

Part I

Health services policy and its implementation

As for health services policy and its implementation, three issues shall be explored including (1) Policy for halving the number of new HIV infection cases by 2011 (Half by 2011); (2) Enhancement of counseling services and provider-initiated counseling and testing (PICT); and (3) prevention of mother to child transmission (PMTCT). All three issues will have a significant impact on the implementation and delivery of HIV /AIDS-related health services, in particular in the area of HIV transmission prevention.

(1) Policy for halving the number of new HIV infection cases by 2011 (Half by 2011)

Since 2007 when the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007 - 2011 (2007 – 2011) was launched, efforts have been intensified to implement policy and enhance prevention. The Subcommittee for Advancing the Prevention Program Effort has been set up to work on the reduction of new cases by

half by 2011. Four populations were determined as the Most at Risk Populations (MARPs): Intravenous Drug Users (IDUs), Men who have Sex with Men (MSM), Sex Workers (SWs) and Migrant Workers (MWs). The plan's implementation has been made possible by funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, or Global Fund), from the continuation of the first, and the eighth rounds consecutively. Particularly, in the eighth round, direct funding has made possible working directly with the four target groups. It is clear how policy implementation is geared toward working with these groups.

Civil society claims that the development and implementation of the 'Half by 2011' policy has mostly been based on epidemiology, employing epidemiological tools and formats to calculate and estimate new cases. Emphasis was given to the channels through which the virus is transmitted, in order to highlight populations which feature high prevalence rates. The data is then classified and ranks risk groups and MARPs including the receiving and transmitting of HIV from these to other populations.

Findings derived from employing epidemiological tools and models include projected prevalence rates among various

populations, major conduits for HIV transmission and major populations affected, including: IDUs who share syringes and needles with PLHIVs; have unsafe sex with PLHIVs (both sex workers, MSM); and sex between heterosexual spouses. Based on these findings, preventive measures can be developed, including raising awareness about the infection of HIV, promoting the use of condoms and harm reduction.

It is deemed by civil society that such a policy has been developed hinging primarily on epidemiological knowledge and that preventive measures have then been determined according to different risk groups including the MARPs. Resources and cooperation can then be applied to reduce new cases, but only in the short term; prevention and alleviation efforts are not sustained in the long run.

What epidemiological tools fail to recognize are “sexual orientations that are diverse and mutable”, as expressed through gender and sexuality. The four populations thus constitute diverse sexual orientations which in themselves are diverse, mutable and not subject to biological sex or any fixed sexual orientation. In other words, MSM may not have sex exclusively with other men. They may also have sexual relationships with women and other genders. Meanwhile, sex

workers do not just adhere to one single sexual orientation or sexual relationship. They are also engaged in spousal and other types of sexual relationships.

The epidemiological domain tends to ignore or be less sensitive to the mutable and diverse nature inherent in sexual orientation/identity, and simply focus on promoting sex with condoms as the prevention for HIV infection. What the epidemiology fails to explain, however, is why these different populations, despite knowing how infection occurs and receiving condoms, continue to perform unsafe sex with their hetero-homosexual relationships or in sex work. The answer may be related to the management of “power within sexual relations” which is uneven. Whoever has this power determines whether to have sex or not, to have safe or unsafe sex, to have protected or unprotected sex, to have enjoyable or non-enjoyable sex, or to have forced sex/functional sex/desirable sex. Focusing simply on raising awareness about the causes of infection and distributing condoms will not make the four main populations engage in safe and proper sex.

In addition, the epidemiological approach also fails to address social stigmatization and discrimination as a result of the existing policy and implementation. Those people classified

as most at risk are blamed for HIV transmission. This approach helps reinforce negative attitudes and bias against those who are different from us and simply complicates access to services, and decreasing respect for rights and status.

The policy and solutions concerning prevention should be developed based on broader realms of knowledge covering socio-cultural dimensions and be informed by a rights-based approach. Social and cultural vulnerabilities should be taken into account since they are related to the violation of sexual rights and human dignity as a result of bias and rejection, a lack of respect for diverse sexual orientations, and a lack of power to manage sexual matters. Also, stigmatization, discrimination, isolation and sexual discrimination have made people feel powerless and unable to access the prevention, care and treatment services, making them more vulnerable to infection.

The sexual identities of MSM are not socially recognized. They are largely determined by fixed stereotypical views closely influenced by biological sexual identity. Thus, manifesting sexual differences is not respected and is even used as an excuse to promote dehumanization.

Sex workers find themselves vulnerable in the context of managing their own sex life. This is due to their

marginalized economic power, a lack of safety/security and social welfare from their work and the fixed perception of their sexual identities related to the work they do. As a result, sex workers' sexual identities as well as social status have been ignored, with few attempts made to enable them to have more choices and become stronger.

Migrant workers and IDUs are similarly subject to these fixed and stereotypical attitudes regarding the main causes for HIV transmission, which here too, stems from the exclusive reliance on a medical point of view and a disregard for their diverse sexual orientations/identities.

Such a static view and attitude has been applied with the MARPs, causing them to become more vulnerable. A lack of dynamism and the process of lexicalization have made the identities of IDUs, MWs, MSM, and SWs subject to stigmatization and social discrimination, with the situation deteriorating.

Civil society would like to propose the following recommendations concerning the Half by 2011 policy:

- The state should promote efforts to foster greater understanding for the way of life individuals in each group

have chosen. Their life style choices should be regarded holistically – including their sex life as it relates to culture, tradition, and beliefs – in order to further develop knowledge that can then be applied while working to reduce stigmatization in the areas of prevention, care and treatment. This work should be based on a multidisciplinary approach that covers aspects of epidemiology, social-cultural perspectives and human rights.

- The state should focus on raising public awareness about risk and prevention of risk without pointing to any particular populations, while at the same time it is necessary to work with the different groups in the context of each individual's way of life. In particular, attention should be paid to sexual diversity and respect for human dignity in order to allow everyone to feel safe and lead a happy life in society.

- The state should help civil society work more effectively by adjusting existing laws to allow all individuals and groups to gain access to prevention, care and treatment services. The laws should be reformed to better reflect the concept of human rights, to help promote the decriminalization of drug users, to minimize harassment by state officials of sex workers, and to

remove the perception that love and sex between people of the same sex are abnormal and dangerous.

- Current policy and prevention measures tend to focus on power, sexual inequalities and the eradication of discrimination based on differences in sexuality, gender and ways of leading one's life. Though sexual and reproductive health rights are incorporated, the above-mentioned individuals are still perceived as one of the 'issues' contributing to the perpetuation of HIV transmission, rather than being viewed as human beings whose rights and human dignity must be respected.

- Respect of sexual rights and human dignity should be promoted to enhance sexual health in a way which is safe and suitable to the gender and sexuality chosen freely by each individual.

- Efforts to help various groups and couples practice safe, protected sex, and enjoy sexual health should therefore be based on the notion of "mutable and diverse sexual orientation/identity" and the management of the uneven "power within sexual relations". In other words, "sexual rights" must be respected.

● Funding support should be allocated to promote networking, the strengthening of working potential and greater coordination among working groups. Proposals submitted by the target groups should include the request for funding to provide for capacity building and networking to enhance the dignity of affected groups who themselves would prefer to live a life free of HIV/AIDS like anyone else in society.

(2) Enhancement of counseling services and Provider Initiated Counseling and Testing (PICT)

The promotion of (Voluntary Counseling and Testing) VCT has intensified again after the expansion of anti-retroviral (ARV) treatment in Thailand. It has been implied that VCT shall be promoted to enable PLHIVs and AIDS patients to know of their status sooner and be able to have faster access to care and treatment, as well as to enhance overall prevention of HIV transmission.

VCT services have been developed and implemented in various forms by different actors to achieve better efficiency including mobile VCT and more recently the inclusion of VCT in the country's universal health care package and the

expansion of training in basic counseling among nurses in public hospitals.

Nevertheless, it was found that very few people decide to access VCT services. Thus, another form of VCT called Provider Initiated Counseling and Testing (PICT) has been promoted. In this format, service providers are supposed to convince or persuade clients to request counseling and blood testing. This kind of a practice could have been initiated before.

Promotion of PICT seems to have intensified at the policy level. This is based on the assumption that if many people decide to undergo testing, it would help to speed up the screening process and allow us to discover greater numbers of PLHIVs and AIDS patients. In the context of the goal to identify more people living with HIV, this would increase the efficiency and success rates of medical, treatment and prevention interventions.

In the few years, a study titled “The Potential of Provider - Initiated Voluntary Counseling and Testing in Health Care Setting in Thailand” was published. It was conducted by the Health Intervention and Technology Assessment Program (HITAP) with funding support from the Global Development Network, the Thai Health Promotion Foundation and Health

System Research Institute (HSRI). The study helps to prove that PI(V)CT is successful in significantly increasing the number of those applying for testing. There has been a 50 - time increase of the counseling and testing. It was also found that PI(V)CT makes the per head investment most economical (Yot Triwattananond, 2010). Findings of the study have been presented to policy makers including the National Health Security Office (NHSO).

Reviewing the approaches taken by VCT, VCCT, PIVCT, or PICT, one may find that all these measures or models share similar objectives/needs, including the intent to develop a more accessible, speedy format/channel that helps people use the service and learn about their HIV status sooner so they can prevent further transmission and gain prompt access to treatment. This would enhance the treatment efficiency and reduce mortality rate.

Their differences probably lie in the hidden agenda behind the need to develop various approaches, evolving from VCT to PIVCT and/or PICT, and how the different tools have been used to serve different purposes. If the purpose is to identify PLHIVs and AIDS patients sooner in order to improve control and prevention, PICT should be used. Yet this approach

could also potentially distort the basic aim of VCCT. In other words, the aim may shift in the direction of CCTV (closed circuit television), which strives to monitor and identify those who have HIV/AIDS in order to screen them out. This is similar to recent attempts by the state to screen out those having new strains of flu, with implications of increased labeling, stigmatization, discrimination and prejudice against those found to have the virus and who are classified as clearly dangerous persons.

Though essentially PICT aims to give people choices in treatment and to promote safe behavior, it also aims to increase the number of people registering for blood testing in order to identify as many HIV-positive people as possible sooner. PICT has good intentions: preventing transmission and enabling people to have faster access to treatment.

Nevertheless, this approach may also inadvertently cause rights violations and infringement on an individual's human dignity. It may result in efforts that focus on forcing more people to get tested, simply to increase the number of those applying for testing and to meet the target numbers. This may subsequently affect the quality of counseling, become less sensitive to and take for granted the differences among clients, including their sexual identities and other aspects.

The expectation of having a large number of people getting tested may compel us to ignore the rights of clients to give informed consent and to maintain confidentiality. This is the case when PICT is provided as part of Prevention of Mother to Child Transmission (PMTCT) programs for pregnant women, where the focus is on persuading pregnant women to have their blood tested for HIV in order to get into the PMTCT. This has happened without concern for the pregnant woman's willingness or the consequent impact on her human dignity. The bodies and reproductive health systems of pregnant women who live with HIV/AIDS are simply viewed as a mechanism in the HIV transmission process, the implication of which shall be explained in further sections. Civil society also feels concerned with the purported effort to apply this testing with groups that have been identified by epidemiological means as the groups most at risk.

What is missing in the implementation is perhaps respect for clients' readiness and willingness as well as a genuine decision-making process. The service should be made available to provide for counseling and promoting access to information and knowledge, including the assessment of one's behaviors and chances in order to help individuals address the

vulnerabilities in their lives. They should be allowed to decide whether to undergo testing or not, and service providers should keep any information confidential, respecting the fundamental right of each client.

In order to make VCCT a tool to help clients come to terms with their own vulnerabilities and their risky behaviors, service providers have to develop positive and open attitudes. They should be ready to embrace the mutable and diverse sexual orientations/identities of their clients and understand the unequal power distribution within sexual relations. Services should be provided without stigmatization and discrimination. This will make VCT, VCCT, PIVCT, and PICT tools to effectively achieve the Half by 2011 policy based on the respect for rights and human dignity.

Another important issue is access to VCT among youth under 18 years old. Although VCT services have been included as part of the national universal health care scheme, the offer of such a service to people under 18 is still not possible since it violates the “Guidelines for Medical Persons Concerning HIV/AIDS” (Medical Council of Thailand, 2545). Section 2.4 (on keeping clients’ information confidential and disclosure) provides that should the client be a person who is: younger

than 18; not older than the legal age due to early marriage; of physical and mental disability and not able to understand and make his/her decision at different stages during the counseling prior to the testing, then the seeking of consent and the disclosure of results and counseling after testing must be a matter for his/her parents or custodians

A major challenge is therefore finding a way to improve current methods used to encourage youth to access HIV testing in order to receive subsequent services without breaking the law and serving the best interests of children and youth. Civil society organizations led by PATH have reviewed relevant laws and proposed to the subcommittee for drafting the guidelines concerning HIV/AIDS under the Medical Council of Thailand. The proposal is currently under consideration.

Another major challenge regarding VCT services is that ethnic minority groups and migrant workers still have no access to such services. It could be said that at present, no migrant workers have access to HIV testing.

Civil society would like to propose the following recommendations concerning VCCT policy:

- VCCT should be provided for and delivered alongside efforts to promote access to information, counseling and alternatives in prevention, care and treatment services based on a voluntary and confidential approach, rather than be applied with the goal to force people to get tested for HIV for the sake of prevention and control.
- The measure should not be applied among specific groups due to certain attitudes, stereotyping and bias. Instead, such a measure should be aimed at including all people equally and universally.
- Appropriate and friendly one-stop service systems should be set up and include counseling, condom distribution, reproductive health services, peer group support for PLHIVs and AIDS patients , ARV services, services for pregnant women, and more. VCCT services should be provided to all groups based on understanding of and sensitivity to culture, ways of life and sex life.
- In order to make VCCT accessible to all groups, efforts must be made to regularly provide information and offer

counseling within the community. In addition, more personnel should be recruited and receive training to provide counseling. The counselors do not need to always be governmental officials; outreach work can include civil society representatives, who would be empowered and could function as counselors as per standard counseling procedures. Also, PHAs who participate in the Comprehensive and Continuum of Care Centers (CCCs) in more than 500 hospitals throughout the country should be encouraged to perform VCCT with funding support provided.

- The services should be delivered in the languages or dialects used by migrant workers and ethnic minority groups. Any NGO volunteer or staff who trains as counselor should be considered service providers and they can then be asked to help provide friendly VCCT services among ethnic groups and migrant workers since they speak the same language as the workers and have proper understanding of their culture and society.

- The implementation of VCCT, VCT and PICT should be monitored and evaluated in order to review and adjust National

Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation including the reproductive health and rights protection plan to ensure effective results in decreasing the number of new cases and guaranteeing access to quality care and treatment services based on collaboration between state agencies and civil society.

(3) Prevention of Mother to Child Transmission (PMTCT)

Since 1999 the Department of Health has declared PMTCT part of the national agenda. Over the past ten years, it is deemed by civil society that this PMTCT policy has drawn exclusively on medical knowledge, making issues concerning the prevention of HIV transmission to newborns into a solely medical matter. This is visible in the program name itself, 'PMTCT', which only includes medical aspects while ignoring social and cultural impacts that pregnant women who live with HIV/AIDS experience and the stigmatization that they are the ones who pass HIV on to the newborns. It is suggested that the name should be changed from PMTCT to 'prevention of the HIV transmission to newborns'. While medical aspects are retained, the new title helps to raise social and cultural

awareness and steer people away from condemning pregnant women who live with HIV/AIDS.

As this policy has been implemented along with the expansion of ART led by the Department of Disease Control which began almost simultaneously, we have found the implementation of policy and quality of service delivery unrelated to each other. Our findings reveal a huge gap between the services provided by the Department of Health for mothers and children and the services run by the Department of Disease Control to provide ART in clinics. As a result, a number of women who manage to maintain good health after child delivery and do not need ART, are not informed of ART services, though this information is useful for future planning of possible treatment needs. Though coordination has recently been enhanced, the gap in collaboration between the Departments of Disease Control and Health still exists.

Civil society holds that PMTCT still stresses the protection of the newborn while ignoring the importance of the health of pregnant women who live with HIV/AIDS. This can be observed in the context of the debate around and concern over pregnant women who live with HIV/AIDS, and are recruited into PMTCT programs in order to receive ARVs; some of them have developed resistance to the drug regimen.

Due to advocacy from civil society led by TNP+ and its alliances in 2009, NHSO and the Department of Health have agreed to change the regimen used in PMTCT to a triple-drug regimen to enhance the efficiency in preventing the HIV transmission to the newborn and to prevent drug resistance among pregnant women. The regimen has been incorporated into pilot programs and shall be made available countrywide in October 2010.

In addition, civil society believes that PMTCT fails to protect women's reproductive health rights, including the decision to carry to term or to terminate their pregnancies, to have new pregnancies and to choose the preferred number of children. The information and service delivery provided is still by and large subject to the discretion of medical doctors and nurses, while medical personnel maintain different views regarding HIV/AIDS and PLHIVs and AIDS patients. Some are biased against providing services and planning, the act of which may lead to the violation of sexual and reproductive health rights of women who live with HIV/AIDS and are married.

In addition, some services provided to pregnant women may cause violations of sexual rights, including their choice to conduct their sex life as they see fit, or to have new spouses.

Most of the pregnant women seeking the services are told to stop thinking about having new spouses. They are told that having new spouses is tantamount to committing a sin; this places great pressure on pregnant women who seek services from mother and child and ARV clinics.

Civil society believes that PMTCT policy should be implemented based on a respect for sexual and reproductive health rights and the decisions made by the women themselves. Pregnant women should be provided with voluntary counseling and blood testing and the information has to be kept confidential. Quality counseling should be developed to enable women to make decisions whether or not to be tested and other contingency plans, including:

- Should they find themselves infected, how can they continue living?
- Should they participate in the PMTCT programs?
- Should they disclose their status, and how can they disclose to their partners? Is it proper to take their partners to get tested?
- Should they find themselves not infected, how can they continue living?
- How can they reduce their risky behaviors and the

vulnerabilities to getting infected and also protect their partners?

The counseling service should also cover family planning, repeated pregnancies, and choices in the termination of pregnancy.

Civil society would like to propose the following recommendations concerning PMTCT:

- The title of this program should be changed from Preventing Mother-to-Child Transmission (PMTCT) to “minimizing the transmission to newborns” in the attempt to prevent labeling and discrimination.

- Let the services be delivered through the normal universal health care package, with PMTCT not placed under the care of the Department of Health, whereby;

- A triple drug regimen should be provided to pregnant women who live with HIV/AIDS All women seeking prenatal care should be given VCCT. However, neither they nor their husbands should be forced to have it.

● The VCCT service should be delivered while keeping potential clients fully informed, including risks related to pregnancy of each pregnant woman, information concerning ART, how to look after oneself after child delivery, and impacts on oneself and spousal life, etc. This information should be part of the required service provision, given before pregnant women decide to have the blood test or not and whether they are still pregnant or have already delivered the child.

● Along with information concerning VCCT, it should be mentioned that under the universal health care program pregnant women and their spouses are entitled to seek counseling and VCT twice a year free of charge. Mothers who live with HIV/AIDS should be treated similar to other mothers.

● Every woman living with HIV/AIDS has the right to reproductive health and sexual rights. They can decide about their sexual relationships, planning their pregnancy and/or its termination, and can access family planning while being kept informed of comprehensive news and information, for example, their right to access and seek services, news, information, health care, treatment and ART. It should be reiterated that

such a right also enables pregnant women who live with HIV /AIDS to decide whether or not to seek PMTCT.

- The different opportunities and choices pregnant women have due to their HIV status, marriage status, Thai nationality status or being illegal migrant workers or dependents should be taken into account. Due to these different choices, economic opportunities and livelihoods, each pregnant woman may seek a different kind of support and care.

- Officials should receive training to enhance their counseling skills, with a particular focus on highlighting the importance of gender and sexuality as well as human rights and reproductive health. This should enable officials to provide counseling, information and support to PLHIVs and AIDS patients. With an understanding of sexuality they shall be able to encourage more discussion on sexual relationships, violence and unsafe sex among PLHIVs and AIDS patients. Support should also be given to women who are unable to disclose their HIV status because they are victims of violence, so they can receive mental rehabilitation as well as social and legal assistance.

● Efforts should be made to promote collaboration with networks of women living with HIV/AIDS, TNP+ as well as other civil society networks. Their participation should be equal in the advocacy for pregnant women and mothers living HIV/AIDS to have access to services.

● Clear policy concerning safe termination of pregnancy should be promoted to make it suit the needs of women and women living with HIV/AIDS. At the very least service provision facilities that are safe and efficiently run should be set up.

● The Department of Health is encouraged to develop an action plan on reproductive health and work with people of all genders. It should stress awareness-raising on reproductive rights from a human rights perspective. In other words, people from all walks of life, all ages, genders and statuses, should be able to access knowledge and understanding around issues of sex, gender and sexuality which are the fundamental rights of all people. Services should be provided based on a voluntary basis and when women and men have the option to protect their own reproductive health rights.