

**Special Report of Thai Civil Society:
Monitoring the National Response to
The Declaration of Commitments on UNGASS-AIDS 2001**

**The Implementation of Sexual and Reproductive Health Related Policies
Focusing on
Prevention of Mother-to-Child Transmission**

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Abbreviations

| | |
|--------|---|
| AIDS | Acquired Immuno Deficiency Syndrome |
| ANC | Ante Natal Care |
| ARV | Antiretroviral |
| ART | Antiretroviral Treatment |
| AZT | Zidovudine |
| CD4 | CD4 T lymphocyte or Helper T lymphocyte |
| CS | Civil Society |
| HIV | Human Immunodeficiency Virus |
| MOPH | Ministry of Public Health |
| NGO | Non Governmental Organization |
| NVP | Nevirapine |
| PLHA | People Living with HIV/AIDS |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PPW | Positive Pregnant Women |
| SRH | Sexual and Reproductive Health |
| UNGASS | United Nations General Assembly Special Session |
| VCT | Voluntary Counseling and Testing |

I. INTRODUCTION

A major challenge of HIV/AIDS situation in Thailand recently is the increasing rate of HIV among young people and particularly women. The ratio of HIV+ women to men has significantly increased from 1:7 in the early day to 1: 2.5 in 2005. From 2002, the morbidity of female youth from AIDS at age of 15-19 years has been higher than male youth at the same age (2:1). The youth groups at 15-24 years tend to have a high level of unsafe sex. According to the national behavioral surveillance survey (BSS) conducted by the Ministry of Public Health (MOPH), the percentage of youth having ever had sex is increasing, and with low condom use. This unsafe sex correlates with the increased incidence of HIV infection among youth and unwanted pregnancy as well. As a consequence, transmission to infants will continue and may increase.

At the end of year 2007, 324,790 cases of AIDS and symptomatic HIV infection were reported to the division of epidemiology. Of these, 85,398 are women from 15-45 years, 29,499 are youth (from 15 -24 years) and 13,076 are children under 15 years living with AIDS because of the transmission from mother to child. The sentinel surveillance of pregnant women attending ANC clinics has found that HIV has gradually decreased from 1.71% in 1997 to 0.84% in 2007 (Division of Epidemiology, MOPH, Thailand, December 2007).

Although Thailand succeeded in responding to HIV/AIDS epidemic, this success does not guarantee that the HIV epidemic will come to a halt. In particular, the roots of the problem still exist and have often been overlooked by many programs. Furthermore, information and government campaigns in the past 20 years have caused social misperceptions that have brought about fear and negative attitudes towards people who are infected or living with HIV/AIDS (PLHA). This has become a barrier, and has separated the PLHA from their community, thus wasting their potential to contribute to society due to stigma. Many PLHA dare not disclose their health status, leading to more unintended negative consequences such as further transmission, limited accessibility to treatment or other forms of support. This has contributed to the increasing rate of HIV infection among young people and women, particularly housewives. Finally this has resulted in more infections of children.

The majority of HIV positive women face more difficulties in life, many carrying more burdens after their husband dies. Moreover, stigmatization from their own communities prevents them from participating in everyday activities that are part of normal life. In addition, the inadequate information hinders accessibility to treatment, ARV, or appropriate counseling and other support activities in relation to the HIV/AIDS epidemic and impact mitigation.

Prevention of Mother-to-Child Transmission (PMTCT) in Thailand

Around 800,000 women give birth annually. About 12,000 infants are born at risk for HIV annually. If there is no intervention, one- third of infants born to HIV-infected mother become infected. Approximately 3,600 infants will be infected (Bureau of Health Promotion, Health Department, 2004). In 1994, the clinical trial ACTG 076 of the United States demonstrated the success in reducing transmission from mother to her child, but this protocol is not feasible for the developing countries due to the cost and complexity of regimen. Therefore, the Bangkok study (Shot-course AZT trial) was conducted in Thailand during 1994-1996. The study was a success. The transmission rate from mother to child decreased from 25-30% to 8%¹. As a result, Thai Ministry of Public Health conducted a pilot project on prevention of mother-to-child transmission (PMTCT) during 1997 to 1999 in the northern and northeast parts of Thailand in parallel with PHPT-1 perinatal trials.² As a result of the success of its pilot project and other trials conducted in Thailand and elsewhere, the Ministry of Public Health (MOPH) launched a national policy and program on PMTCT, and implemented this starting in 2000. The program covered only voluntary counseling and testing (VCT), AZT treatment for pregnant

¹ Talawat S, Dore G, Le Cœur S, and Lallemand M (2002) *Infant feeding practices and attitudes among women with HIV infection in northern Thailand*, AIDS CARE, Vol. 14, No.5, pp.625-631

² Lallemand M,etal. *PHPT-2Nevirapine plus zidovudine to prevent perinatal HIV in Thailand*

women and infants, and formula milk for infants.³ The PMTCT policy and program has been modified as new knowledge is gained. At present the PMTCT service has expanded to cover the period after delivery by providing care and necessary support for infected mothers and their family including spouse and children. This program was called PMTCT Plus (PMTCT+). Three main service activities include VCT, care during pregnancy and in labor service, and care and support after delivery.⁴ At a glance, the PMTCT+ has impressive outcomes as seen in reduction rate of mother-to-child transmission.

Amidst the success of several HIV/AIDS policies and programs, there are many strengths, shortcomings, and gaps that can be found in their implementation. This can be seen through the peak of HIV infections in the early years of the AIDS epidemic in Thailand, the dramatic decrease since 1992, and then a rising trend of new cases of HIV infection at present. In response to UNGASS Goals regarding participation of civil society in monitoring the national response to HIV/AIDS in sexual and reproductive health after the declaration of commitment on UNGASS-AIDS 2001, this study was conducted to provide visibility to the gaps and to the existing potential of the country in order to effectively face the feminine side of the HIV/AIDS pandemic. This monitoring study has the standpoint of civil society's perspective on policies that affect HIV/AIDS and sexual and reproductive health. The main focus of the study is the policy implementation process and the concretization into public services.

Study objectives:

1. To collect essential data for monitoring the implementation of the national sexual and reproductive health policies in response to HIV/AIDS in Thailand after the declaration of commitments on UNGASS-AIDS 2001.
2. To analyze key issues affecting the success, failure and challenges of the policy and its implementation in order to promote advocacy work with the government based on the findings.

Scope of the Study:

1. This study is a qualitative study aimed at finding the gap between the expected goals and implementation process. This monitoring study places an emphasis on civil society's point of view in response to national policies on HIV/AIDS, specifically regarding sexual and reproductive health (S&RH) policies and implementation.
2. Civil society in this study includes people living with HIV/AIDS (PLHA), community-based organizations, NGOs and academics working with the study-related issues. In order to fill the gap between the defined policies and their implementation, the study also includes viewpoints from government officials both at policy making and implementation levels. Officials of local government agencies working on HIV/AIDS are also included as the focal point of the administrative structure in local settings that playing a greater in the local context of PLHA and AIDS.
3. Under the S&RH policies on HIV/AIDS, the main activity selected to be focus of the study is Prevention of Mother-to-Child Transmission Plus (PMTCT+). In order to study the whole process of PMTCT+, inputs from PLHA and health service providers are reflected through three main activities i.e. Voluntary Counseling and Testing (VCT), PMTCT care during pregnancy and delivery, and care and support after delivery.
4. Key UNGASS civil society indicators applied in the study are coverage, reach, access, care, quality, effectiveness, and participation. Impact of related activities to implement the policy is also critical and was analyzed.

Study area:

The study area covers the implementation process of the main selected activities in 9 provinces of 5 parts across the country. These are as follows:

³ Ministry of Public Health, *National Guidelines for the Clinical Management of HIV Infection in Adults and Children*. 6th ed. Nonthaburi, Thailand, Ministry of Public Health: 2000

⁴ Ministry of Public Health, *National Guidelines for the Prevention of Mother-to-Child Transmission and Care for Infected Mother-Child and their Family*, Department of Health, Bangkok: 2007.

North: Phayao, Lumpoon
 Northeast: Uboratchathani, Srisakes
 East: Trad
 Central: Suphanburi, Ayudhaya
 South: Nakornsri thammarat, Pattalung

In addition, as the center of policy and implementation administration, Bangkok was also the focus for data gathering via in-depth interviews with ministerial officers, academics, and NGO representatives.

Samples and sampling:

Samples: Key informants in this qualitative study are divided into 4 main groups i.e. PLHA who are people affected from the policies and also being health service receivers, health personnel and local staff as implementation practitioners, ministerial personnel and academics as policy makers, and NGO representatives as partners in the HIV/AIDS implementation process. All groups of the mentioned people are in the selected study areas.

The total of samples is 195 key informants. These are:

| | | |
|--|-----|--------|
| Infected pregnant women | 108 | people |
| Community and provincial hospital staff | 23 | people |
| Provincial health staff | 19 | people |
| Staff of local administrative organizations | 22 | people |
| Officials at Policy and Administrative Level | 6 | people |
| Representative of NGOs | 12 | people |
| Academics | 5 | people |

Sampling: The selection of key respondents in the study area is mostly deterministic. The reasons for including the various groups in the sample are as follows:

1. *Infected pregnant women:* These women are people living with HIV/AIDS who are directly affected by the implementation of the national health policy on HIV/AIDS. The group is also classified into 3 sub-groups i.e. pregnant women who *just learned about their infection after going for ANC service*, pregnant women who *already knew* about their infection before their pregnancy, and women who were *infected at the second or third pregnancy*.

The approach to conduct in-depth interviews with these women groups requires two key conditions: their infection disclosure and their willingness to give an interview. These positive pregnant women (PPW) can be reached by their participation in group meetings at the hospital and/or the list of their disclosure for home visits from their PLHA network. For cases who are not in the list, these women can be accessed by chance if they come to receive certain services from state hospitals.

2. *Health personnel and local staff:* This group is also divided into 3 sub-groups according to their responsibility in relation to the implementation of S&RH in the study areas. Specific selection is made on crucial positions in the structure of the service. These are health personnel working on HIV/AIDS and mother and child health at provincial health office, health personnel working in ANC clinics at provincial and community hospitals, and local government staff in three levels of the local government structure working in relation to HIV/AIDS or support to PLHA in the local areas, namely Tambon Administrative Organization (TAO), Municipality, and Provincial Administrative Organization (PAO).
3. *Ministerial personnel and academics:* This group is specified to gather data from people who are responsible for the S&RH policy in response to HIV/AIDS at the ministry level. Academics in this field are also named to be approached for interviews according to their roles in assisting the policy making process, and availability of giving the interviews (see details in appendix B).

4. *NGO representatives*: This group is focussed on representatives of NGOs that work in relation to HIV/AIDS and the S&RH policy. List of related NGOs is made and then the samples are selected from their active performance on the related issues as well as their availability for giving the interview (see details in appendix B).

Duration of the study:

| | |
|--|------------------------------|
| Interview Guidelines preparation | November 2007 |
| First study team meeting for field work | November 2007 |
| Data Collection | November – December 2007 |
| Second study team meeting | December 2007 |
| Additional data collection | January 2008 |
| Draft study report preparation | December 2007 – January 2008 |
| Study presentation at the National UNGASS Forum, Bangkok | 16-17 January 2008 |
| Third study team meeting | January 2008 |
| Final study report | January 2008 |

Limitation of the study:

1. Due to time limit and financial constraints, this study is limited to monitoring UNGASS goals only on the national policies and implementation in relation to S&RH that respond to HIV/AIDS in PMTCT.
2. There are some gaps of data collection from in-depth interviews in the study areas. These resulted from the following constraints.
 - Social stigma still persists for PLHA, thus making access to all groups of PLHA difficult. Middle and high income groups of PLHA therefore cannot be accessed by this study.
 - Most data collectors are also PLHA in each study area. Although this is the good bridge to gain the trust of the PLHA to talk about their life and the effect and impact of PMTCT service, skills in data collection may vary from person to person. This constraint, to some extent, limits the interpretation of the acquired information.

In order to cope with the above constraints in this study, working group meetings and discussions were arranged. The first step is to clarify the objectives, data collection method, and clarification of required information, feedback and discussion concerning the topics for in-depth interviews in the field. The second meeting of study team was organized after first round data collection. Discussion of collected information was conducted in parallel with the PLHA network experience in each study area. The third study team meeting was conducted to reaffirm the corrections and interpretation of the study outcomes, and also to clarify more information needed to be obtained by re-interviews for some cases.

Key concepts:

Goal 54 – Prevention

“By 2005, reduce the amount of HIV infected breast fed babies in about 20%, and by 2010 in about 50%, offering to 80% of all pregnant women prenatal services with information, psychological support, and other HIV prevention services, growing the availability of efficient treatment to reduce the transmission of the virus from mother to child and giving access to treatment for HIV infected women and babies, and offering access to treatment for HIV infected women that are breast feeding, as well as efficient interventions for HIV infected women that should include psychological support and the voluntary and confidential testing services, access to treatment, particularly the antiretroviral therapy and, when appropriate, to the substitute of breast milk, and a continuous series of attention services;”

Thai National response to UNGASS goal 54:

Prevention of Mother to Child Transmission PLUS (PMTCT+): Related policy, activities, and work procedures that can be done in order to prevent HIV transmission from mother to child. In local practice, this means the whole process given by state hospitals for pregnant women. Three main activities include pre and post counseling, voluntary counseling and testing, support and care during pregnancy, during labor service, and after delivery including the provision of breast milk substitutes.

Pre and Post Counseling: Counseling services provided for pregnant women before blood testing and after receiving the result of the test. Essential information about protection, prevention and care of HIV/AIDS infection as well as psychological support are expected to be given at the counseling service.

Voluntary Counseling and Testing (VCT): Pregnant women receive a blood test for HIV infection by personal consent, and their test result will be kept and used confidentially.

Care for Infected Pregnant Women: Care provision covers ART and other medical necessary treatment provided for pregnant women during their pregnancy, in labor service, and after delivery. Important information about treatment and side effects as well as possible alternatives in personal care or other PMTCT+ channels should also be sufficiently provided.

Support for Infected Pregnant and Child: All forms of necessary support including economic, social, psychological and breastmilk substitutes for the new born child.

Monitoring UNGASS civil society indicators⁵

- *Adequateness:* Does it provide the answers for the problems considered critical by civil society?
- *Reach:* Does it include all different types of people affected by the problems the policy tries to solve?
- *Coverage:* Does it reach the most amounts of people affected by the problem?
- *Civil Society Participation:* Are there, in fact, representatives from civil society, specially the epidemic's most affected populations, involved in designing, monitoring, and evaluating the proposed actions?
- *Access:* Do people who need services get them at ease, or are there challenges?
- *Care:* Do people feel well received, respected, and respected in their rights?
- *Quality:* Do people get their needs fulfilled?
- *Effectiveness:* Does it happen in practice? Does it have a budget? Are there trained human resources for its implementation? Does it have a communication strategy for reaching civil society?

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Research Tool for Monitoring Sexual and Reproductive Health after the UNGASS-AIDS Goals, developed by LACCASO and ICASO, Panos, 2007.

II. Findings

Background information of key informants:

According to data collected from the study areas, the following table shows basic information of key informants in this study. Basic information of positive pregnant women (PPW) is summarized in table 1 while key details of each study area are presented in Appendix C. Table 2 provides information about key informants who are health service providers and other related people in the study.

Table 1: Basic information of PPW divided by group

| | Group 1 | Group 2 | Group 3 | Total |
|-----------------------------------|-----------|-----------|-----------|------------|
| Total PPW in each group | 42 | 46 | 20 | 108 |
| Age Less than 20 yr. | 2 | 0 | 0 | 2 |
| 21-25 yr. | 4 | 6 | 2 | 12 |
| 26-30 yr. | 17 | 13 | 6 | 36 |
| 31-35 yr. | 11 | 19 | 8 | 38 |
| 36-40 yr. | 6 | 5 | 3 | 14 |
| More than 40 yr. | 2 | 3 | 1 | 6 |
| Education | | | | |
| No Education | 1 | 1 | 2 | 4 |
| Primary school | 19 | 31 | 10 | 60 |
| Secondary school | 11 | 10 | 5 | 26 |
| Grade 12 and/or vocational school | 8 | 4 | 2 | 14 |
| Bachelor degree | 3 | 0 | 1 | 4 |
| Occupation | | | | |
| Farmer | 6 | 8 | 7 | 21 |
| Laborer | 23 | 27 | 8 | 58 |
| Housewife | 8 | 7 | 3 | 18 |
| Merchant | 0 | 1 | 1 | 2 |
| Others | 5 | 3 | 1 | 9 |
| Income baht/month | | | | |
| No information | 11 | 7 | 5 | 23 |
| Less than 2500 | 13 | 20 | 7 | 40 |
| 2501 – 5000 | 10 | 15 | 8 | 33 |
| 5001 – 7500 | 4 | 2 | 0 | 6 |
| More than 7500 | 4 | 1 | 1 | 6 |

Table 2: Basic information of key informants from related organizations

| Groups of key informants | Total | Female | Male |
|--|-------|--------|------|
| Public hospital staff | 23 | 23 | 0 |
| Staff of provincial offices | 19 | 14 | 5 |
| Staff of local authority | 22 | 19 | 3 |
| Officials at policy and administrative level | 6 | 5 | 1 |
| NGO Representatives | 12 | 10 | 2 |
| Academic | 5 | 2 | 3 |
| Total | 87 | 73 | 14 |

Key Characteristics of Positive Pregnant Women in the study

Positive Pregnant Women (PPW) in this study are divided into three groups in response to the reality of PPW attending prenatal care. Although these PPW have some things in common other than being positive pregnant women, there are many key characteristics that differ from the others. The common and differences among these PPW are presented below.

Similarities:

- being a positive pregnant woman,
- hiding their positive status from their husband,
- no negotiation power about condom use,
- no knowledge about contraception,
- mostly depend upon husband in economic terms.

Differences:

Group I: PPW who just learned about their positive status after going for ANC

- Mostly are newlyweds couples, their husbands are their first sex partner.
- The couple intended to have a baby. There is a greater percentage of planned pregnancy than the other two groups.
- Their husbands are more likely to be HIV-positive than in the other groups.
- Nearly all of PPW in this group thought that HIV/AIDS is beyond their risk and far from their involvement.
- After knowing about their positive status, PPW in this group have difficulty in accepting the blood result. They did not want to tell the result to their husband. The ones who do so are tentatively ending up with family problems and many cases are breaking up with their husbands.
- Intention to have an abortion is higher than the other groups.
- PPW in this group receive more sympathy from health personnel than the second group.

Group II: PPW who has knew about their infection before going for ANC

- Present husband of PPW are mostly a new partner.
- PPW do not disclose their positive status to the new partner, while the new partner wanted to have a baby.
- PPW have more unplanned and unwanted pregnancies because of the knowledge that they are living with HIV/AIDS.
- PPW in this group receive complaints from health service providers. A common scolding that this group of PPW hear is the question “why did you let yourself get pregnant when you are already infected!”.
- Health service providers give less information about PMTCT+ to these PPW because they believe that PPW in this group should already know the information.
- After disclosure of their positive status to their new husbands, those men are tentatively more accepting of the result more than spouses of the other two groups.

Group III: PPW who were first infected at their second, third or fourth pregnancy

- Most characteristics are similar to the PPW group 1, except these PPW already have had children. They were not infected at their preceding pregnancy.
- Unplanned pregnancies are mostly the result of inadequate knowledge about contraception and unaware of being at risk of HIV transmission.

In addition to comparative characteristics among groups of PPW in this study, the following table show data collected for each group. Some data will be used for discussion in later parts of this study.

Table 3: Information of PPW divided by study groups

| Related Information | Group 1 (n = 42) | | Group (n = 46) | | Group 3 (n = 20) | | Total # | % 100 |
|--------------------------------|------------------|-------|----------------|-------|------------------|----|-----------|--------------|
| | # | % | # | % | # | % | | |
| Marital status | | | | | | | | |
| Living together | 29 | 69.05 | 41 | 89.13 | 15 | 75 | 85 | 78.70 |
| Separated | 11 | 26.19 | 4 | 8.70 | 4 | 20 | 19 | 17.59 |
| Husband dead | 2 | 4.76 | 1 | 2.17 | 1 | 5 | 4 | 3.70 |
| Present husband is new partner | 9 | 21.43 | 26 | 56.52 | 6 | 30 | 41 | 37.96 |
| Husband's blood result | | | | | | | | |
| HIV negative | 4 | 9.52 | 7 | 15.22 | 5 | 25 | 16 | 14.81 |
| HIV positive | 20 | 47.62 | 13 | 28.26 | 7 | 35 | 40 | 37.04 |
| Unknown | 18 | 42.86 | 26 | 56.52 | 8 | 40 | 52 | 48.15 |
| Readiness for | | | | | | | | |
| Planned pregnancy | 23 | 54.76 | 12 | 26.09 | 6 | 30 | 41 | 37.96 |
| During pregnancy | 29 | 69.05 | 39 | 84.78 | 15 | 75 | 83 | 76.85 |
| After delivery | 31 | 73.81 | 42 | 91.30 | 16 | 80 | 89 | 82.41 |
| Abortion wanted | 18 | 42.86 | 10 | 21.74 | 10 | 50 | 38 | 35.19 |
| Induce abortion | 3 | 7.14 | 3 | 6.52 | 1 | 5 | 7 | 6.48 |
| Infection disclosure | | | | | | | | |
| To husband | 33 | 78.57 | 42 | 91.30 | 17 | 85 | 92 | 85.19 |
| To relatives | 29 | 69.05 | 37 | 80.43 | 14 | 70 | 80 | 74.07 |
| To community | 12 | 28.57 | 30 | 65.22 | 6 | 30 | 48 | 44.44 |
| Latest child's HIV status | | | | | | | | |
| Negative | 24 | 57.14 | 27 | 58.70 | 7 | 35 | 58 | 53.70 |
| Positive | 1 | 2.38 | 1 | 2.17 | 2 | 10 | 4 | 3.70 |
| Unknown ⁶ | 17 | 40.48 | 18 | 39.13 | 11 | 55 | 46 | 42.59 |
| Satisfaction toward PMTCT+ | | | | | | | | |
| Acceptable | 35 | 83.33 | 35 | 76.09 | 17 | 85 | 87 | 80.56 |
| Unacceptable | 7 | 16.67 | 11 | 23.91 | 3 | 15 | 21 | 19.44 |

Reflection towards PMTCT+

This study analyzes information according to the process of PMTCT+ implementation in state hospitals, both at the community and provincial levels, in the 9 provinces of the study areas. The PMTCT+ process is divided into three parts according to main activities under the implementation guidelines i.e. a) Voluntary Counseling and Testing, b) Care during pregnancy and delivery, and c) Care and support after delivery (see details in MOPH, *National Guidelines for the PMTCT+*, Bangkok: 2007). The findings are presented in the same analytical frame work i.e. main activities, expected results, outcome, comments and additional information from infected pregnant women, who receive the PMTCT+ service, and hospital health staff, who are health service providers. Gaps among the process are addressed at the end of each part. Conclusions regarding the UNGASS civil society monitoring indicators will be presented thereafter.

⁶ The unknown status of these children is mainly because of the children's age ranging from a month to less than one year and a half, during which confirmation of HIV infection is difficult.

A: Voluntary Counseling and Testing (VCT)

Main Activities:

- Pre counseling
- Blood Testing for HIV, VDRL (Syphilis), Hct (Hematocrit), HbsAg (Hepatitis B), and
Thalassemia.
- Post counseling

Expected Results:

- Pregnant women have an opportunity to access information about HIV and are able to consider their risk, impact and its elimination possibility, as well as are able to make decisions for receiving the blood test.
- Pregnant women get psychological and social support from the counseling process.
- Husband of PPW should also receive VCT.

Outcome:

- All pregnant women receive pre counseling in a group. The hospital provides individual pre counseling in cases of pregnant women who have a positive result and require a second test for confirmation of the result. The majority of positive pregnant women (PPW) receive individual post-test counseling after the second test is confirmed.
- All PPW know about the HIV test but are not aware of other blood tests. Only few know about the syphilis blood test and its result. Very few cases know about the other blood tests.
- After knowing the positive result, 38 cases would like to have an abortion. After receiving information about PMTCT+, only 7 cases induced an abortion and only one case was able to terminate her pregnancy. Means of inducing abortion reported from PPW are taking pills to perform their own abortion, going to an abortion clinic and or deliberately neglecting their pregnancy i.e. hard physical labor and poor nutrition.
- Main reasons for giving up the idea of abortion are
 - o Decreasing worries about HIV transmission by information about PMTCT+.
 - o Encouragement from husband, relatives or counselors,
 - o Afraid of sin,
 - o Pregnancy is too late for a safe abortion,
 - o Fears, and
 - o Do not know where to go for inducing an abortion
- Post counseling has positive effect on PPW by helping them to accept their infection, providing psychological support and PMTCT+ information.
- Some PPW, however, have bad impressions of the post counseling service. These include:
 - o Not enough information to reduce negative impact from disclosure of their HIV status to their husbands. Many PPW have family problems as a consequence. Out of the majority had negative impacts in the family, 19 cases have broken up with their husband. All of these PPW reaffirm that their infection came from these husbands.
 - o Six PPW are unable to accept their positive blood result and have bad impressions about post counseling service. These PPW did not go back to ANC but will wait until delivery to go for another health service.
 - o Nine PPW are not confident in their HIV status confidentiality.
- Only three PPW were able to persuade their husband to come for pre-post counseling.
- Out of 108 interviewed PPW, only 6 couples report 100% condom use. In all of these couples both the man and woman are infected.

Comments and Additional Information from PPW:

- All PPW think that HIV blood test is a kind of unavoidable procedure for ANC. Nobody knows that they can opt out of the test if they are not ready for it.
- A majority of PPW, or about 81% of 108 cases, has a good impression with the pre-post counseling service, and state that the psychological support is quite good and PMTCT+ information is very useful. Evaluation criteria for this service are from encouragement, useful information and confidentiality. Two out of three factors of the criteria are present for acceptance of a good quality counseling service.
- Acquired information from pre-post counseling include information on prevention of mother to child transmission, condom use as means of prevention, disclosure to husband. In addition,, some low-income cases received extra financial support for traveling expenses.

- There are differences among study areas about the counseling service and the impressions of PPW. The better practices can be seen in the northern and eastern parts of the country while poor services seemed to be more in the northeast and south.
- PPWs in group 2 are mostly scolded by nurses about their knowing HIV positive status but still getting pregnant. PPWs in this group feel that they are wrong in doing so. One felt so miserable about her pregnancy, and induced an abortion because of the complaint. In general, PPW have no other choice but to be patient to receive needed care service from the hospital.
- Problems encountering VCT in PPW's views are: no appropriate setting for counseling service (in particular in the northeastern and southern areas), inappropriate verbal expression of health staff and the lack of some needed information such as safe places for an abortion, results of other blood tests. Some PPW think that the time allowed for counseling is not enough.
- PPW needs for improved VCT include requests for couple counseling and means to persuade men to come for VCT at the same time with their wife at ANC. PPW feel less able to negotiate condom use with their husband, and most have difficulty disclosing their blood result to their spouse.

Comments and Additional Information from Health Service Providers:

- Implementation of VCT follows the guidelines of Ministry of Public Health. Two blood tests are used with ELISA for confirmation of the result.
- Most nurses on duty do not believe in reproductive decisions by PPW. Many are disappointed with the repetition of PPW's pregnancies.
- They realize that most men are excluded from the PMTCT+ process. Although they admit that working with men has become difficult task, requirements are made for the expansion of VCT to cover men whom are spouses of PPW.
- Health staff are aware of the sensitivity of HIV positive disclosure by PPW to their spouses, in particular for ones who may have different blood results. They themselves, however, have no appropriate guidelines to provide useful counseling for this critical situation.
- Health personnel, especially nurses who are appointed to be responsible for counseling, have their own problems in performing such duties. Although they accept its importance, limitation of time and certain skills, for example, talking about sexual related issues prevented them to continue effective counseling. They suggest that PLHA networks may assist in this specific context.
- In terms of abortion, physicians accept the PPW' decision but do not want to provide such service. This is due to an issue of morale and also no supportive regulation for this practice. Doctors are reluctant to provide certain procedures and are concerned about consequences, including going to court. Therefore, they would rather provide information than inducing abortion.
- Capacity building for health staff is quite good in following the implementation guidelines of counseling and ART, but less in areas of rights and communication skill about sexual issues.

Gaps:

- Unplanned pregnancy occurred for nearly 60% of interviewed PPW. Reasons for unplanned and in some cases, unwanted pregnancy, include social factors that are implicit in their lives and their socio-cultural contexts. Many PLHA, either men or women, hide their HIV status from their spouse and this leads to unsafe sex and unwanted pregnancy. This reflects the problem of HIV disclosure, even between husband and wife. It also means PPW and their spouse have less knowledge about prevention and dual protection contraception. In more specific and important causes of the problem, PPW have no negotiation power about condom use for safe sex. These factors become complicated in the context of HIV transmission.
- Although the post counseling may reduce PPW' intention for an abortion, and at the same time, increase readiness of PPW to accept the HIV result and have courage to continue their pregnancy, new PPW entering the PMTCT+ program will continue to rise. This is because the roots of unplanned or unwanted pregnancy still persist in the society.
- There is no awareness of VCT importance for men. Although it is specified in the implementation guidelines, there is no means to include men in the process.
- There is no appropriate guideline for disclosure of HIV status. Since this sensitive issue leads to instability of marriage, concerned people have to fill this gap.
- Because of lack of individual counseling for pregnant women who have negative blood result, they and their spouse will be lost from the PMTCT+ process. This means the system fails to

use this opportunity to provide useful information and raising awareness of couples in continuing to stay negative.

- Some health service providers have misconception about reproductive rights of PLHA.

B: Care during Pregnancy and Delivery

Main Activities:

- Counseling and providing information about PMTCT+ and CARE project.
- Physical check up and giving more concern about opportunistic infection.
- CD4 testing and giving ARV if PPW have CD4 less than 200.
- Providing AZT for PPW who are willing to receive PMTCT service.
- Providing psychological support during labor and deliver NVP+AZT during labor.
- In case of no ANC, providing counseling and rapid test in order to manage ARV intake for the newborn.
- Suggesting contraception following the priority i.e. Female sterilization, **Norplant** and other methods.

Expected Results:

- PPW received useful information for personal care, baby care and able to have safe sex.
- PPW understand usefulness and advantage of taking regular ARV.
- Health staff can provide good and appropriate care for PMTCT as well as managing appropriate labor service.

Outcome:

- PPW receive positive information about PMTCT+ and do not receive information about side effects of medicine. Nearly all PPW are willing to receive PMTCT+ service, except ones who were lost during the VCT process.
- The lost cases of PPW consist of 6 cases that stopped going to ANC and changed hospitals when they need labor service. Another case had her husband to help during her labor at their own home.
- Most PPW have normal labor service, except cases in the north and specific case in Ubonratchathani in the northeast. The later groups of PPW receive **caesarean section (C/S)** by their own extra expense.
- PPW have regular prescribed medicines, as their infants.
- Most PPW chose to use contraceptive pills, but no one knows about the interaction of the pills with ARV.

Comments and Additional Information from PPW:

- Most PPW have a good experience with the ANC service during pregnancy and delivery. All are confident in the service provision and do not know what else they should deserve. PPW who are migrants reported only they are unable to write or read in Thai and this constraint prevented them from accessing more useful information given by the hospital e.g. care manual, leaflet.
- Some PPW in the northeast, specifically in Srisaket Province, and in the south feel they were given service with stigma and discrimination. An example of such a service can be seen in separation of PPW from regular pregnant women, both before and after labor. In addition, some care is given poorly. When they perceive stigma toward them from health personnel, the PPW feel bad about it but feel that there is nothing they can do.
- Many PPW feel uncomfortable when they were asked to have a sterilization. There are many cases willing to do so, but many feel they and their husband may want to have a baby in the future. One case, however, reported that she decided to have a sterilization right after delivery, but is unable to tell her husband about this due to her concealment about HIV infection. Her concern is about the instability of her marriage because her husband wants to have another baby in the future.
- All PPW received guidance to use condom, but it is very difficult to do so. Most of them cannot negotiate with their partner to use it. Only 6 from 108 couples of the study that perform 100% condom use. Problems arise are the attitude toward condoms and misunderstanding about condom used as means of only contraceptive not also means of prevention. This problem is combined with the lack of women negotiation power about sex to men.

- Many chronic stresses pressuring on PPW during their pregnancy because they are unable to disclose their HIV status to their husband.
- Many PPW feel uncomfortable with service setting in the hospital that mostly is not in private. When there are conversations either by counseling or examination, the other patients will learn about their HIV positive status.
- In case of PPW who wanted to induce abortion, the condition may be imposed that they agree to post-abortion sterilization. Some mention that this violates their reproductive rights in the future.
- Many PPW report that some wording is difficult to understand since such wording is in English or are technical terms. For example: follow up, pap-smear, consult, phase I, VDRL.
- The recommendations from PPW include more information about side effects of ARV, taking medication, and alternative methods for delivery of their baby. There are special request for information and guidance about prevention of HIV transmission in case of an infected couple who really wants to have a baby. This should be provided with more sympathy toward them from the health workers, as people who have their own reproductive rights, and are not doing anything sinful.
- In addition, PPW wanted to have some nutritional support for PPW during pregnancy. Most of all, they need psychological support from their own spouse.

Comments and Additional Information from Health Service Providers:

- In providing care during pregnancy and labor, staff try to persuade PPW to undergo post-partum sterilization.
- Nurses admit that they themselves lack skills to talk openly about sex related issues. Also, they do not have enough information about specific recommendations to provide PPW including other possible methods for contraception .

Gaps:

- There are differences in the quality of care provided for PPW in each study area. Discrimination is tentatively high in the northeast and the south while the other places have less stigmatization.
- PMTCT+ places an emphasis more on the child than the mother. Information about side effects of ARV and knowledge about other options of contraception are rarely given

C: Care and Support after Delivery

Main Activities:

- Providing care after delivery and giving more attention for certain symptoms after delivery.
- Providing continuous counseling.
- Regular checking of CD4 levels every 6 months for the mother, and prescribing ARV when their CD4 is less than 200
- Providing breastmilk substitutes for babies in the amount of 4 kgs./month until a child is one year old.
- Blood testing of child for HIV at 12 months and re-test at 18 months.
- Expanding care service to husbands of PPW, giving information and suggestions for personal care, contraception, safe sex, family planning and appropriate nutrition.

Expected Results:

- All PPW and their families receive appropriate care and support after delivery.
- Children who were born from PPW can access breastmilk substitutes and grow up normally as well as being followed up and receiving care and treatment if necessary.
- PPW and their husband have knowledge on family planning and contraception and are able to practice safe sex.

Outcome:

- All new born babies received blood tests according to hospital appointments. Many PPW whom are mothers, however, do not want to go to the hospital because of their concern about disclosure of their HIV status.

- Most PPW or their relatives go to receive breastmilk substitutes, but some do not want to because of the addressed problems. Few of these PPW buy formula for their baby. One case is actively breast feeding her baby.
- In general, most children receive breastmilk substitutes until one-and-a-half years old. In the north, children receive breastmilk substitutes until 5 years old and in the central region at Ayuthaya Province they receive formula until 2 years old, the same as same as in Ubonratchatani in the northeast. Provision of breastmilk substitutes depends upon the health and growth condition of the child.
- Other problem of breastmilk substitutes occurs in case of children who have a positive father but a negative mother, these children will not get breastmilk substitutes though they may have other conditions of infection or transmission if their mother is infected later.
- In most study places, there is continuous care after delivery except in large hospitals where positive cases may be lost from the case referral process after delivery.

Comments and Additional Information from PPW:

- Most PPW agree that provision of breastmilk substitutes is not enough, it should be extended to children until 3-4 years of age.
- A common question in the community is why PPW do not breastfeed their baby.
- Necessary information about abortion and side effects of ARV or contraception are derived from PLHA network as peer education, rather than from health staff.
- PPW request continuous counseling service for couple, for about 2-3 years after delivery. PPW want the nurse or doctor to give information and to tell men about condom use, since men do not believe in this message if PPW are the only ones who inform them.

Comments and Additional Information from Health Service Providers:

- Ministry of Public Health has a policy on accessibility to ARV, but no policy on care after delivery. In general, when a child reaches one year old and receives negative blood test results, both the child and the positive mother will be lost from the system. They will come back when they begin to develop symptoms.
- In their opinion, ARV is not the last answer to the AIDS problems. They believe that if most of the attention is placed on treatment, then the AIDS problem will not be solved.
- At the local hospital level, AIDS is just one piece of work. There is no single unit that is responsible to manage the needed services. Health personnel in the hospital suggest policy coordination in the hospital in order to have well-planned services, and to treat AIDS as other chronic diseases.
- In many cases, health personnel try to give support and help for PPW whenever possible. This can be seen through flexibility to manage breastmilk substitutes provision. However, some PPW use their eligibility to access free breastmilk substitutes from other organizations and make profit by selling this free support to others.

Gaps:

- There are gaps in various steps of PMTCT+ that lead to cases being lost during the process.
- There are differences in terms of attitude and service provision of health personnel, depending on the experience in AIDS problems in each area. This reflects the quality of service given to PPW.
- As seen from flexibility in managing breastmilk substitutes that vary from local hospital to hospital, it shows that certain restriction in the health service setting can be managed if the health personnel have a better attitude toward AIDS and HIV-positive people.
- There is less importance of family planning issues after delivery of PPW.

Additional comments and concerns of related persons working in relation to PMTCT+, HIV/AIDS and SRH in Thailand

- In general, AIDS problems are given attention and importance only in terms of medical and public health condition. There is less understanding to perceive AIDS and PLHA in terms of a life that interacts with socio-cultural and economical factors. This leads to assigning the major responsibility of coping with AIDS to the Ministry of Public Health which is unable to solve problems in a holistic way.
- In accordance with the above perspective on AIDS and PLHA, the problem of hiding the HIV status of positive women from their partner creates problems for AIDS intervention and

- prevention. Combined with unequal rights and negotiation power about sex in women, AIDS prevention becomes more complicated. Without serious consideration of these complex factors, the worsening of the AIDS epidemic in Thailand is unavoidable.
- Health service provision from the state hospital is given to PPW and PLHA through relationship of power from a higher to a lower level. PLHA in general dare not request their rights in health care provision. Some are very miserable with stigmatization and discrimination in health care service.
 - Creating and raising good understanding about AIDS and PLHA in the whole society will decrease societal stigma. Prevention campaigns should come with consideration for the socio-cultural and economical context that will make AIDS a part of daily life, not just only a story of disease and transmission. Responsible prevention campaigns should make use of social stream to create or organize social dialogue among all groups in Thai society.
 - Lately, there are less preventive campaigns since the government sector is placing more emphasis on treatment and accessibility to ARV. Advocacy prevention by NGOs is also in decline due to greater interest in accessibility to ARV and treatment. To some extent, this reflects the need and direct benefit of PLHA networks to directly respond to the issues that are having a direct effect and impact on their life. Prevention is for new infection, not ones who already infected. In terms of prioritizing the management of AIDS policy and problems, there needs to be key active roles from both sides of government sectors and civil society, in particular key stakeholders of AIDS problems. Considering the changing trend of infection without any active advocacy work, the preventive policy should be to make more effort to formulate and implement the program in the society as a whole.
 - At the national level, AIDS issues became less importance due to the changing structure of the National AIDS Control and Prevention Committee, i.e. from prime minister to deputy prime minister as a board president. This has brought the AIDS agenda down to the level of a general issue in government sectors rather than a key national agenda as before. This change is also affecting the commitment of government in relation to policy formulation, monitoring and evaluation.
 - At the implementation level, there is no direct responsible unit for AIDS especially on counseling in local hospitals. This leads to less important work for health staff to pay attention to. Overall, there is no integration of AIDS work in the hospital. Some service settings, e.g. counseling or examination room cannot ensure privacy. The settings in many hospital lead unintentionally to disclosure of HIV status of PLHA.
 - In terms of the PLHA network at the national level, although the network and some potential PLHA can help to care for positive people at the hospital while having group support or home visit activities, there are less potential ones to perform such activities. If a responsible unit could conduct certain capacity building training for PLHA network, some areas of work, especially in psychological support and other supportive activity in PMTCT+, can be improved. Effective cooperation between health service providers and PLHA networks can then be formed.
 - Importantly, PLHA network should reconsider their strengths and their weaknesses including behavior of some PLHA networks that may prevent possible cooperation among them and other related organizations including health service providers in local hospitals.
 - From information derived from the field, some local authorities admit that they do want to provide assistance to the AIDS problem in their own community but, except for providing some financial assistance, they do not know what should be done. Many studies including this one reaffirm that the local authority is generally not aware of AIDS issue and how appropriate interventions should be made.
 - In the near future, there will be decentralization in the Thai administration structure, and local authority will have more power in terms of legal authority and annual budget. Appropriate preparation for good understanding about AIDS and its related issues including capacity building for the local personnel should be prime concerns. This is to enhance their capability that is suitable with the new authority and annual budget power.
 - In terms of R&D, there is no guarantee for any benefits to the PLHA whom participate in the research. There is no concrete procedure for them to eliminate the side effects and other impact that may arise after the end of the project.
 - Develop positive prevention packages including counseling for reproductive health, family planning, sexuality and partner communication for PLHA.

III. Filling the Gaps

As learned from the findings, the implementation process of PMTCT+ reflects not only problems and outcome of the national response program, but also reflects the context of HIV/transmission beyond the PMTCT+ services, including the overlooked issues that deepen the roots of AIDS problems in the country. Specifically, these are the socio-cultural dimensions of HIV/AIDS pandemic which include gender, sexuality, rights in sexual and reproductive health, human rights, and human potential. In order to fill the gaps, existing potential and overall gaps of PMTCT+ process and its context are presented in the monitoring on UNGASS indicators.

Monitoring UNGASS indicators on PMTCT+

- PMTCT can reduce mother to child transmission rate, but not new infected pregnant women. If the problem of new-coming positive pregnant women and unplanned pregnancy of positive women continues, PMTCT is only following the problem of HIV transmission, and will not overcome it. Gaps seen in this complicated problem are concealment about HIV positive status among spouse or partners and less awareness of HIV transmission and its prevention method, particularly practicing of safe sex. Other causes of the mentioned unplanned pregnancy are less understanding of general public in reproductive health especially on family planning and contraception,, and post-partum and continuum of care are not enough in terms of family planning and contraception as well.
- In terms of reach, although all groups of people affected by the HIV problems are recognized, gaps in implementation process have prevented certain groups to be reached, for example pregnant women who have negative blood results. There is not enough post counseling for these women and their spouses in order to have awareness on HIV prevention and to practice safe sex in order to stay negative. The limited participation of men whom are spouses of positive pregnant women is also a key gap in the PMTCT process. To some extent, the lack of men participation in VCT causes family problems when they find out that their wives are infected.
- Overall, the quality of care service as perceived by a majority of positive pregnant women is impressive. PMTCT+ service receivers feel confidence in treatment and confidentiality of health personnel. There is, however, some negative feedback about these. Some have strong sense of being discriminated against and disrespected in their rights. In this context, the differences of health services in different study areas should be taken into account. In addition, there are gaps in terms of the respect to their reproductive rights and their potential to make decisions towards their own reproductive choices. Positive pregnant women need to receive useful information about PMTCT other than only prevention of mother to child transmission. Such information includes ARV and its side effects, delivery methods, sterilization and other means of contraception.
- There is a good designed policy on PMTCT+ to respond to the critical problems in Thai society. Some limitations in implementation, however, means that there is not complete coverage of information about the PMTCT+ to PPW. Only in the northern part in this study did respondents say that they received both negative and positive sides of PMTCT+ and this assisted them to make an informed decision. The PPW in other regions stated that they were informed only about the positive side of PMTCT+ and mostly do not know about side effects or other choices that they can make.
- In general, accessibility of PPW to the PMTCT+ service is designed for all groups. Some obstacles seem to occur because of individual constraints such as travel expense to come for the service. Nevertheless, in many cases, travel expenses for a one-day trip to receive ARV of for positive children may exceed the family budget in one month. Additionally, key points have to be considered when linking with the above coverage in particular, incomplete information given to PPW can be major gaps for their access to full benefit of the PMTCT+ service. Clarification about this can be made through information about caesarian section, and if it has the possibility to prevent transmission to their baby in addition to receiving AZT during normal delivery, the PPW will seek such practice even by their own expense. Such information would also include information on side-effects of ARV and contraceptive pills as well.

- Many community-based groups in particular PLHA networks can participate in the PMTCT+ process in various ways. There is good cooperation among health staff and PLHA network, though some dimensions have to be reviewed for further benefit and effective outcome of this collaboration. In terms of UNGASS monitoring process, civil society takes more role in the 2008 monitoring national report than previous ones. This is the result of the openness of the government sector for exchanging information among sectors. Networks of PLHA at many levels are included in certain parts of the monitoring. Although it may not reflect all activities and all groups of affected populations, this time is the beginning of civil society participation in monitoring UNGASS goals of the country.
- Overall, PMTCT+ policy is a very concrete and effective prevention project of Thailand. It has implementation guidelines and several training processes for each level of health personnel. Although it has less effective communication strategy for reaching civil society, the overall policy evaluation is satisfactory. This is particularly in area of the reduction of mother to child transmission rate. Generally, health service provision is also acceptable. Another strength is the good collaboration among health staff and NGOs and PLHA network. Although there are certain constraints within this coordination in certain areas, it is not major obstacle to overcome.

Policy Recommendations

Filling the gaps of its implementation process would benefit by linking PMTCT+ to the priority of many key issues in further policy formulation process. Main challenges among these issues lie in reproductive rights, gender equity among men and women including partner communication, and relationship of power among health service providers and receivers. Next key steps should be concentrated on the following concerns.

PMTCT+ Implementation

- **VCT**
 - Active promotion on creating knowledge and raising awareness about VCT in all groups of people, in particular youth and people in reproductive age. The campaign should be performed as raising health consciousness for individual basic health care. In the meantime, quality of VCT should also be improved.
 - Setting goals for men's participation in the VCT process at the same time of service to their pregnant wives. Consideration about expenses of blood testing should be one of concerns. Additionally, expanding VCT service to be accessed more easily in the local community and provide opportunity for potential and trained PLHA to assist PMTCT+ process in appropriate steps, for example, supportive pre-post counseling and care during pregnancy and after delivery, group meetings for distribution of necessary information such as sexual and reproductive health, family planning, contraception, and increasing of sexual negotiation power to their partners.
 - Expanding post counseling service for negative pregnant women and their partners in order to provide knowledge and necessary information for them to stay negative.
 - Creating appropriate counseling training curriculum that responds to the combination of gender, sexuality, social structure and power, and economical factors in AIDS and PPW life.
 - Developing counseling guidelines for specific purposes on HIV positive disclosure of PPW to their husbands in consideration of real life situations and gender inequality.
 - Enhancing continuous capacity building of health personnel especially in the counseling unit. Providing case consultants for counselors who may require more guidance and support to release the tension and burnout.
- **Care during Pregnancy and Delivery**
 - Increasing communication skill of nurses and health staff in order to provide specific knowledge and support to PLHA and PPW. The training should cover knowledge and good attitude toward reproductive rights and stigmatization on PPW and other PLHA.
 - Coordinating work with PLHA network in supporting health staff to provide care for PPW during their pregnancy. Possible supportive activities of PLHA network are psychological support to accept the blood result, to cope with community stigma, to learn about side effects of ARV and related useful information to PPW such as care and nutrition for the newcoming baby including for PPW themselves during their pregnancy.

- **Continuous Care and Support after Delivery**
- Extending duration of provision of breastmilk substitutes support to children born from PPW up until 3-4 year of age.
- Raising awareness about safe sex, contraception as well as increasing necessity of family planning and related useful information.
- Providing accessible free condoms in order to use as means of AIDS prevention campaign.

Though PMTCT+ has been quite successful in reducing vertical transmission, it is not achieving the comprehensive 4 prongs of PMTCT according to WHO as it does not address primary prevention, prevention of unintended pregnancies, continuum of care and family planning. Thus for the next step, these remain prongs that need to be addressed.

Integration of AIDS Problems Management

- Increasing and strengthening AIDS prevention campaign under concrete policy and implementation plan as well as budget allocation. Key messages upon this prevention campaign should go for promotion of safe sex, sex ethics, equality in sexual life among partners, including increasing negotiation power of women with men.
- Promoting mass psychological campaign to eliminate stigmatization accumulated in Thai society caused by the fear-arousal approach of previous AIDS prevention campaigns. Key messages about HIV/AIDS, right attitude toward sexual rights, reproductive rights, and safe sex should be blended in a general mass media campaign e.g. commercial spots, photo-novellas, comics, television series or movies. People in this area of work such as writers or script writers should also be of specific target for campaigning and raising understanding and awareness towards AIDS and its related issues.
- Coordinating work with PLHA networks in supporting health staff to provide care for positive pregnant women during their pregnancy. Possible supportive activities of PLHA network are psychological support to accept the blood result, to cope with community stigma, to learn about side effects of ARV and related useful information such as nutrition.
- At the national level, integrating all related dimensions of AIDS problems and cooperating with concerned agencies that are equipped with available supportive budget and capable personnel. The integration should be performed through joint policy formulation and coordinating implementation plan. The integrated policy and implementation plan should also pay attention to other dimensions of AIDS, particularly sexuality and gender, and socio-cultural-economical dimensions, apart from emphasizing on treatment and care.
- Promoting and increasing knowledge and awareness of local authorities about AIDS and its related issues. This is so that, after decentralization, local authorities can manage and coordinate plans and budget allocation for an appropriate response to AIDS and PLHA in their local communities.

Key Issues for Further Study:

- Changing attitude toward sex and sexuality including sex ethics and sex education for youth,
- Planned and Unplanned pregnancy,
- Social stigma and its mitigation,
- Participation of men in PMTCT+ and AIDS prevention,
- Civil participation, particularly participation of PLHA network in PMTCT+ process,
- Holistic view of AIDS problems and its related work,
- Preparation for local authorities to be ready for working on AIDS and its related issues after decentralization.

Appendix A: Study Background

Raks Thai Foundation participated with the South to South cooperation which initiated by GESTOS and supported by Ford Foundation for monitoring UNGASS on sexual and reproductive health. In September 2007, Raks Thai Foundation organized the First UNGASS forum for Civil Society (CS). Twenty NGO representatives and 1 government official participated in the two-day forum. The UNGASS indicators and participation role of CS were discussed and the special report of Thai Civil Society point of view was initiated with financial support from GESTOS and active participation of 17 NGOs and PLHA network in four parts of the country.

This study is conducted as a monitoring process from CS to provide visibility of the gaps and the existing potential of national response to HIV/AIDS. At the same time, this study is one of several comparative studies for monitoring UNGASS Goals among 16 countries around the world⁷.

Data collection in this study is the result of collaboration among NGOs and community-based groups in 9 provinces of the study areas. These are:

- Infected Women Network – North Phayao
- Infected Women Network – North Lumpoon
- Infected Women Network – East Trad
- Infected Women Network – Northeast Ubolratchatani
- Infected Women Network – South Nakornsrithamarat
- Infected Women Network – South Pattalung
- Infected Women Network – Central Ayuthaya
- Ganlayanamitr Group Supanburi
- Pha Sai Wan Swang Group Ayuthaya
- Trad Si Thong Group Trad
- Friends of New Life Group Srisakes
- Tan Tawan (Sun Flowers) Group Ubolratchatani
- Thai national AIDS Foundation Bangkok
- Thai NGO Coalition on AIDS Bangkok
- Thai Network of People Living with HIV Bangkok
- Migrant and Family Organization Bangkok
- Raks Thai Foundation *as a study team coordinator* Bangkok

Appendix B: Key Informants

⁷ The sixteen countries are Argentina, Belize, Brazil, Chile, India, Indonesia, Kenya, Mexico, Nicaragua, Peru, South Africa, Uganda, Ukraine, Uruguay, Venezuela, and Thailand.

Organizations of key informants

Policy and Administrative Level

| | |
|--|---------------------------------------|
| Bureau of Health Promotion, Department of Health | Ministry of Public Health (2 persons) |
| Reproductive Health division, Department of Health | Ministry of Public Health |
| Department of Disease Control | Ministry of Public Health |
| Department of Mental Health | Ministry of Public Health |
| National Health Security Office | Ministry of Public Health |

Academics

Institute for Population and Social Research, Mahidol University
Faculty of Journalism and Mass Communication, Thammasart University
WHO, Thailand
Health Counterparts Consulting
Anjaree

NGOs

Thai Network of People Living with HIV
Thai NGO coalition on AIDS
PSI Foundation (Thailand)
Women Foundation
Friends of Women Foundation (2 persons)
Program for Appropriate Technology in Health (PATH)
AIDS ACCESS Foundation
AIDS Net
Siam-Care Foundation
Planned Parenthood Association of Thailand (PPAT)
Women Health Advocacy Foundation (WHAF)

Appendix C: Key Information of Positive Pregnant Women by Study Areas

| Study Areas | PPW (number) | Latest HIV+ Child | HIV+ disclosure to Community | Planned pregnancy | Abortion wanted | Abortion induced | Case lost |
|--------------------|--------------|-------------------|------------------------------|-------------------|-----------------|------------------|-----------|
| Payao | 12 | 2 | 10 | 5 | 9 | 0 | 1 |
| Lumpoon | 12 | 1 | 10 | 1 | 2 | 0 | 1 |
| Ayuthya | 12 | 0 | 0 | 11 | 4 | 0 | 0 |
| Supanbuti | 12 | 0 | 0 | 4 | 7 | 0 | 0 |
| Trad | 12 | 0 | 6 | 5 | 4 | 1 | 0 |
| Ubonratchathani | 12 | 0 | 4 | 4 | 7 | 2 | 0 |
| Srisakes | 12 | 1 | 9 | 5 | 5 | 1 | 0 |
| Nakornsri thamarat | 12 | 0 | 3 | 3 | 7 | 2 | 0 |
| Pattalung | 12 | 0 | 4 | 8 | 4 | 2 | 1 |
| Total | 108 | 4 | 46 | 46 | 49 | 8 | 3 |

| Study Areas | Breast Feeding | Couple counseling | HIV+ spouse | HIV- spouse | Unknown HIV spouse | Not Confident in Confidentiality | 100% condom |
|--------------------|-------------------|-------------------|-------------|-------------|--------------------|----------------------------------|-------------|
| Payao | 0 | 0 | 4 | 1 | 7 | 0 | 0 |
| Lumpoon | 0 | 0 | 4 | 0 | 8 | 0 | 0 |
| Ayuthya | 0 | 1 | 6 | 2 | 4 | 0 | 1 |
| Supanbuti | 0 | 1 | 10 | 2 | 0 | 0 | 2 |
| Trad | 0 | 1 | 2 | 1 | 9 | 1 | 1 |
| Ubonratchathani | 0 | 0 | 1 | 5 | 6 | 0 | 0 |
| Srisakes | 0 | 0 | 3 | 3 | 6 | 2 | 1 |
| Nakornsri thamarat | 0 | 0 | 6 | 2 | 4 | 4 | 1 |
| Pattalung | ⁸ 1 | 0 | 4 | 0 | 8 | 2 | 0 |
| Total | 1 | 3 | 40 | 16 | 52 | 9 | 6 |

⁸ Newly born child, this case is lost from the PMTCT+.