Situation of HIV/AIDS epidemic in Thailand

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; it has accumulated a vast repertory of 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, and behaviours have responded sensitively to an aggressive campaign of information and education as well as availability of access to services, condoms and support. Although the stigma attached to HIV/AIDS still persists, the public discourse about sexuality and sexual health has become more open and objective.

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 the 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, the following signs indicate 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 last year (2005) was among women who were in a stable relationship and yet became infected by their spouses or regular sexual partners. Adolescent boys and girls engage in risk behaviours more frequently than their peers did a few years ago, exposing themselves to HIV infection.

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, resulting in a lowered adherence to safer sex practices and insufficient supplies of condoms.

Experiences and lessons learned

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 for the prevention of the disease to a more clinical focus on infection after the disease 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. Every HIV infection prevented alleviates much suffering and forestalls costly medical interventions in the future. It is, therefore, important to recognize that the movement which has led to behavioural change and a gradual, although slow, disappearance of stigma attached to HIV needs to be revitalized.

The following opportunities and reasons stress the need 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 at the 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 are 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 are in a sustained relationship with, HIV-infected partners. Prevention strategies must adapt to the evolving patterns of HIV risk behaviours and risk situations involving sex workers and their clients, men having sex with men, drug users and minority groups such as populations along the international borders, as well as legal and illegal migrants, for their own health and for the sake of the 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, behavioural, health system and intervention-based research.

Civil society, in particular nongovernmental and community-based organizations, need to be more effectively supported and financed by 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. Given the high level of political commitment, the exemplary capacities of the health services staff and the readiness of Thai civil society to confront the epidemic, the above-mentioned opportunities can clearly serve as a stepping stone to carry forward a people-centered response to HIV/AIDS, and thus meet the current and emerging challenges with confidence.
Towards UA 2010

Strategy for HIV Prevention

During the early phase of HIV epidemic in Thailand, it was believed that number of annual incidence of HIV could be as high as 140,000-150,000 cases. However, due to the effect of several prevention programs, number of new infection has been reduced to approximately 17,000 cases in most recent years. Effective prevention programs which have cited to contribute to the reduction of new HIV infection include the Condom 100 % Program, universal HIV screening in blood services, universal precaution in health care services and the Prevention of HIV from mother to child Program and other.

In order to forecast for the new infections in the future, it is expected that, with similar amount of affords, and if there is no significant changes in other attributable factors on the spread of HIV, the trend for annual new infection would be reduced around 1000 cases every year (Table 1). So, in year 2010, there would be around 11651 new infected cases.

Based on the number of new HIV infections in 2005, it was believed that the highest proportion group was female who contracted the virus from their male partners (36.9 %), followed by men who have sex with men (MSM) (21.4 %), men seeking sex with female commercial sex workers (10.7 %), men contracting HIV from female partners (9.1 %) and others (Table 1). To further strengthen prevention efforts, it is necessary to improve interventions among these target groups. It is proposed that strategic targets for prevention have to be set and the annual incidence must be further reduced than the expected from a regular program. The proposal was to reduce number of new infections to less than half of it was previously expected by 3 years.

Table 1 Number of new HIV infections in Thailand 2005-2010 (in a condition that no additional effort be made)

<table>
<thead>
<tr>
<th>Group</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female from male partner</td>
<td>6399</td>
<td>5583</td>
<td>4828</td>
<td>4139</td>
<td>3538</td>
<td>3034</td>
</tr>
<tr>
<td></td>
<td>(36.9 %)</td>
<td>(34.9 %)</td>
<td>(32.7 %)</td>
<td>(30.4 %)</td>
<td>(28.2 %)</td>
<td>(26.0 %)</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>3707</td>
<td>3693</td>
<td>3672</td>
<td>3643</td>
<td>3609</td>
<td>3577</td>
</tr>
<tr>
<td></td>
<td>(27.4 %)</td>
<td>(23.1 %)</td>
<td>(24.9 %)</td>
<td>(26.8 %)</td>
<td>(28.7 %)</td>
<td>(30.7 %)</td>
</tr>
<tr>
<td>Men from sex with CSW</td>
<td>1861</td>
<td>1652</td>
<td>1473</td>
<td>1314</td>
<td>1173</td>
<td>1048</td>
</tr>
<tr>
<td></td>
<td>(10.7 %)</td>
<td>(10.3 %)</td>
<td>(10.0 %)</td>
<td>(9.7 %)</td>
<td>(9.3 %)</td>
<td>(9.0 %)</td>
</tr>
<tr>
<td>Men from female partner</td>
<td>1578</td>
<td>1483</td>
<td>1382</td>
<td>1280</td>
<td>1180</td>
<td>1083</td>
</tr>
<tr>
<td></td>
<td>(9.1 %)</td>
<td>(9.3 %)</td>
<td>(9.4 %)</td>
<td>(9.4 %)</td>
<td>(9.4 %)</td>
<td>(9.3 %)</td>
</tr>
<tr>
<td>Men/women, extramarital sex</td>
<td>1189</td>
<td>1108</td>
<td>1022</td>
<td>934</td>
<td>849</td>
<td>769</td>
</tr>
<tr>
<td></td>
<td>(6.8 %)</td>
<td>(6.9 %)</td>
<td>(6.9 %)</td>
<td>(6.8 %)</td>
<td>(6.7 %)</td>
<td>(6.6 %)</td>
</tr>
<tr>
<td>Intravenous drug user</td>
<td>1056</td>
<td>1015</td>
<td>989</td>
<td>971</td>
<td>955</td>
<td>941</td>
</tr>
<tr>
<td></td>
<td>(6.1 %)</td>
<td>(6.3 %)</td>
<td>(6.7 %)</td>
<td>(7.1 %)</td>
<td>(7.6 %)</td>
<td>(8.1 %)</td>
</tr>
<tr>
<td>Female sex worker</td>
<td>723</td>
<td>640</td>
<td>570</td>
<td>506</td>
<td>449</td>
<td>399</td>
</tr>
<tr>
<td></td>
<td>(4.2 %)</td>
<td>(4.0 %)</td>
<td>(3.8 %)</td>
<td>(3.7 %)</td>
<td>(3.6 %)</td>
<td>(3.4 %)</td>
</tr>
<tr>
<td>Pediatrics from mother</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td></td>
<td>(4.6 %)</td>
<td>(5.0 %)</td>
<td>(5.4 %)</td>
<td>(5.9 %)</td>
<td>(6.4 %)</td>
<td>(6.8 %)</td>
</tr>
<tr>
<td>Total</td>
<td>17313</td>
<td>15974</td>
<td>14736</td>
<td>13587</td>
<td>12553</td>
<td>11651</td>
</tr>
<tr>
<td></td>
<td>(100 %)</td>
<td>(100 %)</td>
<td>(100 %)</td>
<td>(100 %)</td>
<td>(100 %)</td>
<td>(100 %)</td>
</tr>
</tbody>
</table>
This proposal has been reviewed by the National Committee on HIV/AIDS Prevention and Problem Mitigation in January 2006. The Committee endorsed on the following working targets, as followed:

- By the year 2008, annual HIV incidence would be less than 7500 cases, and
- By the year 2010, annual HIV incidence would be less than 6000 cases.

The target by year during the next 5 years from 2006 - 2010 is illustrated in Table 2. The overall additional averted cases in this five years period would be 24285 cases. In order to achieve this, it is necessary to launch many innovative interventions such as the prevention of HIV among discordant couples and the following intermediate targets must be met within 2010:

- Consistent condom used among discordant couples, not less than 30 % (as to be increase from approximately none)
- Consistent condom used among MSM, not less than 90 % (as to be increase from approximately 80 %)
- Consistent condom used among direct sex worker with client, continue to not less than 95 %,
- Consistent condom used among extramarital sex, not less than 60 % (as to be increase from approximately 30 %)
- Sharing of injecting equipments among IDU, reduced to 18 % (as to be reduced from 36 %)

Table 2 Target of new HIV infections (not exceed) by year, 2006-2010, in a condition that Prevention Program and activities are strenthened

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous estimate</td>
<td>17313</td>
<td>15974</td>
<td>14736</td>
<td>13587</td>
<td>12553</td>
<td>11651</td>
</tr>
<tr>
<td>New Target</td>
<td>-</td>
<td>13724</td>
<td>10322</td>
<td>7492</td>
<td>6687</td>
<td>5991</td>
</tr>
<tr>
<td>Additional Averted cases</td>
<td>2250</td>
<td>4414</td>
<td>6095</td>
<td>5866</td>
<td>5660</td>
<td>4991</td>
</tr>
</tbody>
</table>

Interventions

It is essential that all prevention activities targeting to vulnerable groups through all potential modes of transmissions be implemented seriously. The prevention activities among risk groups that already existed should be maintained, assessed and improved according to the assessment result. However, to expedite the prevention program, there are major vulnerable groups that needed to be focussed immediately. These groups include:

1. Discordant couples.
   It is now well aware that partners of HIV infected people are at risk of HIV infection. It is proposed that voluntary counseling and testing services which will cover the prevention effort to protect discordant couple will be integrated into the ART services. There is a plan to supply condoms to all HIV infected individuals.

2. Male who have sex with male (MSM).
   MSM is another vulnerable group that required a strong intervention and support. During 2003 and 2005, a serial of HIV prevalence study among MSM in
Bangkok was conducted. The results were alarming that the HIV prevalence rates increased from 17 to 28%. There were studies conducting in other provinces revealing, though not as high as in Bangkok, a serious infection rate in this population. At the present time, interventions to raise awareness among MSM is carried out and will continue in the future. It is expected that condom will be used more as compared to the past.

3. Female sex workers and clients.
   Though the 100% Condom Program is still implementing all over the country and condom is provided free of charge to sex worker who needed them. However, the pattern of sex work business has shifted towards a more indirect type of service and more freelance sex workers have been observed during recent years. The interventions and activities for HIV prevention among this group must be adapted to fit with new situation. Supply of condoms must also be ensured on its sufficientcy and accessibility.

4. Intravenous drug users
   The rates of HIV infections among intravenous drug users have been high since the start of the epidemic. A new scheme of activities targeting the reduction of sharing injecting equipments and the implementing of maintenance treatment has been revised and expanded. The activities will be executed in the treatment facilities, as well as in the field through outreach program.

5. Youth as cross cutting population
   There are evidences suggesting that young people are at increasing risk of HIV infection. Many studies conducted in recent years indicated that higher proportion of youth have their first earlier in their lifes as compare to same aged group in the past. More young people also having sex with their friends, and partners who are not sex worker without using a condom. In addition, the reports of sexually transmitted infections among young people also increased during the past few years. All of these information indicate an urgent need to interrupt HIV transmission among youth.

Universal Access 2010: Thailand’s Treatment Perspective
The ARV program in Thailand has started since 2001 and gradually adapted to the available resources and tailored to the situation and PLHA needs. The goal of the program is to prolong the survival and restoring the quality of life of people living with HIV/AIDS, moving towards the ultimate goal of universal access to antiretroviral therapy for those in need of care through a comprehensive treatment response to HIV/AIDS. The comprehensive and quality treatment services will be available and provided to all individual living with HIV/AIDS in need of treatment, care and support by the end of 2010. Core principles of strategic framework include comprehensive, quality and equity. The strategies for strengthening treatment access for all towards Universal Access 2010 contains key actions and deliverables under each strategy. The fact that not all of the people who are at risk of getting HIV infection know their HIV status. Access to VCT is quite critical in terms of prevention program strengthening and early care and support to those people who may need. In 2006, the ARV program will be included in the national health insurance scheme. So, some of services that are the cores of the program has been designed to be included in the package of benefit in HIV/AIDS that is accessible by the people are as followed.

By using the concept of voluntary counselling and testing (VCT), we plan to strengthen HIV testing and counseling system by establishing an HIV testing and
counseling service unit in hospitals to provide free of charge, more accessible services. For the newborn and the baby delivered by the HIV positive mother, early diagnosis of HIV infection of those children is necessary for early care and treatment. A pediatric HIV testing system through PCR techniques for infants born to HIV positive mothers will be established. Integrated monitoring and quality improvement scheme for HIV diagnostics and HIV counseling will be developed to make sure that we are on the right track.

Up until now, the ART program has provided the first line ARV regimen to Thai people. The increasing demand of second line regimen has grown year by year. Apart from ARV program that we are implementing, we are moving toward giving the care to the asymptomatic HIV infected people. We are facing the broadening of demand of services that far beyond the current ARV program. So, the comprehensive program has been developed to response to the more and more complexed situation which has arised such as the antiretroviral programs for first line and second line regimens by establishing a CD4 monitoring service for asymptomatic HIV individuals, establishing treatment schemes for all category of HIV individual such as naive, pregnant, TB/HIV, experienced, Hepatitis B, C co-infection, crossed-financial health care scheme, establishing viral load and drugs resistant testing monitoring services to support treatment schemes, improving supply chain management for diagnostic reagents and medicines and securing reliable sources of affordable, quality diagnostic reagents and medicines.

PLHA is the group of people who play a vital role in dealing with the HIV/AIDS epidemic in may areas. Including PLHA in the services can facilitate the more effective program delivered the people. Strengthening involvement of people living with HIV/AIDS in treatment services can be done by establishing mechanism where people living with HIV/AIDS and healthcare facility incorporate in providing treatment services. Prevention measures can also be strengthened by applying prevention programs to people living with HIV/AIDS who are involved in comprehensive antiretroviral services, developing and establishing of prevention initiatives to prevent re-infection, STIs, resistant strain of HIV viruses and providing condoms to people living with HIV/AIDS who are involved in comprehensive antiretroviral services. One the key success factor in ARV program is promoting adherence to the treatment. It has been to proposed to apply adherence advocacy programs to people living with HIV/AIDS who are receiving antiretroviral treatment. The proposed interventions are to develop common adherence strategy and inmplement adherence strategy to all people living with HIV/AIDS who are receiving antiretroviral treatment.

**Care and support**

The children and the elderly affected by the HIV/AIDS epidemic have not received equitable care and support from the government eg. body, mind, social, economical, education, rights, etc.. The obstacle lies on the following facts. Lacking of policy is still there. The culture of health services do not respect to the capacity of the elderly. We do not have the supporting system for the elderly who take care of the affected children. The social welfare for affected children cantt cover the whole target. Some of the schools and communities still lack of understanding and are reluctant to allow infected children to stay in school and community.
The solutions are to change attitudes of the authorities that the elderly has capacity to cope with some parts of the problem and can be strengthened. The care and support system should be strengthened to cover the affected children and elderly more effectively. The local authorities can take part in relieving the impact of HIV/AIDS. Stigma, discrimination and human rights issues should be specially addressed by various organisations which could be GO or NGO or local authorities that be involved by the communities and PLHA.

One of the problems that the groups of PLHA have to face is income generation. As the result of some occupations’ characteristics, certain occupations are not suitable for the life style of PLHA. Creating the choices for PLHA is necessary for maintaining their lives. Self rely economy and support should be encouraged. Stigma and discrimination still exist in Thai society and should be lessened by continuous education and promoting the right attitude. Access to the support and income generation activities should be seen by the communities as the ordinary support that be given to the chronic diseases.

Compulsory HIV testing for workers who are finding job is one of the issues for the workers. Routine health examination in some factories and companies require HIV testing that could lead to the termination of job. The law still give the rights to the employers to initiate the termination of job and pay compensation for that. Some factories and companies are not aware and understand about HIV/AIDS and the human rights issues.

Ministry of Labour, Ministry of public health and NGOs are working on the promotion of Thailand AIDS Response Standard Organization (ASO) that let the factories and companies adopt it. ASO guideline can be used by any size of industries. Information and education among all stakeholders regarding the principles/elements of the ILO code of practice should be advocated. Legislation to protect the employees’ confidentiality and the rights of HIV infectaed workers should be considered.

Conclusion

HIV/AIDS epidemic in Thailand is sill evolving. Adapting the existing programs, whether prevention, treatment, care and support, is necessary and should be seen as the continuous process. Coping with such dynamic needs more involvement of various sectors in continuous monitoring, evaluation and implementation. As Thailand moving toward decentralisation of power and budget to local authorities, the transitional period should be managed in order to make sure of smooth transition.