

**FOLLOW-UP TO THE
DECLARATION OF COMMITMENT
ON HIV/AIDS (UNGASS)**

COUNTRY REPORT FORMAT
Reporting period: January-December 2002

PREAMBLE

The proposed generic reporting format is meant to assist National AIDS Councils (or equivalent) in drafting their national report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DoC) signed in June 2001 at the UNGASS on HIV/AIDS

Countries should carefully review the *Guidelines on construction of core indicators – Monitoring the Declaration of Commitment on HIV/AIDS* (named hereinafter Guidelines) before embarking in any data collection exercise. As explained in the Guidelines, a total of 13 core indicators divided into three categories are supposed to be collected/reported on at national level to monitor the DoC on HIV/AIDS:

Category 1: Two indicators on national commitment and action

Category 2: Nine indicators on national programmes and behaviour trends

Category 3: Two indicators on impact.

The Guidelines provide countries with technical guidance on the definition of the core indicators, the measurement tools required for their construction and frequency of data collection. It is essential that countries follow those Guidelines to ensure quality of the reported information. Countries are also encouraged to report on additional nationally representative coverage indicators since this report will be used as baseline to monitor progress over time. While selecting data to be reported on, it is recommended to avoid anecdotal information.

For **2003** General Assembly Session, reporting is required for all three categories of indicators. In view of time constraints, the following is recommended to all countries:

Category 1: Collect information through desk reviews and survey on financial resource flows

Category 2: Compile existing data (1) recent surveys such as DHS or MICS for those indicators requiring population-based information; (2) health facility, school-based, or workplace surveys for the other indicators. Countries are also encouraged to consult the following indicator database that contains data on some core indicators collected through household surveys: www.measuredhs.com/data.

Category 3: For HIV prevalence among young people, compile data from HIV sentinel surveillance (for countries with generalised epidemics) and recent specific surveys (for countries with concentrated or low epidemics). For HIV prevalence among infants, calculation of estimates needs to be done using programme coverage data.

<p style="text-align: center;">2003 General Assembly Session Target dates</p>
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<p>End of data collection: 10 March 2003 Reporting to Geneva: 31 March 2003.</p>
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For **2004** General Assembly Session, no reporting on national indicators is required.

For **2005** General Assembly Session, reporting is required for all three categories of indicators. This means that countries that have not yet planned any surveys for collecting information on the second category of indicators need to do so as soon as possible and latest early 2003.

**2005 General Assembly Session
Target dates**

End of data collection: 30 September 2004
Reporting to Geneva: 28 February 2005

A total of four annexes should be attached to the national report: (1) the consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS form; (2) the National Composite Policy Index Questionnaire; (3) the nine forms related to the National Programme and Behaviour Indicators; (4) the country M&E sheet.

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ANNEXES

ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index Questionnaire

ANNEX3: Nine national return forms national programme and behaviour indicators

ANNEX 4: Country M&E sheet

I. STATUS AT A GLANCE

<p>NATIONAL COMMITMENT & ACTION</p> <ol style="list-style-type: none"> 1. National Composite Policy Index 2. Government funds spent on HIV/AIDS 	<p>Details as in 3.1.1 \$ US 37.75 millions</p>
<p>NATIONAL PROGRAMME & BEHAVIOUR</p> <p>Prevention</p> <ol style="list-style-type: none"> 3. % of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year 4. % large enterprises/companies that have HIV/AIDS workplace policies and programmes 5. % of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT <p>Care/Treatment</p> <ol style="list-style-type: none"> 6. % of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled 7. % of people with advanced HIV infection receiving ARV combination therapy <p>Knowledge/Behaviour</p> <ol style="list-style-type: none"> 7. % of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention (Target: 90% by 2005; 95% by 2010) 8. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner 9. % of injecting drug users who have adopted behaviours that reduce transmission of HIV (<i>where applicable</i>) <p>Impact alleviation</p> <ol style="list-style-type: none"> 10. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school 	<p>To be surveyed</p> <p>20 % (estimated from research project result)</p> <p>77.1%</p> <p>85.29%</p> <p>12.9 % (estimated)</p> <p>75% (estimated from research project result)</p> <p>high school = 25% conscript = 30% factory worker = 20 – 38.6 % (all are estimated from research project results)</p> <p>no data</p>
<p>IMPACT</p> <ol style="list-style-type: none"> 11. % reduction of young people aged 15-24 years of age who are HIV infected (Target: 25% in most affected countries by 2005; 25% reduction globally by 2010) 12. % reduction of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010) 	<p>HIV prevalence among pregnant women aged <19 = 0.6%; aged 20-24 = 1.39%</p> <p>52.1%</p>

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Twenty years ago, due to limited knowledge and scientific information with regard to HIV/AIDS, its contribution factors and its consequences, HIV/AIDS was regarded as a health problem responsible merely by health professional. This perception was wrong and put the country in a complacency state. HIV/AIDS is a social and development issue and if neglected will pose serious threat to the family, community, country and global security.

2.1 The evolution of Thailand's AIDS Epidemic

HIV/AIDS arrived in Thailand in the mid-1980s. The prevailing view was that this was an epidemic brought from aboard that would be confined to a few individuals in high-risk groups, like gay men and injecting drug users, and would not spread more widely. Before the end of the '80, that view was proved incorrect. The first major wave of the HIV epidemic exploded among injecting drug users, rising from almost nil to 40% in a single year.

At nearly the same time, a second wave of infection spread among sex workers. In 1989, the national epidemiological surveillance found 1-5% of brothel-based sex workers were infected in sentinel provinces. The rising infection levels among sex workers, which reached 31% nationally by 1994, launched subsequent waves of the epidemic in the male clients of sex workers, their wives and partners, and their children. In 1993, infection rates among 21-year old army conscripts reached 4% nationally and the infection rates among pregnant women was 2.3% two years later. Although the report number of AIDS cases and deaths in 1990 was still low in number with less than 1000 cases, but it was estimated that 140,000 people got new HIV infection in a single year and the total number of people living with HIV/AIDS was around 300,000.

2.2 Beginning of national responses?

In 1990-1991, the Thai government acted decisively, launching a nation wide campaign to reduce HIV transmission. The key elements of the programme were a massive public information campaign through the media, government, and Non-government organisations. A 100% condom programme to promote universal and consistent condom use in commercial sex. Providing of accessible voluntary counselling and testing sites in all provinces. The response was led by a multi-sectoral National AIDS Prevention and Control Committee, chaired by the Prime Minister that actively engaged NGOs and civil society.

The national response resulted in fewer men went to brothels, condom use in sex establishments rose to more than 90%, the number of sexually transmitted infection seen in the clinics was reduced by more than 90% and HIV infection rates among army conscripts dropped by half a few years later.

? This section benefits greatly from an key note speech of H.E. Ms Sudarat Keyuraphan, Minister of Health on Economic Impact of HIV/AIDS in Thailand and the Thai Responses, world Economic Forum 2002, Malaysia.

The most recent epidemiological model by the Thai Working Group on HIV/AIDS projections in 2000 suggests that the annual number of new HIV infections peaked in 1992 and has declined by more than 80% with approximately 29,000 persons a year. Anyhow, the total cumulative HIV cases since the beginning is close to 1 million people with 300,000 deaths. At present, it is estimated that an annual of 50,000 HIV turns to AIDS and need medical care and social support.

With the strong political commitment and all the aggressive responses of the country, at least a million of people were protected from getting HIV. All of us who are working in HIV/AIDS field would agree that life of a people could not be measured by any monetary term. Therefore, investing in HIV/AIDS prevention and care is definitely a priority.

2.3 HIV prevalence at a glance

In its latest sentinel survey conducted in June 2002, the Bureau of Epidemiology of the Thai Ministry of Public Health reported 211,878 (as of February 28, 2003) cumulative AIDS cases. Surveillance data indicate additional 800,000 cases of HIV infection. Of all reported cases, there was a gender ratio of 3:1 male to female. Approximately 40% of total HIV infections were in the 15-29 year age group. Majority of them is in the young age group and working as labourer, farmers and recruits, etc.

The national behaviour surveillance survey conducted from 2000-2001 found a shift in sexual's partner selection among men from sex workers to casual partners (friends, girlfriends, etc.). Several research studies among youth aged 15 -25 showed high levels of knowledge and positive attitudes toward condom use. However, a much lower proportion of youth reported using condoms with all types of partners. In a second national survey (2,295 youth aged 15-25) conducted in February 2002[?], a large majority (72%) believed that using condoms is the most effective way to protect against AIDS, STI and pregnancy, and most youth (74%) indicated that carrying condoms is not unusual. Despite positive general opinions, 68% felt uncomfortable carrying condoms themselves. Reasons for feeling uncomfortable include fear of being stigmatised as a promiscuous woman or a sex worker, or feelings embarrassed to buy condoms. Thus, despite the Ministry of Public Health's aggressive national programme to promote 100% condom use in sex establishments, results from the behavioural surveillance survey indicated that the programme did not reach the general population, and youth, factory workers and mobile population groups in particular.

HIV prevalence in military conscripts at the national level decreased from 4% in 1993 to 0.5% in the year 2002. Cohort studies in conscripts confirmed the patterns seen at the national level, for example, a ten-fold reduction in incidence had been observed in the North in 1995 when compared to the early 1990s. It was evident that with a strong national response, we have seen a large decline in new HIV infections. The prevalence rate among intravenous drug users however, continued to increase from

[?] Survey conducted by Chulalongkorn University and the Ministry of Public Health

39% in 1989 to 51% in 1999 and decreased from 50% in 2001 to 41.67% in 2002 and is considered one of the major challenges to Thailand efforts to control HIV.

In the year 2002, from a total population of 61 million, it was estimated that 1,033,424 persons were infected with HIV since the beginning of the epidemic. Among these, 398,367 had died and 635,057 are currently living with HIV and AIDS in the country of which 55,000 would develop serious AIDS illnesses and approximately the same number will die of AIDS complications (Table 1). It was also estimated that 23,676 new infections would occur during this year compared to 143,000 new infections in 1990.*

Table 1 Estimated Cumulative Numbers of HIV/AIDS in the year 2002

HIV infections (adults and children) ¹	1,033,424
Deaths (adults and children) ¹	398,367
PWHA ¹	635,057
New HIV infections in 2002 ¹	23,676
New AIDS cases in 2002 ¹	51,738
Orphans due to AIDS ² (2001)	289,000

Source: ¹ Thai Working Groups on HIV/AIDS Projection 2000

² Children on the Blink 2002, UNAIDS.

2.3.1 Percentage of Young People aged 15-24 who are HIV-infected

The National HIV-Sero Surveillance reported HIV prevalence among pregnant women aged under 19 was 0.6% and HIV prevalence among pregnant women aged 20-24 was 1.3%.

2.3.2 Percentage of infants born to HIV infected mothers who are infected

Since 2000, Thailand has implemented a national programme to prevent mother-to-child transmission. Bureau of Health Promotion, Department of Health reported that from January to December 2002, among 578,320 women giving birth, 559,970 (96.8%) received antenatal care. Of 559,702 women giving birth who had antenatal care, 540,970 (96.7%) were tested for HIV before giving birth and of these, 6,336 (1.15 %) were found to be HIV positive. Of 6,336 HIV-positive women giving birth, 4,882 (77.05%) received prophylactic antiretroviral drugs before delivery. Of 5,561 neonates of HIV-seropositive women, 4,604 (82.8%) received prophylactic antiretroviral drugs and 5,232 (83.6%) received infant formula.

Based on previous findings, the risk of peri-natal transmission for doing nothing is 18.9 %. With ARV prophylaxis to interrupt perinatal transmission, the rate declined to 9.4 %. If these figures were applied to the services provided in year 2002, the rate of reduction of HIV perinatal transmission would be

* Bureau of AIDS TB and STIs, Department of Disease Control (2002) Report on HIV/AIDS and STIs in Thailand, Country Report (18/01/2002), Page 3.

The Perinatal HIV Surveillance Project in four provinces conducted by Bureau of Epidemiology, Department of Disease Control revealed that overall perinatal transmission rate is 5.4%. Therefore, there was 70% reduction of infants born to HIV infected mothers who are infected (Bureau of Health Promotion, Department of Health).

III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

The current national plan on HIV/AIDS is a comprehensive and holistic programme including both biomedical and social approach. The programmes are carried out by the joint effort of all government sectors, community-based, business sector, non-government organisation, and international organisations. Some important highlights of responses carried out by the Thai National AIDS Prevention and Alleviation programme are:

Sustain condom use in commercial sex and encourage safer sexual behaviour.

The highest priority for improving the effectiveness of the response is a continually push to sustain the high levels of condom use. The national response resulted in fewer men went to brothels, condom use in sex establishments rose to more than 90%, the number of sexually transmitted infection seen in the clinics was reduced by 90% and HIV infection rates among army conscripts dropped by half a few years later. Condom use among other high-risk groups like fishermen, registered and non-registered migrant workers would also have a large impact relative to their cost. The government has continuously provided free condom for sex workers in addition to self-buying.

National Prevention of HIV from Mother to Child Transmission programme (PMTCT)

Since 1999, HIV-positive mothers were provided with short regimen of AZT during antenatal period and delivery, AZT syrup to the baby, and replacement feeding on a routine basis. To enroll these women into the program, all pregnant women are offered with voluntary counseling and testing for HIV. Voluntary counseling and testing has been provided for all pregnant women since more than a decade ago.

The PMTCT is now covered more than 70% of all pregnant women. When fully implemented, it is expected that the National PMTCT programme can decrease the rate of mother to child transmission from 30% to 8% and the programme has the potential to prevent approximately thousands of infant HIV infections each year. The reduction of HIV transmission from mother to child resulted from this intervention is approximately 52 %.

National Anti-retroviral therapy (ART) programme †

Currently, the Government Pharmaceutical Organisation (GPO) is producing several ARVs and one of these is a combination drug of Navirapine, didanosine (ddI) and stavudine (d4T) generically at a substantially lower prices than imported brand-name drugs. The cost of treating a patient is 1 US dollar a day. It is estimated that Thailand needs to spend US \$ 500 per person for direct medication to treat a case of HIV that has low level of CD4. With the current government budget and the Global Fund to Fight AIDS, TB and Malaria. The Ministry of Public Health is expanding the access to ART from 2000 patients in previous year to 13,000 by the end of this fiscal year (September 2003). Although this will cost up to US\$ 20 million, but the programme will lengthening and enhancing the quality of life of AIDS patients. A proposal to expand access to ARV for all needed AIDS patients which will cover approximately 50,000-60,000 patients in the next fiscal year is being reviewed and considered.

3.1 National commitment and action

3.1.1 National Composite Policy Index

Strategic Plan

National Programme for Prevention and Alleviation of HIV/AIDS has developed strategic plan, which facilitated the multisectoral approach. The plan covers not only the prevention of direct HIV/AIDS epidemic but also cover the strategy on alleviation of aids impact through the national social and economic development plan starting from 2002 – 2006. The National Committees functions as the co-ordinating body and facilitates each committee to function as determines in their terms of references. Members of each committee were selected from different structure such as government, academic institution, NGOs, networks of PWAS and private organisation.

Ultimate outcome of the national response is to have a civil society response through good governance. This aim was set up not only for HIV/AIDS problem but also for all public health problems. Therefore people participation is encouraged through possible activities and lied within their way of life. Significant improvement can be highlighted as follows:

Impact of the HIV/AIDS epidemic

Although Thailand has instituted all necessary prevention and control measures to slow down the HIV epidemic but HIV has proved that its spreading speed is faster than our implementation. It is sad to see 300,000 deaths from developing AIDS and the country has to bear these following consequences.

Disability Adjusted Life Years (DALYs)

Deaths due to AIDS were grossly under-reported; only deaths in hospitals whereby causes were verified by professionals and reported to Bureau of Epidemiology. Cause of deaths at home was verified by layperson to the Central Registry. A verification of death certificate in Nan - one of the northern province hard hit by AIDS was done by

† This section benefits greatly from an key note speech of H.E. Ms Sudarat Keyuraphan, Minister of Health on Economic Impact of HIV/AIDS in Thailand and the Thai Responses, world Economic Forum 2002, Malaysia.

a comprehensive verbal autopsy for all deaths during July 1997 to June 1998 in every district (Nan PHO 1999 and Choprapawan 1999). There were 10.8 times under-reporting by death certificates. The macro-level information on AIDS morbidity and estimation in terms of DALY was estimated by Bureau of Health Policy and Planning based on the adjusted for underreporting, was that for each single day lost in life is a big lost of productivity. The total number of disability adjusted life years for HIV/AIDS was 1.3 million years lost (14% of total DALYs) and rank first of the top ten disease Category in 1999.

Life expectancy

Estimates made by the Bureau of the Census suggested that life expectancy in Thailand is 2-3 years less than it would have been in the absence of AIDS. In the northern region of Thailand which is the most severely hit by HIV/AIDS, life expectancy of children, under four has dropped by 10 years for boys and 5 years for girls.

Orphan

The results of the "Global Orphans Study for Thailand" estimated that in 1998 there were approximately 35,000 children under the age of 15 who had already lost their mother to AIDS and another 57,000 whose mothers were living with AIDS. A more recent estimate reveal that this number has been increased to 298,000 children, aged less than 15 years old, become orphans due to AIDS in the year 2000. Surviving parents and relatives usually elderly people cares for most children surviving by AIDS in Thailand, including HIV-positive children.

Children with HIV/AIDS

Today, approximately 1,200 Thai children are being infected with HIV each year from mother to child transmission. New knowledge showed that 20% of these children died during their first or second year of life but the majority will suffer a chronic HIV illness and will require ongoing medical management for their health as well as counselling and support.

Decreasing Labour force

Of those 700,000 people living with HIV/AIDS, 675,000 are adult in their high reproductive age. Over 90 % of all new deaths in the year 2000 are in the 20-44-age range, the most productive segment of the labour force. This demonstrates that the epidemic will have a serious effect on the Thai labour force. Because the HIV and death distributions are shifting to older ages, the impacts will increasingly hit the more experienced and skilled portion of the labour force. In the northern region, the local labour workforce is dramatically diminishing and workforce from other regions or neighbouring countries is required.

Increasing need of health care services and cost.

Since 1992, the number of bed in both community and provincial hospitals occupied by HIV related illness and AIDS is increasing rapidly. In Phayao province, the rate of bed occupation rose to 34.5% among male and 11.8% among female of internal medicine department. On the average 20 patients with AIDS stayed at the hospital a

day. In the community hospital of the same province the average length of stay of AIDS inpatients was more than double that of patients with other condition.

Family poverty and coping strategies

A paper on the economic impact of HIV/AIDS on households in rural Thailand analysed various household coping strategies. The researchers interviewed members of 600 rural households of which 50% had recently experienced chronic HIV morbidity. Information was collected in 1999 from household heads and caregivers involved in the care of the chronically ill. It was found that to cope with chronic morbidity, households used various strategies, which included decreasing household consumption, reallocating of labour, particularly by withdrawing children from school, dis-saving, and sometimes depending on the extended family system or the community for support. The income of some household cases decreased by as much as 70%. It was also found that total income per capita and total consumption per capita decreased by 68.4% and 43.5% respectively. In an effort to maintain consumption level, the primary coping strategy used by households was to delve into their savings. When savings were spent, households resorted to borrowing. Households incurred per capita loans of 28.4% and per capita debt of 118% relative to total household income per capita. Each of these strategies had a negative impact on welfare of the household. The high level of dissaving and significant percentage income devoted to health care expenditure indicated that HIV/AIDS could push households into poverty.

The programme for uniformed services

1. The Royal Thai Army Medical Department (RTAMD) organised the RTAMD AIDS Committee in 1989 to set up policy guidelines regarding HIV/AIDS in the Army and co-ordinate the various HIV/AIDS activities internally and externally.
2. The Ministry of Defences set up its MoD AIDS Committee in 1991 in accordance with the National AIDS Committee guideline that all ministries should organise their AIDS committee. The Royal Thai Air Force and Royal Thai Navy also organised their own AIDS committee.
3. Following the National AIDS Policy Guideline for 1998 – 2001, the RT formed the RTA AIDS Committee in 1994 to facilitate education of unit commanders and implementing interventions at unit level.
4. The Thai armed forces especially the Royal Thai Army played a unique and significant role in Thailand's successful fight against HIV/AIDS with its proactive policies and actions that can be itemised as follow.
 - 4.1 The early threat assessment in 1991 that classified HIV/AIDS as a threat to national security, this perception of HIV/AIDS as a security threat was instrumental in bringing about the prompt response and total mobilisation of the Thai society to deal with the problem.
 - 4.2 The behavioural surveillance in conscripts was done early in the epidemic with later collaborations with the Ministry of Public Health.
 - 4.3 The Royal Thai Army was among the first institutions in the country to develop behavioral intervention programmes to target its conscripts specifically e.g. the peer-

based intervention model by Kai Somdej Pranaresuan Maharaj Hospital in Pitsanuloke, the SOMSEX model by Kai Kawila Hospital in Chiang Mai and the PKK model by the AFRIMS team in Prachuab Kirikhan. These targeted intervention models have been widely adapted for use by other sectors.

4.4 The biomedical research programmes. The Royal Thai Army has several ongoing biomedical research projects in HIV/AIDS being conducted by AFRIMS, the most notable being several phase I-II trials of HIV preventive vaccines and the cohort development leading up to the phase III trial of the prime-boost vaccine concept currently ongoing in Rayong and Choburi provinces.

4.5 The RTA AIDS Committee is chaired by the Assistant Chief of Staff for Personnel and the secretary of this AIDS committee is the Director of the Preventive Medicine Department of the RTAMD. The Army AIDS policies reflect the national guideline set down by the National AIDS policy.

5. The Royal Thai Army has been working very closely with allies from the civilian sectors, government and non-government, and is a truly fine example of who have been called Multi-sectoral Co-ordination and Civil-Military Alliance Against HIV/AIDS.

The contribution of the Royal Thai Army in helping to control HIV/AIDS is well-recognised internationally, Currently the Thai Army has formed a team to write a Best Practice manual for UNAIDS.

Prevention activities

The programme has had a policy to inform Thai population through all channels. Mass media, social networks, and individual basis such as counselling in different setting including health service settings.

Different media such as poster, and pamphlet had been designed and disseminates. Approaches for publicise the message was changed from fear carousal to lifestyle integrated and positive approach. Specific target groups such as IDUs, men having sex with men have also been covered with all mediums and out reach activities.

For cross border issues, the committee has tried to address through the border committee at the ministerial level. Human right was also a concern to all parties involved. Committees were set up to monitor the violation of human right in term of research and treatment. Campaigns to promote sympathy and reduce social discrimination and gender differences were also periodically carried out.

Comprehensive HIV/AIDS care and supports were implemented to assure social equity. Access to care and medicine is now in progress through the provision of the universal coverage policy and the home and community based care.

3.1.2 Government funds spent on HIV/AIDS

Since the beginning of HIV/AIDS in Thailand in 1984, the national budget spending from Thai' government on this programme increased from less than US\$ 50,000 annually to the more than US\$ 35 millions for the year 2002. An estimated of the total of US\$ 400 millions has been allocated from the national budgets since then. If there is no AIDS, this amount of budget could be used for other social problems such as education, social welfare or fight against poverty or other natural disasters.

Allocated national funds comprise expenditure on the following five categories of programme in Fiscal year 2003 (October 2002-September 2003):

1. STD control activity about US\$ 1.38 million
2. HIV prevention about US\$ 2.20 million
3. HIV/AIDS clinical care and treatment about US\$ 29.19 million
4. HIV/AIDS impact mitigation about US\$ 3.59 million
5. Research and development about US\$ 1.42 million

Amount of national funds spent by governments on HIV/AIDS (US\$ 37.79 million) which included budget allocation for care (item 3) in 2002 for clinical care (universal coverage) US\$ 12.0 million, Antiretroviral drug US\$ 6.25 million, Laboratory US\$ 1.1 million, alternative care US\$ 0.1 million, comprehensive and continuum of care US\$ 5.2 million, social care network US\$ 0.75.

Government funding for HIV/AIDS was more than half used for curative (ARV and OI), the other 45% was for prevention (vertical transmission, breast milk replacement, blood screening, universal precaution, NGO subsidy, laboratory test and condom distributions). Analysis indicates non-MOPH budgets were spent on programme activities related to prevention, community empowerment, IE&C and other campaign. Then more than 70% of total national AIDS budget was aimed for prevention and disease control. It is difficult to estimate expenditure per capita as the magnitude of cross-subsidy using public hospital non-budgetary source of finance was not available.

3.2 National programmes and behaviour

3.2.1 Prevention

Since the outbreak of the AIDS pandemic, the AIDS education for in school and out-of-school youths and also for the general public has been one of the major vehicles for prevention and control of the epidemic in this country. The emphasis of the program has been directed towards the value clarification and modification and change of behaviour of vulnerable groups of people. The behaviour surveillance program has been initiated to monitor the behaviour change. The data from the behaviour surveillance was used for further improvement of the prevention programmes.

Life-Skill-based HIV/AIDS education in school

As for in-school youth under the Ministry of Education, The information and facts about HIV/AIDS have been incorporated into the curriculum of all levels. At least one teacher from each of the 33,200 public schools and 421 private schools have participated in AIDS awareness training and have been trained to teach the AIDS incorporated lessons.

The AIDS Education program has now been geared towards the participatory learning and Life Skills training approach. Life Skills Based participatory learning packages and support materials for HIV/AIDS education curriculum for primary and secondary school levels have been developed and distributed to primary and secondary schools in the country to facilitate schoolteachers. A group of core teachers and the educational supervisors who work with schools in the provinces have been oriented for the proper use of the Life Skill Based AIDS Education package. The effort has

demonstrated a great potential in raising HIV/AIDS awareness among students and lowering the misconception about HIV/AIDS among youth and general population.

Attempts have also been made to incorporate Life Skills training into the existing curriculum of all levels aiming to help young people develop and utilise their critical thinking, creativity, language and communication skill, coping, Empathy and self awareness to a greater potential. The Life Skills Training modules for Students and the package for training of trainers are currently in the process of development and trying out.

HIV/AIDS in the world of work

There are a number of programmes in place addressing HIV/AIDS in the work place. The programmes have involved various departments under MOPH and Ministry of Labour. Some programmes have been supported by UN agencies, NGOs and employers and employees associations.

In 2001, Ministry of labour by the Department of Labour Protection and Welfare in collaboration with the International Labour Organisation (ILO) had drafted a plan for HIV/AIDS programme in the world of work (Model development on HIV/AIDS Prevention and Management in Workplaces: Outreach to Factories in Rayong Province and the role of business can play on HIV/AIDS). The programme was piloted in 44 factories in Rayong province at the industrial park. The programme outcome and impact are being observed. The project is still ongoing.

In July 2002, the Ministry of Labour and Social Affairs organised a national workshop on HIV/AIDS and the world of work where the Thai edition of the ILO Code of Practice on HIV/AIDS and the World of Work was presented.

The ILO, the Thailand Business Coalition on AIDS and the Employers Confederation on Thailand jointly developed an Employers' Guide on how to manage AIDS in a Company.

The Thai Labour Solidarity Committee, which brings together various workers' organisations and NGOs in Thailand, is promoting AZT coverage by the Social Security Scheme. It is also addressing with the Ministry of Labour the issue of forced blood screening of workers.

There are also activities and research carried out by NGOs, and university programme. Thailand Business Coalition on AIDS[?] one of NGOs active in workplace programme had revealed data from their programme carried out from March to June 2001 in Bangkok and Chiangmai where there are high prevalence levels of HIV infection and large number of employees. There are total 165,500 companies with 3.3 million employees in Bangkok and Chiangmai, which are 42 percent of the total employees in Thailand (Ministry of Labour and Social Welfare, 2000). For companies with more than 100 employees, the project sampled only 100 employees from each company. If a company has less than 100 employees, they collected information from

[?] Panakitsuwan, Surachai, Thailand Business Coalition on AIDS (TBCA)

all employees in each company. Thus, the questionnaires were distributed to each section of the company proportionally, based on the number of employees in the section, and then each section distributed the questionnaires to the employees. A total of 9,799 employees have been sampled from 74 companies in Bangkok and 50 companies in Chiangmai. Informed consents are provided for all interviewees. Only project staff members used individual questionnaires. The other interested parties were provided with the aggregated data only.

The finding indicated that a high degree of discrimination against people living with AIDS still exists in the workplace at the individual level.

In the analysis of logistic regression, it has demonstrated that the familiarity with people living with HIV/AIDS, knowledge on HIV/AIDS, and gender, are the important determinants of discriminatory attitudes toward HIV-infected co-workers.

This study also revealed that approximately half of the employees have inaccurate knowledge about people living with AIDS. Half of them also were not familiar with people living with HIV/AIDS. Thirty five percent of Single male employees have casual sex with condoms. Twenty five percent of Single female employees have casual sex with condoms. And seventy percent of male employees have sex with sex workers with condoms.

Another study on the business sector's responses to aids problems in the workplace: a study of industrial estates in Bangkok[‡], which aimed to investigate how to tackle AIDS problems within the industrial estates in Bangkok and to examine the security and welfare of their employees and new applicants as a consequence of the industrial estates' ways of coping with AIDS problems.

The results of the study show that the level of understanding and acknowledgement of AIDS situation is low. Confidentiality and welfare policy existed in a small number of workplace. There are still rooms for workplace education programme in Thailand.

Prevention of MTCT: antiretroviral prophylaxis

A study conducted in Bangkok demonstrated that a short course of twice daily oral zidovudine (AZT) was safe and well tolerated and, in the absence of breast feeding, lessened the risk for mother to child HIV-1 transmission from 18.9% to 9.4%. A pilot testing using AZT was initiated in 1998 in the northern high sero-prevalence provinces. Assessment in pilot areas found a satisfactory result and high programmatic feasibility for a wider implementation resulting in policy decision to implement on a nation-wide scale.[‡] This prompted the Thai Government to provide

[‡] A thesis submitted by Miss Kullapa Lertaveepornkul on 18 April 2001 in partial fulfilment of the requirements for the degree of Masters of Arts, Faculty of Social Welfare, Thammasart University.

[‡] Kanchana S, Thewanda D, Teeraratkul A, et al. Implementing short-course zidovudine to reduce mother-infant HIV transmission in a large pilot program in Thailand. AIDS. 2000;14(11):1617-23.

universal access to Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) in 2000.†

The Bureau of Health Promotion, Department of Health reported that 4,882 HIV infected pregnant women provided with ARV therapy to reduce the risk of MTCT from January to December 2002. There were 578,320 women who gave birth in the last twelve months. Of these, 559,970 (96.8 %) came for ante-natal care and 540,970 were tested for HIV (96.7%), only 1.1% that were HIV-infected case (6,336 cases). Therefore, 77.1% (4,882/6,336) of identified HIV infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT.

If the risk of perinatal transmission for doing nothing is 30 %, and the transmission was reduced to approximately 8 % with ARV and other prophylaxis regimen, there was approximately 52.1 % reduction of infants born to HIV infected mothers who are infected (Bureau of Health Promotion, Department of Health).

3.2.2 Treatment and Care

In Thailand the majority of people with HIV/AIDS are cared for by family members and supported in some cases by the services of NGOs and community-based organisations (CBO). Capacity building of the communities is being encouraged. This includes the roles of monks in providing psychological support and care for terminally ill patients with AIDS.

Sexually transmitted infection: comprehensive case management

As STD rates are an accurate co-indicator of HIV transmission, a rapid expansion of STD services, especially those assessable to rural populations, was initiated in 1991. The incidence of STI included gonorrhoea and non-gonococcal infection as well as syphilis during 1987-1989 was stable, but after 1989 when the implementation of condom promotion and 100% condom use brothel programme began, the incidence dropped rapidly.

Prior to the HIV epidemic in Thailand, the STD control programme had been built largely around case finding, treatment and follow up, contact tracing, health education, and control of STD among sex workers. However, in response to the HIV epidemic the country has strengthened and improved the STD programme with a number of additional strategies that included the following factors:

1. Extensive health promotion of safer sexual behaviour and condom use.
2. The “100 percent condom programme” with distribution of sufficient free, good quality condoms for commercial sex workers.
3. Prevention programmes among populations at high risk for STD and HIV, including education programmes for military recruits, IEC and peer education programmes for sex workers, migrant workers, fishermen, factory workers etc.

† Thaineua V, Sirinirund P, Tanbanjong A, et al. From research to practice: use of short course zidovudine to prevent mother-to-child HIV transmission in the context of routine health care in northern Thailand. *Southeast Asian J Trop Med Public Health* 1998; 29(3): 429-42.

4. Comprehensive STD case management aimed at accessibility of services for vulnerable populations, effective treatment, counselling for reduction of risk behaviour, partner notification, and increased condom use. The reach of these services has been expanded through integration of STD services at the community and primary health care levels and through promotion of the role of the private sector (pharmacies and private clinics) as partners of government agencies.
5. Mass media campaigns and a national STD campaign aimed at improving STD health seeking behaviour.
6. Enhanced screening for detection of asymptomatic STD cases.

Among 4,393 adults with STI attending public STI clinics in all over Thailand, the Bureau of AIDS, Tuberculosis and STI, Department of Disease control reported 85.79% for whom received correct procedures of the Thai National Treatment Guideline for sexually transmitted infections.

HIV treatment: antiretroviral combination therapy

In Thailand, services for the treatment and prophylaxis of common opportunistic infections such as Tuberculosis, Pneumocystis Carinii Pneumonia, Cryptococcal Meningitis and diarrhea are being expanded to ensure universal coverage. A Task Force was established to implement a work plan with objectives to 1) ensure the availability of prevention and treatment for opportunistic infections at all health care levels 2) to enhance information for people with AIDS on available prevention and treatments for opportunistic infections 3) to change provider attitudes that discourage AIDS patients from obtaining treatment and 4) to develop a well-defined 'package' of health care benefits in the different public insurance schemes for people with AIDS.

Services are also being developed to provide combination anti-retroviral therapies for HIV-infected individuals in Thailand in a limited number of health care settings. At the same time, costs, benefits, affordability and equity implications of different types of the combination therapies will be assessed and monitored.

Thailand introduced the health care delivery and social services strategies for HIV and AIDS to measure how the country is providing anti-retroviral drugs in all types, especially triple drugs. There are also provision of ARV drugs in form of projects to promote systematic comprehensive and continuum cares for the persons living with HIV/AIDS in Thailand. In this regard, the following criteria are used for the enrollment:

1. HIV infected patients with AIDS defining illness, regardless of CD4+ count level;
2. Patients with HIV infection, and one of these following symptoms: oral thrush, chronic fever, pruritic papular eruption, chronic diarrhea, weight loss of more than 15 % in 3 months;
3. Patients with HIV infection with the level of CD4+ cell < 250 cell/cu.mm.

In addition to the biomedical indications stated above, the hospital is encouraged to use the social indicators as to enroll the patients. Community Organization, existing NGO and people with HIV Group have been participating in the selection of patients.

With these inclusion criteria, number of people with advanced HIV infection receiving ARV combination therapy are reported:

- Number of people receiving HARRT at the beginning of year 2000 is 1,200 cases.
- Number of people who commenced treatment in the last 12 months(2001-2002) is 7,910 cases
- Number of people for whom was terminated is 769 cases
- Total number of HIV/AIDS currently receive HAART (2002) is 8,341 cases.

Based on the above figure, it is estimated that, out of 64,832 AIDS persons living in year 2002, the coverage of these patients receiving ARV combination therapy is 12.9 % (8,341/64,832).

3.3 National behaviours at a glance

National strategies carried out strengthening access to and utilisation of services. Primary prevention service needs for secondary school youth include counselling, information, and provision of condoms as dual protection and STI services. The Ministry of Public Health's "Friend Corner," Regional Health Promotion Services, and the Youth-friendly Pharmacy Programme comprise entry-points to provide services tailored for youth. Current guidelines and training processes already developed for these services will be delivered to an expanded network of providers. These providers had undergone specialised training in order to provide more responsive counselling, referrals and other services to youth clients. The introduction of national standards for service provision will ensure that providers adhere to quality standards. In order to increase demand for and utilisation of services by youth, introduction and promotion of services will be integrated as a key component of the Life Skills and Parenting packages and outreach activities.

Young people knowledge about HIV prevention

However, in this report, data were not classified as indicated in the UNGASS report form, so it is impossible to fill in the form as indicated. Moreover, Thailand has gone beyond what is needed in the reporting form in terms of the preventive (knowledge) behaviour aspects. Therefore no appropriate data collected which is relevant to the UNGASS reporting indicator in this aspect at the time being.

Young people's condom use with non-regular partners

The HIV/AIDS risk behaviour surveillance was initiated in 1995 to supplement other HIV/AIDS surveillance systems (Bureau of Epidemiology, Department of disease control, Ministry of Public Health). The risk behaviour surveillance presented in this paper derived from the annual survey conducted during 1995-2002 with male (military conscripts, factory workers and students) and females (factory workers, pregnant women and students).

Among **conscript group**, number of subjects in which data were gathered varied from 4,463 to 6,775. It was found that majority (73.6-90.5 %) of these people were single at the time of the survey. Their average age at the survey period were 21 years old. Of all subjects, 68.5-89.1 % reported to have sexual experience. Of these, median age when they had first sex was 17-18 years old. Rate of condom used in their first sex

increase increase from 27.6 in 1995 to 34.1 in 1998 and then gradually dropped to 22.2 in 2002.

Proportion of conscripts reported to have sex with sex-worker during one year period prior the survey declined continuously, from 48.8 % in 1995 to 19.5 in 2002. Rate of always use a condom with sex worker also rose up from 50.4 % in 1995 to 63.4 % in 1999 and then declined to 55.6 % in 2002. When ask question with regard to sex with other women (non sex-worker, non lover and not a friend) during one year period prior the survey, proportion of conscripts reported having such partner declined from 52.8 % in 1996 to 24.9 % in 2001 and 27.2 % in 2002. Condom use every time when having sex with other women in this group increased from 20.1% in 1996 to 30.9 % in 2002.

Among **male factory worker group**, number of subjects participated in the survey varied from 3,926 to 4,858 subjects. It was found that approximately half of all subjects (54.1-59 %) were single at the time of the survey. About 52.4-62.3 % were less than or equal to 24 years old. Of all subjects, 77.4-80.3 % reported to have sexual experience. Of these, median age when they had first sex was 18 years old.

Proportion of subjects reported to have sex with sex-worker during one year period prior the survey declined continuously, from 30.6 % in 1995 to 14.7 in 2002. Rate of always use a condom with sex worker also rose up from 53.1 % in 1995 to 63.4 % in 1999 and then declined to 55.6 % in 2002. When ask question with regard to sex with other women (non sex-worker, non lover and not a friend) during one year period prior the survey, proportion of conscripts reported having such partner declined from 45.2 % in 1995 to 21.8 % in 2001 and 25.4 % in 2002. Condom use every time when having sex with other women in this group increased from 26.2 % in 1996 to 38.6 % in 2002.

For **female factory worker group**, number of subjects participated in the survey varied from 4,824 to 5,618 subjects. The average age of these subjects in each round range from 22-24 years old. About half of all respondents (47.6-56.2%) were married. Of all subjects, 56.9 % reported to have sexual experience in year 1996 and this figure increase to 65.8 % in year 2002.

Proportion of subjects reported to have sex with friend or lover who was not husband during the year 2000-2002 was around 11 %. Rate of always use a condom in this group was low at about 10 %. There were 3 % of these subjects reported to have sex with a man (or more) who was not friend, lover or husband. Less than 20 % of such subjects reported that they always use a condom.

Of all male high school students, 76 – 81 % reported to have ‘no girl friends’ or in other words never engaged in sexual intercourse. Of those who reported having sex, 70 % stated that they used a condom.

Similar to male high school students, only 2% of female students reported having their ‘first sexual encounter’ with a friend/lover and 1% with ‘other men’. Approximate 1-2 % of students reported ‘having sex with a friend/lover’ and 0.5% with ‘other men’ within the year prior to the survey

Based on these findings it is clear that Thailand is still at risk of having another outbreak of HIV among the general population due to the lack of condom use during casual sex. Despite continuous reductions in commercial sex visitation by men, many still engage in casual sex without condoms. This finding is further supported by the female population survey. These findings pointed to the urgent need to improve levels of condom used in casual sex in Thailand.

According to the report from the National Statistic Office, there was a survey to interview the general population aged 15-24 (12,000 subjects) about the exposure to media producing by the Office of Prime Ministry on HIV/AIDS knowledge, attitude and perception. It was found that high proportion of the interviewed subjects were able to answer the questions on HIV transmission correctly. Those were: HIV can be avoided by having sex with only faithful, uninfected partner (76%); and; HIV can be avoided by using condom (76%). However, a substantial portion of subjects still answered incorrectly about HIV transmission. These included; a person can get HIV from mosquito bites (21%); and; a person can get HIV by sharing a meal with someone who is infected (7%).

% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner

In summary, approximate rate of consistent condom use when having sex with non-regular non-sexworker sexual partners among group of populations are as follow:

Among Male conscript: 30.9%

Among Male Factory Worker: 38.6%

Among Male grade-11 student: 25.7%

Among Female Factory Worker: 20%

Please be reminded that the proportion of each group to engage in having such casual sex varied greatly and interpretation of this information must be done with caution. (Source of data: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health)

Injecting drug users: safe injecting and sexual practices

% of injecting drug users who have adopted behaviours that reduce transmission of HIV (where applicable)

The results of the Behavioural Surveillance Survey of male addictive drug users in Bangkok, 2002. The survey performed self-administered questionnaires. The anonymous manner of self-administered questionnaires encourages more reliable information about individuals' health risk behaviour.

The finding indicated that 95 % of male addictive drug users (N=335) have had sexual experience. In the past year , we found that almost 88 % of male addictive drug users have had sex with their girlfriends and 19 % use a condom every time , 16.7 % have had sex with CSWs and 89 % use a condom every time. At last sex, 40.7% male addictive drug users used a condom. For drug users, we found that 61 % shared a syringe and needle with other users and 50 % cleaned their syringe and needle. Approximately 4.2 % of users usually had sex after injecting drugs and 20% used a condom every time, approximately 13% did not use a condom during sex after

injecting drugs. Almost 40% of users who occasionally had sex after injecting drugs and 14% used a condom every time; 37.9% did not use condom

When we compared the data in male addictive drug users in 2001 and 2002 only. It was found that about 40% of male addictive drug users were unemployed. It was slightly lower in 2002. Most of them were sexually active and had had their first sexual intercourse. Pattern of condom use was reported, safe sex practice was highest when having sex with commercial sex workers, while the condom use was lower when having sex with girlfriend or casual partner. However, safe sex practice was improved from prior survey. It also revealed that the disease prevalence decreased from 12% to 9%. Approximately 9% of drug users had sex in exchange for money or rewards in 2002.

3.4 Impact alleviation at a glance

Ratio of orphaned to non-orphaned children 10-14 years of age that are currently attending school

Orphans' school attendance

Thailand has a national policy on the six-year compulsory education. Therefore we can assume that all orphans in Thailand are entitled for attending schools. However, at the beginning when the society misconception existed, discrimination might have been reported. At present, there are different organisations took this issue in to account and established the umbrella to reassure that all AIDS orphans have access to school education with good understanding from teachers, classmates, and parents.

The total of orphan's who have lost both parents from HIV/AIDS was 14,886 (boys; 7,732 and girls; 7,154). However, orphan data on attending schools is not available at the time of this report.

IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS

Key challenges faced throughout the reporting period by 2005 was to identifying focal point for the M& E Country Achievement report. Many sectors, both governments and NGO were invited and brainstormed to identify focal point, and set up mechanisms for the country report. As a result, Bureau of AIDS, TB and STIs, Disease Control Department, Ministry of Public Health was selected as the focal point.

Other challenges included quality and relevancy of the data collected by different report formats and ways of analysis, data were collected for different purposes, therefore review of the forms and analysis were taken place. It was recognised by the working group that Thailand has to come up with the special body to complement the existing data collection relevant to monitoring and control of HIV/AIDS indicators since the existing information system is not applicable for UNGASS indicators.

Recently a number of the Bureau staff have been trained on CRIS (Country Response Information System) introduced by UNAIDS that would help strengthen this process. Without discussion and participation from members of different sectors who were appointed as the working group, these challenges would not be identified and met. However, the data collection plan was to be developed.

V. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Key actions needed from development partners to assist Thailand in achieving goals and targets are to provide financial support to a project aims to strengthen Thailand's capacity for M&E country achievements following UNGASS 'Declaration of Commitment on HIV/AIDS.' The project aims to assure the commitment from all sectors, and enhance each sector of their monitoring and evaluation system based on the M&E based model introduced by UNAIDS.

Project activities include organising workshop for members of all sectors to discuss and facilitated by the local resource person who are identified by the Bureau of AIDS, TB and STIs. Expected output of the project is to set up a mechanism of M&E which fits with the context of HIV/AIDS Prevention and Care Programme in Thailand.

VI. MONITORING AND EVALUATION ENVIRONMENT

In writing a report for March 2003, and September 2003, an institutional support was requested due to the different systems and different parties involved in submission of the data. In order to assure the quality of the data, a team of AIDS expert in statistics, management, economics and behavioural sciences was contracted. The Team from the Faculty of Public Health, Mahidol University has to functioned as a temporary consultant to the Bureau of AIDS, TB and STIs in 1) reviewing and giving suggestions on what should be and how to set up a mechanism to collect the indicators, 2) to write two reports, and 3) to present the report at the official meeting or events such as National Aids Conference seminar in July. And 4) strengthen M&E for long term UNGASS reporting system.

ANNEX 1
**Preparation/consultation process for the National Report on
monitoring the follow-up to the Declaration of Commitment on
HIV/AIDS**

1) Which institutions/entities were responsible in filling out the indicators forms?

a) NAC or equivalent	<u>Yes</u>	No
b) NAP	<u>Yes</u>	No
c) Others (please specify)	Yes	No

2) With inputs from:

Ministries:

Education	<u>Yes</u>	No
Health	<u>Yes</u>	No
Labour	<u>Yes</u>	No
Foreign Affairs	Yes	No
Others (please specify) Defence, Local government ie, BMA	<u>Yes</u>	No

Civil society organisations	Yes	No
People living with HIV/AIDS	<u>Yes</u>	No
Private sector	<u>Yes</u>	No
UN organisations	<u>Yes</u>	No
Bilateral	<u>Yes</u>	No
International NGOs	<u>Yes</u>	No
Others (Please specify)	Yes	No

3) Was the report discussed in a large forum? **Yes** No

4) Are the survey results stored centrally? **Yes** No

5) Is data available for public consultation? **Yes** No

Name/Title: Dr. Sombat Thanprasertsuk

Date: 31 April 2003

Signature: _____

ANNEX 2
NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

Yes : †	No	N/A
Comments: The plan has been developed through the multisectoral participation approach and based on the human development focus and integration approach.		

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Yes : †	No	N/A
Comments: The plan is for 2002 –2006 period with the periodical review of the plan.		

3. Does your country have a functional national multisectoral HIV/AIDS management/co-ordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes : †	No	N/A
Comments: The coordination body is functioned based on the term of reference to facilitate all subcommittees to function in their scope of work as scheduled.		

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes : †	No	N/A
Comments: Beside the national levels, at the implementation level, the coordinating body also exists to function as the facilitating body as described at the national level.		

5. Does your country have a functional HIV/AIDS body that assists in the co-ordination of civil society organisations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes : †	No	N/A
Comments: Yes, the body from multi sectors are working towards facilitating the civil society to involve in the AIDS prevention and control programme.		

6. Has your country evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes?

Yes : †	No	N/A
Comments: Yes, the programme has been evaluated by different indicators and methods covering the psychosocioeconomical and medical aspects of the HIV/AIDS affected aspects.		

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defence forces?

Yes : †	No	N/A
Comments: Not only a policy guideline was developed but also continuing education programme has been carried out in the uniformed group population.		

Prevention

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

Yes : †	No	N/A
<p>Comments: Yes, the policy has not been only promoting information but emphasising on the health literacy in some special group such as teenagers, or housewife. However the coverage and intensity of the promotional activities may not be even.</p>		

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Yes : †	No	N/A
<p>Comments: Yes, the policy for carry out a programme for the young people are not only offered by the teacher, but NGO, and health personnel. The issues and medium to promote learning are broad base and on the edge technology as well.</p>		

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

Yes : †	No	N/A
<p>Comments: Yes, the policy is supportive to reach out those who are vulnerable or at risk as well as to promote health of the general population.</p>		

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

Yes : †	No	N/A
<p>Comments: Yes, pilot project is now launching to promote learning about HIV/AIDS along the border. Moreover the policy advocacy activities such as ministerial meeting has also been taken place.</p>		

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

Yes: †	No	N/A								
<p>If yes, please list</p> <table border="0" data-bbox="336 472 1366 696"> <tr> <td data-bbox="336 472 869 515">Groups:</td> <td data-bbox="869 472 1366 515">Commodities:</td> </tr> <tr> <td data-bbox="336 515 869 557">Youth reproductive age group.</td> <td data-bbox="869 515 1366 557">Condom via vending machine</td> </tr> <tr> <td data-bbox="336 557 869 600">HIV positive pregnant women</td> <td data-bbox="869 557 1366 600">antiretroviral drug</td> </tr> <tr> <td data-bbox="336 600 869 642">Vulnerable group and general population</td> <td data-bbox="869 600 1366 642">voluntary counselling testing</td> </tr> </table>			Groups:	Commodities:	Youth reproductive age group.	Condom via vending machine	HIV positive pregnant women	antiretroviral drug	Vulnerable group and general population	voluntary counselling testing
Groups:	Commodities:									
Youth reproductive age group.	Condom via vending machine									
HIV positive pregnant women	antiretroviral drug									
Vulnerable group and general population	voluntary counselling testing									
<p>Comments: Activities for improving the coverage and public awareness may be needed.</p>										

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

Yes: †	No	N/A
<p>Comments: Every pregnant woman will be advised to test and if positive will receive ARV to reduce the transmission to her babies.</p>		

Human rights

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

Yes:	No †	N/A
<p>Comments: There is no specific law and regulations. However, the Constitutional law guarantees human rights towards education, accommodation, occupation and health service. The National Human Right committee has been set up along with the Ethical Research Committee in human subject to assure the human right of the Thai people.</p>		

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

Yes:	No †	N/A
<p>If yes, please list groups:</p>		
<p>Comments: The social measures policy to promote understanding and sympathy towards the affected groups and vulnerable group was promoted. Additional comment to this question is similar to what stated in no.1 above.</p>		

3. Does your country have a policy to ensure equal access, for men and women, to prevention and care, with emphasis on vulnerable populations?

Yes: †	No	N/A
<p>Comments: The latest development of equal access in Thailand is the thirty Baht universal coverage scheme, which is one of the major government policies. This policy also covers HIV/AIDS treatment.</p>		

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

Yes: †	No	N/A
<p>Comments: All research proposal and protocol are reviewed and approved by the MOPH ethical committee. Moreover other institution both education and medical service in Thailand are now implementing this ethical review policy mechanism.</p>		

Care and support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes: †	No	N/A
If yes, please list Groups: Commodities:		
Comments: It was stated in the Ninth National AIDS plan to assure the provisional of the service for the vulnerable group.		

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretroviral and drugs for the prevention and treatment of opportunistic infections and palliative care.)

Yes: †	No	N/A
If yes, please list Groups: Commodities:		
Comments: It was stated in the Ninth National AIDS plan to assure the provisional of the comprehensive care for every vulnerable group.		

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

Yes: †	No	N/A
The bureau has recently convened a meeting with related ministries and the meeting designated Ministry of Social Development and Human Security to develop five years strategic plan on the children and families affected by HIV/AIDS		

**ANNEX 4
COUNTRY M&E SHEET**

COUNTRY: Thailand as of: April 29, 2003

1. Existence of national M&E plan

Yes: † Years covered:2003-2006	In progress: Years covered:	No:
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2. Existence of a national M&E budget

Yes: † Amount: 37.70 mil. Years covered:2002-2003	In progress: Years covered:	No:
---	--------------------------------	-----

3. Amount secured as of today ____

4. Existence of an M&E unit for HIV/AIDS within the government

National AIDS Council	Ministry of Health	Elsewhere: _____
Yes: - No: -	Yes: : † No:1	

5. M&E focal point on HIV/AIDS within the government

Name: Dr. Sombat Thanprasertsuk
Telephone: 66 2 590-3200
Email sombat@aidsthai.org

6. Existence of information systems:

Health Information System

Yes: : † National level: Sub-national*:	No: 1
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** If yes, please specify the level, i.e., district*

Education Information System

Yes: : † National level: 1 Sub-national*: -	No:1
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** If yes, please specify the level, i.e., district*