



Thailand
Operational Plan Report
FY 2012



Operating Unit Overview

OU Executive Summary

Thailand COP Executive Summary

EPIDEMIOLOGY OF THE HIV EPIDEMIC IN THAILAND

Twenty-seven years after the first reported case of AIDS in the country, in 1984, the HIV epidemic in Thailand remains a serious public health challenge. Thailand continues to experience a concentrated epidemic, with an estimated HIV prevalence of 1.3% among persons aged 15–49 in 2009, translating to 530,000 persons living with HIV/AIDS (PLHA), including 14,000 PLHA ages 0–14. The epidemic is concentrated among most at-risk populations (MARPs), including men who have sex with men (MSM), female sex workers (FSW), persons who inject drugs (PWID), prisoners, and migrant workers. Asian Epidemic Model (AEM) estimates projected 10,853 new HIV infections in Thailand in 2010, a substantial number but a decline from 150,015 infections in 1990.

HIV Infection in the General Population

Based on HIV surveillance among military recruits, pregnant women receiving antenatal care (ANC), and blood donors, HIV prevalence in Thailand has been declining in all regions of the country. HIV prevalence among military recruits declined from 4.0% in 1993 to 0.5% in 2005. HIV prevalence among pregnant women attending government-run ANC clinics peaked at 2.3% in 1995, with declines since,³ to an estimated 0.65% in 2009.¹ Among blood donors at the Red Cross central blood bank, HIV prevalence decreased sharply starting in 1993 (1.6%), reaching a nadir in 2002 (0.33%).³ Since 2002, prevalence has increased slightly to a fairly constant prevalence of 0.45%.³

HIV Infection in Most At-Risk Populations

The AEM estimates that 45% of HIV infections occurred in MSM, PWID, and FSW in 2010, and 66% will occur in MSM, PWID, and FSW by 2025 under current projections.²

MSM and TG

An estimated 3% of men ages 15–49 (560,000 men total) in Thailand were MSM, according to AEM estimates.² MSM accounted for 23% of new HIV infections in 2010, according to AEM, and will account for 52% by 2025.² HIV prevalence among MSM in large urban centers is particularly high (17–31% in



Bangkok, Phuket, and Chiang Mai, in recent surveys) and lower but still substantial in less urban areas (5%–6% in Udon Thani and Phatthalung). HIV prevalence among TG in large urban areas in 2005 was 12%–18%.¹

FSW

HIV prevalence among the 145,000 FSW estimated to work in Thailand declined to 2.8% in 2009 from 4.3% in 2007.³ Prevalence was higher among non-venue-based FSW in Bangkok (21%) and Chiang Mai (11%).³

PWID

According to AEM, 9% of new infections in 2010 occurred among the 40,000 PWID estimated to live in Thailand.² HIV prevalence among PWID remains high—41% in government drug rehabilitation sites in 2010 and 24% and 11% in Bangkok and Chiang Mai, respectively, in 2009.³

Prisoners

Of 209,427 prisoners in 142 prisons in Thailand in 2009, 86% were men.³ In 2008, a survey of three prisons showed HIV prevalence of 6.5%–11.5%. In 2009 1768 prisoners (0.8% overall) were known to be PLHA.³

Migrant Workers and Fishing Boat Crews

HIV prevalence among migrant workers increased from 0.8% in 2007 to 1.2% in 2008.³ Among migrant fishing boat crews, HIV prevalence increased from 1.3% in 2007 to 2.5% in 2008.³

Status of the National Response

Overall funding for HIV has been reduced compared to peak funding in 1996. From a total health expenditure of 383.1 billion Thai baht (\$11.6 billion) in 2009, 1.9%, or 7.2 billion baht (\$218 million) was spent on HIV/AIDS programs. The Royal Thai Government (RTG) provided 93% of this funding, with 7% coming from international sources. Only 14% of the HIV/AIDS budget in 2009 was set aside for prevention work, including condom promotion (3%), while 76% went to care and treatment services and 10% for other areas, such as orphans and vulnerable children, strengthening program management administration, enabling environment and community development, and social protection and social services.



Although Thailand has well-established HIV sero-surveillance systems, the current national budget for surveillance and monitoring and evaluation (M&E) remains small. Consistent with Thailand's overall approach to decentralize activities, local authorities have taken on increasing responsibilities, and need capacity development in using strategic information (SI) for decision making and facilitating multisectoral engagement. The Global Fund Provincial Coordinating Mechanisms provide a forum for this purpose.

RTG made antiretroviral treatment (ART) available nationally in 2004. Under Thailand's current national AIDS strategy (2007–2011), treatment, care, and support services were fully integrated. Currently, all Thai health insurance plans cover ART as well as care and support. The percentage of PLHA in care, including MARPs, is not captured by the national M&E system or other systems. In 2009, an estimated 216,118 PLHA, including 8,076 PLHA younger than age 15, were receiving antiretroviral treatment (ART).¹ The percentage of adult PLHA in Thailand receiving ART who were eligible based on 2006 WHO guidelines (CD4 < 200 cells per mm³) and 2010 guidelines (CD4 < 350 cells per mm³) was 76% and 61%, respectively.¹ For PLHA ages 0–14, the percentage receiving ART who were eligible based on 2006 WHO guidelines was 86%. Among PLHA initiating ART, 93% of adult women, 78% of adult men, and 90% of PLHA ages 0–14 were known to still be taking ART 12 months after initiation in 2009.

RTG funding for treatment, care, and support for PLHA in Thailand is channeled through three programs. In 2009 58% of PLHA received services funded by the National Health Security Office's (NHSO's) universal coverage program, with RTG's social security and civil servant medical benefit programs covering most other Thai nationals.³ GFATM funds some treatment, care, and support services for non-Thai nationals (e.g., migrant workers). Finally, a minority of PLHA—the percentage is unknown—pay out of pocket for care and treatment in private hospitals and clinics. The 941 hospitals participating in NHSO are funded both through NHSO's HIV-specific and general medical mechanisms that cover basic medical care, laboratory monitoring, opportunistic infection (OI) prophylaxis, provision of condoms, screening for STIs and TB, and management of adverse effects of ARVs.

Quality of HIV care, as well as treatment, remains variable in Thailand, in part because of insufficient human resources in some areas. Furthermore, many PLHA access both care and treatment late in infection. Focus group interviews suggest that MSM access care late because of stigma, discrimination, and lack of knowledge about HIV care and treatment. Few data for other MARPS are available, although anecdotal information suggests that similar barriers exist for them. As HIV care and treatment services continue to expand, there is an ongoing need to monitor service quality, and the Ministry of Public Health (MoPH) and NHSO are working to expand quality systems for care and treatment.

PMTCT remains a critical concern in Thailand. The MTCT rate in Thailand was 2.9% in 2007 (5.6% if



dead infants are included).³ PMTCT is also a key goal of the draft National HIV/AIDS Strategy for 2012–2016, which aims that by 2016, MTCT will decrease by 75%. USG provided TA to MoPH to update PMTCT policy (in October 2010) to recommend ARV treatment during pregnancy regardless of CD4 count, using a protease inhibitor-based regimen (WHO option B); to routinely offer CHCT in ANC settings; and to use molecular rather than serologic tests for early infant diagnosis (EID).

Of note, Thailand is currently drafting its National HIV/AIDS Strategy for 2012–2016, with USG TA. The strategy has three main goals: drastically reducing new infections and deaths from HIV/AIDS and eliminating stigma and discrimination around HIV/AIDS.

U.S. Government Role in Assisting with the Thai National Response to HIV/AIDS

Thailand is a middle income country, and as such the U.S. Government (USG) team focuses on technical assistance (TA) and capacity building for government and civil society. PEPFAR in Thailand represents an innovative, cost-effective approach: focusing on TA, developing strong health systems, and building capacity for Thailand to own a strong comprehensive program. While service delivery is funded mainly by RTG, with additional funding by GFATM, gaps remain in capacity, quality, coverage, focus, and policy to achieve a comprehensive, successful response to the epidemic. As with many middle income countries, wide disparities exist in Thailand in income, access to services, and risk. PEPFAR Thailand focuses TA on areas where people remain at risk, coverage is low, and systems require improvement. TA emphasizes building model programs for MARPs, quality systems, and strategic information (SI). The collaborative approach with RTG has been a successful model in PEPFAR for engaging with middle income countries, has yielded a strong relationship in health between USG and RTG, and has enabled a close working relationship in general between USG and RTG.

Consistent with the vision of PEPFAR and the Global Health Initiative (GHI), USG supports RTG leadership and management of a national HIV/AIDS program in partnership with civil society for full country ownership. RTG has led the scale-up, coordination, and oversight of HIV prevention, care, and treatment programs; however, gaps in human capacity, technical implementation, program quality, program M&E, and engagement of civil society remain challenges. USG uses a TA-based strategy to address these gaps, focused on sustainability, country ownership with government leadership in partnership with civil society, and coordination, working closely with RTG, other donors, international organizations, and local non-governmental organizations (NGOs/CBOs). USG assistance to Thailand primarily focuses on providing TA and capacity building to RTG and Thai civil society organizations to strengthen RTG's and civil society's ability to provide oversight and manage the national HIV response in a sustainable manner. USG introduces and evaluates innovative evidence-based models with a focus on scale-up and sustainability through these partners, with a goal of facilitating integration of models into



routine systems. As a result of this approach, numerous USG-supported high-quality models (including combination prevention for MARPs and QI for HIV/AIDS treatment and care) have been introduced, evaluated, scaled-up, and incorporated into the national system through RTG or external support, principally GFATM, allowing USG to address new areas.

Coordination with Other Donors and the Private Sector

The USG strategy is aligned with partners throughout the country, including UNAIDS, WHO, bilateral donors, and other NGOs. As a TA provider, USG supports RTG in many coordination tasks involved in such alignment, as well as helping to monitor progress toward meeting RTG commitments. USG has demonstrated commitment to supporting RTG in its relationship with GFATM, and is one of two voting donor representatives on the Country Coordinating Mechanism (CCM). GFATM has awarded Thailand a \$106 million grant focused on MARP prevention over five years through GFATM Round 8. Thailand's success in winning the grant was based partially on two factors: the ability of MoPH and interagency work groups (with USG TA) to write an excellent proposal, and the transfer by RTG's well-developed health financing system of resources from the national to the provincial and local levels. Yet these levels require further TA to effectively implement quality MARP-focused interventions. USG's successful implementation of the TA-based model, its role in GFATM coordination, and its relationship with RTG and international organizations in Thailand, uniquely position it to provide TA to RTG as the Principal Recipient (PR) and to the Sub-Recipients (SRs) and Sub-Sub-Recipients (SSRs), which are mainly represented by civil society organizations, to ensure quality implementation of the GFATM HIV and TB grants.

Other Contextual Factors

* Women, Girls, and Gender Equality Approach: As articulated in GHI's Women, Girls, and Gender Equality principle, gender equality and women's empowerment are integrated throughout USG's approach, including data collection and analysis; policy and advocacy work; development of tools to better measure gender inequalities in health outcomes; innovations in behavior change communication and community mobilization techniques; operations research to test innovative service delivery models; capacity building of health personnel; improvements in health systems to better meet the needs of youth, women, and men; linkages with non-health sectors to provide comprehensive services dissemination and training on state-of-the-art gender interventions and resources; and development and harmonization of gender and health indicators.

USG is a technical leader in sexual orientation/gender identity issues and HIV in Asia. Continuing priorities for USG include supporting interventions that target the unique needs of women and TGs at high risk of HIV infection. In FY 2012, USG activities to address these priority groups will focus on couples HIV



counseling and testing (CHCT) for pregnant women and their male partners at ANC clinics; Positive Health, Dignity and Prevention for PLHA who are young, MSM, TG, and/or women; HIV prevention for FSW, MSM, and TG; and care, support, and treatment for MSM and TG. Also, both RTG and a women's fund of the UN, UNIFEM, are addressing gender issues, particularly promotion of gender roles and equality, development of M&E on AIDS rights protection, and awareness of violence against women.

* Political Context: Thailand's government has turned over several times since a military coup in 2006, and anti-government protests in 2010 briefly disrupted USG work. A July 2011 election led to a peaceful change of government. Despite the uncertain political environment and new political leadership at the top levels of MoPH, RTG continues to adopt USG model programs for prevention in MARPs, quality systems, and SI. Through several changes of government, several ministers of public health, and violent protests, RTG support for a strong HIV/AIDS program has not wavered.

PEPFAR Focus in FY 2012

* Key Priorities for USG in FY 2012:

- Combination prevention for MARPs. Provide TA to governmental organizations and NGOs/CBOs to support implementation and M&E for combination prevention efforts aimed at MSM and TG persons, and FSW, including in GFATM-funded sites. Exploratory work will be conducted with local provincial authorities to develop a small focused program for most-at-risk Burmese migrants along the Thailand-Burma border.
- Continued refinement and demonstration of the MARPs-focused Comprehensive Prevention Package (CPP) and Continuum from Prevention to Care to Treatment (CoPCT) service delivery models. Continue advocacy for replication and scale-up by RTG and GFATM.
- Evaluation of program effectiveness and cost efficiency for the USAID-supported community-based VCT rapid testing with same day results demonstration project.
- Health systems strengthening. Focus on building capacity and strengthening national and community health systems to facilitate country ownership of an effective, sustainable HIV response.
- Prevention for PWID. Provide TA to BMA to undertake a formative assessment in Bangkok regarding increasing use of injection drugs, including methamphetamine, and to help develop HIV prevention services.
- Prevention for Prisoners. Provide TA to support expansion and monitoring efforts in prisons, especially related to linkages between prisons and local healthcare facilities providing HIV services.
- PMTCT and EID. Provide TA to MoPH to update surveillance systems for PMTCT and infant outcomes, monitor implementation of new PMTCT and EID guidelines, and evaluate the EID system.
- Strategic information. Provide TA to partners to better use SI to inform policy development, program planning, and resource allocation.



- Contribution to health diplomacy through facilitation of government-to-government collaboration and building capacity of local organizations.
- Coordination with / support for GFATM. Continued support and TA to MoPH (as the PR) and the SR and SSRs for effective implementation of GFATM Round 8.
- Further definition and development of the not-yet-released Capacity Building Framework and TA-based indicators. Work with OGAC and other PEPFAR country staff to incorporate these into routine PEPFAR reporting in the future, thus strengthening the ability of USG to measure critical inputs related to TA achievements and progress to build country capacity at all levels.
- Development of TA models that can serve as examples for other PEPFAR programs, including facilitation of adapting and sharing these models with other countries.
- Exploration of increasing private sector engagement in the national HIV response.
- Build capacity of communities to address HIV/AIDS prevention and engaging youth in peer outreach, life skills training, and stigma reduction.

USG Thailand PEPFAR Team and the Global Health Initiative

The approaches used to implement the objectives of the USG Thailand PEPFAR Team have four underlying themes: building capacity, strengthening health systems, strengthening government ownership and coordination. All activities supported by USG are aligned with the GHI principles and goals to develop national and local leadership and capacity to create an enabling policy environment, and integrate new activities into routine, sustainable systems. Coordination among RTG, NGOs, GFATM, and other donors is facilitated by USG through participation in government and multilateral meetings, and active membership on the GFATM CCM.

The USG vision is that RTG and key NGO partners will gain the technical capacity and financial ability to provide policy oversight, manage, and coordinate the MARP-focused prevention and care implementation that is a necessary component of an effective response. To achieve that vision, USG will provide intensive targeted TA and capacity building to RTG, GFATM-funded programs, and civil society, strategically refining current models, as well as adapting and testing additional models that have been proven in other settings for use in Thailand. USG will provide critical policy input, build the capacity of targeted health care workers and community-based organizations (CBOs), improve the quality of MARP-focused HIV services, and strengthen key elements of the health care system at the national, provincial, and local levels. To address the GHI principle of improving metrics, USG will continue to support state-of-the-art HIV surveillance efforts, and provide critical input into the monitoring and collection of data, improving data quality, data use, and evaluation. USG will promote research and innovation, and provide technical expertise in national activities through its TA implementation model. The other core principles of GHI follow below:



* Sustainability and Country Ownership: USG TA supports a national HIV/AIDS program led, managed, and coordinated by RTG.

In addition to USG fostering successful Thai adoption, scale-up, and ownership of model programs, dissemination of successful models is also shared through TA to other countries. This increasingly successful provision of country-to-country TA to other PEPFAR countries serves several critical functions. First, PEPFAR benefits from successful models developed and implemented in Thailand, and adapted in the broader PEPFAR context. Second, this activity provides a road map to developing successful models of TA/ collaboration between PEPFAR countries, regionally and beyond. Third, as Thailand moves to enhance its developing donor assistance, USG plays a substantial role in mentoring Thai government and locally employed USG staff to begin to provide TA to other countries. This activity maximizes the contributions of PEPFAR technical and capacity building investments, and increases the sustainability of PEPFAR efforts in the region. To capitalize on these successes, USG will continue to engage both the U.S. Centers for Disease Control and Prevention (CDC) and Thai government staff to respond to increasing requests from other PEPFAR countries for TA.

Thus far, TA has focused on laboratory, SI, care and treatment QI, outreach, PMTCT, TB, and pediatric care and treatment. Examples include provision of TA for development of laboratory QA systems in Ethiopia and Vietnam; technical visits and trainings with Ethiopia, Kenya, Zambia; TB infection control trainings and assessments in Asia; and development of peer outreach programs for PWID in Tanzania. These TA activities are funded partially by the requesting country, with CDC Thailand contributing staff support through Thailand COP funding including a small amount of funding for travel and coordination. U.S. Agency for International Development (USAID) Regional Development Mission Asia (RDMA) staff and partners also provide TA support for SI analysis and use, prevention with MARPs, care and treatment models (including livelihoods), policy analysis, and stigma and discrimination reduction, in addition to strengthening regional networks of MSM and PLHA in Asia. USAID does this through regional funding (not Thailand COP funds), and these activities are described in their Regional Operational Plan.

* Integration across the USG: USG TA is highly valued by RTG, not only in health, but also in economic, political, and legal spheres. Even with extremely limited resources, USG TA has a high impact and exerts a strong influence on RTG's HIV/AIDS response. In line with both PEPFAR and GHI principles, USG PEPFAR agencies in Thailand (CDC, USAID/RDMA, and Peace Corps) work closely together and use their comparative advantages for maximum impact, as follows:

-CDC: TA relationship with MoPH and BMA focuses on best-practice guidance and technical approaches, capacity building, model development and scale-up, quality systems, and M&E. This includes prevention,



care and support for MARPs, QI for care and treatment and laboratories, and surveillance.

-USAID: TA relationship with civil society and provincial and local governmental and nongovernmental partners focuses on developing high-quality implementation models for prevention, care and support, and building an enabling environment for effective service delivery for MARPs, particularly MSM.

-Peace Corps: building capacity of communities to address HIV/AIDS prevention and engaging youth in peer outreach, life skills training, and stigma reduction.

Of note, PEPFAR is only one part of an extensive Thailand and regional health cooperation matrix conducted by CDC, USAID/RDMA and the U.S. Armed Forces Research Institute for Medical Sciences (AFRIMS) The Thailand MoPH–U.S. CDC Collaboration (TUC) works on TB, emerging infections, influenza, immigrant screening, and outbreak investigation. USAID/RDMA provides health development and public health disease prevention work in the region, including Thailand, for control of malaria, TB, avian influenza, and other emerging pandemic infections. The U.S. National Institutes of Health (NIH) has a long history of collaborations with Thailand, and the National Institute of Allergy and Infectious Diseases (NIAID) currently funds over 30 projects in Thailand in infectious diseases (HIV/AIDS, H1N1, malaria, and dengue fever), many through major HIV/AIDS Clinical Trials Networks. USG staff informally discuss and consult with NIH staff and NIH grantees on research development and results.

* Health Systems Strengthening and Human Resources for Health: One of GHI's core principles is to build sustainability through health systems strengthening (HSS). USG support for HSS and human resources for health (HRH) is focused on capacity building of existing health care workers, government public health staff, and civil society organizations to allow for improved quality, implementation, and sustainability of HIV programs. USG support includes didactic in-service training; mentoring of and TA to health care providers, government staff, and civil society organizations; development of tools and curricula that are then used at a national level with government funding and USG technical support; and development, implementation, evaluation, and expansion of models for task shifting and decentralization. MoPH conducts annual health workforce assessments, and approved a master HRH plan for 2004–2013. USG contributes to the plan's goals through specialized training, tools, and other technical support to build the capacity of health care workers to conduct better HIV programs.

MoPH provides leadership development training, with specified courses required before a health officer can be promoted. To complement training, a Thai adaptation of the CDC Atlanta Management in Public Health course is provided primarily to provincial-level staff through Mahidol University. Training for task shifting is taking place in several ways. MoPH supports village health volunteers to provide health education at household and community levels, and serve as liaisons to the health system and focal points



in emergencies. USG also supported projects to increase community-based health care workers' HIV knowledge so that care can be decentralized from congested tertiary centers.

Complementing efforts to build capacity of RTG, USG will continue to provide targeted TA to local government at the subnational level, and community-based groups to ensure that strong, robust institutions with the requisite capacities to continue to implement the CPP and the CoPCT models for MARPs. USG capacity building efforts with cooperating agencies in Thailand have focused on enhancing skills in the following areas: monitoring and evaluation, MARP-friendly service provision, and enabling environment, including livelihoods support.

PF/PFIP Monitoring

The USG Thailand PEPFAR team does not currently have a PF or PFIP.

Country Ownership Assessment

The Thailand PEPFAR Team has engaged for many years with Thai technical, political, and civil society counterparts in a way that is consistent with PEPFAR 2 and GHI goals. The TA-based model employed by USG has the full political support of RTG, including MoPH, the Bangkok Metropolitan Administration (BMA), and provincial level government where we implement programs. Projects deemed technically suitable for TA, in collaboration with MoPH and civil society partners, are outlined in (and funded through) cooperative agreements with MoPH or BMA (for CDC) or with contracts and cooperative agreements with NGOs as well as MOUs with provincial level government (for USAID). Many of these projects aim to help improve prevention, care, support, and/or treatment service delivery to MARPs, and both CDC and USAID engage with representatives of NGOs/CBOs during the planning and implementation phases of projects and strategic planning efforts, including the COP.

Measured on four dimensions, an assessment of country ownership shows that Thailand is a model country to demonstrate PEPFAR's shift to increasing TA:

* Political ownership/stewardship: Thailand is a model country in terms of ownership, with RTG taking stewardship of the national response in close collaboration with civil society. RTG led the way in the early years of the Asian epidemic with the development and implementation of the innovative "100% condom use" campaign among SWs and has in more recent years shepherded new activities such as the nationwide rollouts of QI programs for care and treatment, following successful piloting with USG TA.

* Institutional ownership: Institutional ownership of the HIV/AIDS response in Thailand clearly lies with



RTG and civil society (NGOs/CBOs). USG continues to work with national and subnational government to refine and assess the CPP and CoPCT models of service delivery for MSM and TG in Bangkok, Chiang Mai, and Pattaya with an eye towards transitioning the models to a fully locally owned and managed response through rigorous documentation of project activities to provide evidence of program effectiveness to decision-makers. RTG and subnational governments fund most HIV activities for prevention, care, support, and treatment, as well as SI, with additional funding from GFATM and other donors.

* Capabilities: While RTG and nongovernmental partners historically possess substantial technical and management capacity to manage the national HIV/AIDS response, gaps in MoPH capability, coupled with turnover of key positions, means that in order to maintain an effective response, and to create a system that can adapt to the changing epidemiologic conditions, existing capacity requires augmentation, which is accomplished through USG TA.

* Accountability: RTG regularly conducts its own M&E efforts, at times enlisting TA from USG for those activities; examples include the National AIDS Program database, which electronically collects data on care and treatment of PLHA nationwide, facilitating evaluation of care and treatment efforts. RTG is also committed to an ongoing upgrade of PMTCT M&E databases and an evaluation of implementation of new PMTCT guidelines. RTG publicly disseminates SI data regarding the epidemic and results of the response in Thailand to both domestic and international stakeholders, further demonstrating its commitment to accountability.

USG is supporting country ownership along these four dimensions by encouraging continued RTG leadership in and financial commitment to the national response to HIV/AIDS by actively working with and including civil society in the management of that response, providing TA to augment the capacity of governmental and nongovernmental partners in the response, and assisting those partners with TA to monitor and evaluate the response in a transparent way.

Central Initiatives

The USG Thailand PEPFAR Team does not have any centrally funded projects.

1 AIDS Data Hub for Asia-Pacific. Thailand.
https://skydrive.live.com/view.aspx/spreadsheets/thailand/thailand%5E_all%5E_indicators.xls?cid=afd9edea3ddfb75c&sc=documents. Accessed 9/26/11.



2 FHI and BATS, DDC, MOPH, RTG. The Asian Epidemic Model Projections for HIV/AIDS in Thailand 2005–2025. Published 2008.

http://aidsdatahub.org/dmdocuments/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf. Accessed 9/26/11.

3 UNGASS Country Progress Report Thailand, Reporting Period January 2008- December 2009.

http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/thailand_2010_country_progress_report_en.pdf. Accessed 9/26/11.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	520,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Adults 15-49 HIV Prevalence Rate	01	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV						
Deaths due to HIV/AIDS	28,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults	12,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Estimated new HIV infections among adults and children	12,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated number of pregnant women in the last 12 months	977,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS	530,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)	350,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	210,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			



Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

In what way does the USG participate in the CCM?

Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

4-6 times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

None

If None why not?

USG provides technical assistance to GFATM planning, implementation, and evaluation, and sits on the CCM. Staff meet regularly with portfolio managers from Geneva. We have not met with LFA.

In any or all of the following diseases?

Round 11 HSS

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.

Yes

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?

No

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation



and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?

Redacted

Did you receive funds for the Country Collaboration Initiative this year?

No

Is there currently any joint planning with the Global Fund?

Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)

Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	Assessment of False Recency Rate (FRR) for HIV incidence surveillance	Recent HIV Infections	Other	Development	N/A
N/A	Implementation of AIDS/HIV case surveillance with ART-program-based monitoring	AIDS/HIV Case Surveillance	Other	Implementation	N/A

	system				
N/A	Monitoring of HIV drug resistance Early Warning Indicators (EWI)	HIV Drug Resistance	Other	Implementation	N/A
N/A	Monitoring of Outcomes and Impacts of Antiretroviral Treatment Program	HIV-mortality surveillance	Other	Development	N/A
N/A	Projection and estimation of number of persons accessing ART and antiretroviral demands using modeling scenario analysis	Other	Other	Publishing	N/A
N/A	Strengthen self-administered behavioral surveys using personal digital assistant (PDA) technology among students	Population-based Behavioral Surveys	Other	Development	N/A
N/A	Strengthening national integrated bio-behavioral surveillance surveys among female sex workers	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Implementation	N/A
N/A	Strengthening national integrated bio-behavioral surveillance surveys among injecting drug users	Behavioral Surveillance among MARPS	Injecting Drug Users	Implementation	N/A
N/A	Strengthening national integrated bio-behavioral surveillance surveys among men who have sex with men	Behavioral Surveillance among MARPS	Men who have Sex with Men	Implementation	N/A
N/A	Utilization of Strategic Information for Measurement of Impact of HIV Prevention Program, National and Provincial Levels	Modeling Infections Averted	Other	Implementation	N/A



Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
HHS/CDC		4,000,000	240,000		4,240,000
PC			40,000		40,000
USAID			220,000	1,000,000	1,220,000
Total	0	4,000,000	500,000	1,000,000	5,500,000

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	HHS/CDC	PC	USAID	AllOther	
HBHC	249,339		165,528		414,867
HLAB	286,747				286,747
HTXS	111,436				111,436
HVCT	204,157		175,029		379,186
HVMS	1,100,048	40,000	41,050		1,181,098
HVOP	602,183		637,342		1,239,525
HVSI	657,825		201,051		858,876
HVTB	89,758				89,758
IDUP	59,229				59,229
MTCT	104,121				104,121
OHSS	356,476		0		356,476
PDCS	329,531				329,531
PDTX	89,150				89,150
	4,240,000	40,000	1,220,000	0	5,500,000



National Level Indicators

National Level Indicators and Targets

Redacted



Policy Tracking Table

(No data provided.)



Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	414,867	0
HVTB	89,758	0
PDCS	329,531	0
Total Technical Area Planned Funding:	834,156	0

Summary:

Thailand COP 2012 Care TAN

This Care Technical Area Narrative addresses the context and background for HIV care activities in Thailand, the role of USG in those activities, accomplishments related to HIV care since COP 2011, and objectives for USG work in the care arena during 2012–2013. Finally, cross-cutting priorities related to HIV care are discussed.

CONTEXT AND BACKGROUND

The first case of AIDS was reported in Thailand in 1984. The Royal Thai Government (RTG) made antiretroviral treatment (ART) available nationally in 2004. Under Thailand’s current national AIDS strategy (National Policy for HIV/AIDS Prevention and Alleviation, 2007–2011), treatment, care, and support services were fully integrated. Currently, all Thai health insurance plans cover ART as well as care and support. Providing effective care for PLHA is a major aspect of Thailand’s national HIV/AIDS response, reflected in the inclusion of “zero AIDS deaths” by 2016 as one of three main goals (along with “zero new infections” and “zero discrimination and stigma” for people living with HIV/AIDS, or PLHA) in RTG’s draft National HIV/AIDS Strategy for 2012–2016.

Thailand continues to experience an HIV epidemic concentrated in MARPs, rather than a generalized epidemic. The overall estimated HIV prevalence among adults ages 15–49 in Thailand is 1.3%. An estimated 530,000 PLHA were living in Thailand in 2009, including 14,000 PLHA ages 0–14 years.¹

Among 10,853 new HIV infections among adults in Thailand in 2010, an estimated 33% occurred as a result of male sex with other males, 9% occurred as a result of injection drug use, 14% occurred as a result of contact between female sex workers and clients, and the remaining 38% occurred from heterosexual transmission. Transmission among men who have sex with men (MSM) accounts for an increasing percentage of new infections, from 12% in 2000 to an estimated 52% by 2025 under current Asian Epidemic Model (AEM) projections². Serosurveys have identified Bangkok, Chiang Mai, and Phuket—all large cities and major tourist destinations—as the areas with the highest HIV prevalence among MSM (as high as 25–31%, 17%, and 20%, respectively, in recent surveys).¹

The percentage of PLHA in care, including MARPs, is not captured by the national M&E system or other



systems. In 2009, an estimated 216,118 PLHA, including 8,076 PLHA younger than age 15, were receiving antiretroviral treatment (ART).¹ The percentage of adult PLHA in Thailand receiving ART who were eligible based on 2006 WHO guidelines (CD4 < 200 cells per mm³) and 2010 guidelines (CD4 < 350 cells per mm³) was 76% and 61%, respectively.¹ For PLHA ages 0–14, the percentage receiving ART who were eligible based on 2006 WHO guidelines was 86%. Among PLHA initiating ART, 93% of adult women, 78% of adult men, and 90% of PLHA ages 0–14 were known to still be taking ART 12 months after initiation in 2009.

RTG funding for treatment, care, and support for PLHA in Thailand is channeled through three programs. In 2009 58% of PLHA received services funded by the National Health Security Office's (NHSO's) universal coverage program, with RTG's social security and civil servant medical benefit programs covering most other Thai nationals.³ GFATM funds some treatment, care, and support services for non-Thai nationals (e.g., migrant workers). Finally, a minority of PLHA—the percentage is unknown—pay out of pocket for care and treatment in private hospitals and clinics. The 941 hospitals participating in NHSO are funded both through NHSO's HIV-specific and general medical mechanisms that cover basic medical care, laboratory monitoring, opportunistic infection (OI) prophylaxis, provision of condoms, screening for STIs and TB, and management of adverse effects of ARVs.

An estimated 130,000 persons in Thailand had TB in 2009, making Thailand 19th among countries in the world in terms of TB burden. Of 62,000 new cases, 76% (49,955 persons) have known HIV status, of whom 16% (8202) are HIV-infected. Among HIV-positive TB patients in 2009, 72% and 51% initiated co-trimoxazole preventive therapy (CPT) and ART, respectively. Among new TB cases, 1.7% are estimated to be multidrug-resistant TB (MDR-TB).

Quality of HIV care, as well as treatment, remains variable in Thailand, in part because of insufficient human resources in some areas. Furthermore, many PLHA access both care and treatment late in infection. Focus group interviews suggest that MSM access care late because of stigma, discrimination, and lack of knowledge about HIV care and treatment. Few data for other MARPS are available, although anecdotal information suggests that similar barriers exist for them. As HIV care and treatment services continue to expand, there is an ongoing need to monitor service quality, and the Thailand Ministry of Public Health (MoPH) and NHSO are working to expand quality systems for care and treatment.

ROLE OF USG

The USG PEPFAR program has been fully aligned with the RTG National AIDS Program and will continue to be fully aligned with RTG policy as outlined in the draft National HIV/AIDS Strategy for 2012–2016. Although the existing RTG health services infrastructure is fairly robust, the quality of both care and treatment, including laboratory services, remains inconsistent and needs strengthening. USG's approach in the past several years has been to provide focused technical assistance (TA) to support RTG and its partners to develop sustainable approaches to strengthen health systems, improve service delivery, develop human resources for health, improve M&E and information systems, and implement quality improvement (QI) programs for care services. These systems include performance measurement and QI for care and treatment through the HIVQUAL-T model, in which HIV clinics establish care and treatment-related indicators, abstract data from clinic records to determine which aspects of care and treatment need to be improved, and then establish and implement QI plans to address those needs. USG also provided TA to expand pediatric care services, community- and home-based care services, and demonstrate and evaluate best practices for TB/HIV in selected provinces.

Driven by the epidemiology of HIV in Thailand, as discussed above, the vast majority of USG TA focuses on programs and services, including care for PLHA, that is aimed at MARPs—in particular, MSM and TG individuals. Thailand has a strong and increasing need for client-centered, culturally competent services for the care and treatment of MSM and TG living with HIV.



ACCOMPLISHMENTS SINCE COP 2011

Adult Care and Support

USG efforts have focused on providing TA to strengthen care and support services for MSM and TG PLHA and on QI for the HIV care and support system overall.

* MSM and TG PLHA: In collaboration with MoPH and numerous community-based organizations (CBOs), USG provides TA to support development and expansion of combination prevention for MSM that, in line with PEPFAR guidance on combination prevention, includes a strong emphasis on positive health dignity and prevention (PHDP). One example of this combination prevention approach in Thailand—known also as the Comprehensive Package of Services model as a part of the broader Comprehensive Prevention Package (CPP) and Continuum of Prevention to Care and Treatment (CoPCT) models—provides target MARP groups with a full range of prevention, care, support, and treatment services, and better enables them to access these services without fear of stigma and discrimination. The approach also argues for focusing limited resources and ensures the provision of a comprehensive prevention package of services to those most at risk of being infected or transmitting HIV to others so as to avert the maximum number of new infections. Efforts to date have been focused on the three urban areas—Bangkok, Chiang Mai, and Pattaya—with the highest HIV prevalence among MSM.

An integrated package of care services is provided to persons in community-based programs through the CoPCT programs for MSM and TG PLHA at the designated USG-supported hotspot sites. At these sites, the integrated services package combines strengthened RTG institutional care and treatment, CBO/NGO community- and home-based care, including treatment adherence, and PLHA support group services. The CoPCT model includes essential building blocks such as care and treatment (consisting of clinical care and ART treatment, OI treatment, TB diagnosis and treatment, comprehensive community-based services, and social support). These are delivered by various local subnational government departments and CBOs. The full package of care interventions also extends to psychosocial support and livelihoods trainings for PLHA and MARPs. USG has supported these service interventions, networking, and establishing referral networks to existing local government services wherever necessary. USG also recognizes the importance of supportive interventions needed to create an enabling environment and thus has also supported activities in the six supportive intervention components: capacity building of local civil society, community mobilization, income generation, policy, stigma and discrimination reduction, and strategic information.

USG has worked closely with MSM and TG HIV-positive community-based care and support groups to provide community-based care and support, psychosocial support, and improved treatment adherence counseling among these groups. A USG small grants program for organizational capacity development for MSM- and TG-focused CBOs also aims to improve treatment adherence and access to standard care and treatment services at existing facility based sites. Expected results include better uptake for ART for MSM and TG, development of a positive lifestyle with community support leading to positive health, and reduction of self-stigma with significant changes in the enabling environment for MSM and TG-targeted services. USG is currently documenting those results for dissemination to national and regional authorities.

Community-facilitated care and support services are essential components of the CoPCT. Through this model, the USG has also supported effective and reliable models of livelihood development interventions for HIV-positive MSM and TG. These livelihood activities help improve economic security and quality of life for MARPs and PLHA, and enhance positive public health outcomes for HIV/AIDS care and prevention programs. To enhance sustainability, these programs will be assessed and documented with an eye toward serving as models for planned future scale-up and replication through leveraging of



GFATM.

* PHDP for MSM and TG: USG will continue to support The Poz Home Center, which is the only organization in Bangkok whose sole mission is the support of MSM and TG people who are living with HIV. With USG support, the Poz Home Center implements both the CPP and CoPCT models for MSM and TG PLHA with a strategy that includes both behavioral and biomedical interventions in community-based and clinic settings. Please refer to the Prevention TAN for a more detailed description.

* QI for the HIV care and support system overall: As discussed in detail in the Treatment TAN, HIVQUAL-T is a key focus of continued USG TA. Following a successful USG-supported pilot, MoPH began national expansion of HIVQUAL-T in 2007 with funding from NHSO. USG TA in FY 2011 supported that expansion by assisting with establishment of HIVQUAL-T networks with advisory, technical, and evaluation responsibilities. USG TA also has helped integrate HIVQUAL-T in the healthcare system in Thailand, with HIVQUAL-T now required by MoPH and the (Thai) Healthcare Accreditation Institute for health facilities and for hospital accreditation, respectively. USG also provides TA to assist with capacity building for QI through extensive training.

Pediatric Care

USG efforts in pediatric care and support focus on positive health dignity and prevention for youth and on pediatric HIV care networks, including QI for pediatric HIV care and support.

* PHDP for youth: USG conducted a program evaluation of the PHDP program for youth, which encourages ART adherence, following pilot implementation of the program in three centers. Data on project outputs and outcomes are being analyzed. A PHDP Youth manual is being finalized for sharing with HIV care providers in FY 2012.

* Pediatric HIV Care Networks, including QI for pediatric care and support. As discussed in detail in the Treatment TAN, USG worked closely with MoPH and NHSO to expand pediatric HIV care networks and QI programs to 30 provinces. Designed to transfer the burden of HIV care from tertiary care facilities to community hospitals closer to where pediatric PLHA live, pediatric HIV care networks provide ongoing training and technical support from tertiary care facilities to community hospitals, to which clinically stable pediatric PLHA are referred. By the end of FY 2011, 50% (191/388) of community hospitals were providing HIV treatment and care for children. A key element of pediatric HIV care networks is use of pediatric HIVQUAL-T, a QI system modeled after HIVQUAL-T.

TB/HIV

Many core TB/HIV program interventions are now relatively well developed in Thailand, with high coverage of provider-initiated testing and counseling for TB patients (76% with known HIV status), relatively high coverage of CPT (72%) and steadily increasing ART provision (51%) for HIV-infected TB patients in 2009. While USG has supported piloting and evaluation of these activities in the past, the national programs are now well placed to complete scale-up.

Within a TA-based approach, USG is supporting RTG in the 3 I's of TB prevention and control (intensified TB case-finding [ICF], isoniazid preventive therapy [IPT], and TB infection control [IC]) through capacity building and focused monitoring and evaluation, rather than service delivery. Assessments of more sensitive ICF consistent with new evidence-based guidelines that incorporate Xpert, a diagnostic platform for detection of multidrug MDR-TB endorsed by WHO in December 2010, are in development. An initiative to build subnational capacity for laboratory quality systems and EQA will continue. There is relatively wide access to liquid culture currently but it is targeted toward MDR-TB diagnosis; USG will continue to work with MoPH counterparts on advocacy to include more sensitive and rapid diagnostic



methods for ICF in PLHA under the national health insurance program.

USG staff participate in a technical working group that will be revising national IPT guidance after completion of a pilot evaluation early next year. USG continues to support curriculum refinement and to co-facilitate TB IC trainings, and is conducting a large public health evaluation of the efficacy of a standardized TB IC intervention. National M&E indicators currently include WHO-recommended TB/HIV indicators. USG is assisting the national TB program with audit tools and targeted sites for more intensive record review, in order to improve data quality.

USG has supported training and guideline development for early ART initiation for PLHA with TB and continues to serve on guideline committees and to monitor guideline implementation. USG also works closely with, and provides TA for, implementation of Global Fund to Fight AIDS, TB, and Malaria (GFATM)-supported activities. Few other donors are involved in TB in this middle-income country. Geographic coverage is addressed by MoPH, with GFATM support for specific “gap” populations such as illegal migrants.

OBJECTIVES FOR FY 2012–2013

In FY 2012 USG TA will focus on the following objectives related to HIV care:

Adult Care

* Combination prevention: TA will focus on increasing coverage and efficiency of care and support services by enhancing the capacity of MoPH and CBOs operating in combination prevention sites and strengthening the CoPCT model for potential scale-up and replication to national, subnational, GFATM-funded sites. TA related to HIV care will specifically aim to strengthen linkages between HIV counseling and testing and access to facility based and community-based care services, and promotion of adherence to care and treatment. Additionally, to build the capacity and strategic planning processes for MSM and TG, USG will continue to work with Provincial Coordinating Mechanisms to better integrate community-based with health facility-based services as part of enhanced GFATM implementation.

* HIVQUAL-T: USG will work with adult HIV care teams to facilitate the integration of quality HIV care to hospital accreditation systems by training, coaching, and sharing lessons learned. An evaluation of program outcomes and impacts will be developed and implemented.

Pediatric Care

If shown to be feasible, acceptable, and successful, the PHDP program will be expanded to other provinces through the pediatric HIV care quality network, with funding from NHSO and TA from USG. USG TA will support MoPH in scaling up the pediatric HIV quality care network in 15 new provinces, aiming at a cumulative total of 60 provinces and 250 hospitals. Additional TA will be provided to four regional network training sites, updating knowledge and skills in the areas of PHDP for youth, transition to adult HIV care programs, and promotion of performance measurement data analysis.

* PLHA with TB: TA will focus on building capacity for quality systems and a service network approach within the TB laboratory network; evaluating the use and implementation of combining the Xpert diagnostic platform with new, evidence-based ICF algorithms developed in the region; and improving TB surveillance data systems at national level, in particular for MDR-TB. TA will also be provided to community-based partners for strengthening of referrals of HIV-positive MSM and TG as well as providing treatment adherence counseling for both TB treatment and ART.

CROSS-CUTTING AREAS RELATED TO HIV CARE



Public-Private Partnerships:

USG is not engaged with any PPP related to HIV care in Thailand.

Gender

USG is not aware of gender disparities in the delivery of care services for PLHA in Thailand. As described above, adherence to ART one year after initiation is higher among adult women (93%) than adult men (78%). With USG TA, MoPH has recently updated PMTCT guidelines, including recommending routine couples HIV counseling and testing in antenatal settings. Additionally, USG TA focuses substantially on assisting governmental and nongovernmental partners with combination prevention efforts, including those for MSM, TG persons, FSW, and PHDP programs for youth of all genders.

MARPs

Please refer to the discussion of combination prevention for MSM, TG persons, and FSW above. Additionally, USG provides TA to the Bangkok Metropolitan Administration to improve HIV services to people who inject drugs, as described in the Prevention TAN.

Human Resources for Health (HRH)

USG provides substantial TA to governmental and nongovernmental partners to increase HRH related to HIV care, including supporting trainings related to adult and pediatric care and care of PLHA with TB, as described above.

Laboratory

USG TA aims to improve the quality of laboratory services related to TB diagnosis, as described above. Additional TA aimed at strengthening laboratory systems in Thailand is described in the Governance and Systems TAN.

Strategic Information

USG provides TA to governmental and nongovernmental partners for program M&E related to combination prevention, the CPP and CoPCT service delivery models, HIVQUAL-T and pediatric HIVQUAL-T, and implementation of new TB/HIV guidelines.

Capacity Building

RTG does not have a formal capacity building strategy related to HIV care. Most USG activities qualify as TA for capacity building for governmental and nongovernmental partners.

Food and Nutrition, and Orphans and Vulnerable Children

On the basis of the epidemiology of the HIV epidemic in Thailand, needs assessments from the RTG and USG, and limited resources available for USG work, USG does not engage in a substantial way with issues around food and nutrition or orphans and vulnerable children.

1 AIDS Data Hub for Asia-Pacific. Thailand.
https://skydrive.live.com/view.aspx/spreadsheets/thailand/thailand%5E_all%5E_indicators.xls?cid=afd9ed



ea3ddfb75c&sc=documents. Accessed 9/26/11.

2 FHI and BATS, DDC, MOPH, RTG. The Asian Epidemic Model Projections for HIV/AIDS in Thailand 2005–2025.

Published 2008.

http://aidsdatahub.org/dmdocuments/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf. Accessed 9/26/11.

3 UNGASS Country Progress Report Thailand, Reporting Period January 2008- December 2009.

http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/thailand_2010_country_progress_report_en.pdf. Accessed 9/26/11.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	286,747	0
HVSI	858,876	0
OHSS	356,476	0
Total Technical Area Planned Funding:	1,502,099	0

Summary:

Thailand COP 2012 Governance and Systems TAN

INTRODUCTION

The PEPFAR Thailand team focuses on technical assistance (TA) and capacity building for government and civil society, rather than service delivery. PEPFAR in Thailand represents an innovative and cost-effective approach: focusing on TA, developing strong health systems, and building capacity for Thailand to own a strong comprehensive program. While service delivery is funded mainly by the Royal Thai Government (RTG), with additional funding by the Global Fund to Fight AIDS, TB, and Malaria (GFATM), gaps remain in capacity, quality, coverage, focus, and policy to achieve a comprehensive, successful response to the epidemic. TA for all programs emphasizes building model programs for MARPs, quality systems, and strategic information (SI).

In Thailand, wide disparities exist in income, access to services, and risk. PEPFAR Thailand focuses TA on areas where people remain at risk, coverage is low, and systems require improvement. To promote the most effective response, PEPFAR Thailand works with RTG to identify program, policy, and system gaps, and then provides TA to fill those gaps. This collaborative approach has been a successful model in PEPFAR for engaging with middle income countries, has yielded a strong relationship in health between USG and RTG, and likely has enabled a close working relationship in general between USG and RTG.

Thailand’s government has changed several times since a coup in 2006. Anti-government protests in 2010 temporarily disrupted USG work but did not meaningfully decrease productivity. An election in July 2011 led to a peaceful change of government. Despite the uncertain political environment and new political leadership at the Ministry of Public Health (MoPH), RTG continues to work closely with USG, including PEPFAR Thailand.



Major Actors and Constraints

RTG funding accounted for 93% spent on HIV/AIDS in Thailand in 2009, an increase from 83% in 2007.2 RTG spending on HIV/AIDS in 2009 was 7.2 billion baht (US \$240 million), a 4% increase from 2008, of which 76% was spent on care and treatment and 14% on prevention. National Health Security Office (NHSO) and GFATM funds targeted prevention outreach with female sex workers (FSW), people who inject drugs (PWID), men who have sex with men (MSM), and migrants.

RTG funding for treatment, care, and support for PLHA in Thailand is channeled through three programs. In 2009 58% of PLHA received services funded by NHSO's universal coverage program, with RTG's social security and civil servant medical benefit programs covering most other Thai nationals. GFATM funds some treatment, care, and support services for non-Thai nationals (e.g., migrant workers). Finally, a minority of PLHA—the percentage is unknown—pay out of pocket for care and treatment in private hospitals and clinics.

USG engages with and provides TA to both NHSO and MoPH. Of note, MoPH formerly both funded and provided healthcare services in Thailand. In 2006, RTG created NHSO to fund services that MoPH provides. In its role as a funder, NHSO determines the package of HIV testing, treatment, care, and support services provided under universal coverage. NHSO also funds key laboratory services, including external quality assessment (EQA) for HIV serology and CD4 testing, HIV prevention services such as outreach and STI services, programs such as the pediatric HIV care network, and new initiatives including molecular testing for Early Infant Diagnosis (EID) and HAART for PMTCT. MoPH provides HIV/AIDS care and treatment at ~900 public facilities. In theory NHSO and MoPH roles are distinct. In reality, however, MoPH and NHSO are still defining their roles, which sometimes leads to confusion over management and delays in policy development and program implementation. Other international entities involved in HIV/AIDS include UNICEF and NGOs, including FHI, PSI, and PACT.

Some constraints hamper the HIV/AIDS response in Thailand. HIV prevention has slipped lower on the national agenda than other health concerns, although the draft national HIV/AIDS strategy for 2012–2016 reaffirms preventing new infections as one of three key priorities (along with preventing HIV-related deaths and eliminating stigma and discrimination for PLHA). Some key areas, such as MARP interventions and laboratory quality testing, lack focal points. In some other areas (e.g., PMTCT) long-term funding is not secure, likely due to healthcare reform and decentralization of services. Finally, despite RTG and nongovernmental efforts, HIV prevalence remains steady, with incidence and high-risk behaviors increasing in some MARPs. More intensive and innovative approaches are critically needed.

Global Health Initiative (GHI)

USG objectives have four underlying themes: building the capacity of RTG and civil society; strengthening health systems; strengthening country ownership and coordination; and increasing Thailand's ability to respond to the epidemic. All activities supported by USG align with GHI principles and goals of developing leadership and capacity to create an enabling policy environment, and integrating new activities into routine, sustainable systems. USG facilitates coordination among RTG, NGOs, GFATM, and other donors by participating in government and multilateral meetings, serving on the GFATM country coordinating mechanism, and contributing to Technical Working Groups.

The USG vision is an effective, high-quality, country-owned national HIV/AIDS program achieved through improving the technical and financial capacity of RTG and NGO partners to provide policy oversight, management, and coordination. To achieve that vision, USG will continue to provide TA to RTG, GFATM-funded programs, and other partners, and to adapt and/or test interventions in Thailand. USG will provide critical policy input, build the capacity of healthcare workers and community-based organizations



(CBOs), improve the quality of MARP-focused services, and strengthen key elements of the health care system. To address the GHI principle of improving metrics, USG will continue to support state-of-the-art HIV surveillance efforts, and provide critical input into the collection and use of SI. USG will continue to promote research and innovation, and provide technical expertise in national activities through its TA model.

LEADERSHIP AND GOVERNANCE AND CAPACITY BUILDING

Thailand is more advanced than many PEPFAR countries in funding and managing programs; however, as described above, gaps remain. Strengthening surveillance and M&E is a major focus, in support of the draft National HIV/AIDS Strategy for 2012–2016. That strategy, as well as the new national M&E plan, was developed with intensive USG TA. Use of SI, including mathematical models for use in policy making, is another focus of USG TA. Another gap that USG is focused on is strengthening the linkages between facility- and community-based services for HIV prevention, care, support, and treatment so targeted MARPs are reached with a continuum of response for services that meet their needs.

USG builds capacity in RTG and civil society through trainings on program design and implementation, M&E, and data use. For example, USG TA has assisted CBOs in delivering high quality peer education services and managing GFATM grants. USG TA also helped Rainbow Sky, an MSM CBO, develop a database to monitor peer educator activities.

Quality improvement (QI) activities are part of some programs, including HIV care networks. USG supports training at all levels to use QI data and develop QI plans.

USG facilitates integration between national offices to ensure program sustainability. For example, USG TA facilitated integration of QI standards between the Hospital Accreditation Institute, the Bureau of Nursing Standards, and MoPH.

In four pilot provinces, USG helps build capacity of HIV-positive MSM and TG peers to provide HIV counseling and assist with care and treatment, STI, and risk behavior reduction as a part of a positive health dignity and prevention (PHDP) program. USG participates on an advisory board that assists CBOs serving HIV-positive MSM in developing a national network, vision, goals, and action plan.

USG provides TA to RTG to use SI to set priorities and make policy. USG staff serve on national TA committees and TWGs, mentor MoPH staff, and provide training and capacity-building to MoPH and partners. In this fashion, USG ensures that its TA supports a sustained country-owned response in which partners assume responsibility for policies and programs. Additionally, at the government subnational level and with civil society, USG provides TA for M&E, specifically in the utilization of routine program data to inform strategic planning, program implementation, and resource allocation. USG TA also focuses on conducting basic program evaluations, special studies, and assessments (like the Routine Behavior Tracking Survey) to help understand sexual risk behaviors and healthcare seeking behaviors as they pertain to program implementation coverage, uptake, and access to MARP-friendly services.

In care and treatment, USG supported MoPH and NHSO in creating the National AIDS Program (NAP) database. NAP data were used to guide counseling, testing, and referral policies to increase early access to care and treatment programs, and to adjust treatment policies to initiate ART at a higher CD4 count. Key Challenges of FY 2011

USG's promotion of an effective continuum of response faces challenges, including:

- Lack of leadership: HIV prevention programs require multisectoral involvement, including health and non-health governmental organizations, civil society, and the private sector. Currently, national and local leadership in HIV/AIDS has not been fully developed. Building leadership capacity is both a priority



and very challenging.

- Decentralized policy: Local governments have been authorized to set up their own intervention programs, complicating MoPH efforts to implement vertical HIV/AIDS programs.

The effectiveness of many current interventions has not been evaluated. Intensive TA is needed to provide key information to guide budget allocations.

Human resources capacity remains limited, in both the government sectors and civil society, and at national and provincial levels, particularly regarding use of SI and advocacy skills.

Strategic Priorities/Responses for FY 2012 – FY 2013

USG will provide technical support to MoPH and civil society to develop guidelines on use of SI for program planning. Training and field supervision in using SI for program planning will build capacity to:

- analyze SI to define emerging epidemics and responses
- synthesize and use SI to guide policy making, strategic planning, and resource allocations
- access SI to monitor program impact
- use communication skills to engage policy-makers

STRATEGIC INFORMATION (SI)

USG provides TA to RTG for the development of the National HIV/AIDS Strategy for 2012–2016 and implementation of sustainable country-led approaches to understand, respond, and monitor the HIV epidemic.

Key Successes of FY 2011

Key successes of USG TA include facilitating the development and implementation of innovative HIV surveillance, M&E, and health management information systems (HMIS).

HIV surveillance systems

- Piloted community-based integrated behavioral and biomarker surveillance (IBBS) among non-venue-based FSW in three provinces, to be implemented nationally in 2012; FSW had previously been a “blind spot” in venue-based national surveillance
- Revised HIV/AIDS case reporting surveillance procedures, and developed a tool to collect care and treatment program data from NAP for surveillance reports
- Integrated existing behavioral surveillance into HIV serosurveillance among male military conscripts
- Scaled up on a national level previously piloted IBBS models among venue-based FSW, IDU, and MSM, using RTG and/or GFATM funds
- Expanded, in collaboration with BMA, BED-CEIA HIV incidence surveillance among pregnant women in Bangkok

National program monitoring and evaluation

- Developed new national M&E framework to monitor implementation of the National HIV/AIDS Strategy for 2012–2016
- Determined national five-year targets for indicators and designed measurement tools.
- Participated on the national M&E committee, and provided TA to the National AIDS Committee by developing national HIV/AIDS profiles and globally sharing them through UNGASS and the WHO Health Sector Response
- Supported M&E capacity strengthening of CBOs by including SWING and Poz participants (representing FSW and MSW and HIV-positive MSM) in developing and assessing the national M&E

system

- Provided TA to MoPH in evaluating GFATM grant implementation
- Participated in a national TWG on MARP size estimation

Integration and interoperability of HMIS for national program monitoring and surveillance

- Designed an HMIS to monitor facility-based harm reduction interventions, including outcome monitoring, and to track serosurveillance among PWID
- Revised the informatics infrastructure to ensure availability of NAP data for program monitoring and surveillance at hospital, provincial, regional, and national levels
- Explored the feasibility of integrating systems used to monitor PMTCT, VCT, ART, early warning signs of HIV drug resistance, and HIV/AIDS case reporting surveillance; designed an integration plan using the NAP database
- Wrote National AIDS Program Data Analysis and Reporting (NAPDAR) software to support NAP data management and generation of standard reports needed for program monitoring and surveillance; piloted NAPDAR software for hospitals; began designing plans for its use at all levels of the NHSO informatics infrastructure
- Strengthened data management and reporting systems of CBOs—Poz and SWING—to align with national-level HMIS efforts

Use of SI for national and provincial policy and program planning

- Helped establish the national HIV/AIDS situation analysis working group, which triangulated data from multiple sources, then synthesized it for policy development and program planning
- Modeled current and projected HIV epidemiology, and used results to develop the National HIV/AIDS Strategy for 2012–2016
- Developed rationales to prioritize MARPs and geographic areas for intensive prevention interventions
- Built human resource capacity at provincial levels to use SI to describe HIV epidemiology and measure impacts of interventions
- Developed guidelines for HIV/AIDS situational analysis using SI data
- Trained staff from 12 provinces in Phase I situation analysis to strengthen their use of SI

Key Challenges of FY 2011

- Duplication of effort: multiple vertical systems are used for program monitoring and surveillance by various stakeholders; process of harmonizing systems is challenging
- Limited human resources at provincial levels with sufficient knowledge and skills to manage, interpret, and disseminate SI for policy and program planning
- Lack of HIV/AIDS leadership to actively engage health and non-health governmental organizations, civil society, and the private sector in HIV interventions, and to effectively use SI for policy and program planning

Strategic Priorities/Responses for FY 2012–FY 2013

USG will promote the implementation of the National HIV/AIDS Strategy for 2012–2016 by developing a harmonized comprehensive SI framework with an effective HMIS to ensure the availability and accessibility of SI at all levels. It will also build human resource capacity to use SI at government and civil society levels to describe Thailand's HIV epidemic, measure the impact of the HIV/AIDS responses, and interpret the results to guide policy and program planning at all levels.

SERVICE DELIVERY

RTG clinical services are well developed. However, these RTG services are not well linked or coordinated



with a growing and robust community-level comprehensive HIV response for MARPs that is developed and owned by civil society and supported through the USG.

HIV treatment quality remains variable in Thailand, owing to insufficient human resources in some areas. Many HIV-infected persons access care late, with median CD4 at treatment initiation low but increasing (102, 116, and 147 cells per mm³ annually, from 2009–2011). Focus group interviews suggest that MSM access treatment late because of stigma, discrimination, and lack of knowledge about HIV care and treatment. Little data for other MARPs are available, although anecdotal data suggests that similar barriers exist for them. As HIV care and treatment services continues to expand, there is an ongoing need to monitor service quality, and MoPH and NHSO are working to expand quality systems for care and treatment.

In support of a national continuum of response (CoR), USG provides TA around model replication and scale-up of a Comprehensive Prevention Package (CPP) and a Continuum of Prevention to Care and Treatment (CoPCT) prevention, care, and support program model. In addition, USG helps RTG to refine and strengthen its own service delivery programming to MARPs, making it more comprehensive for the target populations and attempting to eliminate gaps in service provision at the facility or community levels.

To accomplish this transition, USG has continued to develop and strengthen the CoPCT programs for MARPs and PLHA at sites in Bangkok, Chiang Mai, and Pattaya. At these sites, an integrated services package, which other RTG- and GFATM-supported projects are replicating, combines strengthened RTG institutional care and treatment, CBO/NGO community- and home-based care, and PLHA support group services. The CoPCT model includes essential building blocks such as clinical care and treatment, comprehensive community-based services, and social support. These are delivered by various local government departments and civil society organizations. USG will continue to provide support to several of these interventions, including HCT, STIs, and MSM programs; peer treatment adherence support for PLHA at drop-in centers; and livelihood development support for PLHA and their households. As part of the model rollout, USG provides documentation and lessons learned for program replication, funding for study tours, and participation in internship courses provided at the model sites.

The USG CoR strategy described above is fully aligned with PEPFAR's CoR Core Principles. This pragmatic approach to HIV prevention in Bangkok, Chiang Mai, and Pattaya (known as the Comprehensive Package of Services (CPS) model as a part of the broader CPP and CoPCT models) is designed to surround target MARP groups and PLHA with the full range of prevention, care, support, and treatment services, and better enable them to access these services without fear of stigma and discrimination. USG has worked within the context of a technical assistance model promoting the CPP and CoPCT models and in response to the HIV epidemic in Bangkok, Chiang Mai, and Pattaya and this approach will continue in FY 2012 with some enhancements to the program and eventual transition to local ownership through leveraging of RTG and GFATM.

This CPP approach argues for focusing limited resources and ensures the provision of a comprehensive prevention package of services to those most at risk of being infected or transmitting HIV to others so as to avert the maximum number of new infections. The CPP approach has been used with FSW, PWID, MSM, and PLHA in "hotspots" selected for their high HIV prevalence in Thailand. The package of services that needs to be provided to each at-risk group includes behavior change communication (BCC) aimed at providing information that leads to a choice of healthy behaviors, HTC with rapid tests with same day results (VCT), STI checks and treatment, capacity building of grassroots groups, and linkages to existing care, support, and treatment services such as ART, OI treatment, TB diagnosis and treatment, home-based care, and psycho-social care and support. USG has supported these service interventions, networking, and establishing referral networks to existing government services wherever necessary. USG also recognizes the importance of supportive interventions needed to create an enabling environment and thus has also supported activities in the six supportive intervention components: capacity building,



community mobilization, income generation, policy, stigma and discrimination reduction, and strategic information.

To further support local ownership of service delivery, USG continues to provide TA and quality assurance support for RTG and GFATM Round 8 scale-up of the CPP and CoPCT models, which argue for a comprehensive approach for providing care and support services to PLHA that includes ARV adherence, home-based care and support, OI prophylaxis, regular ART follow-up services, clinical monitoring, and condom promotion.

HUMAN RESOURCES FOR HEALTH

In Thailand USG supports core GHI principles of health systems strengthening (HSS) and human resources for health (HRH) trainings and mentoring of health care workers, RTG staff, and civil society. Tools and curricula are developed and used at national and subnational levels with government funding and USG TA. USG contributes to a master HRH plan for 2004–2013, and to annual MoPH health workforce assessments, through specialized training, tools, and other TA.

MoPH provides management and leadership training through its Institute of Health Workforce Development. Designated courses are required before health officers can be promoted. To complement training, a Thai adaptation of CDC's Management in Public Health course is provided, primarily to provincial-level health staff through Mahidol University. Training for task shifting is taking place in several ways. MoPH supports village health volunteers to provide health education at household and community levels, and to serve as liaisons to the health system and focal points in emergencies. Volunteers train for five days and then attend periodic brief courses on priority issues for the province, and annual refresher training.

Complementing efforts to build capacity of RTG, USG will also provide targeted TA to local government and sub-national, community-based groups, and GFATM. The TA aims to ensure that strong, robust institutions with the capacity to continue to implement the CPP and CoPCT models (described above) remain in place. USG capacity building efforts with cooperating agencies in Thailand have focused on enhancing skills in the following areas: monitoring and evaluation, MARP-friendly service provision, quality assurance for service delivery, policy and advocacy, community systems strengthening, community mobilization, and strengthening the enabling environment. As programs start to transition to local ownership, efforts have been made to strengthen the organizational capacity of partners to identify and secure new funding while leveraging existing resources. These efforts will continue in FY 2013, with significant focus on the strengthening and transition of proven programmatic models to a fully locally-owned and managed response.

In FY 2012–2013, USG will provide capacity building to implementing partners to: a) develop monitoring and data utilization systems to provide SI to the PMTCT program; b) support regional and provincial coaching teams in using M&E and performance measurement data for program improvement; c) ramp up VCT and couples counseling and testing; d) improve laboratory quality monitoring systems; e) improve HIV drug resistance surveillance and IBBS using respondent driven sampling (RDS); f) develop HSS and enabling environments. Working with MoPH and NHSO, USG will provide TA build capacity for epidemiologic modeling, ART forecasting, and program planning using SI from multiple sources. USG will continue to provide TA to develop targets and prioritize intervention sites for implementing the National HIV/AIDS Strategy for 2012–2016.

LABORATORY STRENGTHENING

Thailand has a well-structured laboratory network with three tiers. All hospitals provide some laboratory testing, including HIV serology, while tertiary hospitals offer more complex tests and serve as reference



laboratories. Demand for HIV laboratory services, however, often outstrips supply, and test results can be delayed.

USG supports national policies to improve the quality of laboratory services by focusing on improving national EQA programs and supporting networks for laboratory accreditation and validation of new technology and laboratory testing.

USG has supported and provided TA for the development and implementation of laboratory quality systems and HIV testing QA to other PEPFAR countries and regional laboratories. The program has used “South-South” TA to strengthen laboratory services in Laos, Papua New Guinea, Cambodia, Vietnam, Ethiopia, and Zambia.

In FY 2011, USG provided TA to help implement HIV genotypic drug resistance testing, rapid HIV testing among MARPs, and evaluation and implementation of a new EQA program using dried tube specimen technology.

In FY 2012–2013, USG will continue to provide TA to improve EQA programs, augment HIV drug resistance testing efforts, prepare laboratories for accreditation, implement rapid testing for MARPs, support HIV incidence surveillance, strengthen STI testing capacity, and provide “South-South” TA.

HEALTH EFFICIENCY AND FINANCING

A key focus of USG TA is assisting RTG and international donors in assessing costs and budgetary forecasting and planning. In FY 2008, USG provided TA in conducting a cost-effectiveness analysis of providing HAART to all HIV-positive pregnant women. That work led to a change in national policy in October 2010. In FY 2011, USG provided TA to NHSO to forecast the cost to implement new ART guidelines that recommend initiating treatment at CD4 count <350 cells per mm³. In FY 2012–2013, USG will provide TA to NHSO for a cost-effectiveness analysis of that policy change.

USG supports initiatives which lead to increased quality and efficiency, including program integration (e.g., pediatric HIV care network). In addition, USG has provided intensive TA to implement a quality improvement program nationally (HIVQUAL-T, with similar programs in development for STI and VCT services).

SUPPLY CHAIN AND LOGISTICS

USG does not work in this area, as it is not an issue in the HIV/AIDS response in Thailand.

WOMEN, GIRLS, AND GENDER EQUALITY APPROACH

As articulated in GHI's Women, Girls, and Gender Equality principle, gender equality and women's empowerment are integrated throughout USG HIV programs. USG's work in these areas encompasses relevant data collection and analysis; policy and advocacy; development of tools and methodologies to better integrate gender, and measure gender norms and inequalities and their impact on health outcomes; innovations in behavior change communication and community mobilization techniques; operations research to test innovative models of service delivery; capacity building of health personnel; improvements in health systems to better meet the needs of youth, women, and men; linkages with non-health sectors to provide comprehensive services dissemination and training on state-of-the-art gender interventions and resources; and development and harmonization of gender and health indicators. Additionally, USG is a technical leader in sexual orientation/gender identity issues and HIV in Asia.

Developing and supporting interventions that target the unique needs of women at high risk of HIV



infection is a continuing priority, as is transgender (TG) health because global and regional information about HIV among TG persons is scarce. Data collection methods at testing sites do not accurately identify and track TG persons or capture their experiences or risks behaviors. Health professionals, due to assumptions and/or discomfort about gender identity, miscount TG persons. Many agencies do not even allow for the reporting of TG as patients.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	1,181,098	
Total Technical Area Planned Funding:	1,181,098	0

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	379,186	0
HVOP	1,239,525	0
IDUP	59,229	0
MTCT	104,121	0
Total Technical Area Planned Funding:	1,782,061	0

Summary:
Thailand COP 2012 Prevention TAN

This TAN summarizes HIV epidemiology in Thailand and discusses USG efforts to prevent HIV among most at-risk populations (MARPs), including adolescents; prevent maternal-to-child transmission (MTCT) of HIV; and promote positive health, dignity and prevention (PHDP) among persons living with HIV/AIDS (PLHA) in Thailand.

EPIDEMIOLOGY OF HIV INFECTION IN THAILAND

New infections in Thailand 1990–1991 declined from 150,015 in 1990 to 10,853 in 2010, according to Asian Epidemic Model (AEM) projections. In 2009 HIV prevalence among adults ages 15–49 years was estimated at 1.3%. In 2009, an estimated 530,000 persons living with HIV/AIDS (PLHA) resided in Thailand.²

Thailand’s HIV epidemic disproportionately affects most-at-risk populations (MARPs), including men who have sex with men (MSM), female sex workers (FSW), persons who inject drugs (PWID), prisoners, and migrant workers. The AEM estimates that 45% of HIV infections occurred in MSM, PWID, and FSW in



2010, and 66% will occur in MSM, PWID, and FSW by 2025 under current projections.¹

MSM and TG

An estimated 3% of men ages 15–49 (560,000 men total) in Thailand were MSM, according to AEM estimates.¹ MSM accounted for 23% of new HIV infections in 2010, according to AEM, and will account for 52% by 2025.¹ HIV prevalence among MSM in large urban centers is particularly high (17–31% in Bangkok, Phuket, and Chiang Mai, in recent surveys) and lower but still substantial in less urban areas (5%–6% in Udon Thani and Phatthalung). HIV prevalence among transgenders (TG) in large urban areas in 2005 was 12%–18%.²

High-risk behaviors for HIV transmission and acquisition among MSM are prevalent, with only 36%–66% of MSM in more urban areas, and 56%–57% in less urban areas, reporting consistent condom use in the past three months in surveys conducted during 2006–2008.² Condom use during last anal sex was reported by 88% of MSM in a 2007 national survey.²

FSW

An estimated 25,000 direct and 120,000 indirect FSW work in Thailand, according to AEM estimates.¹ HIV prevalence among FSW overall declined to 2.8% in 2009 from 4.3% in 2007. Prevalence was higher among non-venue-based FSW in USG-supported surveys of FSW in Bangkok (21%) and Chiang Mai (11%).³ According to 2009 data, 92% of FSW reported condom use with their last client.²

PWID

Approximately 40,000 PWID live in Thailand, according to AEM estimates.¹ According to AEM, 9% of new infections in 2010 occurred among PWID.¹ HIV prevalence among PWID remains high—41% in government drug rehabilitation sites in 2010 and 24% and 11% in Bangkok and Chiang Mai, respectively, in 2009.³ Surveys have also found 14% and 66% of PWID in Bangkok and Chiang Mai reporting needle sharing in the past six months.³ Injection of multiple drugs, particularly methamphetamines, is increasing. In 2011, the Royal Thai Government (RTG) determined that current law forbids needle exchange, on the grounds that it contravenes laws prohibiting promotion of drug use.

Prisoners

Of 209,427 prisoners in 142 prisons in Thailand in 2009, 86% were men.³ Routine HIV surveillance in prisons is not conducted, and HIV testing is voluntary.³ In 2008, a USG-supported survey of three prisons showed HIV prevalence of 6.5%–11.5%. In 2009 1768 prisoners (0.8% of the total), of whom 77% were men, were known to be PLHA.³

Migrant Workers and Fishing Boat Crews

HIV prevalence among migrant workers increased from 0.8% in 2007 to 1.2% in 2008.³ Among migrant fishing boat crews, HIV prevalence increased from 1.3% in 2007 to 2.5% in 2008, following declines during 1997 to 2006.³

HIV PREVENTION IN THAILAND

Thailand is rich in strategic information (SI), with surveillance, surveys, special studies, and program data focused at all levels. The challenge has been to use SI effectively in strategic planning processes to drive policy, programs, and resource allocations appropriately.



Thailand's draft National HIV/AIDS Strategy for 2012–2016, developed with USG TA, prioritizes HIV prevention in MARPs. USG TA will be directed at providing TA to partners during FY 2012–2013 in support of the strategy.

Combination HIV Prevention for MSM, TG, and FSW

* Context and Background: USG has developed and is working with the Thailand Ministry of Public Health (MoPH) to implement combination prevention interventions for MARPs, with a particular emphasis on MSM and TG (currently) and FSW (to begin in FY 2012). For MSM/TG, MoPH's combination prevention program includes behavioral, biomedical, and structural elements that address primary, secondary, and tertiary prevention of HIV as part of the continuum of response, as follows:

1. Primary (i.e., preventing new HIV infections), including peer outreach, education, individual and group counseling, and providing condoms/lubricant.
2. Secondary (i.e., early detection of HIV infection), including peer outreach to promote VCT and STI testing in MARPs, providing MARP-friendly venues for VCT and STI services, and promptly linking newly diagnosed PLHA to ART and care services.
3. Tertiary (i.e., mitigation of morbidity and mortality among PLHA), including peer promotion of access and adherence to HIV care, support, and treatment and risk-reduction behaviors and providing community- and home-based care as well as psychosocial support. These interventions also promote behaviors that decrease risk of HIV transmission, disclosure to partners, and partner HIV testing.

These activities occur simultaneously, with appropriate linkages and referrals to other services. The program also aims to modify the environment to enhance the effectiveness of interventions. Desired changes to help strengthen the enabling environment include decreasing stigma and discrimination around HIV/AIDS for MARPs; building capacity of governmental and NGOs; analysis and use of SI for improved program planning and resource mobilization; mobilizing communities; strengthening community systems; inclusion of MARPs in the design of locally responsive interventions; and providing income-generating opportunities for PLHA. Importantly, MoPH's program aligns with the draft National HIV/AIDS Strategy for 2012–2016, which aims to drastically reduce new HIV infections, deaths from HIV/AIDS, and stigma and discrimination related to HIV/AIDS.

A specific example of combination prevention at the community level is the Comprehensive Prevention Package (CPP) model. USG works under the CPP concept that links prevention, care, and treatment services to critical supportive interventions that help build an enabling environment for marginalized MARP populations. This CPP model includes outreach, behavioral change communication (BCC), condom and lubricant distribution, STI diagnosis and treatment, and VCT, as well as strengthening referral linkages to care and treatment. RTG promotes comprehensive and targeted delivery of combination prevention services in "hotspots" throughout Thailand and the Mekong region.

USG has provided TA to MoPH and civil society for combination prevention interventions in Thailand, focusing on MARPs, MSM, TG, and FSW in particular. Initially developed as pilot projects in six sites, MoPH combination prevention for MSM/TG has expanded, with GFATM Round 8 funding, to 31 of 76 provinces. The USG-developed CPP model is currently implemented in Bangkok, Pattaya, and Chiang Mai with a focus on providing intensive technical support to civil society and RTG for the replication and scale-up of CPP with GFATM funding.

Accomplishments since FY 2011 COP

The focus of USG TA for MSM and TG has been to assist MoPH, the Rainbow Sky Association of Thailand (RSAT, a community-based organization [CBO] serving MSM and TG), and other CBOs as they scale up prevention programs, including CPP in 31 GFATM-funded provinces. Of note, MoPH is the



primary recipient, and RSAT (at this time) the sub-recipient, of the GFATM R8 grant. Impacts of USG TA to partners during the beginnings of national scale-up were as follows:

* Primary prevention: Developed a protocol to standardize community-based outreach; built M&E database for outreach and trained community-based partners use the database; organized a training-of-trainers for outreach workers.

* Secondary prevention: Continued successful implementation of the CPP in USG-supported sites; implemented a VCT demonstration project using rapid HIV tests with same-day results in Bangkok, Chiang Mai, and Pattaya; trained healthcare workers (HCW) in four provinces on rapid tests; and trained MSM staff and HCW on BCC.

* Tertiary prevention: Peer outreach workers reached 426 PLHA, who received 2,654 health services and 591 group activities. USG also 1) assembled a MoPH technical working group to implement VCTQUAL-T, a quality improvement (QI) and performance measurement system for VCT, based on HIVQUAL-T; 2) developed data abstraction forms and surveys and trained 55 HCW from four provinces on HCT for MARPs and VCTQUAL-T, which was implemented in three hospitals; 3) implemented STIQUAL-T, a QI and performance measurement system for STI services, in 20 hospitals after training 640 persons on STIQUAL-T procedures; 4) provided TA to MoPH to develop a proposal and manage GFATM Round 8 funding for STI services for MARPs, including STI screening, condom distribution, and sensitivity and risk-reduction counseling training, and to develop national and MSM-specific STI treatment guidelines.

* Enabling environment: Trained HCW in four provinces on MSM sensitivity; facilitated quarterly meetings of RSAT and partners; delivered multiple trainings for peer outreach workers on VCT, BCC, stigma and discrimination; continued implementation of a grants management program and provision of capacity development assistance to civil society CBOs for MSM prevention, care, and support service delivery of the CPP model; integrated livelihoods initiatives into MSM HIV programs; convened MSM stakeholder meetings to encourage information exchange; provided TA to build capacity in MSM CBOs in six provinces (focusing on organizational skills, financial management, and team building); assisted BMA with developing a five-year strategic plan for HIV prevention for MSM/TG.

USG activities for prevention in FSW will begin in FY 2012.

Key Priorities for FY 2012-2013

USG will provide TA to strengthen combination prevention efforts for MSM and TG persons by building government and CBO capacity; increasing availability of culturally competent rapid testing with the ultimate goal of changing national policy to adopt HIV rapid testing with same-day results for routine use in both facility as well as community settings; refining the CPP model and prevention-related BCC materials including addressing the risks of anal sex in all transmission; enhancing the provision or referral to STI services, HIV care and support, and treatment; improving linkages across the continuum of prevention interventions in all GFATM-funded provinces; strengthening enabling environment interventions, including a focus on the Positive MSM network as platform for sharing information; and continuing to emphasize M&E activities with a focus on utilization of SI and data. With partners, USG will help conduct a program evaluation in 2013 that could lead to national scale-up. Additionally, to build the capacity and strategic planning processes for MSM, USG will continue to work with Provincial Coordinating Mechanisms to better integrate community-based with health facility-based services as part of enhanced GFATM implementation.

For prevention in FSW, USG will provide TA support GFATM-funded projects to promote FSW access to HIV services and strengthen community-based referral systems.



HIV PREVENTION FOR PWID

Context and Background

Although RTG's past anti-drug campaigns resulted in widespread fear and mistrust among PWID, RTG has recently been more supportive toward harm reduction approaches, including methadone treatment, which has been scaled up nationally with funding from the National Health Security Office (NHSO). In addition, MoPH and other RTG offices developed a pilot needle and syringe program (NSP) to be supported by GFATM. However, in August 2011 a RTG legal review held that NSP contravened Thai law prohibiting promotion of drug use, leaving the prospects for implementation of NSP unclear. The National Harm Reduction Policy was not passed by the previous government; the State Council recently stated that NSP is illegal; and the new Prime Minister has pledged to put 400,000 drug users into rehabilitation camps. All of these events add to the growing tenuous situation for PWID program implementation in Thailand. USG efforts for PWID are focused on Bangkok, with BMA as the main implementing partner. TA in past years has focused on developing peer-based outreach to PWID to promote primary prevention and VCT. Moving forward, TA will focus on enabling BMA to better understand injection methamphetamine use and provide better HIV prevention services for PWID.

Accomplishments since FY 2011 COP

USG TA strengthened the peer outreach program, including training in case management, outreach, and referrals. Strengthening of clinic-based HIV services included incorporation of CD4 follow-up in methadone clinics, revision of service guidelines for PWID (October 2010), and piloting of an M&E program in two clinics. Additionally, USG provided TA to develop referral manuals used in clinics and by peers. USG assisted BMA in planning and implementing RDS surveys of PWID and on using the multiplier method to estimate PWID population size in Bangkok. USG TA helped plan a formative assessment of methamphetamine users.

Key Priorities for FY 2012–2013

With USG TA, BMA plans to launch a formative assessment in early FY 2012 to learn more about injection methamphetamine use and sexual risk behaviors. Results will be used to develop, implement, and evaluate interventions to increase access to HIV prevention services, and to strengthen capacity of BMA drug treatment clinics in providing these services.

HIV PREVENTION IN CORRECTIONAL FACILITIES

Context and Background

Approximately 210,000 men and 30,000 women are incarcerated in 141 prisons. Sexual behaviors and injection drug use in correctional facilities put prisoners at risk for HIV.

Since 2006 USG has provided TA to MoPH and the RTG Department of Corrections (DOC) to develop a model intervention program that includes HIV prevention, VCT, HIV care and treatment, and M&E. Piloted in five prisons, the program has expanded, with GFATM Round 8 funding, to 32 prisons, with an ultimate goal of national expansion.

Accomplishments since FY 2011 COP

- Assisted MoPH and DOC in completing a memorandum of understanding (MoU) in 2011 for improvement of prisoners' health that includes HIV. The MoU is the first ever in health between the two Ministries, and will strengthen support from local hospitals for prison-based VCT and HIV care and



treatment services

- Supported MoPH and DOC in 32 GFATM-supported prisons to train 880 peer educators who reached 5,857 prisoners with HIV/AIDS information; provide VCT to 8,715 prisoners; manage 1,046 STI cases; train 32 nurses on M&E activities; and draft HIV prevention guidelines for prison settings

Key Priorities for FY 2012–2013

- Support national expansion and provide support at existing sites
- Conduct M&E activities, share results with stakeholders, and draft and implement action plans based on findings

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

Context and Background

PMTCT remains a critical concern in Thailand. The MTCT rate in Thailand was 2.9% in 2007 (5.6% if dead infants are included). PMTCT is a key goal of the draft National HIV/AIDS Strategy for 2012–2016, which aims that by 2016, MTCT will decrease by 75%.

Among ~800,000 pregnant women who gave birth in Thailand in 2010, 0.7 % were PLHA.² Data from 2006 show that 95% of pregnant women accessed antenatal care (ANC), although only 87% of pregnant PLHA did so.³ Of all pregnant women accessing ANC in 2009, 82% received an HIV test and the results of that test.² Of pregnant PLHA, 95% received ARVs, and 88% of HIV-exposed infants received ARV prophylaxis.² Among HIV-exposed infants, 56% were tested for HIV infection.³ CD4 testing during pregnancy was low, however, at 43% in 2008.³ Low testing rates complicated use of ARV for PMTCT, because recommendations at the time depended on CD4 count. Additionally, increasing transmission of HIV in married couples¹ underscored a need for couples HIV counseling and testing (CHCT).

Two MoPH databases, called PHIMS and PHOMS, were created in 2001 with USG technical and financial support to monitor PMTCT activities and outcomes in HIV-exposed children, respectively. Because of changes in PMTCT policy and RTG health structures, those two databases, although still used, have limited capability and coverage, especially in Bangkok, where many health facilities are under non-MoPH administration.

Accomplishments since FY 2011 COP

USG provided TA to MoPH to update PMTCT policy to recommend ARV treatment during pregnancy regardless of CD4 count, using a protease inhibitor-based regimen (WHO option B); to routinely offer CHCT in ANC settings; and to use molecular rather than serologic tests for early infant diagnosis (EID).

Additionally, USG TA to MoPH and NHSO led to limited upgrades of the PHIMS database and the NAP database (an NHSO database of persons on ART) to enable better program monitoring. USG provided TA in interpreting NAP data, designing national PMTCT indicators, and creating software (NAPDAR) that generates reports on five key indicators that was piloted in 30 hospitals and will be finalized in FY 2012. USG staff provided TA for NHSO-funded PMTCT trainings for 1,200 HCW, and for the design and pilot testing of PHIMS upgrades.

USG TA helped initiate pilot CHCT programs in 16 hospitals in five provinces. In pilot sites, 46% of women attending ANC brought male partners, 41% received CHCT, and 36% did HIV testing together. USG is now providing TA for a NHSO-funded national CHCT scale-up.

USG supported a pilot program for improved EID, including DBS-PCR and whole blood DNA-PCR, in four



provinces in 2009, and EID training at a national PMTCT course.

Key Priorities for FY 2012–2013

USG will provide TA to MoPH in monitoring implementation and outcomes of the new PMTCT policy; work with BMA to provide TA to expand PHIMS and PHOMS coverage to Bangkok and upgrade database capabilities; and continue to provide TA to MoPH and UNICEF in evaluating EID.

POSITIVE HEALTH, DIGNITY AND PREVENTION (PHDP)

Context and Background

* PHDP for Young People: Challenges of caring for 14,000 PLHA ages 0–142 include mental health and behavioral difficulties, drug resistance issues, and transitioning PLHA to adult HIV clinics. Since 2009, USG has provided TA to MoPH and two Bangkok-area hospitals to develop clinic-based programs to educate youth on reproductive health, STI, and ARV adherence; promote self-esteem, self-discipline, and problem solving skills; and provide skills for reducing risks of disease acquisition and transmission.

* PHDP for MSM and TG: Numbers of PLHA, including MARPs, accessing care (besides ART) in Thailand are not known. In considering challenges of HIV prevention, PLHA who are MSM and TG should be recognized as a part of the solution and should be included in service design and delivery. Reaching MSM and TG with HIV prevention, care, and treatment poses significant challenges, especially given substantial stigma and discrimination that make many MSM and TG reluctant to disclose risks in clinical and community-based service settings. Without MSM- and TG-friendly services, MSM and TG risk disappearing after testing positive or presenting for care and treatment with late-stage disease, when outcomes are considerably poorer.

USG supports The Poz Home Center, the only organization in Bangkok whose sole mission is to support PLHA who are MSM or TG. The center implemented the CPP model with a strategy that includes behavioral and biomedical interventions in community-based and clinic settings. Behavioral interventions include correct and consistent condom and lubricant use; promotion of testing and counseling; disclosure of status to partners; partner testing; reduction in number of sexual partners; support in adopting and maintaining strategies that reduce transmission of HIV/STIs; and adherence to HIV treatment. Biomedical interventions include referral for management of STIs, including anal STIs, for PLHA and their sex partners; and referral for care and support services for other health concerns for HIV-positive TG, including hormone therapies, mental health counseling, and sex reassignment surgery.

Accomplishments since FY 2011 COP

The program for PHDP for young people is undergoing evaluation.

In FY 2011, the Poz Home was a new partner for USAID. Project activities and performance will be assessed after one year of implementation.

Key Priorities for FY 2012-2013

If shown to be successful, the PHDP for young people model will be scaled up with NHSO funding through the pediatric HIV care network.

Key priorities for the Poz Home include quality assurance for CPP prevention efforts with PLHA who are MSM and TG; creation of a “Follow-up to Post-Test Counseling Service” model to promote positive health and prevention and provide care and support at BMA and MoPH sites; linkage of HIV-negative MSM and



TG with MSM/TG HIV-prevention organizations; counseling and testing promotion through telephone advice/support line and peer-based online education and support service; and development of the M-Poz network of groups and organizations providing services to PLHA who are MSM and TG. By facilitating experience sharing, cross learning, and the coordination of TA and capacity building for members, the M-Poz network will support replication of the Poz Home Center's model for delivery of the CPP to other GFATM-funded organizations. TA will be provided to local MSM organizations and HCW to improve capacity to provide outreach, VCT, and STI services, with appropriate M&E to all MSM and TG. Rapid testing with same-day results is being piloted at multiple clinics and mobile sites to promote behavior change as well as earlier access to care and treatment. Rapid testing also aims to encourage positive health and prevention services and behavioral risk reduction among HIV-positive MSM and TG. The goal is to transition these proven models to local ownership.

HIV PREVENTION FOR MIGRANTS

Context and Background

International investment, trade, and tourism has resulted in substantial immigration to Thailand, particularly from Burma—refugees, displaced persons, professional and labor migrants, including sex workers. A key challenge for RTG is irregular migration, including smuggling and trafficking in persons, and its impact on the labor market, public health, and social services. The International Organization for Migration (IOM) reported in 2010 a net migration rate for Thailand of 0.3 migrants/1,000 population; immigrants comprise 1.7% of the total Thailand population of 68.1 million persons, and women comprise 48.4% of immigrants. Unofficial estimates suggest over two million Burmese live in Thailand. UNCHR currently estimates that Thailand hosts ~100,000 registered and ~53,000 unregistered Burmese refugees in nine camps along the Thai-Burma border. MoPH collaborates with IOM, UN, USAID, and other donors and multi-laterals to create a positive environment and effective health services for migrants and host communities.

Accomplishments since FY 2011 COP

Save The Children (under PSI/Thailand) is a new USAID subpartner, since mid-FY 2011. Project start-up began in FY 2011 and preliminary activities planned for FY 2012.

Key Priorities for FY 2012-2013

Key USG priorities for most-at-risk Burmese migrants living in Thailand are to develop models of referral systems and mechanisms to facilitate prevention and ensure access to HIV/TB prevention, care, support, and treatment; map and assess their health services and help design a program to address HIV/TB and other health needs; and develop and distribute an BCC publication on HIV and TB, targeting this group.

PEACE CORPS

The US Peace Corps is positioned to target rural youth, the most mobile population in Thailand, through community based events that promote awareness, prevention, and life skills. Peace Corps Volunteers and their counterparts will be trained in HIV/AIDS prevention and stigma reduction activities, such as strengthening peer networks, training peer leaders to provide essential information, developing community based health promotion projects that specifically target adolescent MARPs, and pre-empting risky behavior. Peace Corps will also provide Program Design and Management Training to volunteers and their counterparts so that they can leverage funds to support community-based prevention initiatives. Additionally, Peace Corps' HIV/AIDS Global Initiative Group, comprised of current volunteers with technical support from PC Headquarters, will disseminate best practices and provide assistance (often in Thai) to build the capacity of community leaders.



CROSS-CUTTING AREAS IN HIV PREVENTION

Health Systems Strengthening

USG helps build community systems and local CBOs capacity in providing HIV prevention services.

Human Resources for Health

USG provides TA to train HCW and peers in prevention in community settings, healthcare facilities, and prisons.

Medical Transmission

USG is not actively engaged in this area, except for limited laboratory trainings. Significant medical transmission has not occurred in Thailand recently.

Gender

Gender-related USG efforts include combination prevention for MSM, TG, and FSW and PMTCT activities.

Strategic Information (SI)

Strategic priorities for FY 2012–2013 are as follows:

Health Information Systems

- Implement and evaluate the PMTCT information systems, including upgraded PHIMS, PHOMS, and NAP databases
- Pilot and scale-up the harmonized information system of facility-based harm reduction programs for PWID in BMA; and establish linkages with and integrate use of data from the outreach program to monitor referral services and from facility-based HIV serosurveillance among PWID

Program M&E

- Provide TA to BMA to develop a national M&E framework for interventions at methadone clinics including peer outreach, VCT and STI services, and HIV care; develop and integrate a standardized M&E system for tracking peer education
- Evaluate PWID- and MSM/TG-related peer outreach interventions
- Conduct a formative assessment of PWID to better understand increasing injection use, injecting and sexual risk factors, and HIV prevention service gaps
- Evaluate HIV prevention interventions
- Conduct a venue-based assessment of the acceptability of BCC messages related to condom promotion and lubricant use, and accessibility of condoms and lubricants in provinces focusing on MSM prevention
- Assess gaps in referrals to strengthen linkages across USG-funded sites and collaborate with the subnational and national levels on strategies to fill identified gaps at those sites
- Evaluate VCT rapid test demonstration programs to assess acceptability, uptake and satisfaction for clients and cost-effectiveness; use findings, if appropriate, to advocate for national scale-up of rapid testing

Surveillance and Surveys

- Implement and evaluate revised HIV/AIDS case reporting surveillance (AIDS-OI), PHIMS, and PHOMS databases



- Provide TA to scale-up IBBS among FSW, PWID, and MSM at sentinel sites in 12 provinces
- Complete a Routine Behavioral Tracking survey among MSM to improve the design and implementation of USG-supported interventions for MSM
- Complete a TRaC survey among MSM and TG to monitor and evaluate the impact of HIV prevention programs and inform future program strategies
- Assess feasibility of implementing IBSS and HIV sero-surveillance among male military conscripts using RTG resources

Data Dissemination and Use for Advocacy, Decision Making, and Knowledge Sharing

- Support implementation of GFATM Round 8 by providing TA to RSAT on data management, recording, and reporting systems and data quality assurance
- Build capacity of local organizations to use SI to inform HIV prevention interventions through trainings and dissemination of research methods and findings

1 FHI and BATS, DDC, MOPH, RTG. The Asian Epidemic Model Projections for HIV/AIDS in Thailand 2005–2025.

Published 2008.

http://aidsdatahub.org/dmdocuments/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf. Accessed 9/26/11.

2 AIDS Data Hub for Asia-Pacific. Thailand.

https://skydrive.live.com/view.aspx/spreadsheets/thailand/thailand%5E_all%5E_indicators.xls?cid=afd9edea3ddfb75c&sc=documents. Accessed 9/26/11.

3 UNGASS Country Progress Report Thailand, Reporting Period January 2008- December 2009.

http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/thailand_2010_country_progress_report_en.pdf. Accessed 9/26/11.

4 IOM – Thailand.

<http://www.iom.int/jahia/Jahia/thailand>. Accessed 9/27/11.

5 UNHCR – Thailand.

<http://www.unhcr.org/pages/49e489646.html>. Accessed 9/27/11.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	111,436	
PDTX	89,150	
Total Technical Area Planned Funding:	200,586	0

Summary:

Thailand COP 2012 Treatment TAN



ADULT TREATMENT

Context and Background

In 2004, the Royal Thai Government (RTG) made antiretroviral treatment (ART) available nationwide. Currently, all Thai health insurance plans cover HIV treatment. Assuring effective HIV treatment is a major aspect of Thailand's draft national HIV/AIDS strategy for 2012–2016, which includes “zero AIDS deaths” as one of its three main goals. (The other two goals are zero new infections and zero discrimination and stigma for persons living with HIV/AIDS [PLHA]).

RTG funding for treatment, care, and support for PLHA in Thailand is channeled through three programs. In 2009 58% of PLHA received services funded by the National Health Security Office's universal coverage program, with RTG's social security and civil servant medical benefit programs covering most other Thai nationals. GFATM funds some treatment, care, and support services for non-Thai nationals (e.g., migrant workers). Finally, a minority of PLHA—the percentage is unknown—pay out of pocket for care and treatment in private hospitals and clinics.

In 2009, 76% and 61% of the overall estimated eligible population was on ART based on 2006 WHO guidelines (initiation at CD4 count <200 cells per mm³ for adults) and 2010 WHO guidelines (initiation at CD4 count <200 cells per mm³ for adults), respectively. Overall 216,118 PLHA in Thailand received ART in 2009, including 208,042 PLHA over age 15.

National HIV care and treatment guidelines were updated in October 2010. The guidelines recommend initiation of treatment at CD4 count < 350 cells per mm³, consistent with 2010 WHO guidelines, rather CD4 count < 200 cells per mm³. However, NHSO still requires clinicians wishing to prescribe ART at CD4 counts 200-350 cells per mm³ to provide a short justification in order for NHSO to pay for the treatment.

HIV treatment quality remains variable in Thailand, owing to insufficient human resources in some areas. Many HIV-infected persons access care late. In FY 2008 and 2009, according to data from NHSO's NAP database, 52.6% and 51.9% of PLHA starting ART had AIDS symptoms and/or CD4 levels < 100 cells/mm³.¹ Focus group interviews suggest that MSM access treatment late because of stigma, discrimination, and lack of knowledge about care and treatment. Little data exist for other MARPs, although anecdotal data suggest that similar barriers exist. As HIV care and treatment services continue to expand, there is an ongoing need to monitor service quality, and MOPH and NHSO are expanding quality assurance systems.

Role of USG

The USG role is technical assistance (TA)-focused, aimed at helping Thailand develop, own, and sustain a high-quality, comprehensive HIV program within the health system, generally by developing model programs that are then scaled up and funded by RTG. Examples include:

- * HIVQUAL-T, which combines performance measurement and quality improvement (QI) of care and treatment indicators
- * Positive health dignity and promotion (PHDP) programs for young people, which encourage young PLHA to seek and adhere to HIV treatment and care
- * PHDP programs for MSM and transgenders (TG), which also encourage PLHA to seek and adhere to treatment and care through enhancing the referral system from community-based organizations that provide treatment adherence support, community- and home-based care, and psychosocial support; such programs directly link individuals to standard treatment as needed at facility-based services

HIV drug resistance is addressed through strengthening laboratory capacity for surveillance and clinical



testing and through promotion of ARV adherence (HIVQUAL-T and PHDP). ARV-related adverse events are monitored through HIVQUAL-T.

RTG priorities for HIV care and treatment include improving quality of care and treatment by focusing on infrastructure, financing, policy, and earlier access of patients to care. However, the involvement of a range of stakeholders, including multiple insurance schemes, MoPH, and the Bangkok Metropolitan Administration (BMA), makes coordination challenging. USG TA has focused on the following areas:

- * National HIVQUAL-T scale up, including indicators for ART initiation and monitoring
- * HIV drug resistance, including quality assurance for both clinical care and public health surveillance
- * Training of health care workers (HCW) in prescribing ARVs, especially for HIV-positive MSM and TG
- * Updating and implementing HIV care and treatment guidelines
- * Enhancing referral system for HIV-positive MSM and TG from community-based organizations to facility-based services
- * Strengthening PHDP programming and community-based treatment adherence programming for HIV-positive MSM and TG

Accomplishments since FY 2011 COP

* Health system strengthening through increased integration and monitoring of HIVQUAL-T: National expansion of HIVQUAL-T began in 2007 with NHSO funding, following a successful UGS-supported pilot. During FY 2011, USG TA focused on establishing a network of national, regional, and provincial committees with advisory, technical, and evaluation responsibilities. MOPH has adopted HIVQUAL-T as a standard requirement for health facilities, and the Healthcare Accreditation Institute now uses it for hospital accreditation. NHSO now funds HIVQUAL-T and uses it to monitor and reward quality of HIV care and treatment. A two-day national HIVQUAL-T forum to share lessons learned and strengthen networks, held in Bangkok in August 2011, drew 1,086 participants, including high-level officials. The forum featured 21 oral presentations, 9 workshops, 24 poster presentations, and 22 exhibition booths.

* Capacity building through continued HIVQUAL-T training: USG developed and deployed, in collaboration with MoPH, a HIVQUAL-T training curriculum that reached 355 healthcare providers from six regions and 40 regional and provincial health officers. Over 130 QI projects resulted from the trainings. Additionally, USG developed a HIVQUAL-T software training curriculum that reached 1,048 healthcare providers from 12 regions and enabled 731 hospitals to conduct performance measurements. In FY 2011, USG and MoPH added additional HIVQUAL-T tools, including materials to assist with using HIVQUAL-T for hospital accreditation. USG and MoPH also updated the HIVQUAL-T website (www.cqihiv.com), to enable downloading tools and materials, sharing documents, and communication.

* National policies: USG provided TA to MoPH to develop new HIV care and treatment guidelines, released in October 2010. Important changes in those guidelines included the following:

- Initiation of ART is now recommended at CD4 < 350 cells per mm³, in line with 2010 WHO guidelines, instead of < 200 cells per mm³
- Stavudine was removed from the list of first-line NRTIs, which now include zidovudine, tenofovir, emtricitabine, and lamivudine
- Efavirenz was added as a first-line NNRTI, in addition to nevirapine
- Guidelines for care (rather than just treatment) were added for the first time, including cervical cancer screening and PHDP

USG provided TA to MoPH in formulating the national M&E plan, which includes indicators that reflect the new guidelines. Treatment-specific indicators in the national M&E plan focus on survival, median CD4 count at treatment, CD4 monitoring, and viral load suppression. USG also provided TA to MoPH in preparing a draft National HIV/AIDS Strategy for 2012–2016 (“Getting to Zero”), which aims to drastically



reduce new infections, deaths from HIV/AIDS, and stigma and discrimination related to HIV/AIDS.

* National trainings: USG and MoPH staff provided trainings for HCW and MSM PLHA peer leaders on prescribing ARVs. A total of seven workshops were conducted, three focusing on HIV/TB co-infected persons, reaching over 850 trainees.

* HIV laboratory services: Drug resistance. USG provided TA to conduct external quality assurance (EQA) for 15 laboratories performing HIV genotypic drug resistance testing. This EQA system has been adopted and fully funded by NHSO. USG also provided TA to MoPH regarding use of a threshold survey in Bangkok to detect trends in HIV drug resistance, although the WHO-recommended minimum number of samples to perform that survey (from PMTCT settings) was not obtained. Other laboratory services. USG staff provided TA to improve EQA for six laboratories performing other laboratory testing (e.g., chemistry, hematology, microbiology, blood bank, serology, and immunology) used in HIV treatment monitoring and other clinical care.

Enhanced referral system for HIV-positive MSM and TG from community-based organizations to facility based services: USG enhanced existing referral systems from community-based organizations in order to allow them to function more effectively by delineating the roles and responsibilities between HIV-positive MSM and TG community-based organizations and the existing facility-based services in the community. This ensures that HIV-positive MSM and TG were able to access life-saving treatment from the facilities but also be linked directly to community- and home-based care and support, psychosocial support, and treatment adherence. 716 positive MSM and TG were served through this program.

Goals and Strategies for FY 2012 and FY 2013

USG will continue to provide support to MoPH, BMA, and local community-based organizations (CBOs) to build sustainable, quality, and routinely integrated treatment programs, as follows:

* National policies: USG TA will focus on helping MoPH develop and deploy a curriculum to train regional and provincial health offices on the importance of M&E to support the national M&E plan and the National AIDS Strategy for 2012–2016. USG TA will assist MoPH to operationalize the strategy once it is finalized as RTG policy.

* HIVQUAL-T: For long-term sustainability, USG will provide TA to MoPH for training and coaching to achieve the program goal of at least 50% (or more than 450) of government hospitals fully integrating HIVQUAL-T with existing hospital quality systems by 2015. This move beyond basic adoption of the program—which is nearly universal—to integration will occur through strengthened linkages between the NAP program database and HIVQUAL software, coordination with the Healthcare Accreditation Institute to integrate HIV treatment and care into hospital quality management systems, and expansion of QI networks, coaching, and training.

* HIV drug resistance: Treatment monitoring. USG will provide TA to improve and strengthen the EQA system for HIV drug resistance testing. Threshold surveys. USG will provide TA to MoPH in performing HIV drug resistance surveillance, focusing on MARPs and PMTCT settings in Bangkok.

* Training of HCW in prescribing ARVs for HIV-positive MSM and TG and in treating TB/HIV: USG will provide training upon receiving requests from partners such as NHSO, regional and provincial health offices, and the Armed Forces Research Institute for Medical Sciences (AFRIMS), with funding to be provided by the organization requesting the training.

* Community capacity building for MSM and TG CBOs serving PLHA: USG will continue to provide TA to local MSM and TG CBOs to enhance community- and home-based care, psychosocial support, treatment



adherence, and direct links to high-quality treatment at existing facility-based services.

PEDIATRIC TREATMENT

Context and Background

Most children living with HIV in Thailand become infected through mother-to-child transmission (MTCT). MTCT was 2.9% in 2007 (5.6%, if dead infants are included). An estimated 14,000 PLHA ages 0–14 were living in Thailand in 2007.¹ According to 2009 data, among PLHA ages 0–14, 8,076 were receiving ART in 2009, or 85% of those eligible on the basis of 2006 WHO guidelines.² Of PLHA ages 0–14 living in Thailand, 90% remained on treatment a year after ART initiation, according to 2009 data.²

National guidelines recommend testing of HIV-exposed infants at 1-2 months and 2-4 months. An serologic HIV test at 18 months is recommended as a confirmatory test for all HIV-exposed infants and before 18 months and for children with HIV signs and symptoms. PCR tests using either dried blood spot (DBS) samples (tested by Chiang Mai University, with piloting of additional sites during the past year) or whole blood samples (tested by the Department of Medical Sciences) are supported by NHSO, as are serologic tests. Despite those recommendations and support for free early infant diagnosis (EID), a USG-supported national evaluation of the PMTCT program in 2008 found that only 56% were tested for HIV.¹ Delayed infant diagnosis leads to late ARV treatment initiation and higher morbidity and mortality.

The Thai government supports free ARV treatment and monitoring for all eligible patients. The current Thai national HIV management guidelines (September 2010) recommend initiating ART in all HIV-positive children age < 1 year old regardless of CD4 or clinical staging, and following CDC clinical staging B,C or WHO staging 3,4 for children > 1 year old. Most HIV-infected children receive HIV care and treatment at public tertiary care or provincial hospitals. Some tertiary care centers are overburdened by the number of patients, and many patients come from remote areas of the provinces, making visits to the provincial hospitals difficult. In recent years, an increasing number of HIV-infected children have been referred to community hospitals. However, most Thai community hospitals lack both pediatricians and pediatric HIV treatment experience (only about 100 hospitals have pediatricians available, and all are tertiary or secondary care hospitals). Taking care of children on ART is complex; thus, it is important to ensure the quality of pediatric HIV care in Thailand, regardless of whether care is being provided by pediatricians, general practitioners, or nurses.

* Referrals and linkages: All HIV-exposed infants delivered in hospitals (>95% of infants in Thailand are born in health care facilities) are referred to pediatric clinics for routine immunizations, PCP prophylaxis, growth and developmental monitoring, and follow-up of HIV infection status. HIV-infected children are given CD4 tests and screened for clinical TB. Caregivers are given basic information on HIV and ARVs, and are trained on how to take care of HIV-infected children. HIV-infected children who are eligible for ART initiate treatment, mainly at tertiary care centers. Clinical status, CD4 count, and viral load are monitored according to national guidelines. In provinces with community-based pediatric care networks, HIV-infected children who are clinically and immunologically stable are referred for ART and adherence support at community hospitals near their residence. HIV-infected children > age 15 are referred to adult HIV clinics.

* Policy: Many departments within MoPH are involved in the pediatric HIV care and treatment program. The Department of Medical Sciences and Chiang Mai University provide laboratory support for PCR testing with budget support from NHSO. NHSO supports HIV care and treatment services including ARVs, CD4 count testing twice a year, and viral load testing annually. The Department of Disease Control in MoPH and provincial health offices provide technical support and site supervision to public hospitals providing pediatric HIV care and treatment. Pediatric HIV care and treatment data are monitored using the



NHSO NAP database. Further staff training and management support are needed to develop a long-term plan for coordination, data management, data dissemination, and use of data for improving or sustaining high program coverage.

Accomplishments since FY 2011 COP

* Pediatric network model: USG worked closely with MoPH and NHSO to expand pediatric HIV care networks and QI programs to 30 provinces. USG provided TA to MoPH to:

- develop a proposal for NHSO funding of the network for a three-year period
- provide training and ongoing coaching of tertiary and community HCW as networks were established

• conduct M&E activities for the networks, including establishing EWI for treatment failure

In addition to educating both caregivers and patients on HIV, the networks helped train staff and volunteers at 170 medical facilities across Thailand to provide more comprehensive care for pediatric HIV patients. Staff at participating hospitals form multidisciplinary care teams and work together to encourage dialogue among caregivers, patients, staff members, and volunteers. MoPH plans to continue providing TA to HCW to bring networks to the entire country. In FY 2011, 32 tertiary care and 388 community hospitals in 30 provincial networks and 982 health care providers were trained on pediatric treatment, ARV adherence assessment and promotion, and HIV care. Specific training in pediatric HIV diagnosis, disclosure, and psychosocial support was provided to 153 health care providers from 14 tertiary care and 56 community hospitals in these networks. Monitoring and coaching skills for pediatric HIV care providers was given to 121 providers, 27 provincial health officers, and 11 regional HIV program managers. USG provided technical and budgetary support to maintain four regional training sites for pediatric HIV care networks. Fifteen new provinces were trained, and 213 healthcare workers received knowledge updates or technical support through these training sites. By the end of FY 2011, 50% (191/388) of community hospitals were providing HIV treatment and care for children.

In addition, performance measurement (pediatric HIVQUAL) was integrated as part of pediatric HIV care and QI programs in 151 hospitals, and 95 QI projects were developed by these hospitals, reaching 4,821 children, or about half of the children receiving care in the national program. Key performance indicators (e.g., 91% received CD4 monitoring every 6 months, 90% received VL monitoring, 94% of eligible children received ART) increased compared to the previous year. USG helped analyze EWI, and worked with MoPH and the Hospital Accreditation Institute to develop composite key performance indicators for inclusion in a survey related to hospital accreditation. USG participated in the 3rd National HIVQUAL Forum to share lessons learned from the pediatric HIV care network, integration of pediatric HIV care into the hospital accreditation system, and QI programs.

* PHDP for young people: USG conducted a program evaluation of the Positive Prevention for Youth program, which encourages ART adherence, following pilot implementation of the program in three centers. Data on project outputs and outcomes are being analyzed. A PHDP Youth manual is being finalized for sharing with HIV care providers in FY 2012. More information on the program is in the Prevention TAN.

* Early infant diagnosis (EID): USG supported an EID evaluation project with co-funding from UNICEF to determine barriers to EID. A protocol has been developed and submitted to Thai ethical review committees (MoPH and BMA) and the CDC Atlanta IRB, where final approval is pending. USG also provided TA to MoPH regarding use of DBS for EID, including establishing laboratory EQA procedures. MoPH has piloted use of DBS, previously used only in Chiang Mai, in several other sites and is planning for a national scale-up. Additionally, MoPH has registered with CDC Atlanta's EQA system for DBS for EID, and is developing its own EQA system for this purpose.

Goals and Strategies for FY 2012 and FY 2013



USG will continue to provide TA to MoPH and local partners to accomplish the following:

* Pediatric HIV network: USG will provide TA support to BATS to scale up the pediatric HIV quality care network in 15 new provinces, aiming at a cumulative total of 60 provinces and 250 hospitals. Additional TA will be provided to the four regional network training sites, updating knowledge and skills in the areas of PHDP for youth, transition to adult HIV care programs, and promotion of performance measurement data analysis and EWI. USG will work with adult HIV care teams to facilitate the integration of quality HIV care to hospital accreditation systems by training, coaching, and sharing lessons learned. An evaluation of program outcomes and impacts will be developed and implemented.

* Evaluation of national EID program: In collaboration with UNICEF and MoPH, USG will describe the EID program in Thailand, identifying gaps, barriers to EID and access to pediatric HIV care, and ways to improve the program. Evaluation questions and methodology will include interviews with healthcare providers and laboratory personnel; descriptions of the EID process, from identification of HIV-exposed infants through to informing children's caretakers of the HIV diagnosis and referral to HIV care programs; chart reviews and analysis of the NAP database to determine coverage of EID services, timeliness of EID, coverage of referrals to care for HIV-infected children, and timeliness of initiating ART in children. Results of the evaluation will be reported to MoPH and NHSO, who provide support to the national EID program.

CROSS-CUTTING PRIORITIES

Supply Chain

The Thai national ART program is fully responsible for procuring ARVs. Drugs come from the Thai Government Pharmaceutical Organization (GPO) using the Vendor Managed Inventory System for NHSO-funded treatment; other funders use hospital-based ordering systems. NHSO, which funds most ART, uses a real-time, Internet-based data system (NAP) to process reimbursements and manage HIV treatment funding. The supply chain and reimbursement system for the national ART program have been well managed by RTG, with no significant drug shortages during the past five years. GPO has manufactured and supplied ARVs since 2001 using the Good Manufacturing Practice system. Products include both single-drug formulations and fixed-dose combinations. In 2007, Thailand issued compulsory licenses for lopinavir/ritonavir and efavirenz. A very small proportion of ART—less than 1%, only for migrant workers—is provided through GFATM-funded sites, which have an international supply chain.

ARV Drugs: Pediatrics

All HIV-infected children receive ART through the national program. All eligible children have full access to ART.

Laboratory

* Quality management and biosafety systems: Thailand does not have a national strategic laboratory plan. Rather, health care activities follow national health policy, which aims to strengthen the health care system to ensure equal and ready access to high-quality health care services for all. Biosafety is managed by RTG. Non-PEPFAR components of USG have supported biosafety programs in Thailand in the past, most recently with a training provided by CDC and AFRIMS in May 2011. In another non-PEPFAR project, CDC Atlanta plans to launch a laboratory waste management project in Thailand in FY 2012.

* Policies: Practices across various disease control programs are not well standardized in Thailand. For example, the national TB program is totally vertical. However, the EQA programs and laboratory accreditation program aim to improve the quality of the entire laboratory system, and provide reliable laboratory testing regardless of test type. These two systems support a quality network of tiered



laboratories. Many organizations are responsible to improve the quality of laboratory personnel and laboratory performance, including professional organizations for laboratorians and universities that provide pre-service curriculum and training. Additionally, MoPH and some private companies support in-service training. All of these support the sustainability of laboratory programs.

Gender

USG is not aware of any gender-related barriers to HIV treatment access in Thailand. Currently, the male:female ratio of children in the national ART program is 1:1.2. Of note, the USG-supported antenatal care couples counseling project promotes male involvement in pregnancy and HIV counseling, and encourages couples to share HIV test results and communicate about HIV prevention.

In some parts of Thailand, norms related to masculinity encourage men to have multiple concurrent sexual partners, and older men to have sexual relations with younger women. Also, cultural norms exist that encourage early marriage, and for women and girls to be passive in sexual relationships, preventing them from negotiating safe sex and accessing sexual and reproductive health, including HIV information and services. Women in Thailand identified fear of non-consensual sex, domestic violence, or economic abandonment as barriers to their ability to use male condoms with their partners. USG specifically focuses on female sex worker (FSW), MSM, and TG communities in gender-related approaches to HIV treatment.

Strategic Information (SI)

USG provides technical support for the development and implementation of innovative and replicable approaches to health information systems (HIS), program M&E, and surveillance and surveys in HIV treatment.

* Key successes and challenges of FY 2011: Key successes and challenges in SI during FY 2011 are described in the Governance and Systems TAN.

* Strategic priorities/responses for FY 2012–FY 2013:

- Health Information Systems: Provide TA to NHSO to implement and scale-up the NAP Data Analysis and Reporting software to generate standard reports on ART and HIV drug resistance monitoring indicators at hospital, provincial, regional, and national levels; build human resource capacity for data management and data use for program improvement; evaluate the software/system to determine factors related to data quality improvement and long-term sustainability
- Program M&E: Provide TA to MoPH and NHSO to refine and implement the national ART program monitoring framework, which includes key performance indicators to monitor program outputs, outcomes (including EWI of HIV drug resistance), and impacts at all levels (hospital, provincial, regional, and national)
- Surveillance and Surveys: Provide TA to MoPH and NHSO to determine appropriate approaches for HIV drug resistance surveillance, using experiences learned from pilot models and ART infrastructure

Capacity Building

RTG does not have a formal capacity building strategy related to HIV/AIDS. Most USG activities qualify as TA for capacity building among health care providers, and provincial, regional and national AIDS program managers. All essential service delivery infrastructures and personnel are well supported by RTG. However, the need for ongoing capacity building for these personnel remains strong in many areas, such as HIV treatment and care knowledge, disclosure counseling for children, and PHDP for youth.

Public Private Partnership



USG is not involved with any PPP in Thailand. RTG does partner with PLHA volunteers from NGOs who assist in clinical care settings and home visits to augment care and treatment services.

MARPs

Data from the Asian Epidemic Model for HIV/AIDS in Thailand indicate that 62% of new HIV infections occur in sex workers, MSM, and people who inject drugs (PWID). The proportion of infections among MSM is increasing. Data is not available for the percentage of MARPs receiving ART.

USG is not aware of any concerns regarding MARPs and HIV treatment in the pediatric population. For adult MARPs, stigma and discrimination related to HIV are substantial barriers to accessing HIV prevention, testing, care, and treatment, resulting in many of them accessing treatment services when CD4 counts are already very low. As expansion of HIV care and treatment services occurs in Thailand, there is an ongoing need to monitor and support service quality, and MoPH and NHSO are working to expand quality systems for care and treatment. Specifically, USG is developing and evaluating model comprehensive prevention packages for FSW and MSM in select areas in Thailand that emphasize primary prevention, secondary prevention (i.e., accessing HIV testing), and tertiary prevention (i.e., accessing HIV care and treatment). USG is also supporting GFATM-funded sites providing these services to MSM based on models developed in Thailand with USG TA. Finally, USG is supporting efforts to increase HIV prevention and improve drug treatment services for PWID in Bangkok.

Human Resources for Health

USG provides TA for NHSO-funded regular trainings for healthcare providers in HIV treatment. The pediatric network project also involves substantial training, particularly of community hospital personnel. Training on prescribing ARVs for MSM and TG and HIV/TB co-infected persons helps augment capacity in Thailand.

1 UNGASS Country Progress Report Thailand, Reporting Period January 2008- December 2009.
http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/thailand_2010_country_progress_report_en.pdf. Accessed 9/26/11.

2 AIDS Data Hub for Asia-Pacific. Thailand: National Response.
https://skydrive.live.com/view.aspx/spreadsheets/thailand/thailand%5E_all%5E_indicators.xls?cid=afd9edea3ddfb75c&sc=documents. Accessed 9/26/11.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2012	Justification
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	1,097	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence	7,467	

	and/or meet the minimum standards required		
	By MARP Type: CSW	0	
	By MARP Type: IDU	0	
	By MARP Type: MSM	7,467	
	Other Vulnerable Populations	0	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	2,800	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	0	
	By Age/Sex: 15+ Female		
	By Age: 15+	2,800	
	By Age/Sex: 15+ Male		
	By Sex: Female	600	
	By Sex: Male	2,200	
	By Test Result: Negative		
	By Test Result: Positive		
C1.1.D	Number of adults and children provided with a minimum of one care service	2,380	Redacted
	By Age/Sex: <18 Female		

	By Age/Sex: <18 Male		
	By Age: <18	1,224	
	By Age/Sex: 18+ Female		
	By Age: 18+	1,156	
	By Age/Sex: 18+ Male		
	By Sex: Female	736	
	By Sex: Male	1,644	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	1,843	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	1,263	
	By Age/Sex: 15+ Female		
	By Age: 15+	580	
	By Age/Sex: 15+ Male		
	By Sex: Female	736	
H2.3.D	The number of health care workers who successfully completed an in-service training program	1,806	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	152	



Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
10047	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	0
10050	Thailand Ministry of Public Health	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	1,200,000
10051	Bangkok Metropolitan Administration	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
13727	Population Services International	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	1,103,521



Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 10047	Mechanism Name: Community REACH Greater Mekong Region Associate Award
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	0
GHP-USAID	0

Sub Partner Name(s)

Chiang Mai Public Health Office	Chonburi Public Health Office	HON
Mplus	POZ	PSI/Sisters
RSAT	SWING	Thai Red Cross
Violet Home		

Overview Narrative

The activities is ending and transferring to new mechanism. Please refer back to COP FY10 for overview narrative.

Cross-Cutting Budget Attribution(s)

(No data provided.)



TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID: 10047			
Mechanism Name: Community REACH Greater Mekong Region Associate Award			
Prime Partner Name: Pact, Inc.			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0
Narrative:			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0
Narrative:			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0
Narrative:			



Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0
Narrative:			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0
Narrative:			

Implementing Mechanism Details

Mechanism ID: 10050	Mechanism Name: Thailand Ministry of Public Health
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Thailand Ministry of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,200,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GAP	1,200,000
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY 2012, CDC's Global AIDS Program (GAP) will enter the second year of its third five-year CoAg with MoPH. Specific objectives of the CoAg are to support Thailand's national HIV/AIDS strategy by:



- 1) Supporting replicable models for prevention, care, and treatment;
- 2) Improving the quality of prevention, care and treatment programs;
- 3) Increasing the collection and use of SI;
- 4) Sharing successful models by providing TA to other PEPFAR countries.

Expected outcomes include:

- 1) Strengthening health systems, human capacity, guidelines and protocols, and QA/QI systems to best enable the RTG to finance and manage programs;
- 2) Supporting replicable and scalable models for interventions;
- 3) Improving prevention, care and treatment programs;
- 4) Increasing collection and use of SI;
- 5) Sharing successful models with other PEPFAR countries.

This approach follows GHI principles, including promoting the development of sustainable, country-owned programs, prioritizing M&E, and fostering research and innovation. All USG technical support is for programs that are, or will be, fully integrated into routine, MoPH-managed public health programs. CoAg activities have a national scope. Target populations include MARPs (FSW, IDU, MSM, and prisoners); pregnant women (PMTCT); children (early diagnosis); and efforts that strengthen capacity overall (HCT systems; HIV care; laboratory systems, PwP; and SI).

As a TA-based CoAg, costs continue to be low for this implementing mechanism. Model development and evaluation are supported for a time-limited period, and then other donor or government funding is leveraged for program expansion and integration. This CoAg may be a model for countries transitioning to PEPFAR 2 and GHI approaches to the HIV/AIDS epidemic.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000
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TBD Details



(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Safe Motherhood
- TB

Budget Code Information

Mechanism ID: 10050			
Mechanism Name: Thailand Ministry of Public Health			
Prime Partner Name: Thailand Ministry of Public Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	103,233	0

Narrative:

Strengthening the Quality Improvement of HIV Treatment and Care Programs (nationwide program)
 In 2010 in Thailand, an estimated 480,000 people were living with HIV/AIDS and 280,000 were receiving ART. The national ART program was started in 2000 and fully scaled up in 2004, with over 1,000 hospitals currently providing HIV care and treatment. Of these, nearly 900 are government hospitals, located in all provinces and districts in Thailand. Ensuring quality of HIV care in these hospitals is highly needed as the number of HIV patients in Thailand increases.

The HIVQUAL model was developed in 2003 and scaled up with funding from the National Health Security Office (NHSO) in 2007, which has fully supported all operational costs since 2010. The Department of Disease Control within MoPH provides national program management, and GAP Thailand provides TA on developing tools, materials, and training curriculum, and on program monitoring.

This program is focused on capacity building for healthcare workers and public health officers at national,

regional, provincial, and hospital levels to conduct performance measurement to develop quality improvement activities/projects (related to HIV monitoring, ART, disease screening, OI prophylaxis, and/or positive health promotion); strengthen local HIV care networks, and develop QI coaching systems. For long term sustainability of the QI program, integration of the HIV QI into Thailand's existing hospital quality management and hospital accreditation systems is planned.

In FY 2013, GAP Thailand will focus on TA to enhance capacity building, strengthen regional QI coaching systems, and support program monitoring. A program evaluation plan will be developed to assess program achievement and effectiveness.

Strengthening the Quality Improvement of STI Programs (12 provinces in 12 regions)

Thailand's STI program was reformed in 2001, with most services integrated into outpatient care, leading to weaknesses in STI prevention and control. GAP Thailand began developing programs to strengthen the STI program in 2002 in 3 provinces (not including Bangkok) and 4 institutes. Since then, 4 provinces were added (during the second Co-Ag) to maintain STI management services and regular STI screening for FSWs. GAP Thailand efforts have since been redirected to provide TA to improve the quality of services at clinics receiving GFATM Round 8 funding for HIV prevention among MARPs in 44 provinces. GAP Thailand TA builds the capacity of health facilities to provide high-quality STI services for MARPs, especially FSW and MSM. A QI model was developed and piloted in 2009-2011 in 20 provinces. The model strengthens STI diagnosis and management, promotes interventions to modify behavioral risks and condom use, encourages regular HIV testing and referral to HIV care and treatment among HIV-infected persons, and improves STI SI collection and use.

In FY 2013, the STI program plans to expand to more provinces by developing a training-of-trainers program for QI in 12 regions in Thailand, continuing to monitor program expansion, and conducting program evaluations in existing implemented areas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	15,469	0

Narrative:

New Models and Innovations for TB Control: EQA

GAP Thailand, in collaboration with the Thai MoPH, has evaluated and improved TB diagnosis through laboratory strengthening and the development, improvement and evaluation of new and existing diagnostic tools and methods. Sputum smear microscopy remains the cornerstone of TB diagnosis in Thailand, but access to culture and newer rapid methods is increasing. GAP will support an in-country AFB EQA program to increase coverage by strengthening regional (sub-national) reference laboratories as a TB laboratory network with the national TB reference laboratory; in FY13, QA systems for culture methods will be developed. GAP will support capacity building of regional reference laboratory staff on



requirements for EQA providers and knowledge about quality systems. GAP staff will support the TB reference laboratory to pilot, monitor and evaluate project implementation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	121,516	0

Narrative:

Two projects are funded under this budget code, as follows:

Pediatric Care Network

While adult HIV care and treatment has been decentralized, most pediatric HIV care and treatment occurs at tertiary care hospitals due to the complexity of pediatric HIV care and lack of knowledge and skills of health care workers (HCWs) and multi-disciplinary care teams in community hospitals.

In Chiang Rai province, a network of community hospitals has successfully implemented a holistic approach for pediatric HIV care. This model involved building a multi-disciplinary team, including people living with HIV (PLHA), that provides holistic care to HIV-infected children and adolescents, and strengthens referrals and networking between tertiary and community providers. This model has been scaled up to 30 provinces with funding from GFATM and NHSO.

In FY 2013, GAP Thailand will provide TA to support continued expansion of the pediatric HIV network model by developing four regional training centers for provinces adopting the network model. The training centers will provide technical support and coaching to provincial teams in their geographic area.

Of note, performance measurement and QI using Pediatric HIVQUAL-T is part of the QI program in these networks. In FY 2013, 60 of 76 provinces, covering at least 60% of children living with HIV/AIDS, will be participating in Pediatric HIVQUAL-T.

Comprehensive Positive Youth Model in Health Care Setting

Approximately 10,000 HIV-infected children are receiving HIV care under the national program.

Perinatally infected youth are at risk for mental health and behavioral difficulties. Most perinatally HIV-infected adolescents have been taking ARV medications for most of their lives, and some may have developed resistance. As youths become sexually active, transmission of resistant strains is possible.

Since 2009, GAP Thailand has supported three institutions to develop a clinic-based intervention for HIV-positive youth aware of their status. This model educates HIV-positive youth on reproductive health, STIs, and adherence, promotes self-esteem, self-discipline and problem solving skills, and provides skills for reducing risks of disease acquisition and transmission. The model will be evaluated by the end of 2011. If shown to be successful, it will be scaled up to other provinces with funding from NHSO.

Another challenge confronting healthcare providers working in pediatric HIV care is transferring care of

older HIV-positive youth to adult HIV clinics. Some HIV-positive youth referred to adult clinics have been dissatisfied with their new clinics due to confusion in navigating busy clinics with unfamiliar environments. Developing a model to assist with that transition will be part of a comprehensive model, to include other aspects of preparing youth and their caretakers for adult clinics and preparing youth for adulthood. Key strategies promote involvement of youth and their caretakers to build connections between pediatric HIV care and adult HIV care to ensure successful transition for HIV-positive youth.

By 2013, if the transition model from pediatric HIV care to adult HIV care developed during 2012 has been proven successful at pilot sites, the package of PwP youth model will be scaled up to other provinces through the pediatric HIV care quality network.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	78,732	0

Narrative:

Strengthening the Quality of HIV/AIDS Testing Laboratories of Thailand
Through MoPH, GAP Thailand will help implement and evaluate a new EQA program for HIV rapid testing using dried tubes specimen (DTS) in remote areas and in MARP-focused (MSM and FSW) VCT clinics in Thailand. The DTS sample panels can be stored and transported at room temperature, and can be used as an alternative EQA/IQC program to conventional EQA/IQC panels that require controlled temperature conditions to monitor the quality of HIV rapid testing in some remote sites. This will complement the national plan to promote HIV VCT in MARPS to increase access to testing and care especially at peripheral or community sites for hard-to-reach populations.

Quality Systems in Hospital Laboratories – Saraburi
To support implementation of practical and sustainable quality management systems through the Thailand laboratory accreditation program, GAP Thailand has supported a laboratory network to strengthen and improve the quality of laboratory testing within the network. GAP Thailand will support the Saraburi laboratory network by providing training on QMS and assisting with a laboratory internal assessment according to Thai Medical Technology standards. GAP funds will be used to leverage government funds that are available for system quality and accreditation processes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	250,870	0

Narrative:

Strengthening Surveillance, Management Information System and Human Resource Capacity on Utilization of SI to Promote Effective HIV/AIDS Program Management, Thailand

The Government of Thailand is committed to reduction of new HIV infections by preventing the spread of HIV/AIDS, eliminating AIDS-related deaths, and eliminating discrimination in society. In order to guide the development of effective strategies and operational plans, evidence about the status of the HIV/AIDS epidemic and the ongoing response is needed.

In the past, GAP Thailand provided TA to MoPH to strengthen the existing national surveillance and monitoring systems through innovative epidemiological and informatics approaches. However, challenges remain, including limited number of human resources, especially at provincial levels, with the epidemiological knowledge and informatics skills to use SI for policy and program planning. Hence, GAP Thailand will provide TA to MoPH to strengthen national and provincial capacity on utilization of HIV SI to promote the effective implementation of the 2012-2016 National AIDS Plan, focusing on a better understanding of the HIV epidemics and intervention responses at the national level and in 12 sentinel provinces. In FY 2013, GAP Thailand plans to undertake the following activities:

1. Scale up nationally an innovative model of integrated behavioral surveillance and biological markers (IBBS) among non-venue-based FSW.
2. Ensure the quality implementation of IBBS among venue-based FSW, MSM, IDU and male military conscripts, focusing on standardization of data collection and analysis methods and staff training.
3. Strengthen sero-incidence surveillance using BED-CEIA, considering the lessons learned from evaluating a new laboratory approach (Limiting antigen avidity assay) and the adjustment of False Recent Rate conducted in FY 2012.
4. Develop and implement HIV drug resistance surveillance, using experiences learned from pilot models.
5. Implement HMIS to monitor the facility-based harm reduction program for IDU and assess feasibility of integrating key monitoring data with the monitoring systems for outreach interventions, counseling and testing, care and treatment, and sero-surveillance.
6. Strengthen HMIS to use NAP data for ART program monitoring, PMTCT outcome monitoring and case reporting surveillance.
7. Develop and implement guidelines on synthesis and triangulation of SI for situation analysis, monitoring of program implementation, MARP population size estimation, and estimation and projection for key parameters for policy decision making and program planning at national and provincial levels.
8. Increase capacity of human resources at national and provincial levels through workshop trainings and field supervisions. Expected outputs include capacity to 1) synthesize and use SI to describe HIV epidemics and responses; 2) synthesize SI to develop policy and projections to guide decision-making; and 3) develop communication skills to engage policy-makers to promote improvements in evidence-based programs.

9. Set up web-based information bank to enable linking relevant SI to support the description of HIV epidemics and responses (key indicators for program outputs, outcomes and impacts).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	200,273	0

Narrative:

CDC and MOPH support Thailand's highly trained scientists and public health officials to share their knowledge and experience and provide technical assistance to countries within and beyond the region to promote and support development of high-quality HIV care and treatment and sustainable laboratory capacities, among others. Activities will be provided up on request and the need of countries. Projects focus on building the capacity of the MOPH staff to improve work performance via sponsoring staff to attend conferences and workshops in-country and international trainings, meetings, conferences and workshops. As GAP projects in Thailand focus on model development, and regional and global technical assistance, strong human resources capacity is needed for better programs. Projects include PMTCT services, quality of HIV care and treatment, HIV counseling and testing (including couples counseling at antenatal care centers), STD diagnosis and treatment including MARP-friendly services, and collection, interpretation, and use of strategic information. Others will develop training material for Global Technical Assistance for laboratory activities that improve the quality of all HIV related testing as well as the quality of laboratory systems and laboratory training, meetings, and workshops for activities in Thailand, and internationally. Reliability of laboratory results are fundamental to supporting HIV prevention, care and treatment. A sample project would be providing support to MOH of Vietnam, in collaboration with the U.S. CDC and GAP in Vietnam, to work to improve the quality of laboratory testing; as Vietnam has limited human capacity and infrastructure to support these activities. Therefore, highly experienced Thai staff and experts in laboratory fields will assist the Vietnam MOH in providing technical assistance in the areas of quality management systems and HIV and HIV related test quality assurance according to the needs and requests from Vietnam.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	60,527	0

Narrative:

Strengthening the Quality Improvement of HIV Counseling and Testing Programs (5 provinces)
HIV counseling and testing (HCT) coverage among the Thai general population is very low (< 1%) and less than 60% in all MARPs except in pregnant women (> 90%). Although HCT services are available in more than 1,000 hospitals all over the country, HCT services are variably structured and independently



managed among hospitals. No concrete national program exists to promote HCT for all groups, except pregnant women seeking ANC, TB-infected persons, and MARPs served by clinics funded by GFATM with Round 8 funding. HCT approaches also differ, with PICT for TB patients, persons with HIV/AIDS symptoms, pregnant women, and persons with STIs. However, outreach/mobile-based VCT and special events or campaigns to promote VCT are conducted only in small areas and at demonstration sites. In addition, M&E and QA systems for HCT in general, and VCT in particular, are not well formed. Since 2010, GAP Thailand has promoted HCT among MSM and FSW in four and five provinces, respectively. PICT and VCT with same day results are conducted under the program. A testing algorithm using rapid tests was defined by following the national guideline with EQA and IQC development. Persons diagnosed with HIV infection are referred to care, with M&E of that referral system. For MSM, HIV uptakes in FY 2011 in four provinces were 840 cases, of which 759 (90%) opted for rapid testing. A QI model of HIV counseling was piloted in three MoPH hospitals during 2010-2011, and will be expanded to five hospitals in FY 2012. The target population includes all persons receiving HIV testing in hospitals. Quality of pre- and post-test counseling, follow up among window period cases, psychosocial counseling and referral of positive cases are key services which are assessed and targeted with QI efforts. Client and counselor surveys are conducted annually to assist with QA and QI efforts. In FY 2013, HCT with same day results among MSM and FSW will be conducted in targeted areas, and a program evaluation is planned. Additionally, QI of HCT will be expanded to more hospitals, with development of a training-of-trainers for QI, continuation of program monitoring, and evaluation of existing program areas to help develop a plan for program expansion.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	334,735	0

Narrative:

Capacity Building and System Strengthening for Health Care Personnel on Access to HIV Prevention and Care Among Key Affected Populations -- MSM (5 sites) and FSW (2 sites)
 GAP Thailand will collaborate with MoPH to strengthen HIV intervention activities among MSM and FSW in major affected areas, including Bangkok and southern, eastern, and northeastern provinces where HIV prevalence among MARPS is high.
 MSM. Since 2004, with technical and financial assistance from GAP Thailand, MoPH has supported provincial health offices in key provinces to implement a MSM HIV intervention program that includes peer outreach activities, capacity building and sensitivity training for healthcare providers, and monitoring and evaluation (M&E). After piloting in four sites, the program has expanded to over 30 provinces in Thailand with GFATM support.
 A health promotion model program for MSM living with HIV/AIDS was introduced in 2009. CBOs help



promote access to treatment and care services among MSM living with HIV/AIDS and promote risk reduction behaviors, both in terms of preventing onward transmission of HIV and preventing acquisition of STIs. It is expected that more than 6,500 MSM will be reached by peer outreach in FY 2012, at a cost of approximately \$175,000.

FSW. A RDS survey conducted by GAP Thailand in 2007 among FSW found an unexpectedly high HIV prevalence – 20%. Prevalence was particularly high among non-venue based sex workers. Current GFATM support for HIV interventions among FSW in Thailand does not focus on non-venue based workers.

Linking community-based outreach to VCT and STI services, and MSM or FSW diagnosed with HIV infection to care and treatment services, are key strategies in Thailand's draft national HIV/AIDS strategy (2012-2016) "Getting to Zero." In FY 2013, together with other USG agencies, GAP Thailand will collaborate with MoPH to strengthen the quality of peer outreach activities, promote and create strategies to link key affected populations (MSM and FSW) to VCT and STI services, help ensure linkages of HIV-positive MSM and FSW to HIV care and treatment, and promote quality-of-life and risk reduction among MSM and FSW living with HIV/AIDS. Based on number of non-venue FSW recruited in RDS surveys, peer educators expect to reach over 840 of them through 3 demonstration sites in FY 2012. The proposed budget for the project is \$96,000.

In FY 2013, a program evaluation of HIV-positive MSM will be conducted, with the aim of national expansion, if the program is shown to be successful. Part of this strategy will be to support capacity building of community-based MSM and FSW peer groups and of healthcare providers at the national and regional level to ensure quality implementation of HIV prevention and care programs, along with strengthening strategic information (SI) to help guide HIV/AIDS program planning.

For correctional settings, in FY 2013, USG will support the scale up of HIV peer education and the VCT monitoring system. USG, in line with the national M&E plan, will support capacity building for prison and health care staff on use of data for program improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	34,645	0

Narrative:

Strengthening Couples HIV Counseling and Testing in Antenatal Care Settings
 Approximately 800,000 pregnant women deliver in Thailand each year. More than 95% of pregnant women receive ANC at health facilities. Data show a high uptake of HIV testing among pregnant women; 99% of all pregnant women received HIV testing in 2007. However, only 15% of pregnant women received couples counseling, and 30-50% of new cases of HIV infection in Thailand occur among discordant couples.

The high discordant rate among HIV-infected persons highlights the need for couples HIV counseling and testing (CHCT) for pregnant women and their partners. Following a successful pilot project conducted collaboratively by MoPH and GAP Thailand, routine CHCT for women in ANC settings and their male partners was instituted as new MoPH policy in October 2011. A training-of-trainers program will be conducted in late 2011.

In FY 2012-2013, GAP Thailand will provide TA to MoPH and regional trainers to support the continued roll-out of CHCT. Supervisory follow-up visits to regional offices or hospitals will be conducted to further coach trainers and providers. CHCT indicators will be integrated into the national PMTCT monitoring system (PHIMS v3) to determine uptake and identify implementation barriers. The goal is that, by 2013, at least 60 of 76 provinces will have established CHCT in routine ANC services, and 40% of male partners of pregnant women will be receiving HCT as part of CHCT.

Development of Thailand National PMTCT Monitoring System with Integrated Data Utilization System of the Goals of Elimination of MTCT

Thailand's draft national HIV/AIDS strategy for 2012-16 ("Getting to Zero") aims that by 2016, the mother-to-child transmission (MTCT) rate will be lower than 1% and the mortality of HIV-positive mothers and their exposed infants will decrease by 75%. (Those percentages might change as the strategy is finalized.) This project will support the national PMTCT program by strengthening the national PMTCT M&E system (PHIMS v3) and promoting data utilization for program improvement. GAP Thailand will pilot the revised PHIMS web-based program to capture current national PMTCT guidelines and develop a system for PMTCT data utilization.

By 2013, the goal is to scale up PHIMS nationally, including PHIMS web-based process monitoring, outcome monitoring (using the National AIDS Program [NAP] database), and systems for data utilization (regular data review, monitoring and supervision, and quality improvement planning and implementation). TA will be provided through MoPH and 12 Regional Offices to monitor and provide technical and management support to provinces and hospitals in their administration. The website for dissemination of monitoring data and PMTCT information will be maintained and regularly updated by the central MoPH team.

Implementing Mechanism Details

Mechanism ID: 10051	Mechanism Name: Bangkok Metropolitan Administration
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Bangkok Metropolitan Administration	



Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

CDC's Global AIDS Program (GAP) will in FY 2012 enter the second year of its third five-year CoAg with BMA. Specific objectives of the CoAg are to support Thailand's national HIV/AIDS strategy and BMA priorities by:

- 1) Supporting replicable models for prevention, care, and treatment;
- 2) Improving the quality of prevention, care and treatment programs;
- 3) Increasing the collection and use of SI;
- 4) Sharing successful models by providing TA to other PEPFAR countries.

Expected outcomes include:

- 1) Strengthening health systems, human capacity, guidelines and protocols, and QA/QI systems to best enable the RTG to finance and manage programs;
- 2) Supporting replicable and scalable models for interventions;
- 3) Improving prevention, care and treatment programs;
- 4) Increasing collection and use of SI;
- 5) Sharing successful models with other PEPFAR countries.

This approach follows GHI principles, including promoting sustainable, locally-owned programs, prioritizing M&E, and fostering research and innovation. All GAP technical support is for programs that are, or will be, fully integrated into routine, BMA-managed public health programs.

CoAg activities focus on Bangkok, which administers some hospitals and clinics not run by MoPH. Target populations include MARPs (IDU, MSM); pregnant women (PMTCT); children (early diagnosis); and efforts that strengthen capacity overall (HCT systems; HIV care; lab systems, PwP; and SI).

As a TA-based CoAg, costs continue to be low for this implementing mechanism. Model development and evaluation are supported for a time-limited period, and then other donor or government funding is leveraged for program expansion and integration. This CoAg may be a model for countries transitioning to



PEPFAR 2 and GHI approaches.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000
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TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Safe Motherhood

Budget Code Information

Mechanism ID: 10051			
Mechanism Name: Bangkok Metropolitan Administration			
Prime Partner Name: Bangkok Metropolitan Administration			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	35,488	0
Narrative:			
Strengthening Health Management Information System and Building Human Resource Capacity on Utilization of Strategic Information to Promote Effective HIV/AIDS Program Management, Bangkok Metropolitan Administration			

RTG is committed to preventing the spread of HIV/AIDS, eliminating AIDS-related deaths, and eliminating discrimination in society. BMA is one of five operational research provinces for the intensive implementation and evaluation of effective mechanisms to achieve those goals. To guide development of effective strategies and operational plans, evidence about the status of the HIV/AIDS epidemic and the ongoing response is needed.

In past years, GAP Thailand provided TA to BMA to strengthen existing national surveillance and monitoring systems through innovative epidemiological and informatics approaches. However, challenges remain, especially regarding infrastructure and human resources with sufficient epidemiological and informatics skills to assist in collecting, managing, interpreting, and using SI for policy and program planning. Building human resource and infrastructure capacity are needed. For those reasons, GAP will provide TA to enhance BMA capacity to use HIV SI to promote the effective implementation of the draft national HIV/AIDS strategic plan. In FY 2013, GAP plans to undertake the following activities:

1. Strengthen HIV sero-incidence surveillance using BED-CEIA among pregnant women in Bangkok, considering lessons learned from evaluating a new laboratory approach (Limiting antigen avidity assay) and the adjustment of False Recent Rate in FY 2012.
2. Develop and implement HIV drug resistance surveillance, using experiences learned from the pilot models conducted with GFATM support and ART infrastructure in BMA.
3. Coordinate with Bureau of Epidemiology to ensure that BMA and national behavioral surveillance systems are aligned.
4. Implement HMIS to monitor BMA's facility-based harm reduction program and assess the feasibility of integrating key monitoring data with the monitoring systems for outreach interventions, HCT, care and treatment, and serosurveillance among IDU.
5. In collaboration with MoPH and NHSO, strengthen HMIS to utilize NAP data for ART program monitoring, PMTCT outcome monitoring and case reporting surveillance, and increase cooperation between BMA, MoPH, university and private facilities.
6. Develop and implement guidelines on synthesis and triangulation of SI for situation analysis, monitoring of program implementation, MARP population size estimation, and estimation of key parameters for policy making and program planning for BMA.
7. Increase capacity of human resources at BMA through workshop trainings and field supervisions. Expected outputs include increasing their capability to use SI to describe HIV epidemics and responses and guide policy making, and developing communication skills needed to engage policy-makers in ways that proactively promote improvements to current evidence-based programs.
8. Establish a web-based information bank to link data on HIV epidemics and responses (key indicators for program outputs, outcomes and impacts).
9. Train 120 BMA staff to implement HIV Incidence surveillance, BSS, HIV drug resistance (HIVDR) surveillance and Early Warning Indicator of HIVDR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	20,002	0

Narrative:

CDC and BMA support highly trained scientists and public health officials to share knowledge and experience to promote and support development of high-quality HIV care and treatment and sustainable laboratory capacities, among others. Projects focus on building the capacity of staff to improve work performance via sponsoring staff to attend conferences and workshops in-country and international trainings, meetings, conferences and workshops. Because projects in Thailand focus on model development, strong human resources capacity is needed for better programs. Projects include PMTCT services, quality of HIV care and treatment, HIV counseling and testing (including couples counseling at antenatal care centers), STD diagnosis and treatment including MARP-friendly services, and collection, interpretation, and use of strategic information. Others will develop training material for laboratory activities that improve the quality of all HIV-related testing, as well as the quality of laboratory systems and laboratory training, meetings, and workshops for activities in Thailand. Reliability of laboratory results are fundamental to supporting HIV prevention, care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	14,655	0

Narrative:

HIV Prevention for IDUs in Bangkok - Peer Outreach
 Evidence has shown that many IDU have increasingly injected multiple drugs, including methamphetamine. IDU surveys conducted in Bangkok showed that methamphetamine was the most common drug injected.
 Treatment for methamphetamine users employs therapeutic approaches including the Matrix program, which involves counseling, recovery skills, relapse prevention and family education. Prevention of HIV transmission and harm reduction may be discussed during the program, but the content of these HIV-related sessions are typically not standardized nor tailored to address risks including HV transmission for methamphetamine injectors.
 In response to HIV risk and possible transmission among methamphetamine injectors, in FY 2012 the Office of Drug Abuse Prevention and Treatment (ODAPT) under BMA and GAP Thailand plan to conduct a formative assessment of methamphetamine injection. This assessment will provide information on factors driving methamphetamine users, who have historically taken the drug orally, to switch to injecting. This assessment will also explore existing methamphetamine prevention and treatment options, and



identify gaps in services in relation to HIV prevention for methamphetamine injectors. The results of the assessment, along with information on the current situation of methamphetamine abuse from other data sources, will be translated into recommendations and interventions for HIV prevention, VCT and other HIV-related services for methamphetamine injectors in Bangkok and other areas that are identified as major areas for methamphetamine injectors (e.g., North of Thailand). Part of the assessment will be to strengthen the capacity of BMA drug treatment clinic staff in providing HIV-related services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	29,855	0

Narrative:

Quality Improvement for Prevention of Mother-to-Child HIV Transmission (PMTCT) Program through the Establishment of BMA PMTCT Monitoring and Evaluation System

BMA is unique in Thailand as it runs some of the hospitals and clinics in Bangkok under its own jurisdiction rather than MoPH jurisdiction. Moreover, more than 100,000 deliveries/year (approximately 12% of annual births in Thailand) are in Bangkok. There are 9 hospitals under direct BMA jurisdiction, as well as more than 60 private hospitals, 5 MoPH hospitals, 3 military and 3 university hospitals in Bangkok. BMA's Bureau of Health and Bureau of Medical Services will be the focal points for PMTCT services and HIV program coordination.

GAP Thailand will provide TA to BMA to implement the same PMTCT monitoring systems as the MoPH national program. These include a Web-based centralized database system (PHIMS v3) and a PMTCT outcome database, with data generated from the National AIDS Program (NAP) database used in all 9 BMA hospitals and 5-10 public tertiary care hospitals in the Bangkok area. In FY 2013, the PHIMS v3 Web-based system will be implemented in 8 BMA hospitals, including a data utilization system for feedback on hospital performance and promotion of QI in PMTCT programs. BMA hospitals will be trained on systematic data review, gap analysis and QI for PMTCT.

Implementing Mechanism Details

Mechanism ID: 13727	Mechanism Name: Population Services International
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	



Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,103,521	Total Mechanism Pipeline: N/A
Funding Source	Funding Amount
GHP-State	220,000
GHP-USAID	883,521

Sub Partner Name(s)

APMG	Glory Hut Foundation	Pact, Inc.
POZ	PSI/Sisters	Save The Children Federation Inc

Overview Narrative

The Behavior Change Communication for Infectious Disease Prevention (CAP-3D) project goal is to reduce morbidity and mortality related to HIV, TB and malaria in the Greater Mekong sub-region by increasing an effective regional response, characterized by stronger country ownership, to prevent and mitigate these diseases. CAP-3D’s strategy is to increase the reach and enhance the sustainability of the Comprehensive Prevention Package (CPP) by improving models of delivery through local partners, documenting effectiveness, and advocating for these models to become the regional standard of quality HIV prevention programming for MARPs, implemented by strong local institutions and sustained through local governments and diverse funding sources. CAP-3D will develop and demonstrate successful models for delivering the CPP to MSM and TG in partnership with selected local CBOs, and to recruit other organizations, government offices, hospitals, and donors to use these models.

CAP-3D will focus on: Build the organization capacity of Sisters; Improve the quality of BCC for safer sexual behavior and increased use of HIV VCT and STI services among MSM/TG; Pilot on-site rapid HIV VCT at the Sisters; Expand the scope of CPP interventions offered by Sisters; Provide funding, TA, and capacity building support for the roll-out of improved and expanded delivery of the CPP; Provide financial support to selected CBOs working with MSM and PLHA after their other USAID subawards end in June 2012 to ensure a smooth transition without disruption of services; Support the development of referral systems and mechanisms that will facilitate prevention and ensure access to medical care related to HIV, TB, and malaria for affected and most at risk groups among Burmese migrants in Thailand.



Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVOP	Provincial Level Government	0	As needed/requested, provide HIV-related technical assistance to the provincial government for GF implementation.
IDUP	Provincial Level Government	0	As needed/requested, provide HIV-related technical assistance to the provincial government for GF implementation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

- Addressing male norms and behaviors
- Increasing gender equity in HIV/AIDS activities and services
- Increasing women's access to income and productive resources



Increasing women's legal rights and protection

Mobile Population

TB

Workplace Programs

Budget Code Information

Mechanism ID: 13727			
Mechanism Name: Population Services International			
Prime Partner Name: Population Services International			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	165,528	0
Narrative:			
<p>GHCS (USAID) = \$132,528 GHCS (State) = \$33,000</p> <p>PSI/Thailand will provide a small amount of financial assistance to the Glory Hut to support the provision of shelter and community home-based care (CHBC) for MSM and TG living with HIV.</p> <p>The Poz Home Center launched its Strategic Plan 2011-2014 in FY11. In FY12, with financial support under CAP-3D, the Poz Home Center will focus on promoting HCT through its telephone advice and support line and peer-based online education and support service; providing Follow-up to Post Test Counseling services at BMA and DOH sites; and developing and leading the M-Poz network of groups and organizations providing services to MSM and TG living with HIV. By facilitating experience sharing, cross learning, and the coordination of TA and capacity building for members, the M-Poz network will support replication of the Poz Home Center's model for delivery of the CPP.</p> <p>To help meet the needs of most at-risk Burmese migrants in Thailand for prevention and treatment of HIV, TB and malaria, Save The Children (SC) will produce and distribute an IEC publication on the prevention of these three target diseases, with useful information and appropriate messages for MARPs. SC will also conduct mapping and an assessment of health services for most at-risk Burmese migrants in Ranong and Ratchaburi provinces.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	165,528	0

Systems			
Narrative:			
<p>GHCS (USAID) = \$132,528 GHCS (State) = \$33,000</p> <p>PSI/Thailand will conduct the following three research studies in line with the priorities outlined with USAID:</p> <ol style="list-style-type: none"> 1. A TRaC survey among TG in Pattaya and males sex workers (MSW) in Pattaya and Bangkok, to inform program strategy and to monitor and evaluate the impact of the HIV programs implemented by Sisters and SWING. 2. A venue-based assessment of BCC messages and condom/lube accessibility for MSM, in areas where USAID-supported HIV programs for MSM are being implemented. 3. Routine Behavioral Tracking (RBT) among MSM, in areas where USAID-supported HIV programs for MSM are being implemented. 			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	165,528	0
Narrative:			
<p>GHCS (USAID) = \$132,528 GHCS (State) = \$33,000</p> <p>Please see above description of the inclusion/integration of HIV counseling and testing services as a part of the CPP.</p>			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	606,937	0
Narrative:			
<p>GHCS (USAID) = \$485,937 GHCS (State) = \$121,000</p>			

In FY11, PSI/Thailand facilitated a marketing planning workshop for Sisters, in which the profile of Sisters' audience and Sisters' brand position were thoroughly analyzed to identify strategic priorities for increasing safer sexual behavior and use of HCT and STI services among TG. As part of this marketing plan, in FY12 the Sisters team will develop and implement a strategy for effective interpersonal outreach to TG, and a strategy for effective BCC through the newly developed Sisters website.

Sisters will provide on-site counseling and rapid testing for HIV at the DiC. To strengthen referral linkages to care and support services for PLHA, the Sisters team will hold regular meetings with positive support groups and staff at Banglamung and Somdejsriracha Hospitals, Glory Hut and the Health Opportunity Network (HON). PSI will provide a small amount of financial assistance to the Glory Hut to support the provision of shelter and community home-based care (CHBC) for MSM and TG living with HIV.

In FY12, PSI will explore the opportunity of adding on-site rapid testing for syphilis to the range of services offered at the Sisters center.

The Poz Home Center launched its Strategic Plan 2011-2014 in FY11. In FY12, with financial support under CAP-3D, the Poz Home Center will focus on promoting HCT through its telephone advice and support line and peer-based online education and support service; providing Follow-up to Post Test Counseling services at BMA and DOH sites; and developing and leading the M-Poz network of groups and organizations providing services to MSM and TG living with HIV. By facilitating experience sharing, cross learning, and the coordination of TA and capacity building for members, the M-Poz network will support replication of the Poz Home Center's model for delivery of the CPP.

To help meet the needs of most at-risk Burmese migrants in Thailand for prevention and treatment of HIV, TB and malaria, Save The Children (SC) will produce and distribute an IEC publication on the prevention of these three target diseases, with useful information and appropriate messages for MARPs. SC will also conduct mapping and an assessment of health services for most at-risk Burmese migrants in Ranong and Ratchaburi provinces.

PSI will survey the web chat sites frequented by MSM in Thailand and develop and implement a strategy for disseminating BCC messages on these sites. Messages will address safe sex, knowing one's HIV status, accessing support and treatment services, as well as positive health and prevention. PSI will review the work done by FHI 360 with Cyberfish, including a soap opera VCD, when developing the web strategy for MSM.

In the fourth quarter of FY12, the CAP-3D program will provide financial support to SWING, M-Plus, Violet Home, and the mobile HCT operations of the Thai Red Cross, at approximately the same level that they are receiving under the USAID-supported Community REACH program, which is scheduled to end in June 2012. Beginning in the second Quarter of FY 2012, PSI will engage in meetings with the abovementioned organizations to gain a better understanding of their mission, strategic direction, capacity, needs, and their fit with the CAP-3D program and USAID's strategic objectives, in order to plan their scope of work and budget under CAP-3D from July 2012 onward.



USG Management and Operations

1. Redacted
2. Redacted
3. Redacted
4. Redacted
5. Redacted

Agency Information - Costs of Doing Business U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services			3,027		3,027
ICASS			1,689		1,689
Institutional Contractors			15,000		15,000
Management Meetings/Professional Development			3,210		3,210
Non-ICASS Administrative Costs			10,890		10,890
Staff Program Travel			8,781		8,781
USG Staff Salaries and Benefits			73,882		73,882
Total	0	0	116,479	0	116,479

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
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Computers/IT Services		GHP-USAID		3,027
ICASS		GHP-USAID		1,689
Management Meetings/Professional Development		GHP-USAID	Include Staff training and international conference	3,210
Non-ICASS Administrative Costs		GHP-USAID	For USAID Non-ICASS Administrative Costs breakout as follows; 1. Estimate Annual rent and utilities = 7,005 2. Annual office support cost share = 3,885 (IT equipment, Printing, Office Supplies and Material, Vehicle rental, Courier Services and Other Miscellaneous Services)	10,890

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing	20,800				20,800
Computers/IT Services		15,600			15,600



ICASS		124,400			124,400
Institutional Contractors	35,000				35,000
Non-ICASS Administrative Costs	564,985				564,985
Staff Program Travel	229,725				229,725
USG Staff Salaries and Benefits	1,949,490				1,949,490
Total	2,800,000	140,000	0	0	2,940,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		20,800
Computers/IT Services		GHP-State		15,600
ICASS		GHP-State		124,400
Non-ICASS Administrative Costs		GAP	printing, supplies, equip etc	564,985

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Peace Corps Volunteer Costs		40,000			40,000
Total	0	40,000	0	0	40,000

U.S. Peace Corps Other Costs Details