjine

Region 5

- Regional Office of Disease Prevention and Control Dr. Tanapong Jinvong
- Nakhonratchasima Provincial Health Office Dr. Samroeng Yanggratog, Director
- Maharaj Nakhonratchasima Hospital Ms. Boonchoay Nasungnoun
- Slum Community beside realway Dr. Werasuk Kiatpalangkul
- Community Hospital, Jukkarat Ms. Patcharee Boonse
- Burerum Provincial Health Office Mr. Niwat Ruangdat, city mayor
- Beowlong School Ms. Charunee orosram

Region 10

- Regional Office of Disease Prevention and Control Dr. Tasana Leusaree, Chief of AIDS and STIs Section
- Chiang Mai Provincial Health office Dr. Surasing Visrutaratna, Deputy director
- The Church of Christ in Thailand AIDS Ministry Rev. Sanan Wutti, coordinator
- Nakornping Hospital, Chaing Mai Ms. Jaruwan Wutti, assistance Director

Dr. Prattana Leenasirimakul, Chair of Infectious Control Section
- Technical Promotion and Support Office 10th, Ministry of Social Development and Human Security
  Dr. Suparat Kanjanavanit, Chair of HIV Center
  Mr. Jarun Siriwan, Chief of cluster

- Sansai District
  Prakru Samu Vicien, Wat Chedi Mae Krue
  Prakru Maethawat Chittathonto, Wat Nhong ma jab

- Drug User Network Thailand
  Ms. Dampawan Pinitsuwan
  Ms. Kastanavadee Khamsurin
  Mr. Natthaphol Thananchai
  Mr. Yanyong Jaiwang

- Program for HIV Prevention and Treatment Thailand
  Dr. Lallemant Marc, Director

Region 11

- Regional Office of Disease Prevention and Control
  Dr. Charn Uahgowitchai
  Ms. Ketsasa Yanvaidsakul
  Dr. Sathit paiprasert

- Nakornsritammarat Provincial Health Office
  Ms. Pacharee pechukson
  Ms. Wantee Suppwongsanond
  Mr. Soontorn Jearapan

- Suratthani Provincial Health Office
  Ms. Tadsanee Thaikek
  Mr. Pongprajak Prajen

- Sritawee Temple & Community
  Ms. Tadsanee Thaikek
  Mr. Pongprajak Prajen

- Maharaj NakornsriThammaraj Hospital
  Dr. Bunphong Luengaron
  Ms. Pattara Bunpan

- Twin lotus hotel
  Ms. Noy
  Ms Dang

- Si-chon Community
  Ms. Tharee Thanomnoun
  Ms. Wachaya Cholasin
  Ms. Onouma Janjit

- PHC Nala
  Ms. Suppawat Chnnarong

- Sichon Hospital
  Ms. Supranee Bunsawang

- PHC Tonreang
  Dr. Aakcha Mukdapiraks
  Mr. Sontiya Suntamanon

- Kanchanadi Hospital
  Mr. Suthep Rukmoung

- Phang-nga Provincial Public Health office
  Mr. Boonsong Chaysawai

- Temporary Primary Health care unit (Baan Bang muang)
  Mr. Dumrong Luesiang

- Baan Num Khem Community and Primary School
  Ms. Nanthna Lothong

- Ta Kua Pa Hospital
  Dr. Somsak chksuchort
  Ms. Suchada Ploroy
11 ANNEX 3: LIST OF MAIN DOCUMENTS CONSULTED

- Opening speech by His Excellency Thaksin Shinawatra, Prime Minister of Thailand at the opening ceremony of the XV International AIDS Conference, Bangkok, 2004.
- Policy of the Government. Policy statement of the government of His Excellency Dr Thaksin Shinawatra Prime Minister of Thailand delivered to the National Assembly on Wednesday 23 March 2005.
- Summary reports prepared by BATS for the review:
  o Management and administration,
  o Monitoring and evaluation,
  o Prevention of Mother to Child Transmission,
  o High risk groups,
  o HIV/AIDS care.
- Analysis of policy development on antiretroviral treatment service, its advocacy and integration into universal health insurance, BATS, 2004.
- Situational analysis of the process for developing antiretroviral treatment policy by the Royal Thai Government, by Dr Sombat Thanprasetsuk and al. BATS and Siam University, 2005.
- Evolution and development cycle of Thailand’s Health Systems; from “health for all to all for health”. By Wiput Phoolcharoen.
- HIV/AIDS Voluntary Counselling and testing and psychological support: needs and services. Department of Mental health. 2004.
The success of the 100% Condom programme in Thailand: policy implications and recommendations (in Evaluation of the 100% condom promotion and the validation of the decline in trends for selected STDs)


The National Access to Antiretroviral Program for PHIV (NAPHA) in Thailand, by Sanchai Chasombat and al (draft 2005)


12 LIST OF ANNEXES IN ELECTRONIC FORMAT

The following annexes are in electronic format and are available upon request to Ms Laksami Suebsaeng at suebsaengl@whosea.org

- Annex 4: Detailed review analysis of the HIV prevention activities
- Annex 5: STI services
- Annex 6 Components of the PMTCT
- Annex 7 ARV, others drugs and reagents
- Annex 8 Projected costs of scaling up of ART and review brief overview
- Annex 9 Details on HIV-TB status