ASEAN Institute for Health Development
MAHIDOL UNIVERSITY

AIDS Policy Evaluation

Summary Report

" Evaluation of the National AIDS Response in Thailand "

ASEAN Institute for Health Development (AIHD),
Mahidol University
The International Health Policy Program (IHPP)
Health Counterparts Consulting (HCC)
HLSP, UK

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Summary Report

“Evaluation of the National AIDS Response in Thailand”

Evaluation Team

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Introduction

The Department for Disease Control of the Ministry of Public Health, as Secretariat of the National AIDS Committee, commissioned an evaluation of Thailand's AIDS response for the period of 2007-11. The goal of the evaluation was to apply the findings to the subsequent five-year AIDS plan (2012-2016). The Evaluation Team was led by the ASEAN Institute for Health Development of Mahidol University and partners.

This evaluation report presents a review of the recent developments in AIDS and related policies, the translation of policy into action at the central, regional, and provincial levels, management of the budget for AIDS prevention and control, and the implementation in response to the four core strategies of the National AIDS Plan for 2007-11. Finally, the evaluation report includes recommendations for improving the up-coming plan, prioritizing tasks and target populations, and appropriate resource mobilization.

The Evaluation Team sincerely hopes that the information gained from this evaluation can be constructively applied to the planning process for the 2012-16 National AIDS Program development in order to promote more efficient strategies which more directly address the current context of AIDS in Thailand.

Evaluation Team

November 2011

Acknowledgements

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Finally, the Team is tremendously thankful to the administrators and implementation staff of the provincial headquarters offices, the provincial chief medical office, the district health office, the provincial hospital, the district hospital, the Tambon health promotion hospital, and the local administrative organizations with experience of AIDS implementation in the five case-study provinces for sacrificing their valuable time to meet with the Team and for skillfully facilitating field visits and meetings for the Team throughout.

Evaluation Team
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Acronyms

ANC	Ante-natal Care
ART	Anti-retroviral Therapy
ARV	Antiretroviral
AEM	Asian Epidemic Model
BSS	Behavioral Surveillance Survey
BATS	Bureau of AIDS, TB and STI
BOE	Bureau of Epidemiology
DAC	Development Assistance Committee
DDC	Department for Disease Control
FSW	Female Sex Workers
GDP	Gross domestic product
GF	Global Fund
GFATM	Global Fund to Fight AIDS, TB, and Malaria
HRG	HIV Risk Groups
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Users
JANS	Joint Assessment of National Strategies and Plans
LAO	Local Administrative Organizations
M&E	Monitoring and Evaluation
MSW	Male Sex Workers
MSM	Men who have Sex with Men
MW	Migrant Workers
MDG	Millennium Development Goal
MDG6 6th	Millennium Development Goal
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
M&E	Monitoring and Evaluation
NAPHA	National Access to Antiretroviral Programme for PLHA
NAC	National AIDS Committee

NAMC	National AIDS Management Center
NAP	National AIDS Policy and Program
NASA	National AIDS Spending Assessments
NHSO	National Health Security Office
NSP	National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation
OI	Opportunistic Infections
PLHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PAC	Provincial AIDS Committee
PCM	Provincial Coordinating Mechanism
PHO	Provincial Health Office
PWID	People who Inject Drugs
STI	Sexually Transmitted Infections
SSO	Social Security Office
TBCA	Thailand Business Coalition on AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UA	Universal Access towards Prevention, Treatment, Care and Support
VHV	Village Health Volunteers
VCT	Voluntary Counseling and Testing

This evaluation of Thailand's National AIDS Policy and Management in 2007-2011 comprises three objectives: (1) To assess how responsive the National AIDS Policy and Program (NAP) has been in meeting the targets of the 2007-2011 National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation (NSP), and the 6thUN Millennium Development Goals (MDG6); (2) To evaluate the relevance, efficiency, effectiveness, sustainability and impact of the implementation of the NSP at the national, regional, and local levels; and (3) To provide recommendations as a guideline for improving policy formulation, planning, implementation, monitoring and evaluation of the next 5-year NSP in 2012-2016, and help prioritize the components of implementation, the target populations and the allocation of resources during the up-coming five-year plan period (2012-2016).

The four core evaluation questions of this study are as follows:

a) To what extent is Thailand meeting its objectives to a) reach universal access to prevention, treatment, care and support, b) reach MDG #6 by 2015, and c) to halve the number of new HIV infections by 2011 through accelerated prevention?

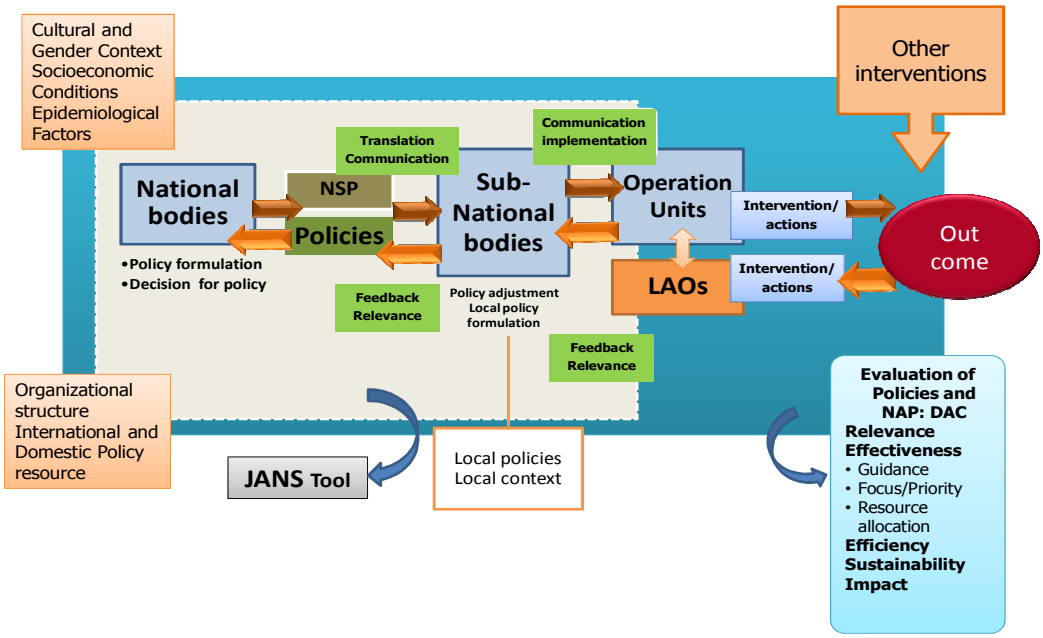
b) Does the NSP for 2007-11 and the Operational Plan for Prevention and Alleviation of AIDS towards Universal Access 2007-11 adequately guide and support an effective and efficient national response to HIV and AIDS both as regards Thailand's overall objectives and as regards the socio-epidemiological context?

c) Are the existing structures and practices, both at the national and sub-national level (province, sub-district) supportive (or non-supportive) to effective planning, coordination, resource allocation/mobilization, implementation, monitoring, evaluation and reporting of the national response?

d) Are policies, plans and implementation practices at all levels facilitating quality services and equal access to prevention, treatment, care and support for all in need?

The conceptual framework of this evaluation of the National AIDS Response during 2007-11 explores policy process and management at the following three areas: (1) Policy formulation at the national level, encompassing implementation and the roles of government and private organizations; (2) Policy translation and communication; and (3) Policy and program implementation. The evaluation applied the conceptual framework based on the Joint Assessment of National Strategies and Plans (JANS tool), and the policy or health program conceptual framework based on the Development Assistance Committee (DAC) principles for development assistance.

Figure: 1 Conceptual Framework of the Evaluation



This evaluation involved reviews of existing documentation, interviews and brainstorming meetings among key informants from the public and private sectors and civil societies. Field investigation was conducted in five provinces as regional representative of the NAP implementation processes and outcomes. This evaluation was conducted during February to May 2011 and focused on policy and planning related to HIV/AIDS, and past achievements. The evaluation team examined the process of policy development, strategies for policy implementation, system bottleneck and outcomes. The team also assessed problems and obstacles in these areas as a basis for recommendations to improve the next five-year plan in the up-coming period.

The scope of assessment on the policy and measures extends beyond the NAP plan for 2007-11 to include policies endorsed and announced by the National AIDS Committee (NAC) during the same period as well as other related policies. This evaluation defines “policy” as the high-level or policy-level public statements regarding the objectives or intention of implementation which can be applicable in practice, plan-managed, and supportive in various dimensions. In addition, “policy” connotes those decisions and declarations of policy-making agencies with direct responsibility for HIV/AIDS work including the Cabinet, the NAC, the Ministry of Public Health (MOPH), the National Health Security Office (NHSO), and strategies of the related, core ministries (i.e., the Ministry of Education, the Ministry of Interior, the Ministry of Social Development and Human Security) and NGOs and other not-for-profit agencies.

Following are the findings of the evaluation.

Part 1 Key Findings

1.1 Overview of the HIV/AIDS situation in 2007-11

Data from the HIV and risk behavioral surveillance systems during 2006-2010 show that prevalence of HIV infection was rather low among the general population as indicated by 0.7% prevalence among pregnant women appearing at ante-natal care (ANC) clinics in 2010. Most of the sentinel populations in the HIV surveillance system experienced declines in prevalence during 2006-2009. However there were increases in 2010 for pregnant women, non-brothel-based female sex workers (FSW) and military conscripts. The number of new infections in Thailand continued to decline as a whole. However there was an increase in new infections among ANC clients and military conscripts aged 20-24 years.

These epidemiological findings are consistent with the surveys of youth behaviors which show the increased risk behavior of multi-partner sex and unsafe sex. These trends could explain the increasing trends in youth experience with sexually transmitted infections (STI) and unplanned pregnancy. In 2008, approximately one-fifth pregnant women were under age 20 when they gave birth. A comparison of HIV risk groups (HRG) between 2005 and 2008 shows an increasing trend (almost doubling) of new HIV infection among non-brothel-based female sex workers (FSW). HIV and STI infections among these free-lance FSW were higher than their counterparts who were brothel-based FSW. In addition, the free-lance FSW do not have routine access to prevention and treatment, or accurate information about risk of HIV and STI. HIV among men who have sex with men (MSM) remains at a high level without showing signs of decline. This is especially true for MSM in large urban areas and big cities with a large number of tourists. Intravenous drug users (IDU) who appear for treatment at out-patient clinics also have persistently high levels of HIV infection rate (30% - 40%). Foreign migrant workers (MWs) who work as fishing boat crew have higher levels of HIV than MW in other occupations. In some locations, MWs have higher levels of HIV than Thais in the same occupation. This could be due to communication difficulties of MW which hinders their access to factual information and supplies for prevention of HIV infections.

1.2 Policy development and mechanisms for prevention and control of AIDS in Thailand

Government reform during 2002-2006 involved the devolution of authority for some operations to the periphery. Accordingly, there were adjustments to the structure and management of AIDS as part of this decentralization. Following enactment of the official ministerial proclamation in 2002, the Ministry of Public Health (MOPH) implemented structural reforms at the central and sub-national level. In particular, at the central level, the role of the Department for Disease Control (DDC) shifted from one of coordination and budget support for implementation and development into a technical support function. A portion of the budget and much of the task of implementation was decentralized to local administrative organizations (LAO). In addition, the budget for clinical services and prevention was integrated into the national health insurance scheme, and allocated to health service outlets in the form of per capita lump-sum payments.

Central mechanism at the national level: The National AIDS Committee (NAC) is formulated as the central mechanism for coordination and integration of the work between the various sectors as they define the policy direction and measures for implementation, up to and including M&E. The National AIDS Committee (NAC) has the Prime Minister as chairperson, and the Director-General of the DDC of the MOPH as the secretary, with other 36 members, representing the various sectors of the government, technical experts, and Civil Society. The National AIDS Management Center (NAMC) has the primary responsibility for coordinating and monitoring implementation. There has been a revision to the internal structure which has separated the NAMC from the BATS in the DDC in 2009. The NAMC is playing a bigger role in strategic coordination, but has no direct role in budget allocation. There are six sub-committees under the NAC to promote and oversee coordination in their respective areas of emphasis including: (1) Planning; (2) Monitoring and evaluation; (3) Accelerated prevention; (4) AIDS in the workplace; (5) Rights protection; and (6) AIDS vaccine trials.

In the various ministries other than the MOPH, there is no specific strategy for AIDS, Instead, the AIDS work is integrated into the numerous and diverse programs of the participating agencies. Up to 2007, these ministries prepared AIDS budgets through coordination with the MOPH. However, starting in 2007, no specific AIDS budget was defined; and this was also reflected by their counterpart offices at the provincial level. Budget for health of the population was allocated as a lump sum based on per capita needs, including AIDS. There was no specific allocation for AIDS prevention and control. Instead, the relevant budget category was "health promotion and disease prevention." This budget was managed through the service provision units, while the budget for the local administrative offices such as the Provincial Health Office (PHO) and technical support agencies such as the regional disease control office has been reduced. The net effect of this change was a dramatic decrease in the allocable budget for AIDS. In addition, the role of the PHO shifted to coordination and monitoring; the PHO no longer had the role of managing and allocating budget for AIDS or of providing health services. Accordingly, the number of dedicated staff for AIDS work at the PHO declined from perhaps ten, to one to three persons.

Provincial level: The core agency for coordination at this level is the Provincial AIDS Committee (PAC), with the PHO as secretariat. Over the past several years, the concern and interest in implementing the AIDS agenda has declined. This is, in part, due to the reduced budget earmarked for AIDS, and there are limited resources for monitoring and evaluation. The scope and outcomes of the AIDS work differ significantly among provinces. The amount of effort is directly related to the motivation of the provincial leadership and the capacity of the provincial AIDS team, including the Civil Society agencies in the province.

At the sub-provincial level: There is neither an AIDS-specific mechanism nor strategic plan at this level. Instead, there is a general coordination mechanism under the routine system.

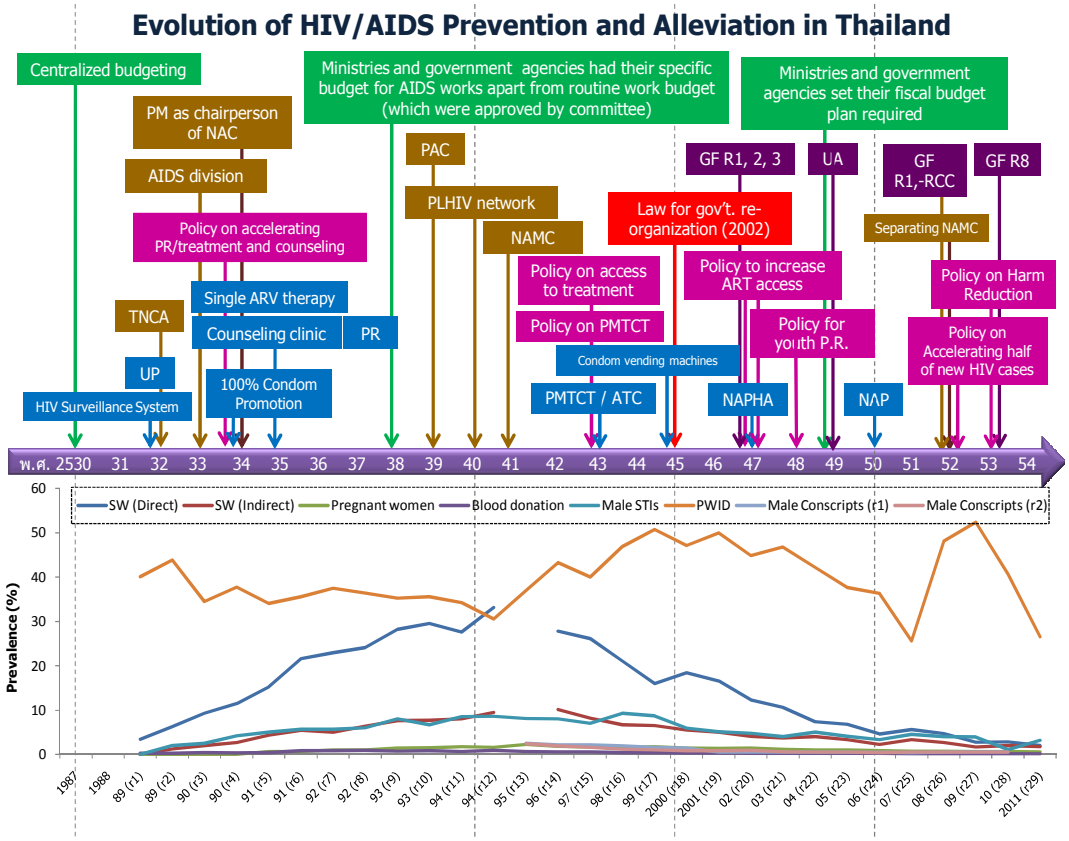
In the area of budget: There were important changes during 2003-2004 in the decentralization of budget to the local administrative organizations (LAO), such as responsibility for paying the monthly welfare stipend for persons living with HIV/AIDS (PLHA). In addition, the budget for prevention of mother-to-child transmission (PMTCT) of HIV and for anti-retroviral therapy (ART) was now managed through the National Health Security Office (NHSO). In 2006, the NAC issued a resolution approving each agency to establish an AIDS-specific budget category, which deviated from the previous system of a centralized planning process (with clear ramifications in 2007). In

addition, the budget for the PAC also declined to the extent that, in subsequent years, there was no budget specifically for AIDS. Provincial agencies had to devise methods to establish their own AIDS funding or draw from alternate sources.

In the area of care and treatment: The Thai government has a clear policy of expanding access to ART. In 2004, the Prime Minister announced the increase of ART coverage to include 50,000 PLHA under the NAPHA initiative of the DDC of the MOPH (at the 15th International AIDS Conference, held at the IMPACT Conference Center in Bangkok). Next, in 2005, the Minister of Health announced the integration of budgeting for ART through the national, universal health insurance scheme. As a result, the responsibility for funding NAPHA was transferred to the NHSO. In 2007, the NHSO completed this transition of responsibility under the designated name of "National AIDS Programme."

In the area of prevention: Most of the prevention activity has occurred under the Global Fund (GF), Round 1 RCC. The emphasis of this support is the development of Provincial Coordinating Mechanism (PCM) and integration of prevention, care and treatment of sexually transmitted infections (STI) and HIV/AIDS among youth. This is referred to as the "youth-friendly services program". This program is being implemented in 43 provinces. The GF Round 8 funding has given priority to extending HIV prevention to the hard-to-reach groups in 48 provinces including MSM, intravenous drug users (IDU), FSW, prisoners, and foreign migrant workers (MW).

Figure 2: Development of HIV prevention and control in Thailand



1.3 Achievement of the objectives of the NSP and MDG6

Implementation in accordance with policy and management of the AIDS during 2007-11 emphasized a response to the principal indicators and targets as follows: (1) Universal Access towards Prevention, Treatment, Care and Support (UA) in Thailand; (2) Millennium Development Goal # 6 (MDG6) by 2015; and (3) Reduction of new HIV infections by half by the end of the plan period. There are some overlapping features of these three targets. Accordingly, the evaluation team decided to be inclusive in the review of indicators and in the determination of the success of implementation as prescribed by the policy:

1.3.1 Universal Access towards Prevention, Care and Support (UA), NAP plan for 2007-11, and MDG6-B;
1.3.2 Reduction of new infections by half by 2011 (as per the NAP for 2007-11);
1.3.3 Six core targets of the MDG to be achieved by 2015

1.3.1 Access to the core program of HIV prevention

Trends toward the achievement of access to the core program of HIV prevention show a high degree of success for PMTCT (with over 90% coverage). However, access to prevention for other population groups was under the target. HIV VCT for the general population youth and factory workers was under 20% and 25-30% respectively. VCT coverage for high-value population groups such as female sex workers (FSW) was 45%, and 55% for MSM as of 2010 (peak levels).

There is a lack of direct data on access to condoms and AIDS information, but there are the following indirection indicators of coverage:

(1) There was continuing effort to expand availability of condoms through a variety of convenient distribution channels. However, Thai youth use of condoms for last sex with a casual partner ranged from 30 to 70%.

(2) The groups reporting the highest level of condom use at last sex (about 90%) was FSW and discordant couples.

(3) Delivery of AIDS knowledge and sex education was integrated into the standard curriculum for high school students and vocational school students. The 2010 report to UNGASS observed that coverage of the curriculum was as high as 68%. At the same time, correct response to the five UNGAS AIDS knowledge questions in 2010 never exceeded 40% for youth and special populations.

(4) Regarding access to care and treatment, particularly ART, it was found that there were distinct increases in access, achieving a level of 75.8% in 2009.

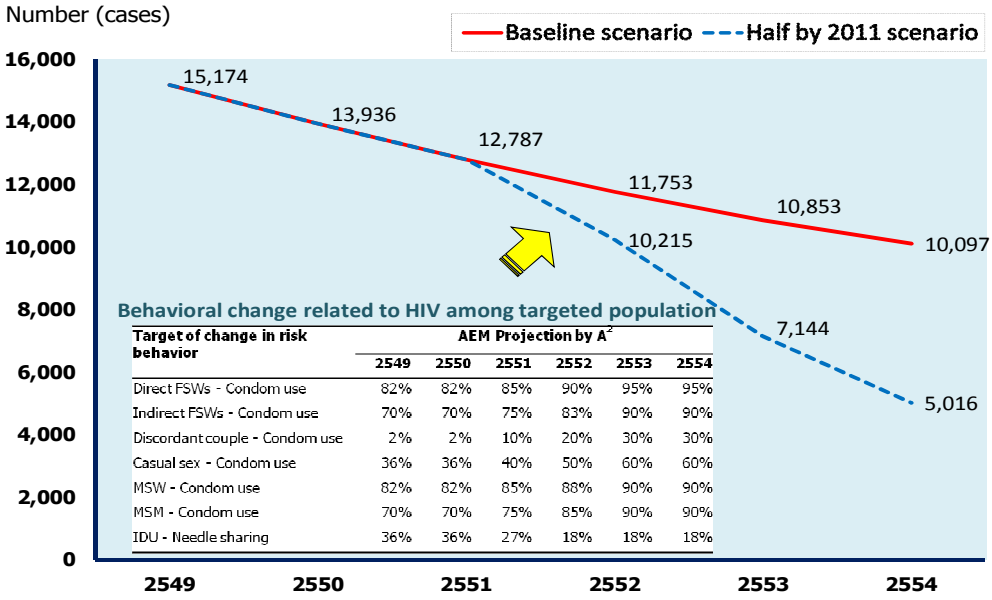
In sum: Access to the core program of HIV prevention is still not optimal because the data do not show increasing trends for most components (the exception being HIV screening of pregnant women and PMTCT). Access to ARV therapy has increased significantly over time.

1.3.2 Reducing the number of new HIV infections by half

To answer the question regarding progress toward the target of halving new HIV infections by the end of 2011, this evaluation used the projections from applications of the Asian Epidemic Model (AEM) which estimated the level of increased prevention behavior required to cut new infections in half (see Figure 3) among various vulnerable populations. These populations

include FSW, MSM, male sex workers (MSW), discordant couples, casual sex partners, and IDUs. Data for condom use and needle sharing for these populations were obtained from the behavioral surveillance survey (BSS) of the Bureau of Epidemiology (BOE) and other sources, such as project reports, etc.

Figure 3: Projections of reduction of new HIV infections by half during 2007-11



Behavioral change related to HIV among targeted population

Target of change in risk behavior	AEM Projection by A[2]					
	2549	2550	2551	2552	2553	2554
Direct FSWs - Condom use	82%	82%	85%	90%	95%	95%
Indirect FSWs - Condom use	70%	70%	75%	83%	90%	90%
Discordant couple - Condom use	2%	2%	10%	20%	30%	30%
Casual sex - Condom use	36%	36%	40%	50%	60%	60%
MSW - Condom use	82%	82%	85%	88%	90%	90%
MSM - Condom use	70%	70%	75%	85%	90%	90%
IDU - Needle sharing	36%	36%	27%	18%	18%	18%

Source : The Asian Epidemic Model (AEM) Projections for HIV/AIDS in Thailand 2005-2025 by The Analysis and Advocacy Project (A[2]), The Thai Working on HIV/AIDS Projections, USAID.c

From this review of the data, trend of behavior change in select targeted populations has not reached levels that would meet the criteria of the AEM model projections in order to reduce HIV incidence by half. These populations include FSW, MSM, PWID, and persons engaging in casual sex. As for discordant couples, there is insufficient data whether the requisite behavior change has occurred to satisfy the prescription of the AEM model projections.

1.3.3 Millennium Development Goal # 6

The 6th Millennium Development Goal (MDG6) has three targets as follows:

1) MDG 6A: Slow and reduce the spread of AIDS by 2015
2) MDG 6B: Provide complete coverage of care for PLHA within 2010;
3) MDG+ : Reduce infection among the reproductive age population to no higher than 1% within 2006.

To help evaluate MDG 6A, UNDP has proposed three indicators as follows:

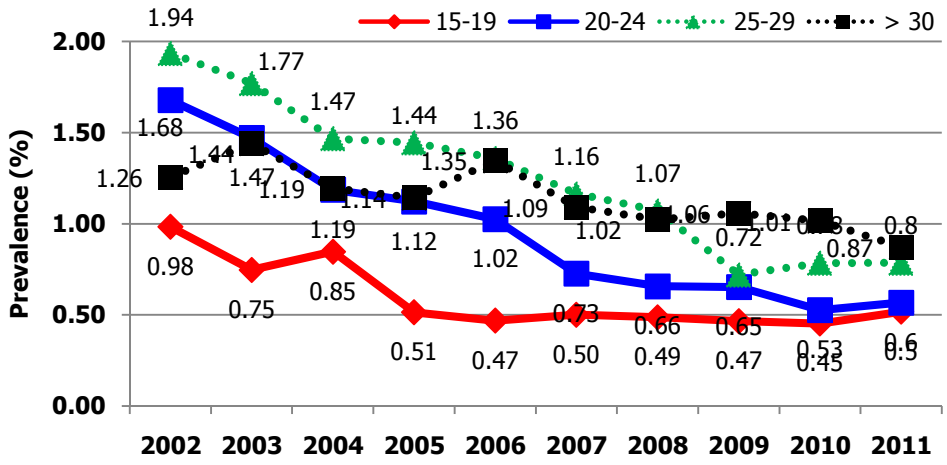
a) Percent of HIV among the population age 15-24 years based on data from the BSS; prevalence of HIV among pregnant women age 15-24 years (which has been declining in Thailand since 2001, though there was a slight increase in 2010);

b) Condom use at last high-risk sex, based on data from the BSS on percent condom use in the past year during sex with non-regular partners among the population age 15-24 years (which in Thailand has ranged from 30% to 70%); and

c) The proportion of the population age 15 to 24 years with accurate AIDS knowledge, based on correct response to the five UNGASS knowledge questions among males and females age 15 to 24 years (which was rather low in Thailand, ranging from 15% to 35%).

From data on the situation and risk factors for HIV among the population age 15 to 24 years, despite the declining trends of HIV prevalence, there is the potential for a resurgence of the epidemic due to the fact that the younger cohorts show persistent vulnerability in the area of AIDS knowledge and HIV prevention behavior (i.e., condom use) which have not improved satisfactorily, and while sex behavior has not declined.

Figure 4: Mean HIV prevalence among pregnant women by age group



Data were not available for many of the indicators, and key data were not always tracked or systematically compiled. This was especially the case for the area of rights, social support, and prevention in the various groups. The evaluation team faced major challenges in assembling data, and which was often incomplete or incorrect. This circumstance points to the lack of application of the Plan specifications or implementation of the M&E strategy so that there might be a reliable and continuous source of evaluation data.

Data on achievements mostly came from reports on progress toward the UNGASS goals. Data on prevention included outcomes (e.g., behaviors). By contrast, data on treatment were mostly outputs, with little data on outcomes. There were no indicators for AIDS rights, research and M&E. These gaps in the data reflect systemic problems in the database and M&E systems to a certain extent.

Many of the data sets were ad hoc and specific to certain localities. The exception to this is the BSS among FSW which has been national in scope and maintained over time. Data for MSM come from pilot studies of the BOE of the MOPH. Data on VCT come from pilot studies of the NHSO. There were no directly-relevant data on rights but only indirect data of school enrolment of children age 10-14. There were no data on the proportion of PLHA and affected persons who had their rights violated and in what way. Data from the rights protection agencies and other reports are limited. These shortcomings of the data point to the need for an M&E system to track

implementation of the policy and strategy, and to provide data that can be applied to help future planning.

Most of the data on treatment comes from the NHSO, and these data cover only the population enrolled in the national health insurance scheme. For example, NHSO data do not include government civil servants receiving ART or those covered by other insurance systems. VCT can be achieved to some extent but the level of coverage is low. A CD4 count has not achieved full coverage, and ART access for foreign migrant population is lacking. The Ministry of Social Development and Human Security (MSDHS) has put its efforts to work for persons affected by AIDS. However progress has been slow (in data collection) and the level of coverage is hard to estimate. Data on the quality of interventions is still vague and limited.

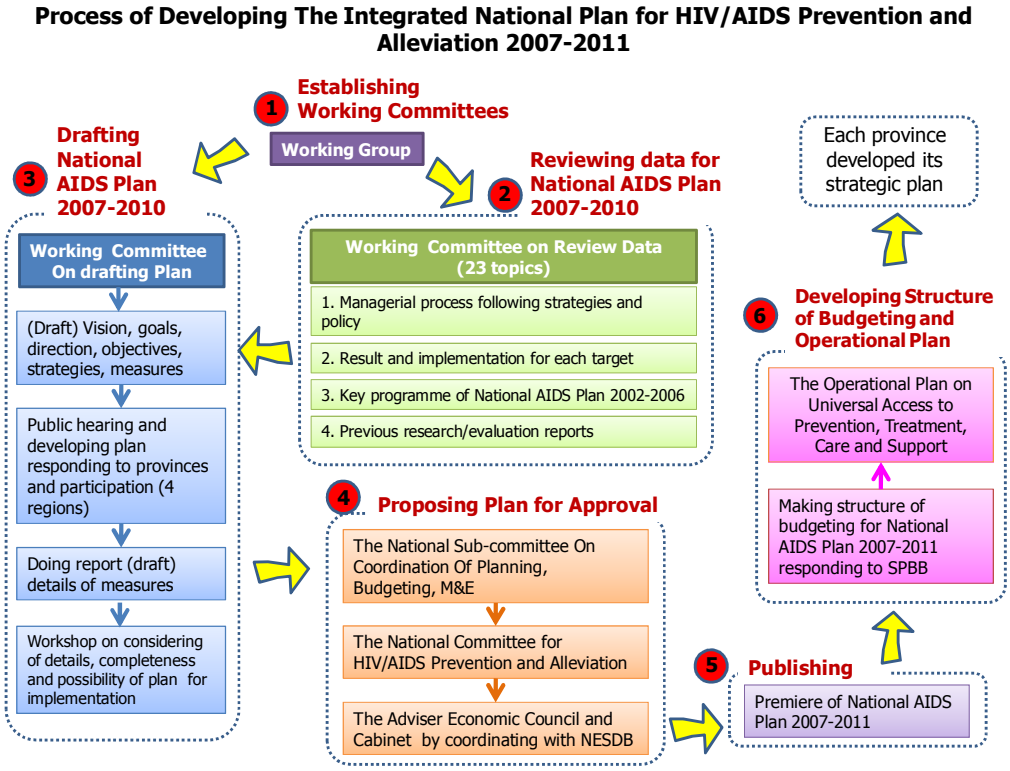
1.4 Policy development process and mechanism to translate policy into action

1.4.1 NSP for 2007-11

The Department of Disease Control (DDC) of the MOPH provided leadership for plan development. The DDC serves as Secretary of the NAC, and is the coordinating agency for implementation during 2005-6 along with its partners. New mechanism in this plan formulation was the establishment of task forces which had active involvement from experts, technical resource persons, implementing staff of related agencies, and civil society were formed to analyze and synthesize key issues across 23 topic areas. The Bureau of AIDS, TB and STI (BATS) served as general secretary for these task forces. This collaboration across and within sectors is a notable feature of the Thailand strategic process. Fully 19 meetings were held with the budget expenditure of 4.89 million Baht. The empirical data analyzed and synthesized by the task forces were mostly epidemiological (from studies of HIV prevalence and behaviors associated with HIV) and HIV estimates and projections. These quantitative data were rechecked through the experience and opinions of the participants. Notably data on socio-cultural dimensions were scarce, and there was insufficient evaluation of the plan, projects, or other measures in the past. This is a limitation for this evaluation and for future strategic formulation.

Development of the core strategies of the implementation plan relied on a process of small group meetings and brain-storming sessions to define the strategy components and indicators for achievement. Members of the secretariat played a key role in defining indicators, taking into account of the viewpoints from stakeholders, and in proposing feasible projects and activities to address the different strategies. From this, the final strategy was collated by the secretariat for submission for approval by the Cabinet. The budget for each component was addressed by the respective agencies under their budgetary framework. There was no supplementary government funding specifically for AIDS.

Figure 5: Process of the NSP formulation for 2007-11 (National level)



The NAC issued a resolution that the relevant agencies, including the local administrative organizations (LAO), work together to produce operational plans for the five-year period, with collaborative responsibility by the LAO in allocating their annual budgets. The NAC resolved that the AIDS monitoring and evaluation system should be further improved in order to provide clear achievements during the 2007-11 plan period. In 2008, the operational plan was developed, including support to achieve universal access, however, without the required budget support.

Content of the plan: The strategic plan defines the direction of implementation to address HIV/AIDS problems in the various target populations, comprehensively. There are new directions for improving management through decentralization and revision of the budgeting system. There is specification of the partner agencies in each sector; however the principal responsible agency is not always specified for each strategy component. There is a lack of articulation of how to translate some plan components into action, and some activities are lacking of clear indicators of achievement.

There are also inconsistencies between the recommendations of the Task Force for AIDS Data Analysis and Synthesis made during the Plan development process and the measures set in NSP for 2007-11. For example, prevention measures in Strategy # 2 of NSP have components that do not address or are inconsistent with the recommendations of the Task Force. The component for PMTCT does not address the mobile populations who cannot access this service or STI diagnosis and treatment. In addition, there was a recommendation for outreach services for sex workers in the province through the community health centers and with participation of the local NGOs. However, there were no clear measures or directives to support this.

In the operational plan, under the NSP' Strategy # 1, the four different levels of implementation are specified as central government, province, community, and inter-country collaboration. In Strategy # 2 there are measures specified for prevention, care and treatment to cover special populations-at-risk. However, implementation is not consistent with measures in the plan and the specified budget is merely a number, without any allocation of funds to represent it.

1.4.2 Translating and applying the strategic plan to action

The evaluation of the NSP in the five case-study provinces found that, after Cabinet approval and the directive to use the NSP in 2006, the DDC of the MOPH forwarded a statement to that effect to the relevant agencies at the provincial level, and advised them to take action. However, no explanation was given or assurances requested that the field would take the required action. The DDC statement was merely an advisory for the province to consider. This announcement was repeated at the National AIDS Seminar of that year. The nature of activities in response to the NAP was still in the form of a centrally-driven plan, despite the fact that there was no earmarked budget for support for the plan or for field-based agencies. Accordingly, local agencies developed plans that were consistent with a decentralized process.

Some provinces did use the Cabinet authorization to develop their own five-year strategic plans. But others did nothing. Implementation and M&E focused on those areas that were part of the MOPH reporting requirement. At the start of the plan period, there was encouragement from the central authorities to report on the key AIDS indicators. However, over time, reporting on these indicators declined. The provinces were also expected to establish their own budgets for AIDS but only some did. For M&E at the provincial level, the provinces did this by simply compiling the plan components by results of activities, sorted by strategy.

The National AIDS Management Center (NAMC) is the principal agency with responsibility for overseeing the translation of the plan into action. However, the evaluation found that there was no mechanism for accomplishing this or motivating the field to apply the plan.

Within the MOPH, the Bureau for AIDS, TB and STI (BATS), which should have played a key role in plan implementation, was not able to do so because the DDC, as Secretariat of the NAC, did not have relevant plan to directly address the needs of the plan What is more, according to its vision statement, the DDC did not feel it had the role or national authority for AIDS generally. Instead, their focus was on special projects and technical support. In the past, the BATS had been the technical arm of the NAC. However, in the last four years of the plan period under review, BATS had a diminished technical support role. Thus, application of the NAP plan relied more on the initiative of the NAC, which left considerable gaps in implementation of policy.

Other agencies outside the MOPH did not take distinctive steps to implement the strategic plan, but instead mostly supported on-going projects and, thus, did not have much impact on the plan objectives or nature of the work. These agencies needed to give first priority to their own respective ministry's mission, vision and strategy, and there was no specific budget for AIDS. Accordingly, funds for AIDS had to be drawn from line budgets in other areas. This had the effect of reducing the importance of AIDS in these agencies' implementation plans.

Agencies at the provincial level applied the plan as an ad hoc project framework more than as a vision for overall implementation. No province adopted the Plan as its own and there was no

apparent effect of the Plan on method of implementation. Also, since there was no budget allocated from central sources, the provinces had to mobilize local funds to support their versions of the Plan. The Plan did not concretely specify how the province should integrate implementation with the localities. Further, there was no training or orientation on Plan implementation, with the exception of some sites receiving Global Fund support.

1.4.3 Key policies during the five-year period (2007-11)

The policy and measures for harm reduction from use of needles for addictive drug use was formulated. This policy was implemented on a pilot basis in 17 provinces starting in 2011 and, thus, the outcomes are too preliminary to judge. The concept of using criminal suppression of drug dealing and drug use still defines the principal control strategy. Thus, the crime-suppression approach to IDU is at odds with the public health approach of the NAP. For example, the harm reduction activity of distribution of clean needles and syringes is illegal. So this inconsistency of policy remains a challenging area for the NAP to reconcile these conflicting views and interventions.

As of 2010, implementation of diagnosis, treatment and care of PLHA was not always in accord with the guidelines because the Board of the NHSO proclaimed that ART could only be prescribed (as a benefit) for persons with CD4 counts less than or equal to 350 under certain conditions. The various networks of PLHA protested this proclamation and advocated that all PLHA with CD4 counts equal to or less than 350 be allowed unconditional access to ART as part of the national health insurance coverage.

AIDS in the workplace is a collaborative effort among the Thailand Business Coalition on AIDS (TBCA) and the Department of Labor Protection and Welfare. TBCA conducts inspections of worksites to see if they comply with AIDS-in-the-workplace standards as advocated by the NAC. If so, then a certificate is issued. However, this activity is only conducted in the commercial sector and is only a supportive function. Any programmatic achievement depends on the priorities and diligence of the business owner. Thus, it remains a challenge to find ways to motivate businesses as well as other public agencies to apply AIDS-in-the-workplace standards. Until then, it is difficult to report the degree of actual progress in applying the policy.

Regarding, the policy for accelerated reduction of new infection (by half), the National AIDS Management Center (NAMC) and the Coordinating Center for Development HIV Prevention Approaches and Mechanisms worked with relevant government and Civil Society agencies to develop a specific plan for halving new HIV infections and advocating for the necessary budget to support campaigns and accelerated actions. Yet this component is still not concrete in practice, especially in the area of integrated AIDS work of the various agencies and ministries which have line budgets to support this. Their direction and appropriateness of action is still inefficient in addressing the NAP targets. Some of the implementation is not fully consistent with the established policy/measures (as stipulated in the NAP plan) to improve access for prevention services for key target populations with full and equal coverage, mindful of the need to respect and protect the basic rights of these vulnerable groups.

Regarding the policy on unplanned pregnancy, the Prime Minister has delegated direct responsibility for this to the Ministry of Social Development and Human Security (MSDHS). However, in practice the problems facing today's youth are cross-cutting among different ministries and agencies. In particular, unwanted pregnancy and HIV infection are closely linked by virtue of unsafe sex behaviors. Thus, the plans of different agencies need to be linked and coordinated in practice to effectively address the issue of unplanned pregnancy.

Even though a number of constructive policies emerged during the past five years (e.g., harm reduction for IDU, AIDS in the workplace, the national reproductive health policy, etc.) translation of these policies into practice to address the targets is not yet optimal. A key strategy of the NAP

to increase up-take of AIDS prevention and VCT services is the expansion of client-friendly services. However, this effort is not intensive enough or fully established in the service systems which serve the target populations.

The NSP strategy focuses on particular sub-groups of the population. This can result in overlooking some vulnerable groups in the general population who are equally need of services. The groups of MSM, FSW, IDU, MW all receive high priority at present. This is partially the result of GF influence through earmarked financial support. This has improved understanding and services for these vulnerable populations by government and Civil Society agencies, and expanded networks. When these agencies work with a common goal, this increases the potential for policy advocacy. However this narrow focus on certain HRG has led to some neglect of the general population, including PLHA and their partners in the areas of reproductive health and quality-of-life interventions. There is presumed high risk of HIV infection among some of these general-population groups despite the lack of data and research. Furthermore, public media campaigns to raise concern about risk in the general population are sporadic and inadequate.

1.5 Budget for AIDS prevention and control

Overall, in 2009, Thailand programmed approximately 7.208 billion baht for HIV/AIDS, or an increase from 3.728 billion baht in 2007 (NASA and UNGASS reports). This represented about 1.9% of all health expenditure or about 114 baht per capita per year (and 14,417 baht per PLHA). Fully 93% of the budget was from domestic sources; the remaining 7% was from external sources. About three-fourths (76%) of the budget was allocated for treatment while 13.7% was for prevention.

For the domestic budget, the NHSO was the largest provider (55%) followed by the social welfare program of the Department of the Comptroller-General, while the MOPH contributed 4%, 80% of which was for medical care and treatment. Among external sources, the Global Fund was the largest donor, and most of this budget was for prevention interventions.

During the five-year period of this evaluation, the amount of Thai government support for AIDS did not decrease. Among most of the related ministries, the allocation for AIDS work remained rather constant. The exception was for the Ministry of Education and MOPH which significantly reduced their expenditures for AIDS. The reduction of MOPH expenditure is attributable to the transfer of fiscal responsibility for ART from the MOPH to the NHSO.

It is noteworthy that, since Fiscal Year 2010, the Ministry of Education had only one-fourth of the AIDS budget that they received during 2007-2009. The budget for care and treatment increased by 20.3% when compared with 2008. This increase was mostly for ARV drugs and treatment of opportunistic infections (OI). The budget for prevention in 2009 was 13.7% of the total, representing a decline from 2008 of 34.2%. Most of this prevention budget was for universal precautions in the clinical setting and post-exposure prophylaxis. Other portions of the prevention budget went for PMTCT. Most of the prevention budget came from the GF and other external sources.

Table 1: Budget for AIDS in Thailand, and overview of AIDS budget allocations by various agencies during 2006 – 2011.

Financing for HIV/AIDS program

Program financing 2007-2009, source: UNGASS 2008, 2010

	2007	2008	2009
1. HIV/AIDS program expenditure			
1.1 Total HIV/AIDS expenditure, mln Baht	5,855	6,928	7,208
2. Source			
2.1 Domestic, % of total AIDS exp.	83	85	93
2.2 International, % total AIDS exp.	17	15	7
3. Expenditure profiles			
3.1 Care and treatment, % total AIDS exp.	72	66	76
3.2 Prevention, % total AIDS exp.	14	22	14
4. ART expenditure*, Baht per patient year	8,610	10,722	16,201

*inclusive of the first and second line ARV and treatment of all clinical complications

- International sources were 7% of total HIV/AIDS spending → **financially self-reliance and sustainable**
- Unfortunately, prevention program was only 14% of total HIV/AIDS spending in 2009 → **is this a good sign?**

Institute	2006	2007	2008	2009	2010	2011
Ministry of Public Health	3,109,044,020	339,549,100	255,657,900	244,742,400	250,006,100	237,576,000
MSDHS	46,675,000	51,249,600	55,688,200	58,554,300	58,961,600	61,230,600
Ministry of the Interior	69,056,000	263,269,000	284,461,600	338,577,700	308,322,700	308,381,800
Ministry of Education	104,259,080	123,496,600	125,363,100	124,863,100	34,459,400	102,018,300
Ministry of Defense	21,818,700	22,483,000	24,172,100	24,372,800	24,372,800	23,909,100
Global fund				596,817,611	902,707,941	899,827,266
Other		12,956,200	18,539,900	15,453,000	15,018,387	14,772,400
NHSO		3,855,600,000	4,382,400,000	2,983,773,000	2,770,853,000	2,997,736,600
TOTAL	**3,350,852,800**	**4,668,603,500**	**5,146,282,800**	**4,387,153,911**	**4,364,701,928**	**4,645,452,066**

(Source: National AIDS Management Center (NAMC) of Thailand)

An analysis of the AIDS expenditure data from the various sources, compared with the international support (primarily the GF) shows significant trends. In 2009, the domestic budget for AIDS was 6.726 billion baht, 80% of which was for treatment and only 13% for prevention. By contrast, the external funding for AIDS amounted to 482 million baht and was distributed across a range of programmatic areas, e.g., 33% for staff motivational costs, 29% for prevention, 17% for management and institution building, and 16% for treatment.

At the provincial level, the case study of five provinces found that, in some, their spending for AIDS declined significantly, especially the budget for management and PAC. The budget for prevention was vague; the PHO and service providers had to draw on multiple sources of funds, including those from the NHSO, LAO, the provincial development fund and the GF. Those provinces with large numbers of tourists or foreign migrant workers (MW) may have allocated some of their general development budgets for AIDS, or got funding for HIV prevention among MW from the NHSO. Those provinces which did not have access to external funding, such as that from the GF or UNFPA, were able to seek supplemental resources from the local administrative organization (LAO) in their locality. This funding mostly was project-specific and, thus, was not conducive to overall coordination and integration. By contrast, the funding for treatment was unambiguous and specifically allocated to the health service outlet.

Strengths and weaknesses of AIDS budgeting in Thailand

Thailand has good financial capacity and can achieve self-reliance for funding prevention and alleviation of AIDS. Nevertheless, in the past NSP plan period, there has been an increase in the proportion of domestic funding of AIDS care and treatment, while funding for prevention has declined (proportionately). Prevention cannot be neglected since trends in risk behavior and sexual lifestyles in a rapidly changing society could set the stage for renewed epidemic spread of HIV. In particular, it is clear that GF funding is phasing out, and that has been a strong source of support for prevention. Thus, Thailand will need to mobilize domestic sources of funds to compensate for these changes and make sure the urgent needs are met.

In addition, changes in the management structure at the central level, the region and local areas in recent years has impacted on the system of financial support, resulting in a generally reduced amount of funding for support and strengthening across a range of areas which facilitate implementation. Also, the financial monitoring system is not conducive to tracking AIDS budgeting and expenditure since data are not always disaggregated, are inaccurate or incomplete in all the provinces which the team visited. There is an urgent need for a management information system with quality data, efficiently entered and accessed, which can produce descriptions to inform decision-making and policy formation that is tailored to the local context and challenges of the country, the province and the periphery. This system will increase cost-effectiveness of operations and improve the overall M&E system.

Strengths and weaknesses of budget from GF support

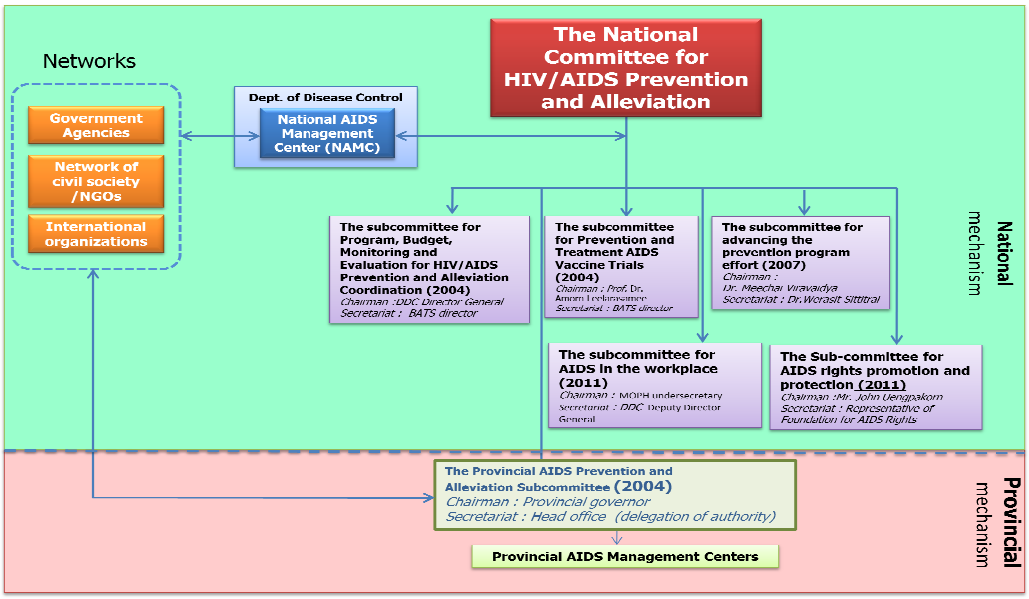
From the review of documents and interviews with key informants, the evaluation team can conclude that the strength of the GF support is its emphasis on prevention and promotion of participation of all sectors in the AIDS response – not just the government. In addition, the GF has a system of financial monitoring and evaluation of project outcomes and results that is strong.

At the same time, an important weakness of the GF support is that it is not sustainable and places an over-emphasis on indicators of activities. Thus, in some cases, there is a lack of flexibility in implementation, or makes it difficult to tailor the interventions to the context or time required to achieve sustained results. An important limitation is that the GF assistance doesn't strengthen the health service system over the long-term and, instead, may foster a sense of weakness in the health system overall.

1.6. Structure and implementation at the national and provincial level

1.6.1 Overview of the structure and implementation at the national level

Figure 6: Structure of implementation of AIDS prevention and control at the national level during 2007-11



The review of existing documents and in-depth interviews with key informants show that the structure of AIDS policy in Thailand centers with the NAC, with the NAMC as the secretariat for coordination, and the MOPH. The NHSO has the principal role of supporting medical intervention for those covered by the insurance program in collaboration with health and medical service outlets. However, the NHSO support does not cover government civil servants, state enterprise employees and MW.

The composition of the NAC includes the various sectors (public, private and Civil Society) and technical specialists. The Prime Minister chairs the NAC. There are no representatives of the NHSO and the Social Security Office (SSO) despite the fact that the NHSO has a board and committee with direct responsibility for AIDS management and coordination. The membership comprises technical experts and representatives from the relevant agencies and Civil Society. They formulate guidelines for AIDS treatment and clinical services. They have a clear budgeting system which is national in scope. However, there is no formal coordination link with the NAC. This reflects an area of duplication and gaps in policy coordination at the national level between government organizations.

The NAC has the designated role of formulating the policy and implementation framework for the participating agencies. However, this management role has evolved during the Plan period under review as a result of the government budget reform process. There is no longer a direct AIDS earmark in the national budget. The relevant ministries and agencies must designate the budget for AIDS through their own mechanisms.

In the past five years (2007-11) key policies that were developed include the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation (NSP), universal access and harm reduction. The latter two policies were promoted by the international AIDS community and adopted by Thailand in 2005 and 2009. These components were incorporated into the NSP for the period and it was intended to implement these policies through broad collaboration among the government, private and Civil Society sectors. However, there were major obstacles to this including different degrees of flexibility, speed, and effectiveness in translating the plan and policy into action. M&E of implementation was often not timely enough to be fed back into the planning process to improve performance. This is reflected in the length of time required for the resolutions to emerge from meetings of the NAC and sub-committees, often as long as one to two years for a given issue. Some areas of needed improvement are not being sufficiently addressed, for example, the call for each agency to establish a budget for AIDS, to support prevention among the adolescent population, to intensify efforts to halve new infections, etc. These issues were raised in January and April 2007, but guidelines for action weren't completed until July, 2009. The roles of the relevant agencies were stipulated in 2009 and, in November 2010, a set of performance indicators was proposed to help clarify implementation.

The structure of Plan coordination and M&E is related to the policy structure as first established through the NAC and sub-committees for planning, budgeting, control, and M&E. Over time, the coordination and integration of the Plan among agencies became more problematic. Staff, who were familiar with integrated management with curtain budget allocated, now had to establish separate ministerial budgets to support AIDS activities in a context of different degrees of importance and priority. There was a decrease of activity for some agencies, while others maintained a static level of AIDS funding without any improvement in implementation, and the secretariat of the NAC was not able to oversee progress or accelerate implementation of the Plan components. Staff of the secretariat said they did not know what approach they should use to achieve this. The sub-committee for Planning, Coordination and M&E did not meet frequently, and the participants kept rotating. This reduced continuity of action and delayed the process. There was no clear monitoring plan, nor were there any joint, integrated control targets. Later on, in 2009, the NAC issued a proclamation defining a set of AIDS indicators to be shared by all participating agencies in order to try to address problems of coordination. However, up to the time of this evaluation, progress in applying the indicators was only at the preliminary stage. There was no clear process of strategic measures for implementation among the key agencies across ministries, including the budget allocations and original structure. In addition, there was no system for summarizing evaluation findings in a joint forum among agencies sharing the same target beneficiaries.

There were attempts to improve the management mechanism to increase flexibility as proposed in 2009 to the secretariat to create a unit within the Health Systems Research Institute. But the Civil Service Commission and Bureau of Budget felt that the DDC should be the focal point for AIDS. The NAC appealed to the Council of State for an opinion but withdrew the request, and resorted to assigning the DDC as the responsible agency with the NAMC as the secretariat, as before. But, at the same time, the MOPH was undergoing its own reorganization which altered the role of BATS from one of the principal coordinating body to a lesser, vague role with limited interaction with NAMC. Neither the DDC nor BATS has as their vision serving as a national authority in technical and policy areas of AIDS. Instead, they see their role as pioneering best practices through pilot efforts. The NAMC, while under the management of the DDC, has only five

technical staff, which is too few to manage the full range of coordination tasks in a timely manner. They convene occasional meetings of stakeholders, but these are irregular. This is the context which has led to this current situation of unsatisfactory AIDS policy development, coordination and M&E in an effective and efficient way.

At the field level, the implementation structure consists of the Provincial AIDS Committee (PAC). The degree of effort and implementation depends on the secretariat in the provincial health office (PHO) – which primarily consists of the Disease Control Section and certain provincial administrators – and by the participation and interest of the governor and deputy-governor. These key players are responsible for integrating implementation, mobilizing resources, and coordinating interventions with the local administrative organizations (LAO). The LAO involvement is still limited however, and mostly consists of a few pilot projects here and there. The routine system and mechanisms in planning, policy and budgeting that extend to field implementation are still too weak. Despite the inputs of the GF program, the style of implementation is still in the form of isolated pilot efforts which don't lend themselves to integration into the routine system and, as a result, achieve low coverage.

The M&E system is still not well-formulated, lacks continuity and is not systematically applied to improve implementation in practice. Thus, most of the national evaluation comes from the HIV prevalence surveillance systems. There is no organized system to look at the direct outcomes of interventions at the field level by time period, information that is crucial for improving the NAP Plan. There is no system for objectively evaluating the separate strategies of the Plan, nor is there any proposed means of collecting such data. There is no routine supervision and monitoring of the AIDS Plan or measures. The only systematic reporting is the bi-annual report on progress toward achieving the UNGASS indicators. There is no system for soliciting the opinions and problems of the implementing agencies at the provincial level. The agenda of the meetings of the NAC sub-committee on Coordination, Planning, Budgeting, Control and M&E has no item for discussing problems raised by the PACs. The supervision system of the MOPH does not include AIDS indicators. Despite the Cabinet resolution to integrate inspection implementation among the core ministries, this is not widespread or sustained, and there is no mechanism to receive and apply the result of supervision and inspections to improve performance.

1.6.2 Approaches for implementing the different strategies

The structure for implementing the components is different, with implications for effectiveness of operations. In the area of management of treatment and PMTCT there is a clear structure for policy, management and services, directly related to the clinical care system, with budget support from the NHSO, and technical support from the MOPH. This has resulted in a high level of effectiveness and efficiency of treatment, with continuous improvement in coverage of the eligible populations.

Table 2: Advocating AIDS policy by component

Assessment results of overall HIV/AIDS response in Thailand

Component	Policy	Structure	Implement ation	Data System	Budget Allocation	Knowledge manage- ment
1. Integration	+	+	+	-	-	-
2. Prevention						
• PMTCT	++++	++++	+++	++	++++	++++
• General Pop.	-	-	+	+	+	-
• Adolescent	++	+	++	++	+++	+
• Specific Pop.	+++	+	++	+	+++	++
3. VCT	++	++	+	++	+++	++
4. Care & Treatment						
• Treatment	++++	++++	+++	+++	++++	++++
• Care&Support	++	++	++	+	++	+
5. AIDS Rights	++	+	++	-	+	-
6. Research	+	++	+	+/-	+	+
7. M&E	+	+	+/-	+	+	+

However, the structure for HIV interventions in the general population and special sub-groups is the same structure as was applied by the numerous agencies conducting the original interventions, in addition to the MOPH itself. Many of these agencies do not have AIDS as their principal work area, nor do they have reliable budget support for these activities. Thus, coverage in this area is still limited and progress is irregular. Technical support to these agencies to improve effectiveness of operations is also unsatisfactory. This is reflected in the data on condom use and needle-sharing which show that the outcomes are still not achieving the targets for HIV prevention behavior in the Plan period. Despite the call for accelerating prevention to reduce new HIV infections by half by the end of the Plan period, no supplemental budget was allocated, except for the Coordinating Center for Development HIV Prevention Approaches and Mechanisms, which had leftover budget from unutilized treatment expenditures which they applied to prevention. But these activities were ad hoc and ended when the funds ran out.

The structure for the component on rights protection is general and mostly focused at the central level and large provincial urban centers. There is little diffusion of this to the Tambon and community levels. Thus, there are limited channels to file grievances of rights violations, and little data to document these. There is little effort to educate the population about AIDS rights. Health providers throughout the country have been given orientation on patients' rights issues; but this orientation may not have fully covered the aspect of PLHA rights as patients. A sub-committee for AIDS Rights Promotion and Protection was established in 2011, but they had met only once at the time of this evaluation. Their strategic approach is still not clear, other than making sure that PLHA understand their rights. There is very little budget to support this component.

The structure for AIDS research is the traditional structure for research, which includes the universities, technical institutes, under the MOPH and other sectors. This includes the National Research Council which defines research needs. But there is still no national coordination of research, or central mechanism to apply research results efficiently. Most of the research is clinical and medical. Research into prevention and behavior change is sporadic and scattered, lacking continuity, with minimal evaluation at the outcome level. Funding for research largely comes from international donors. Domestic research is small in scope. There is more research

focused on the vulnerable populations such as MSM. But there is less research on youth and adults in the general population.

Evaluation of the various components has weaknesses. There is a lack of clear indicators for prevention and control of disease, at the level of the country, province, district, Tambon, and community. There are indicators for treatment as defined by the NHSO, but there are limitations in compiling data or providing an overview of progress in improving implementation. Correct knowledge of key AIDS awareness indicators is still not widespread.

Participation of Civil Society, not-for-profit NGOs is through representation on the PACs and in implementing prevention programs to close gaps in coverage and improve continuity of services. Much of this activity is concentrated in the target areas of the GF funding, and mostly in the areas of prevention, control, care and treatment. There is very little activity on rights.

1.6.3 Strategies at the provincial and local levels

The strategy for AIDS implementation at the provincial and local levels is partly a function of the structure of the routine government service system through the various line ministries. The efficiency of implementation depends on the nature of the plan and support system from central counterparts. In fact, the budget from the various ministries for provincial-level activity is very limited, when considering the number of population in need. Some activities are part of GF-funded pilot activities. Others come from within the provinces themselves, as promoted by the governor or PHO, for example. The provincial AIDS plan is modeled after the NSP but lacks specific strategies at the provincial level which reflect and are tailored to the local context (with the exception of some provinces).

The mechanism for coordination and integration among the implementing partners is through the PAC, with the Disease Control Unit of the PHO as the secretariat. The results from the case studies of five provinces for this area are summarized in Text Box 3 below.

Table 3: Strength of the strategy to advance AIDS work and results of implementation at the provincial level

Assessment results of the provincial mechanism to responsive HIV/AIDS in five case-study provinces – the assessment of provincial mechanism strengths

Issues	A	B	C	D	E
Provincial AIDS Subcommittee					
• Chairman	+/-	+/-	+	++++	++
• HIV/AIDS team of PHO					
- Administrator's participation	++++	+	-	+++	+
- Number of staff	5+4	3+2	3+2	3	2
- Staff Continuation	++++	++	+++	+++	+++
- Staff capacity in					
○ Data management	++++	+++/+	+++	++++	+
○ Coordination within MOPH agencies	++++	+++/+	++	+++	+++
○ Coordination with other agencies	++++	++	++	+++	+++
○ Coordination with LAO	+	+	+	++++	++++
○ Coordination with Civil Society/NGOs	++++	+	+	++	++
○ Formulation and management of the provincial plan	+++	-	-	+	+
- Internal management system of PHO	++	-	-	+	+
Collaborations of other organizations	++++	+++	++	++	+

Assessment results of overall HIV/AIDS response at the provincial level

Component	A	B	C	D	E
1. Integrations					
• with agencies outside the MOPH	++++	++	+	++	+
• with local administration organizations	++	++	+	++++	+++
2. HIV/AIDS Prevention					
• PMTCT	+++	+++	+++	+++	+++
• General Pop.	-	-	-	-	
• Adolescent	+++	+++	+	+	++
• Specific Pop.	++++	+++	+	+	+
3. VCT	+	+	+	+	+
4. HIV/AIDS Care & Treatment					
• Treatment	+++	+++	+++	+++	+++
• Care & Support	++	++	++	++	++
5. AIDS Rights	++	+	-	-	+
6. Research	++	++	-	-	+
7. M&E	+++	++	++	+++	+
8. Data management for HIV surveillance	++++	++	++	+++	+
9. Provincial HIV/AIDS plan	Yes, both provincial AIDS plan and provincial development plan	No	No	No, but has PHO strategic AIDS plan	No, but has provincial strategic map for AIDS

The information shows that the key components which influence coordination of implementation encompass three dimensions: (1) Leadership of the province including the governor or deputy-governor; (2) The responsible agency for AIDS in the PHO which manages central coordination and advances implementation; and (3) Presence of other supporting organizations including AIDS NGOs, and active PLHA support groups.

If the leadership of the province (i.e., the governor or deputy) has the interest, information and understanding of AIDS implementation, this can stimulate action and coordination of resources from various agencies in the province. In the five case-study provinces, interest and motivation declined over the Plan period. This is attributable to the diminished information on the severity of the epidemic and the general belief that the crisis was over. Other problems, such as drug abuse or economic hardship acquired higher priority. There was also a lack of clarity of government policy in this area.

With respect to the work of the PHO, it was found that there were different levels of effectiveness of performance, depending largely on the following factors: (1) Participation and interest of the PHO administrators or experts and technical section chiefs, who could spearhead development of guidelines for internal coordination or integration of various AIDS projects, with linkages to the other provincial offices; (2) The capacity of the AIDS implementation team which depends on the number of staff assigned directly to AIDS work, continuity and experience these staff in AIDS, skill in data management, ability to translate data, skill in coordinating with other units in the PHO and management offices at the district, Tambon and LAO levels, and with Civil Society. These skills are important to sustain implementation, improve quality, and develop innovative approaches which are tailored to the local context and challenges.

The support agencies, such as NGOs or PLHA support groups, can help in facilitating access to the target population which is hard to reach. These could be other PLHA or youth, laborers, or foreign MW. The GF has supported these agencies to work with the vulnerable populations in collaboration with the PHO. However, most of the activities are still of a project nature, and designed to address the objectives of the donor.

Implementing mechanism related to AIDS at the Tambon and local level: The local administrative organizations (LAO), community leaders, village health volunteers (VHV), and Tambon health outlets are the key players in this area. Most of the activity is AIDS prevention with the general population and youth, rather than a specific project. The LAO pay the monthly stipend to PLHA, support the activities of PLHA support groups in self-health care, promote risk behavior reduction and safe sex, etc. Most of the activities are general, such as orientation for community health volunteers and the local community on/around World AIDS Day, or supporting youth sports activities. But there is limited understanding of effective AIDS interventions at this level and limited acquisition of new information. There is lack of clear central support, whether in the area of budget, staff, or technical support. The exception to this is those areas receiving support from the GF or other technical agency.

The scope and diversity of implementation of AIDS prevention and control at the peripheral level depends on the vision and interest of the local leaders of the LAO and community at large. Also important is the level of concern and motivation of the PLHA groups in the locality.

1.7 Results of implementation to address the AIDS strategy

Strategy 1: Management for integrating AIDS into related sectors:

This evaluation found that there has been very little development of the system. Most of the designated implementing agencies have different operating mechanisms and separate lines of accountability. There has been no integration or linkage of plans among the government entities. Where there is some integration this occurs in pilot project sites in local areas funded by the GF, but with very little coverage. There has been no macro-development at the central level even though the plan specifically calls for this integration. No agency has developed an efficient integration of the work, and there is vague budget support for this. There is a lack of strategic managers who understand the concept of integration, and there is no strategy for controlling the policy to steer it in the right direction, both within and outside the MOPH.

Strategy 2: Integration of prevention, care, treatment and reduction of impact on the target population

Implementation of prevention in the care setting, and prevention of mother-to-child transmission (PMTCT) has attained over 90% coverage, and is provided on a continuous basis, through a clear system of operations. However, prevention activities for the general population and the various HRG have still not reached the target, despite the lack of any significant reductions in the budget from all sources. There is a lack of effective strategies for coordination and management at the national, provincial and peripheral levels for this area as an independent effort. Each related agency operates in its own traditional area of responsibility and has not received enough technical support, knowledge management, research and evaluation, and innovation development.

The national mechanism for advancing implementation, coordination and management of the AIDS prevention program in the various target populations is imperative. At present, there is a subcommittee for accelerated prevention of HIV/AIDS with these responsibilities. However, performance in the past three years has concentrated mostly on management and approving project budgets for projects in support of the program. There has not been any visible accelerated advancement of the agenda to increase efficient implementation in the appropriate direction.

Civil Society is an important ally in implementing the prevention component of the national strategy, especially in the area of outreach to vulnerable populations and high risk groups. At present, most of the support for Civil Society in this area comes from international donors, and most of this external support is from the GF. This introduces an element of uncertainty and threatens the ability of the program to sustain core interventions.

In the area of care, this evaluation found that coverage of ARV drugs in Thailand increased steadily during the plan period. By 2009, 76% of eligible PLHA were receiving ARV drugs, and most clients were adhering to the regimen and treatment resupply visit schedules. There are clear standards of quality service. There is a structure for services and support through the routine system from the central level to the sub-national regions, provinces and the community. There is a large number of diverse members of the service network, who are been participating together to improve care since the beginning of the epidemic. There has been a continuous program of clinical research to inform the knowledge base and for exploring models of management. Care and treatment with ART has been integrated into the National Health Security scheme which has a clear structure and lines of support. In addition, the implementation team at the peripheral level has received capacity building and technical support on a regular basis, and there are cadres of PLHA peer leaders who assist with services and M&E which have been active for at least the past ten years.

Interventions in the socio-economic sphere have the structure, budget and implementing agencies to take on the task. But most of the activity is passive and minimally responsive to plan requirements. Projects and budgets that are allocated, and the development of the system to accommodate PLHA or those adversely impacted by AIDS, is still not specifically focused. There is

some development of models and standards of services but there is a lack of continuity and no strategy for monitoring and control. There is no unified database or other compilation of data which would clearly show the impact of the work, or how well the intended beneficiaries are accessing services. Most of the data from the implementing agencies is about general support and inputs.

Strategy 3: AIDS rights protection

There are no empirical data on AIDS rights protection which could reflect progress in this area over the past four years. The strategic plan specifies a policy and guidelines for implementation, but there is a lack of legal provisions and activities that are consistent with the direction and intention of this strategy. The management strategy is lacking, and services to protect rights are mostly at the central and provincial levels, and which are hard to access by the persons in need. There is no clear host agency for implementing this component and for conducting surveillance of rights violations related to AIDS. The staff of the relevant agencies still lack adequate knowledge in the area of AIDS, sexual and reproductive health rights.

Strategy 4: Monitoring, evaluation, research and knowledge management for prevention and control of AIDS

The structure and mechanism for monitoring and evaluation (M&E) of the NAP includes the definition of indicators at the central level. However, implementation has been limited in the past period. The NAMC is the mechanism which should drive implementation in this area does not have the requisite capacity, both in management and technical areas. Further, there is no unified system of monitoring implementation of the overall and sub-strategies. The mechanisms at the central, regional and local levels are not clear and lack a database which reflects the status of implementation regularly over time. Even though there is a task force assigned to develop a national AIDS M&E system, the process is only at the early stages Most of the existing data come from the national surveillance and epidemiological systems, and this does not cover newly-emerging risk populations. The budget to support data collection has declined, and this presents a challenge for assuring the accuracy and quality of the data. There are no data which show the results of implementation or quality of the prevention service system, or coverage of AIDS rights protection. There is a partial system for monitoring clinical care and treatment, but it is not yet easily applicable into guidelines for improving quality. Some of the data lack accuracy or credibility, and there is duplication.

There is utility of the epidemiological data to assess status as a method to inform preliminary planning, but not for monitoring progress, or for informing modifications to the plan. Nor can these data be effectively used at the provincial level.

The various measures in the NAP that are related to M&E include the improve of the structure and network of M&E allies to include target groups, strengthening of the epidemic surveillance network to reflect the status at the various localities, and building capacity in M&E. But these are still at the preliminary phase of implementation.

In the area of research and development, overall, this has been successful up to a certain point. The effort to mobilize resources and coordination among the partners for AIDS research, both domestic and international, is significant since the formal allocation of domestic budget for research is only 0.2% of GDP. Yet, there is no strategy which presents a unified direction for research and support for research which addresses national problems. In the past, the research has been mostly supported by external donors. There has been a lack of research on efficient prevention and spread of HIV, including applied research into more efficient service models.

Part 2 Summary of Evaluation Findings

2.1 Achievement of objectives

1. Access to the core program of HIV prevention is still not optimal because the data do not show increasing trends for most components (the exception being HIV screening of pregnant women and PMTCT). Access to ARV therapy has increased significantly over time.

2. From this review of the data, the trends of behavior change in select targeted populations have not reached levels that would meet the criteria of the AEM model projections in order to reduce HIV incidence by half. These populations include FSW, MSM, PWID, and persons engaging in casual sex. As for discordant couples, there is insufficient data whether the requisite behavior change has occurred to satisfy the prescription of the AEM model projections.

3. From data on the situation and risk factors for HIV among the population age 15 to 24 years, despite the declining trends of HIV prevalence, there is the potential for a resurgence of the epidemic due to the fact that the younger cohorts show persistent vulnerability in the area of AIDS knowledge and HIV prevention behavior (i.e., condom use) which have not improved satisfactorily, and while sex behavior has not declined.

2.2 Efficiency and effectiveness of the 2007-11 NSP

From the range of data collected in this evaluation, it can be concluded that there have been limitations in Thailand's application of the National AIDS Program strategy to address the AIDS problem efficiently and effectively. Even though the Plan covers the essential programmatic areas and target populations, it falls short in specifying the direction for the implementing partners or guidelines for adjusting implementation so that it betters matches the strategic vision. Implementation of the Plan has maintained resources at a flat level for most agencies, though some experienced declines in support. There were notable budget increases in the area of treatment, but those new resources were not the result of this Plan. There was supplemental funding from the GF in the area of prevention and which addressed components of the Plan. However, most of this was for continuation of existing initiatives; there was no evidence of longer-term preparations for sustaining the support system, financing, organizational management and technical assistance.

The Plan is monolithic in that the content does not differ across different contexts or socio-epidemic environments. HIV prevalence differs considerably in different parts of the country, as does the risk environment for spread (e.g., areas with tourism, cross-border population movements, or certain rural areas).

The factors affecting degree of efficiency in implementation of the Plan include the following:

a) The Plan content does not specify clear guidelines for implementing partners on the direction or how to translate the Plan into action. There was too little communication with the relevant individuals in how to use the Plan. Thus, implementation was in proportion to the interest and awareness of the given implementing partner. In general, during the Plan period, interest in the AIDS problem has declined. The M&E system of the Plan is vague. There is a lack of indicators and a database to track implementation for comparison with the implementation plan. This makes it difficult to determine the degree of accomplishment, and the data are not timely enough so that they can be of use in correcting implementation.

b) There was confusion in the area of Plan integration across various projects; there needs to be clearer understanding and concrete action. The Plan content specifies the development of guidelines for integrated management, but these were not applied in practice.

c) The support systems for Plan implementation were not clear, including the budget, M&E, and knowledge and skills capacity building for staff. This is partially attributable to the government reform of program financing, changes in the management structure in the MOPH and other ministries, and devolution to local administrative organizations. The management strategy for the Plan was not clear enough. Thus, adaptation to these external changes was inadequate or not timely.

d) The opinion of the key informants in this evaluation was that the most important aspect of the Plan was the budget authorization it generated. They did not view the Plan as a conceptual framework for implementation, or as a way to build organizational capacity in translating the Plan to organizational strategy and action. There are major limitations in this area at the provincial level. The provinces were not clear how to convert the Plan to action. While they adhered to the general strategic categories in prescribing activities, implementation was mostly just a continuation of what went before.

2.3 Are the existing structures and practices, both at the national and sub-national level (province, sub-district) supportive (or non-supportive) to effective planning, coordination, resource allocation/mobilization, implementation, monitoring, evaluation and reporting of the national response?

Implementation of NAP plan is still centralized in terms of management and directives, as it was in the past. This is in spite of the fact that there is no longer an AIDS earmark. There is no support for the regional and local levels to have the capacity in planning and implementation that is consistent with the local challenges. But the devolution and integration process requires that there be this local capacity in order for the national AIDS response to be successful. This applies across sectors, ministries, departments and other related agencies at all levels.

At present, the structure and implementation strategies are facing challenges in the area of translating policy into action, plan coordination, and M&E of implementation. This is particularly the case in the area of prevention and control of disease and rights protection. By contrast, the system for medical care and treatment has a clear structure and monitoring system. However, there are gaps in the ability of the Program to monitor quality of implementation. Coordinating and integrating the Plan strategies with the activities supported by GF funding have been limited, resulting in some confusion and gaps. There is not as much mutual support of these two components as there could be. The implementation structure of AIDS work at the peripheral level is the same system that was in place before. At present, there has been little development and support for this system in the area of AIDS, and thus, there is limited capacity to respond, and limited coverage of those in need.

2.4 Are policies, plans and implementation practices at all levels facilitating quality services and equal access to prevention, treatment, care and support for all in need?

The strategy and implementation for quality control in the Plan were unevenly implemented in practice. Some areas (e.g., treatment) had regular quality-control inspections. Other areas had little quality-control (e.g., prevention, care, support), or none at all (AIDS rights).

National policies that have emerged in the five years from 2007-11 include many important initiatives and measures to improve quality of and access to services, especially for the HRG. These include the policy for harm reduction for IDU, and AIDS-in-the-workplace policy to ensure equal AIDS rights of the workforce, and full coverage of prevention. Despite the fact that these favorable policies are in place, implementation in support of them has not been optimal. Thus, there is limited achievement of the targets in some of these areas.

Establishing client-friendly services is an important initiative under the NSP strategy to improve access, coverage and up-take of prevention and VCT services. However, these services are not yet intense enough, and are not always properly aligned throughout the system, to ensure that the target population has the option to receive client-friendly services.

The NSP and response assigned priority to specific vulnerable populations. This may have contributed to gaps in services for the general population who had similar levels of need and were overlooked during the outreach efforts.

Part 3 Policy recommendations

From the findings of this evaluation which contained reviews of existing documents, interviews key stakeholders, and brainstorming with key informants, the evaluation team offers the following recommendations to address the national AIDS policy demand in various areas:

3.1 Roles in formulation of the National AIDS Strategic Plan (NSP)

Findings from this NSP assessment indicate that in the context of decentralization whereby financial resources and decision making in resource allocation are made at the provincial and district levels, the centralized policy planning approach tends to be ineffective and unsuccessful. Lack of earmarked budgets for HIV/AIDS at the central level results in the inability of the country to achieve the objectives and expected targets stated in the 2007-2011 NSP. In addition, strategies and targets of the NSP are likely to be ignored by authorities at the provincial and district levels due to lacking sense of ownership and inadequate participatory process. Thus, no matter how well formulation of the NSP 2007-11 plan was, without genuine participation and sense of ownership of the implementers at provincial and district levels, the targets and objectives of the plan are difficult to be achieved. Thus, following recommendations are offered for consideration in the preparation of future NSP plans:

Model A: There is an urgent need to change roles of the central authorities in policy planning, target setting, directing programs and monitoring achievements. This should be aligned with the national and international targets, rather than using considerable efforts and resources in detailed planning and policy formulation at the central level. In addition, greater participation

of all sectors and key stakeholders at the central, regional and local levels in the national planning process is vital to ensure their common understanding and application of the national plan to the local context. The central authorities need to adjust their roles as a supporter of planning at the regional and local levels, including resource mobilization to support planning and implementation at all levels.

With the new roles in policy planning and implementation, the central agencies should receive adequate budget for epidemiological surveillance, surveys and monitoring the high-risk and specific groups of the populations, including funds for research and development. In addition, there should be an increased role in monitoring and evaluation of implementation at the provincial and regional levels.

Model B: The central authorities define the content and scope of the NSP in a way that is inclusive, with clear targets for implementation. However, the central authorities should emphasize the process of translating the plan into action at the provincial and local levels, since this has been weakness of previous plan implementation. Also, there should be clear roles in policy planning among different agencies, with the budget framework, and prioritization of budget allocation in supporting implementation of the NSP.

3.2 Structure, mechanisms and process of policy development and coordination

3.2.1 National level

There should be improvements in the flexibility of the National AIDS Committee (NAC) and NAMC. The NAC should include elements which help it keep pace with the changing environment, and should consider adding key institutes and agencies such as the NHSO and the Social Security Office, among others. In addition, there should be improvements in management of committees and mechanisms of the secretariat, both in terms of the positioning of the secretariat (i.e., whether it should be under the MOPH or an autonomous agency). This will improve the ability to adjust itself with any changing environment. The implementation team responsible for management and technical support needs to have the requisite skills to provide continuous and effective support for policy development and coordination.

To support the mechanisms for national policy development, better definition and improvement in capacity in this area, including the original agencies in and outside the MOPH is needed.

3.2.3 Provincial level

The PCM is still an important mechanism for plan coordination and integration of AIDS projects at the provincial level. However, communication about the problems of AIDS implementation between the provincial and national committees requires an improvement. Also, adequate budget for supporting activities of the PCM on a continuous basis, and mechanisms at the central level for monitoring and evaluating provincial implementation are needed.

In addition, the central role of the secretariat of the PCM and role of coordinating implementation falls under the PCMO, as has been the case over time. Some provinces manage this role well. However, there is an increasing shortage of skillful and experienced staff to carry out these tasks. This function does not receive any direct financial or technical support on a regular basis. Mostly, the support comes as part of special projects such as those funded by the GF.

Another important problem is the unclear indicators for M&E. There is a lack of joint indicators which reflect the problems among different localities. Most indicators focus on the status of disease incidence and prevalence in the population, and do not explain the impact of implementation from the various projects. Thus, it is recommended that there should be a comprehensive plan for improving capacity of the provincial coordinating bodies, and a plan for supporting on-going implementation. The senior managers of the agencies should play an active role in plan coordination.

3.2.3 Local level

Support for AIDS implementation at the local level has been in the form of pilot projects with limited coverage for years. Apart from the unclear operation plan at the national level, the periphery still lacks a process for summarizing lessons learned as a basis for knowledge management to develop implementation guidelines. Thus, it is recommended that provincial and national agencies need to conduct a review of lessons leaders in various dimensions which focuses on the activities of the LAO and their responses to AIDS. There is a need for a framework for basic implementation, and implementation guidelines which are tailored to the locality, including plans for knowledge management and capacity building of staff of LAO in AIDS planning through the country. There should be collaborative implementation with the LAO so that they learn to set minimum targets for budgeting for AIDS, including an implementation framework. The Tambon Health Fund partially financed by the NHSO and LAO is another source of finance for improving the AIDS response at the local level.

3.3 Planning process

The planning process for the 2007-11 NSP is quite extensive and covering the prescribed responses to AIDS in various areas. This includes implementation of risk analysis. However, capacity to manage and prioritize implementation of the plan is weak. There is a lack of specification of clear guidelines for plan implementation and M&E. Thus, the results of implementation are not always optimally aligned with the objectives and targets. There should be modifications in the strategic plan in accordance with changing circumstances and structures. This is especially needed in order to align the plan with the decentralization movement and other social development measures, which are currently not clearly synchronized. It is recommended that, for future plans, there should be an analysis and review of data on factors related to socio-cultural values and norms, in addition to the focus on epidemiological data, including data on good practices and challenges in implementation in the field. This will enable a synthesis of the information into a strategy for implementation that is concrete, and which serves as a clear framework and guideline for implementation. The roles and responsibilities of the various allies and related agencies need to be clearly defined.

3.4 Translating policy and planning into action

This evaluation included data collection from the field. The evaluation team found that the principal agency with responsibility for overseeing conversion of NAP content into action at the provincial level is the NAMC. However, there is no discrete mechanism for translating the plan into action. There is a lack of process in building motivation or guidelines for translating the strategic plan into action at the field level. There is an inability to integrate the national strategic

plan with the local plans of the periphery as a framework for defining the direction of implementation in the various localities. There is a lack of budget to support the process. At the same time, some localities do not give adequate importance to AIDS and have no plan or project for implementation. Some sites had not conducted any brainstorming or meetings to discuss how to conduct implementation according to the NAP. Thus, the implementation of the AIDS response at the different localities could not be expected to progress very well toward the targets.

Thus, the NAMC and central authorities – especially the NAC – should involve each sector – especially at the provincial and LAO levels – to play a greater role in the process of national planning, and support the development of provincial plans that are consistent with the plans at the other levels. In addition, there should be capacity development at the provincial and local levels in collaborative coordination and planning at the peripheral level in order to the integrate the provincial and local plans to address the important health problems, including the reduced spread of and risk behavior.

In addition, there should be central budget for capacity development of management and strategic planning on AIDS at the national and provincial levels in view of the changing roles of strategic management agencies as part of the devolution process. These agencies need to have a strategy to facilitate implementation mechanism, M&E, and innovation development, including budget support from the various agencies.

3.5 Budgeting

This evaluation found that the allocation of budget to the various sectors needs to be based on a foundation of quality data, and evaluation of efficiencies. This will improve and inform policy and investment decision-making that is consistent with the context of the problem and status at the national, provincial and local levels. Most of the AIDS budget still emphasizes medical care and treatment at the expense of health promotion and prevention (75% of the total AIDS expenditure). And nearly 85% of national AIDS expenditures from all sources goes toward care and treatment. Thus, the future NAPs should set targets for increasing the proportion of the budget for prevention of HIV spread.

Despite the fact that the overall expenditure for AIDS has not declined over time, the allocation of the budget under decentralization has become dispersed, and is no longer centralized under a single center or agency. Funding for AIDS has been lumped into categories for integrated spending in various sectors at the different levels. In many localities, AIDS is not considered a priority and, thus, funds that might otherwise have gone for the AIDS response are now programmed to other areas. Thus the PAC and PCMO, in its role as secretariat should monitor the allocation of budget in accordance with public health priorities in the periphery to ensure alignment with the NAP and other related plans.

In addition, in consideration of the context of decentralization in which funds for AIDS are subsumed under regional and agency budgets and integrated with other sectors, the NAMC and the DDC should received some direct budget support for implementing key activities such as improving the epidemiological data and surveillance system among high-risk groups and special populations, M&E, and development research, including responding to urgent necessities as they arise.

GFATM funding

In the various sectors, budget for implementation of AIDS prevention and the response in special population groups is mostly from the GFATM (GF). This has both plusses and minuses for the process of budget monitoring and evaluation, in view of the following:

a) The GF is a source of temporary funding, and which overemphasizes indicators of activities, and this inhibits sustainability of interventions or projects which require a longer-term effort to achieve impact. Sometimes, these GF-funded activities are not appropriate to the different and diverse local contexts.

b) Most of the GF-funded activities do not strengthen the health system for a longer-term response.

Thus, it is imperative that the Thai health system and NAP urgently consider reducing dependence on GF funding over the longer-term. There need to be changes in the laws and regulations to allow use of domestic budget to cover all areas of needed prevention in the special populations, including funding of NGOs which implement outreach to access these special populations.

3.6 Management for the integration of AIDS into the various sectors

The integrated strategy for AIDS prevention and response, policies, strategies and measures of the different sectors (in the MOPH and outside the MOPH) at the central, provincial and local levels, are being inadequately implemented due to the lack of a principal, host agency to oversee action. There is a lack of control, monitoring and evaluation of outcomes of implementation according to the plan.

Thus, there should be policies at the national or ministerial level for coordination of policy, plans, projects, and activities for AIDS prevention and response for the various ministries and related agencies at all levels.

3.7 AIDS prevention

This evaluation found that the implementation of AIDS prevention has achieved significant progress – especially in the area of PMTCT, and prevention of transmission in the clinical setting. However, prevention in the various target populations has not been adequate to achieve the targets due to lack of effective mechanisms in overall prevention management. There are constraints of management of prevention at the national, ministerial and provincial level. There are constraints of technical mechanisms. Much of the budget to support implementation of prevention in the various groups comes from the GF, and this is not a sustainable source of funding.

Thus, there needs to be improved and clear mechanisms for managing prevention at the joint strategic level. There should be accelerated improvement in the technical system, knowledge management, and evaluation to enhance implementation of prevention of disease and risk which are effective among the various vulnerable populations, and achieve full coverage. Importantly, there is a need for better preparation of the budget to support prevention in the absence of GF funding.

3.8 Care, treatment and social support

This evaluation found that implementation in the area of socio-economic support has a structure, budget and responsible agencies for the task. However, most of the implementation is in the area of care and treatment because the structure and system for these services from the central to the provincial and local levels is well-developed with a strong network ever since the beginning of the epidemic. There has been extensive clinical research to improve services and drug regimens, and ART has become a part of the package of covered services under the national health insurance scheme. There is a clear structure and budget support for the clinical care component. Although efforts have been made, there is no system for evaluating the process and outcomes of socio-economic services for PLHIV due to limitations of data and indicators of the coverage and success of these services. Thus, future NAPs need to improve the system of M&E in the area of socio-economic support for PLHIV.

3.9 AIDS rights protection

Over the past four years, there have been only slight improvements in AIDS rights protection. The NAP includes measures but lacks policy, law and implementation guidelines that are aligned with each other. In addition, there is a lack of management mechanisms, lack of principal host to guide implementation, and lack of surveillance of violations of AIDS rights. In addition, many implementing staff lack understanding of AIDS rights, sexual rights and reproductive health rights.

Thus, it is imperative to conceive, study, research and develop measures for rights protection in the context of Thai society and the technical systems to implement this to improve clarity. There should be improved mechanisms at the community level for PLHIV groups, volunteer groups, LAO, and service providers at the sub-district and district levels so that they are clearly knowledgeable about AIDS rights. In this way, the concepts can be converted into action. There needs to be improvement in the system of reporting and monitoring of the status of AIDS rights protection, and changes in the laws to facilitate improvement of AIDS rights protection in Thailand.

3.10 M & E for AIDS prevention and response

This evaluation found that the data for many of the indicators were not available or were not collected, or were unsystematically stored. This made it very difficult to assemble data to create a complete picture and overview. Existing data were incomplete, inaccurate or not consistent with the activity. When the results are not according to the target, it is not possible to make accurate modifications to the work plan. This reflects the inability to apply the plan. The mechanisms for M&E of the strategic plan and policies are not well-prepared or part of a unified system. Thus, the existing data could not be properly assembled or arranged for time-series tracking.

Most of the available data come from the periodic reports to UNGASS in accordance with the required reporting indicators. It is noteworthy that, in the area of prevention, data are mostly outcomes, whereas data for treatment are more likely to be outputs. In the area of AIDS rights, research, and the M&E system are not able to produce indicators with data to monitor the situation. This reflects the problem of the data system and monitoring system.

Effective use of the existing data is hindered because there is no unified system of storage or access at the national level. Data are disbursed among pilot projects, or clinical data are located in the NHSO, which only covers those PLHIV who are eligible for insurance under that scheme.

Thus, there should be improvements in the mechanisms and system for M&E on a sustainable basis for monitoring policy implementation, evaluation of efficiency and effectives of projects more than just monitoring of the status of the epidemiology in certain sentinel populations. There needs to be a mechanism for managing supervision and monitoring implementation at the provincial and local levels that is clear. There is a need to specify concrete indicators for M&E including improvements to the database for M&E. There need to be feedback loop mechanisms after monitoring to support or modify the implementation plan to improve progress to the targets of the plan or policy.

There needs to be improvement of M&E of outcomes and impact as specified by UNGASS by strengthening the data management system to inform the indicators in the different areas and with better coverage. The data need to be available in a time series to track trends. There need to be data on AIDS rights protection and social assistance. There should be new improvements in collecting data and increasing accuracy. There need to be mechanism for analysis and conversion of the data for application in improvements to implementation guidelines to increase efficiency, coordination and indicator development at the various levels so that they are linked and used for decision-making.

3.11 Data system

There should be improvements in the data sets and data collection in various areas as follows:

a) The data system for surveillance of HIV incidence/prevalence needs to include new population groups such as youth and MSM, and needs to improve coverage, continuity and use for systematically assessing the status;

b) The data system for social indicators and other risk factors, in addition to data on condom use, needs to include proxy indicators for achievement in AIDS prevention. These data should be able to help assess success of implementation and should be collected on a regular basis. These should include data on socio-economic impact for use in developing new prevention strategies;

c) Data for M&E of implementation in the area of rights protection and social assistance are needed which are accurate and reflect the actual situation;

d) There is a need to improve mechanisms for coordination and control so that there is a set of data for strategic decision-making on a regular basis and which are timely. There should be a mechanism which links M&E at the national, provincial and local levels.

AIDS Policy Evaluation

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