

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

## **COUNTRY REPORT FORMAT**

Reporting period: January-December 2004

## I. STATUS AT A GLANCE

<b>NATIONAL COMMITMENT &amp; ACTION</b>	\$ US 36,629,182.08
1. National Composite Policy Index 2. Government funds spent on HIV/AIDS	
<b>NATIONAL PROGRAMME &amp; BEHAVIOUR</b>	
<b>Prevention</b>	
3. % of schools with teachers who had been trained in life-skills-based education and who taught it during the last academic year	37.9-48.8%
4. % large enterprises/companies that had HIV/AIDS workplace policies and programmes	50.9 % (TBCA: 2005 research project result)
5. % of HIV + pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	85.7% (1 <sup>st</sup> Oct 2004- 30 <sup>th</sup> Sept 2005): PHIMS
<b>Care/Treatment</b>	
6. % of patients with sexually transmitted infections at health care facilities who were appropriately diagnosed, treated and counselled	70.17%
7. % of people with advanced HIV infection receiving ARV combination therapy	45.2%
<b>Knowledge/Behaviour</b>	
7. % of respondents, 15-24 years of age, who both correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission or prevention <b>(Target: 90% by 2005; 95% by 2010)</b>	
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 had adopted behaviours that reduced transmission of HIV ( <i>where applicable</i> )	25% (Thanyarak Institute)
<b>Impact alleviation</b>	
10. Ratio of orphaned to non-orphaned children 10-14 years of age who were currently attending school	
<b>IMPACT</b>	
11. % reduction of young people, 15-24 years of age, who were HIV infected <b>(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)</b>	Capital City 12.36% Other Urban&Rural 23.5%
12. % reduction of infants born to HIV infected mothers who were infected <b>(Target: 20% reduction by 2005; 50% reduction by 2010)</b>	57.9%

# **NATIONAL COMMITMENT & ACTION**

**Government funds spent on HIV/AIDS**

**(Budget allocation by Royal Thai Government)**

## **1. Prevention**

Massive public information by using media communications	708,100.75	(11.60)
100 % condom promotion	1,050,000.00	(17.21)
Build up the empower of people in community to prevent AIDS transmission		(1.59)
Build up NGOs empower	96,925.00	
Set up AIDS conferences in CDC regions	1,035,000.00	(16.96)
Provide formula milk for prevention AIDS transmission from mother to child	1,250,000.00	(20.48)
Prevent the accident of AIDS transmission in health staffs	1,737,500.00	(28.47)
<b>Total US\$ (%)</b>	<b>225,000.00</b>	<b>(3.69)</b>
	<b>6,102,525.00</b>	<b>(100)</b>

## **2. Treatment and Care**

To look after AIDS patients by ARV treatment (training, conferences, monitoring and evaluation programs)	4,851,625.10	(15.89)
OI treatment	1,975,329.05	(6.47)
ARV drugs	16,618,343.73	(54.44)
To provide chemical testing	3,277,034.20	(10.73)
To build up knowledge base (research)	1,184,250.00	(3.88)
Social welfare for AIDS patients and families	2,620,075.00	(8.58)
<b>Total US\$ (%)</b>	<b>30,526,657.08</b>	<b>(100)</b>

**3. Total: US\$ 36,629,182.08**

## National Composite Policy Index

### 1) Past and present

Ever since the first case of HIV/AIDS was reported in Thailand in 1984, it had become a widespread problem affecting Thai people's health, social life and economy. The HIV/AIDS pandemic began with the first HIV/AIDS transmission from an infected homosexual to a commercial sex worker in Thailand. Since then, it had spread to promiscuous men, housewives and eventually to the general public.

Thailand began to recognise the significance of the problem and its progressive effect from the rising infection level. In the past two decades, over 500,000 Thai citizens were estimated to have died of AIDS. However, there were even more people currently living with HIV/AIDS in Thailand, including orphans and others affected by the disease, who were still waiting for assistance.

During the early stages of development of the HIV/AIDS Prevention and Alleviation Plan in Thailand (1984 – 1990), the public did not have much interest. However, when a person acquired the virus through the use of donated blood in 1986, the public became more attentive of the situation. Their renewed interest generated the momentum for the creation of policies as well as short-term and medium-term HIV/AIDS plan (1989 – 1991), which focused on the ways to address the issue, provide AIDS & health education, and monitor the situation. In 1989, the government announced a policy to screen all donated blood for HIV, the virus that causes AIDS.

After that period, HIV/AIDS soon became an epidemic and dramatically impacted society at large. Policy makers began to recognise that HIV/AIDS was a major social issue and decided to utilise the National Economic and Social Development process to rectify any basic issues as well as social & political restrictions in order to prevent and alleviate the effects of the HIV/AIDS epidemic. First, the Office of the National Economic and Social Development Board drafted the strategies for the National Plan for the Prevention and Alleviation of HIV/AIDS. The plan was based on the concepts used in the National Economic and Social Development plan, which stressed on the adoption of a holistic, human-centred approach together with strengthening the community rights, decentralising power, increasing public participation in the decision making process, and promoting good governance. In addition, the plan also recognised the importance in quality improvement and educational services, public health services, and social welfare services. However, during the economic crisis in 1997, the government reduced 27.44% of the overall budget (The data from annual AIDS plan, budget in 1997 budget is 1,891,153,100 Bath and in 1998 budget is 1,372,304,000 Bath so that budget is reduced 27.44%) which greatly impacted the prevention and alleviation of HIV/AIDS strategy. Nevertheless, the government still placed great emphasis on the treatment and care of people living with HIV/AIDS.

The prevalence of HIV/AIDS had declined due to previous effort. Subsequently, it was discovered that the prevalence of HIV/AIDS had expanded to cover a wider variety of population groups, especially in young adult groups. Thus, the original strategies were no longer effective. The original target groups, including commercial sex workers and intravenous drug users, were also more difficult to access even though great progress had been made in revising the rules and regulations that impeded the effort. In the past, there was a disconnection in the services that were being provided to prevent and alleviate the HIV/AIDS problem, which caused tremendous problems. Therefore, the strategy was modified to emphasise on developing the potential of individuals, families, and communities; improving quality; accessing the basic health care services without discrimination; and working together to integrate the tasks of HIV/AIDS prevention and alleviation.

Based on a recent projection by experts at the Thai Working Group, the total number of people with HIV/AIDS in Thailand in 2005 was expected to be about 1,092,327 people. This figure was comprised of 50,620 children, 551,550 anticipated deaths, 540,822 PLWHA<sup>1</sup> that required continuing care and treatment, and 18,172 new cases. For 2006, the total number was likely to rise to be about 1,109,000, of which 53,400 were children, 508,300 were PLWHA that required continuing care and treatment, 17,000 new cases and 600,600 anticipated deaths.

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<sup>1</sup> People living with HIV/AIDS

During 2001-2004, the number of PLWHA as well as the overall prevalence rate had noticeably declined. However, based on close monitoring at each locality, it was evident that the contraction rate in the high risk groups were still elevated, especially among intravenous drug users (42.2%) and "straight" female sex workers (7.64%). The HIV/AIDS prevalence rate for female sex workers was directly related with the higher rate of male who comes for venereal diseases check-up. The decline in overall HIV/AIDS prevalence rate was due to the reduction of HIV/AIDS transmission from donated blood. If we looked at the prevalence of HIV/AIDS by region, the North ranked at the top, followed by Central, South, Northeast regions, respectively (Bureau of Epidemiology, January 2005).

The age group that had the highest proportion of HIV/AIDS infections was the 30-34 year old group at 25.80% and the second highest was the 25-29 year old group at 25.32%. The major risk factor or cause of the infection was sexual intercourse (83.77%). The occupations of PLWHA (in descending order) were general employees (44.29%), farmers, unemployed, merchant, housewife, children, etc.

Most of the reported case of AIDS also had other opportunistic infections. The top 5 of such infections were as follows (from most common to least):

- 1) *Mycobacterium tuberculosis*, Pulmonary or Extrapulmonary infection [79,347 people, 29.61%]
- 2) *Pneumocystis Carinii* pneumonia [57,084 people, 21.30%]
- 3) Cryptococcosis [43,260 people, 16.14%]
- 4) Candidiasis (Trachea, bronchi) [14,177 people, 5.29%]
- 5) Recurrent bacterial pneumonia with multiple occurrences in 1 year [10,054 people, 3.75%]

In 2004, the conscripts were being closely monitored for risky behaviours and condom usage. The results indicated that there was a rise of risky behaviours when compared to the 1997 figures and the rate of condom usage was only 30-60%. For general company employees, 77-84% indicated that they had had sex, and only 15-33% of the people used condom. Likewise for vocational students, 21-32% indicated that they had had sex, and only 10-31% of the people used condom.

## **2) Policy on HIV/AIDS Prevention and Alleviation**

The Ninth National Economic and Social Development Plan (2002-2006) stressed the adoption of a holistic, human-centred approach, which had brought reform through the public service systems, especially the health care system. In addition, the plan provided assurance and gave opportunity to comprehensively improve the standards of medical and health care services. According to Thailand's Prime Minister Pol. Lt. Col. Thaksin Shinawatra, Thailand's policy on AIDS was as follows: (Thaksin Shinawatra's speech of opening ceremony on 11 July 2004. XV International AIDS Conference, Bangkok, 11-16 July 2004.)

1. Promote education and understanding among Thai citizen regarding HIV/AIDS and prevention measures. Everyone should recognise the importance of this epidemic so that all parties involved could work together.
2. Develop a system of medical, public health, social and consultation services so that PLWHA could improve the quality of life. The goals were to reduce mother-to-child transmission to 3%; provide treatment for opportunistic Infections through the National Universal Health Care Scheme (30-Baht health-care program); include antiretroviral medications in the National Universal Health Care Scheme; encourage everyone who was living with HIV/AIDS to have an appropriate job; provide treatment and care for orphans and other affected children; and revise the laws and regulations to help alleviate the problem.
3. Accelerate the development of medical biotechnology, traditional medicine, and AIDS vaccination research to have the most effective method in preventing and alleviating the HIV/AIDS problem.
4. Utilise the "Power of the People" strategy to prevent and alleviate the HIV/AIDS problem. By consolidating the power from all the parties involved, namely the government sector, private companies sector, public companies sector, and the general population sector, the major strength could be used to develop concrete and effective measures to prevent and alleviate the HIV/AIDS problem.

The policy as stated above was consistent with the National Plan for the Prevention and Alleviation of HIV/AIDS Plan (2002 – 2006) which had a vision statement that read: “Individuals, families and communities form a strong and healthy society where people possess wisdom and knowledge, have a mutual sense of concern, and work together to prevent and alleviate the HIV/AIDS problem.” The main objectives were to have individuals, families, and communities take responsibility and act together in a sustained fashion to prevent and alleviate the HIV/AIDS problem, and to strengthen the foundations of society in order to facilitate the process. The specific targets were outlined as follows:

1. Reduce the HIV prevalence in the reproductive age population less than 1%.
2. At least 80% of the PLWHA and affected individuals would be receiving and/or having equal access to proper care and support from public, private and community providers of social, economic, educational, and primary health care services.
3. Local administrations and community-based organisations throughout the country would efficiently and continuously develop work plan and carry out the work on HIV/AIDS prevention and alleviation.

After the above targets for HIV/AIDS had been achieved, additional targets and annual objectives had been developed in order to reach the main objectives. The details of the target were as follows:

<b>Target Description</b>	<b>2002 Result</b>	<b>2003 Result</b>	<b>2004 Result</b>	<b>2005 Target</b>
1. HIV prevalence rate for pregnant women	1.39 %	1.18 %	1.04 %	1%
2. HIV prevalence rate for conscripts (draftees)	0.7 %	0.55 %	0.52 %	0.5%
3. Number of PLWHA or were affected by the disease and needed to use antiretroviral medications.	8,151	16,626	50,752	64,700
4. Number of PLWHA or were affected by the disease and received support & assistance fund	10,000	11,000	12,900	15,100
5. % of children under 2 years old that had contracted HIV/AIDS from their mothers	10.1 %	9.7 %	6.7 %	3.7 %
6. Number of orphans that received care or had access to medical and social services.	-	-	12,200	-
7. % of Provincial AIDS Prevention and Alleviation Sub-Committees that had on-going work plan	70.97 %	75 %	85 %	90 %
8. % of Local administration (government office) that took part in the prevention and alleviation of HIV/AIDS problem.	-	-	-	-

The strategic measures for the above goals were as follows:

1. Develop the potential of individuals, families, communities and the broader social environment in order for them to have the capacity to defend against HIV/AIDS infection. The main focus was to ensure everyone had a sense of duty, generosity, good principles and morale. They must also take joint responsibility to prevent and alleviate HIV/AIDS problem. The ways to achieve this were outlined below:

- 1.1 Build awareness of HIV/AIDS situation by promoting more education, fostering of a sense of duty, and acting consistently with local environment, values, and culture of that locality.
- 1.2 Ensure that individuals, families, and communities could work together in a sustained effort as well as accept and live normally with people that had HIV/AIDS.
- 1.3 Develop education curricula, activities, and tactics to improve formal and informal education for people of all age groups at all levels of the society (e.g. hygiene instructions, public relation campaigns) to protect themselves from HIV/AIDS infection.

2. Establish administration system for health care and social welfare services that enhance the capabilities of PLWHA in order to improve their own health and enable the families and communities to care for any member of their community in times of illness and trouble. These measures could be achieved as follows:

- 2.1 Establish a standardised and comprehensive public health system that improved the health, care and treatment of people living with HIV/AIDS.
- 2.2 Capacity-building for personnel who cared for people living with HIV/AIDS.
- 2.3 Establish budget management system to include the necessary medications.
- 2.4 Develop counselling and mental health services for people living with HIV/AIDS.
- 2.5 Provide social and economic services for PLWHA and their affected family members to improve quality of life and promote economic self-sufficiency in the long-term.
- 2.6 Establish mechanisms to protect the rights of PLWHA and those affected by the disease and put a stop to any violation.

3. Develop knowledge and research for the prevention and alleviation of HIV/AIDS through systematic and sustained development of a body of knowledge and technology that could be utilised to formulate measures to prevent and alleviate HIV/AIDS problem in Thailand. The body of knowledge was obtained by following-up, reviewing, analysing, synthesising HIV/AIDS situations and compiling the knowledge from research within the country and internationally. In order to be able to exchange our knowledge and experience with other countries, it was important to promote research organisations to conduct high quality research. We must also encourage the development of technology to support industrial production which had an effect on the level of protection and problem resolution. These targets could be achieved through the following measures:

- 3.1 Promote education on HIV/AIDS transmission and to approximately predict the trend.
- 3.2 Promote education and research in order to protect and provide treatment for people living with HIV/AIDS.
- 3.3 Increase the capacity of related departments and organisations in utilising Information and Communications Technology to prevent and alleviate the HIV/AIDS problem.
- 3.4 Promote the development of basic research structure and research personnel.

4. Promote International co-operation for the prevention and alleviation of HIV/AIDS by focusing first on the co-operation with countries in the region and then on the international exchange of technology and scientific knowledge. Another important point was the co-ordination of the use of resources from overseas to assure that maximum benefits was derived in accordance with methods stipulated in the National Plan for the Prevention and Alleviation of HIV/AIDS 2002-2006. These targets could be achieved through the following measures:

- 4.1 Mobilise local and international resources to prevent and alleviate HIV/AIDS.
- 4.2 Strengthen co-operation with various countries, particularly those bordering Thailand, to address the issue of cross-border labour and protect the rights of people living with HIV/AIDS.
- 4.3 Promote the exchange of knowledge, science and technology.

5. Develop a holistic program management system to integrate the tasks of HIV/AIDS prevention and alleviation. The main focus was to ensure the work plan and project to prevent and alleviate HIV/AIDS were integral and effective, which was achieved by developing management mechanisms that could integrate the tasks and ensure that all the work became a collective responsibility of all the parties involved. In addition, the administration system in the government sector must be adapted to be consistent with the decentralisation of decision-making authority to the regional and community levels. It should also promote public participation and transparency, and allow private sector or citizen to audit. Above all, the system must be justice.

- 5.1 Foster serious co-ordinated planning and multilateral implementation efforts to assure that the work of preventing and alleviating the problem of HIV/AIDS in Thailand was efficiently undertaken.
- 5.2 Promote the distribution of resources and decision-making authority and develop multilateral checks and balances to assure that the administration of organisations at the regional and community levels was transparent.
- 5.3 Develop mechanisms for the modification of plans to assure systematic and efficient implementation in accordance with the strategies in the National Plan.
- 5.4 Develop systems and mechanisms for monitoring and evaluation with clearly defined indicators.

With at least 540,822 people living with HIV or AIDS at present, and enormous pressure to provide access to ART, Thailand had instead invested the vast majority of its current AIDS budget in care and support for positive people and their families. There was, however, recognition of this imbalance and finances were being sought from bilateral donors and the UN Global Fund for prevention among mobile population (tribal and migrant), youth/casual sex, and seafarers as well as expanded care and treatment.

Civil society had been responsive and had played a large role in prevention and reduction of stigma, especially in the North. The MOPH had developed the capacity to work with NGOs and collaborative with them to work with health officials for prevention, care, treatment and mitigate the impact. However, the various networks of NGOs themselves had recognised their need for improving capacity to document, monitor and evaluate their work and to develop greater sustainability. The major NGOs continuing to provide significant HIV prevention and care programmes in Thailand were: the international NGOs, Medicines sans Frontieres, Save the Children (UK), PSI (with DFID regional funding), PATH; and the Thai NGOs, AIDSNET, Thai Red Cross, CARE/Raks Thai, Population and Development Association (PDA), Thai Business Coalition on AIDS, Empower, and the Reproductive Health for Quality of Life Development Association of Thailand (HAT). There were, in addition, several Buddhist, Muslim and Christian organisations that offered education and hospice care as well as many small local CBOs.

A national programme for preventing PMTCT of HIV had been successfully implemented using short-course AZT and substitutions for breast milk. Early monitoring indicated good programme uptake with a recognised need in the future to pay greater attention to counselling, communication, and training, and better use of monitoring and evaluation data to guide the programme development, expansion, and improvement (Kanshana and Simonds 2002).

Much investment had been made over the past few years in developing and testing inexpensive ART combinations. The Government Pharmaceutical Organisation (GPO) had now produced a generic triple-combination HAART called GPO-VIR, sold for 20 baht (about 50 U.S. cents) per tablet. According to the GPO's calculations, a monthly dosage would amount to 1,200 baht (30 U.S. dollars). The pill consisted of Nevirapine, Lamivudine and Stavudine and dosage was one tablet twice a day. The Thai CDC expected to be able to help about 50,000 patients in the year 2004 with the current government budget, although number of people with HIV/AIDS needing ART in Baseline (NAPHA) Scenario (including asymptomatics with CD4 < 200), they estimated that at least 180,000 (the data from ???) patients needed the ARVs urgently.

Reviews of progress and needs in care and support had shown the continuing need of better use of prophylaxis for OIs, better diagnostics and treatment for OIs, and a more integrated community response to diminish stigma, helped orphans and other affected children, provided economic opportunities for affected families and psychosocial support.

The Global Fund award for HIV/AIDS in Thailand has 3 Rounds, in round 1 was \$13,990,962 in Year 1 (with a total application for \$109,353,700 over 5 years). Of the total for Year 1, \$4.5 million was proposed for prevention of HIV transmission through casual sex (with a focus on youth in school, workplace settings and communities), and the remainder (\$9.49 million) for improving access to HIV/AIDS care, including access to HAART. In HIV/AIDS round 2 was \$27,541,528 and HIV/AIDS round 3 was \$911,542

Global fund has been the largest external input to Thailand's HIV/AIDS resources. Beyond that, UN agencies contributed largely through support for advocacy, planning, training, research, and policy reviews, as well as a considerable number of activities that were technically regional in nature (Task Forces on Mobility, Youth, Drugs and HIV Vulnerability, support of monks to conduct AIDS education and care, youth and drugs meetings, etc.). There was also a UNAIDS Technical Working Group on HIV/AIDS for Thailand that carried out numerous meetings, reviews, documentations, media events, and helps to mobilise funds.

### **3) National Committee on AIDS Prevention and Alleviation**

The management of HIV/AIDS at a national level as well as the formulation of the national plan and strategies had been the mission of National Committee on AIDS Prevention and Alleviation. The details of Committee's structure were described as follows:

The National Committee on AIDS Prevention and Alleviation (NCAPA) is charged by the Prime Minister and Director-General of Department of Disease Control was the Committee's secretary. The proportion of committee's members devided by GO:NGO:PHA:Academic is equal 21:2:1:11. The committee's role was to set policy, work plan, measures and to control, regulate, and co-ordinate the work regarding HIV/AIDS prevention and alleviation. There was a National Centre for management of AIDS Prevention and Problem Alleviation, which acted as a secretariat office.

The Director-General of Department of Disease Control was also the Chairman of the sub-committee to co-ordinate, develop budget, keep track, regulate, and conduct assessment. The Director of Bureau of AIDS, TB and STDs, Department of Disease Control was the secretary of the sub-committee. The committee's members are all of 11 ministries and 1 TNCA (NGO) and 1 TNP (PHA network). The committee's role was to propose the strategy, coordinate, promote, follow-up, regulate, conduct assessment and develop information system for the work plan to prevent and alleviate HIV/AIDS problem.

The Sub-Committee to Prevent and Alleviate HIV/AIDS in the Province was chaired by the respective provincial governor. The role of sub-committee was to set direction and policy, keep track, coordinate, carry out the prevention and alleviation work for HIV/AIDS at the province level. The AIDS Control Program or the provincial office in each the province acted as a secretariat office. Recent assessment indicated that about 70-85% of all the provinces had mechanisms to effectively manage the work, could manage the network, and could develop integrated work plan.

The AIDS Vaccine Sub-Committee which reviews AIDS vaccine study proposal and monitors AIDS vaccine trials had Emeritus Professor Dr.Prasert Thongcharoen, M.D. as the Chair and the Director of Thai Bureau of AIDS, TB and STDs as the Secretary. The role of the committee was to set the policy and guidelines on how to proceed with the research and development of the AIDS vaccine. It also promoted tracks, screens, verified and developed vaccines to protect or treat HIV/AIDS according to the standard. In addition, the sub-committees gathered all the knowledge and wisdom and disseminated appropriate AIDS research to the community.

#### **3.1 Process and Procedure**

- 1) National Committee on AIDS Prevention and Alleviation determined the budget proposal and managed the HIV/AIDS prevention and alleviation operation at the national level according to the suggestions of all 3 sub-committees.
- 2) Related departments determined the budget plan and operated under the policy set by National Committee on AIDS Prevention and Alleviation and within their area of responsibility.
- 3) Follow-up and assess the project. The project assessor was the department responsible for the project. The department was supported by the Sub-Committee to Prevent and Alleviate HIV/AIDS in the Province, who also evaluated the overall picture of the province. For the views of the entire nation, the status was compiled by The National Committee on AIDS Prevention and Alleviation.

#### **3.2 Challenging Issues: National level**

##### **National Level**

- 1) The National Committee on AIDS Prevention and Alleviation lacked of clarity (for what), which caused the National Centre for the management of AIDS Prevention and Alleviation that served as secretariat unable to push the implementation forward as per the policy.
- 2) The prevention and alleviation work lacked an effective information management system; thus, the available information was not sufficient enough to provide useful direction.

- 3) The work mechanism was unable to correspond with the trend in bureaucratic reform, which led to weak on the network of all related parties. Distribution of resources was also inconsistent with the needs of each location.
- 4) The assessments were not systematic and were inconsistent with the changes in epidemiology.

### **3.3 Challenging Issues: Provincial level**

- 1) Sub-Committee to Prevent and Alleviate HIV/AIDS in the Province still lacked of leadership a leader to manage the province and lacked co-ordination for policies and work plans, which caused no changes in policy that would bring about changes in actions.
- 2) Did not receive on-going support from all level of society, which led to lack of continuity and instability.
- 3) Budget system was inconsistent with the Province's strategic plan. There was no co-ordination with the local authorities in order to request for co-operation and support.
- 4) Lack of follow-up and evaluation at provincial level that were mostly related with projects. (This sentence cann't understand)

(Have more any detail in 3.3, if more information???)

### **4) Network of Government Agencies**

The HIV/AIDS Prevention and Alleviation Plan involved 10 government ministries, 39 bureaux and three offices having activities related to HIV/AIDS. These agencies worked within their framework and target group.

The National Centre for the management of AIDS Prevention and Alleviation was a centre for co-ordinating work plan, budget plan and for following-up. The activities implemented by these agencies involved campaigning, health education, developing leaders in each group, treatment, care and psychosocial support for people living with HIV/AIDS. The budgets to prevent and alleviate HIV/AIDS problem for each ministry were as follows:

Name of Ministry	2002 (in million Baht)	2003 (in million Baht)	2004 (in million Baht)
Office of the Prime Minister	NA	NA	4.00
Ministry of Defence	19.4075	17.0758	21.5587
Ministry of Interior	30.07	41.65	58.314
Ministry of Justice	NA	NA	1.79
Ministry of Education	NA	NA	13.15608
Ministry of Tourism and Sports	NA	NA	1.2984
Ministry of Culture	NA	NA	2.91
Ministry of Public Health	1178.7964	885.1133	1309.15622
Ministry of University Affairs	154.8139	154.8139	162.814
Ministry of Labour and Social Welfare	6.32	5.9522	5.782
Ministry of Social Development and Human Security	77.5463	77.3978	44.811
Office of the Attorney General	NA	NA	0.70
Office of the Royal Thai Police	5.935	6.34	3.476
<b>Total</b>	<b>1472.8963</b>	<b>1188.3475</b>	<b>1629.7664</b>

## **5) Network of Non-Government Organizations (NGOs), Community-Based Organizations (CBOs), and Private Organizations**

NGOs Coalition on AIDS, which included organisations that promoted public service in private sector; Community-Based Organizations (CBOs), other religious organization, etc., engaged in public service activities to prevent and alleviate HIV/AIDS problem and played a major role in the implementation at all society level, especially activities that involved high risk or underprivileged people (e.g. hill tribe groups, fisherman groups, and foreign worker) that were difficult to reach.

NGOs Coalition on AIDS was formed by many individuals with a varied skills and proficiency levels (for example: group, association, society or foundation), and had changed its format (What is the meaning?)and communication network as well as support other NGOs.

The NGOs Coalition on AIDS committee was the central organisation of the network. There are smaller committees at the regional level. These smaller committees' role was to co-ordinate, promote the work performed by NGOs AIDS in the network.

For people living with HIV/AIDS, activity groups among infected people were formed and grew to become a strong national, regional, and provincial network. In the near future, there was a strong tendency to have a network within the districts. Currently, there were more than 700 groups of people living with HIV/AIDS and the number is growing rapidly. Most of the activities done by these organizations were group activities to support members within the group, including following up to ensure continuous use of antiretroviral medications.

The government through its Department of Disease Control has provided budget to NGOs since 1992. Following is the number of projects and NGOs requesting for budget and the amount approved from 1992-2004.

Year	Requested Projects			Approved Projects		
	No. of Projects	No. of Agencies	Budget	No. of Projects	No. of Agencies	Budget (Baht)
1992	42	37	66,125,734	35	23	11,917,450
1993	63	39	33,123,813	56	39	15,000,000
1994	120	101	72,903,868	91	76	10,000,000
1995	209	116	350,765,292	153	94	75,000,000
1996	308	186	267,232,488	188	122	80,000,000
1997	387	299	313,544,757	247	184	90,000,000
1998	725	434	494,739,684	343	244	90,000,000
1999	928	583	450,124,685	465	373	87,598,700
2000	882	625	368,671,357	372	293	60,000,000
2001	730	497	404,038,189	457	371	70,000,000
2002	923	660	370,140,183	522	444	70,000,000
2003	987	712	337,938,984	605	519	70,000,000
2004	868	978	289,624,851	577	508	70,000,000

The table shows that the number of NGOs and number of projects requesting financial support rose tremendously while the total budget remained relatively the same from 1997 onwards. During the years 2000-2001, which was when Thailand had an economic crisis. As a result, the government budget to support NGO was reduced to be 60-70 Million Baht per year. However, from 2002-2005, the budget remained constant at 70 Million Baht per year.

## **6) Network of International Organisations**

In Thailand, many international organisations, such as UNAIDS and WHO, had supported various activities and assisted in preventing and alleviating the HIV/AIDS problem. Their sponsorship and operations were usually focused toward working together to co-ordinate resource usage, and exchange of technology. Most of the activities were related to research, organisation of international meetings, study of work methods, and prevention and alleviation of HIV/AIDS problem with specific population groups, such as International Co-operation Projects to Prevent and Alleviate HIV/AIDS Problem at the border area, Co-operation Projects between Thailand and other countries, and Care and Treatment Program under the ASEAN Work Plan II. However, up until now, there was no system that could properly co-ordinate, aggregate and keep track the sponsorship from the international organisation and the resulting output.

The Global Fund was one of funds that was specifically aimed for combating HIV/AIDS, tuberculosis and malaria as per the UNGASS announcement, which stated that there must be a target in finding and setting budget to deal with the HIV/AIDS epidemic in countries with low to medium income of about 7,000 – 10,000 million US Dollars within 2005. Thailand had developed the HIV/AIDS management structure in year 1 of the Global Fund (2004-2005) in the form of working groups at varying levels and allocated the promotion budget to protect against contraction of the disease (US\$ 4,389,168), to treat those living with HIV/AIDS (US\$ 9,213,504), and to manage and administrate the operation (US\$ 388,290). Altogether, Thailand received US\$ 13,990,962. This money was used to fund various projects which were able to obtain 75-100% satisfaction rate. Example of projects are as follow:

- Prevention of HIV through sexual transmission among youth at community level
- Prevent of HIV transmission in school
- Improvement of Accessibility to Health Care for PLWHA
- Expansion of antiretroviral medication service

## **7) Budget Management System**

To develop a national budget for the HIV/AIDS prevention and alleviation plan, many related bureaus must first develop and propose their own budget that was consistent with their goals, strategy, measurement criteria and activities. The budget proposal went through a formal approval process and had to be within the overall budget limit. Key factors that affected the budget, approval amount were as follows:

- Overall government policy in each year
- Economic Growth
- Problems and severity of HIV/AIDS epidemic
- Operating results and statistical/technical information that supported the budget plan for each year
- The capacity of the bureaux that participated in the prevention and alleviation of HIV/AIDS problem

The budget to support prevention and alleviation of HIV/AIDS was first by allocated to the Ministry of Public Health in 1988 with an amount of 4,604,300 Baht. In 1991, the government developed an approach to allocate budget to project that spanned in many ministries. Later in 2002, part of the budget for the prevention and alleviation of HIV/AIDS problem (480.0632 million baht) was combined with the National Universal Health Assurance Budget to pay for medical supplies used for treating opportunistic infections, powder milk, and AZT medicine to prevent mother-to-child transmission. In 2001, additional budget was allocated to provide antiretroviral medicine to AIDS patients and in 2004, the policy was expanded to provide comprehensive coverage for antiretroviral medicine through the National Access to Antiretroviral Program for PLWHA [NAPHA].

To keep up with the changing environment, the National Plan for the Prevention and Alleviation of HIV/AIDS 2002-2005 had also improved its concepts and operational direction. The overall budget structure was separated into 3 main sections: HIV/AIDS prevention, HIV/AIDS alleviation and HIV/AIDS intellectual development & research. The management of the overall budget was included in the alleviation section whereby the allocations were made according to the duties and area of responsibility of each department (both public and private sectors).

**Summary of the National HIV/AIDS Prevention and Alleviation Plan's Budget for 2002-2004  
(Grouped by major activities)**

Type of Activities	Budget (in million Baht)					
	2002	%	2003	%	2004	%
1. Prevention of HIV/AIDS Transmission	288.23005	19.57	181.5789	15.28	244.101	14.98
2. Alleviation/Treatment for people living with HIV/AIDS.	992.287654	67.37	780.13998	65.65	1221.066283	74.92
3. Management of HIV/AIDS Plan	149.5814	10.16	162.5867	13.68	91.91309	5.64
4. Intellectual Development and HIV/AIDS Research	42.80	2.91	64.04	5.39	72.69	4.46
<b>Total Budget</b>	<b>1,472.8963</b>	<b>100.00</b>	<b>1,188.3475</b>	<b>100.00</b>	<b>1,629.7664</b>	<b>100.00</b>

Since 480.0632 million baht of the 2002 budget was transferred to the National Universal Health Assurance Program, the overall 2003 budget got reduced to 1,188.3475 million baht. However, the budget for 2004 rose back up to 1,629.7664 million baht due to the NAPHA program which provided coverage for 50,000 cases (approximately 822.680278 million baht) of antiretroviral medicine. The budget for the antiretroviral medicine was allocated to the Department of Communicable Disease Control and was few managed to support all hospitals inside or outside the Ministry of Public Health providing ARV care to AIDS patients. Therefore other ministries could not set up a budget for antiretroviral medicine in their department.

Due to the success of the expansion policy in providing comprehensive coverage for antiretroviral medicine, the tendency to include this source in the National Universal Health Assurance Scheme was highly probable. On average, antiretroviral medicine in the treatment cost about US\$300 – 400 per person per year to most newly treated patients. Therefore, it was projected that the overall budget required to support program in the long run should be feasible.

## NATIONAL PROGRAMME & BEHAVIOUR

### ***Prevention***

#### **Life-skills-based HIV/AIDS education in schools:**

**Data source name:** Ministry of Education (Office of the Basic Commission), PATH working related to HIV/AIDS education in the schools

**Data source type:** Interviewed schedules with key informants, education programme review, MoENet Survey Service

**Data collected period:** January 2004 - December 2004

Available Indicators	Secondary School
1. School had at least one qualified teacher who had received training in particular life-skills-based HIV/AIDS in the last five years	1,680
2. School had staffs members trained to teach HIV/AIDS education in the last 5 years who had taught the subject on a regular basis to all classes in the last academic year	1,016
3. Number of reported schools (document)	2,083
4. Total number of reported schools in the country (document)	2,675
5. Indicator scores by secondary school (=2/3)	48.8%
6. Indicator scores by secondary school: National as reported schools (=2/4)	37.9%

## **Workplace HIV/AIDS control:**

**Data source name:** TBCA research project (funded by the GFATM)

**Data source type:** Simple random sampling (cross sectional survey in 2004), 27 provinces  
(2,169 workplace/ mostly factory)

**Data collected period:** January 2004 - December 2004

<b>Available Indicators</b>	<b>N*</b>	<b>%</b>
1. Anti-discrimination at work policies		
1.1 Staff recruitment (no policy on HIV blood testing for staff recruitment)	2,168	89.1
1.2 Staff promotion (no policy on HIV blood testing for staff promotion)	2,146	90.7
1.3 Staff benefit (no policy on HIV infected staff to stop working in the factory)	2,169	47.9
2. Workplace HIV/AIDS prevention, control and care programme		
<b>2.1 HIV/AIDS Education</b>	<b>2,163</b>	<b>50.9</b>
2.2 Condom distribution	2,157	36.7
2.3 Voluntary counselling	2,169	20.4
2.4 STI services	2,169	13.2

N\* number of samples in each survey

## Prevention of MTCT: antiretroviral prophylaxis

**Data source name:** The Bureau of Health Promotion, Department of Health

**Data source type:** Monitoring programme

(Report from PHIMS - MTCT and

Report from PHROM - Bureau of Epidemiology)

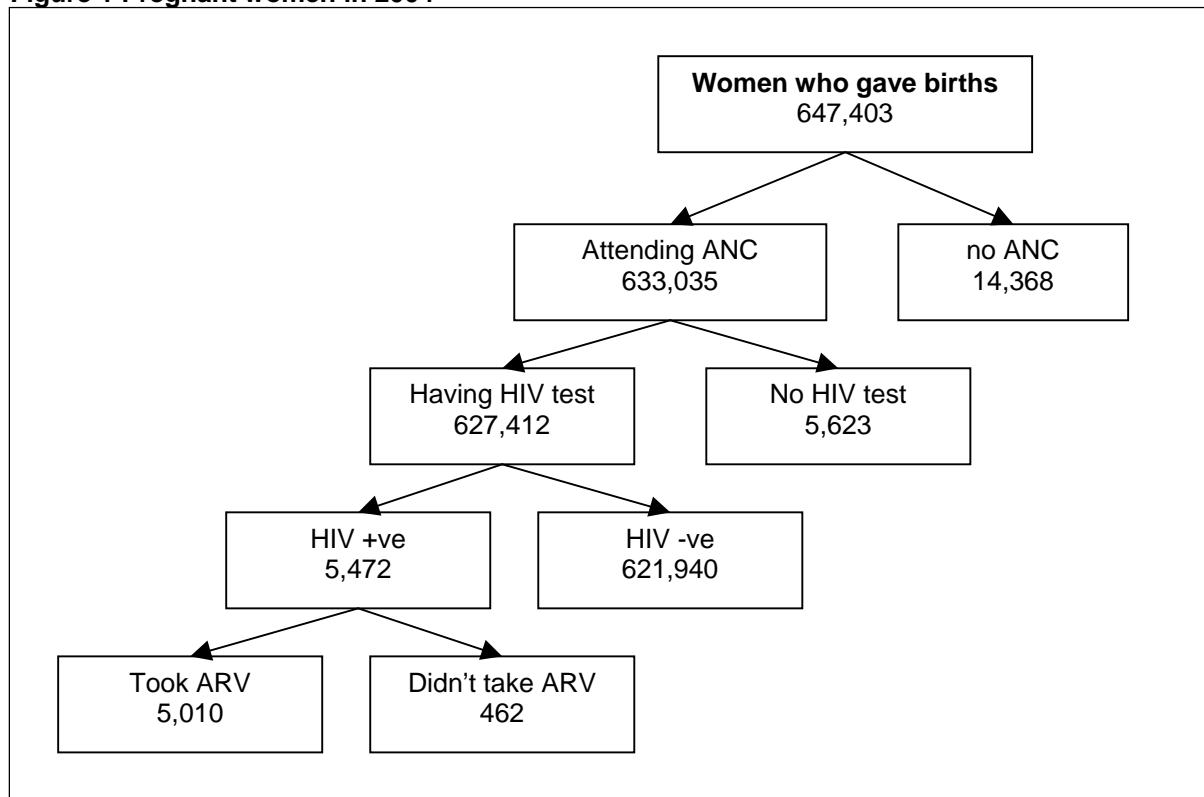
**Data collected period:** Fiscal year 2004 (Oct 2003 - Sept 2004)

With the implementation of short-course AZT to reduce MTCT, the number of infants acquiring HIV had been dramatically reduced..

The Bureau of Health Promotion, Department of Health reported that there were 647,403 women gave birth in 2004 fiscal year of these, 633,035 women received anti-natal care.

Of all pregnant women at ANC clinic, 627,412 women received HIV test and 5,472 women(0.872%) were HIV positive. Of all identified HIV positive women, 5,010 were treated with ARV to prevent HIV transmission to their babies the figure of pregnant women receiving ANC, HIV test and ARV prophylaxis as well as the estimated effects were illustrated in the following diagram. Diagram 1. Pregnant women receiving ANC, HIV test and ARV prophylaxis to prevent vertical transmission in Thailand October 2003- September 2004.

**Figure 1 Pregnant women in 2004**



Supposed there was no program to prevent HIV transmission from mothers to their babies, it could be estimated that there might be 5,645 babies borned from HIV infected mother [all women who gave birth x estimated HIV infection prevalence rate( $647,403 \times 0.872\%$ ) with an assumption that one woman gave birth to one child]. Of these, 30% (estimated natural HIV transmission rate) would be infected with HIV from their mothers or about 1,694 babies would be HIV infected.

However with the PMTCT program, we could observe that, out of the total estimated number women who gave birth with HIV infection (5,645) there were 5,472 women who were able to be identified to be HIV infected . Of all estimated HIV infected pregnant women, 5,010 women (88.7%) were treated with ARV for prevention of HIV from mothers to their babies.

Based on above mentioned figures, it is estimated that, even with an extremely high coverage of ANC and PMTCT services, there were still babies who might be infected with HIV, particularly among babies in mothers who did not receive ANC or had not been tested for HIV, or not received ARV for PMTCT (though were tested positive for HIV). For these groups, it could be estimated that 30% of babies would be infected with HIV giving the figures of 38, 15 and 139 respectively. Babies with ARV prophylaxis, 8% of babies born from HIV infected mother would still be infected, In this group, we would expect to have 401 babies who were still infected with HIV, the estimated total infection would be 193 babies. The averted number was 1,101 babies, these the reduction was 64.9% (1,101/1,694).

## Care

### Sexually transmitted infections: Comprehensive case management

**Data source name:** 63 STI Clinics (Only Public Sector): By Ms. Pensri Phonghirun

<pensri43@hotmail.com>

**Data source type:** Interview the clients, monitoring programme of STI

**Data collected period:** January 2004 - December 2004

Indicators	Male						Female					
	<20	%	20+	%	All age	%	<20	%	20+	%	All age	%
Taking history	110	87.30	415	86.10	525	86.35	46	69.70	270	72.58	316	72.10
Examination	109	86.51	409	84.85	518	85.20	57	86.36	330	88.71	387	88.36
Diagnosis and Rx	126	100	482	100	608	100	66	100	372	100	438	100
Counselling	96	76.19	325	67.43	421	69.24	43	65.15	273	73.39	316	72.15
Number of STI patients for whom correct procedures were followed on all of the above	96	76.19	325	67.43	421	69.24	43	65.15	270	72.58	313	71.46

Indicators	Number of respondents for whom provider-client interactions were observed on all of the above 4 aspects					
	<20	%	20+	%	All age	%
Taking history	156	81.04	685	80.23	841	80.38
Examination	166	86.46	739	86.53	905	86.52
Diagnosis and Rx	192	100	854	100	1046	100
Counselling	139	72.40	598	70.02	737	70.46
Number of STI patients for whom correct procedures were followed on all of the above	139	72.40	595	69.67	734	70.17

## **HIV Treatment: antiretroviral combination therapy**

As the epidemic matures and an increasing number of persons suffered with opportunistic infections (OIs) and AIDS emerged, the priority of work has to include shifted to care, support and treatment. Although an inexpensive triple-combination therapy was now available through the Government Pharmaceutical Organization (GPO), many barriers remained, at the beginning of the initial scaling up phase of the program, for the full implementation of widespread HAART. The MOPH had plans of utilising approximately \$9 million from Global Fund to Fight Against AIDS, TB and Malaria on ART to increase the number of persons who could be treated. In addition the Government through its MOPH had allocated 29,081,827 US\$ or 1,163,273,100 Baht to Implement ART program in 2005.

Integrated care and support programs had been developed most successfully in the North, and emanated from or were linked to district-level hospitals. Buddhist monks and CBOs reached many in their homes. But for a large number of infected people, adequate care was not available at the local level. In the South and Central regions, many health personnel and facilities were not yet equipped to handle the increasing number of persons sick with HIV disease. Stigma remained too great for the spontaneous development of local support groups (Songwathana and Manderson 2001).

### **National Access to ARV**

“National Access to ARV” was on the expansion of ARV service with a direction toward universal coverage goal. This phase was then ongoing. The factors, which attributed to the development of this phase, were based on the continuity of the ART program implementation which started since 1992. The program had founded the essential infrastructure of the program expansion and the lowering of the price of ARV drugs which was a result of the local production of generic medicine.

Generic production of anti-retroviral drugs by the Government Pharmaceutical Organization (GPO) had brought down the price of the ARV drugs, including the combination regimen.. The current price of a combined regimen, named as GPO-VIR was 30 US dollars or about 1,200 Baht per month. The local generic production was a key factor to enhance ARV policy into a more practicality and enabled more number of patients to access to ARV treatment.

At the beginning, or during years 2000-2001, the title of the program was named “Access to Care-1”. At this time, there were 8 HAART regimens for adults and 12 regimens for children. . Only the hospital where health professionals received full training in ARV course and had been approved, could register into this programme. Subsequently, the programme was upgraded to “Access to Care-2” in 2002 when list of ARV regimens was shifted to focus this local production generic regimen. The GPO-VIR was recommended to be the first-line regimen for the naïve patients.

However, in 2003, when the national policy had shifted to expand the programme to cover every needed patient, the title of the program had been called “National Access to Antiretroviral Program for people living with HIV/AIDS (NAPHA)”. Sites to provide ARV were gradually expanded to catch up more and more patients. Training for relevant health care professionals such as medical doctors, nurses, pharmacists, laboratory technicians, and counsellors or social workers, etc, was an essential activity to build up the knowledge and skill of the personnel. In addition to the ARV drugs, the availability of CD4 laboratory service had been developing concurrently with the ARV program.

Initially, number of hospitals participating in the Programme had expanded from 119 hospitals in 2001 to 491 hospitals in 2003. Moreover, during 2003, health staffs from all of the government hospitals or more than 400 additional sites had been trained and participation in the provision of ARV. The intention was to expand ARV service to AIDS patients to every part of the country.

In commitment to the universal coverage of essential health services for all Thais, the Government decided to increase the budget in the ARV programme. Approximate twenty-five million US dollars (1,000 million Baht) was allocated to scale up the access to ARVs in 2004. With this figure, number of patients accessible to ARV would increase from 13,974 patients in 2003 to 50,753 patients in 2004, or a four-fold increase. This figure reflexed the attempt to reach the universal coverage for all who needed the drugs.

As illustrated below, it was estimated that , there would be as high as 112,323 AIDS cases who needed ART. This figure derived from the Thai working Group estimates. It was projected that there were 62,817 cases who would live at the end of 2003 and in addition to that figure 49,452 new cases would thereby in 2004. Thus, the coverage in ART program would be 45.2% (50,752/112,323).

**Data source name:** The Bureau of AIDS TB and STI

**Data source type:** Programme monitoring

**Data collected period:** Oct 2003 - December 2004

<b>Available Indicators</b>	<b>Secondary School</b>
1. Number of people receiving ARV therapy at the beginning of fiscal year 2004	13,974
2. Number of people who commenced treatment in the last 12 months	36,778
3. Number of people receiving ARV therapy at the start of the year who died during the year	NA
4. Number of people whom treatment was discontinued for other reason	6,663
5. Number of people receiving ARV therapy at the end of the year	50,752
6. Number of people with advanced HIV infection	112,323
Measurement = (1)+(2) equal to (5)	<b>45.2%</b>

\* Number of people with HIV/AIDS needing ART in Baseline (NAPHA) Scenario (including asymptomatics with CD4 < 200) by the end of 2004.

## **Injecting drug users: safe injecting and sexual practice**

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

Therefore, Thailand should act quickly to scale up outreach and related harm reduction programmes particularly in urban areas where drug supply and use was most likely to continue. Such interventions had been shown to reduce risk of HIV transmission and do not result in more people using drugs. In addition, because of high HIV prevalence rates for nearly two decades, drug users also needed HIV-related services including VCT, care, support and ART, yet little had been done to address specific challenges of providing these services. Moreover, the trend of the spread of HIV through sexual intercourse in the drug addicts both the intravenous injection and other groups, who neglected the safe sex, was probably high too. The effective prevention should be sought like the success with female sex workers.

**Data source name:** Thanyarak institute (Institutional based data)

**Data source type:** Programme monitoring

**Data collected period:** December 2003 - December 2004

**PART I:**  
Data requirement  
**Numerator**

1. Injected drugs sometime in the last month
2. Injecting drugs users in the last month who avoided sharing injecting equipment in the last month
  - 3a.Injecting drug users in the last month who had sexual intercourse in the last month
  - 3b.Injecting drug users in the last month who avoided sharing injecting equipment but had sexual intercourse (in the last month)
  - 4a.Injecting drug users in the last month who used condoms during the most recent sexual intercourse (in the last month)
  - 4b.Injecting drug users in the last month who never shared injecting equipment and used condoms during the most recent sexual intercourse (in the last month)
5. Avoided sharing injecting drug equipment and used condoms during most recent sexual intercourse in the last month (line 4b)
6. Avoided sharing injecting drug equipment and either avoided having sex or used condoms during most recent sexual intercourse (all in the last month) (line2-line 3b+ line 4b)

Male			Female			Both sexes		
<25	25+	All ages	<25	25+	All ages	<25	25+	All ages

56	497		9	48		55	545	
44	438		8	34		52	472	
32	197		7	32		39	229	
25	169		6	23		31	192	
8	61		3	5		11	66	
6	54		2	5		8	59	

6	54	60	2	5	7	8	59	67
25	323	348	4	16	20	29	339	368

**Denominator**

7. Numbers of respondents who reported having injected drugs in the last month and having had sex in the last month

32	197	229	7	32	39	39	229	268
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**PART II:**

Indicator computation

Indicator scores by sex and age-group

8. Divide the number of respondents who reported having avoided sharing injecting drug equipment and avoided having unprotected sex in the last month (line5) by the total number who reported having injected drugs and having had sex in the last month (line7) and multiply the result by 100

18.75	27.41	26.20	28.57	15.62	17.95	20.51	25.76	25.0
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