THAILAND

GETTING TO ZERO

2011 United Nations General Assembly
Political Declaration on HIV/AIDS
Closing the gap: a mid-term review at country level

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I. ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CDC	Center of Disease Control
CSO	Civil Society Organization
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HML	High Level Meeting
IBBS	Integrated Biological and Behavioral Surveillance
KP	Key Population
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NCCCDE	National Command Center for Combating Drugs Elimination
NCPI	National Commitment and Policy Instruments
NGO	Non-Governmental Organization
NSP	Needle and Syringe Programme
OST	Opiate Substitution Therapy
PHC	Primary Health Care
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child HIV Transmission
PR	Principal Recipient - GFATM
PWID	People who Inject Drugs
STI	Sexually Transmitted Infection
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

II. BACKGROUND AND CONTEXT

The 2011 United Nations General Assembly Political Declaration on HIV/AIDS set ambitious targets to be achieved by 2015. A framework of core indicators was developed to reflect the new targets and elimination commitments. The Political Declaration requests a special report to the General Assembly on progress in accordance with global reporting on the Millennium Development Goals at the September 2013 review of the Goals.

To this effect, in December 2012, the UNAIDS Executive Director sent a letter to all permanent representatives to the United Nations Office in Geneva encouraging Member States to conduct national midterm reviews of progress against the targets of the Political Declaration on HIV and AIDS, referred to as the "Ten Targets".

These national midterm reviews should combine a critical appraisal of progress made, guided by an assessment of progress against relevant Global AIDS Response Progress Reporting indicators and other information sources, with the identification of constraints and gaps in national responses leading to recommendations and commitments for future action.

Thailand's first version of "Getting to Zero" started many years back, when interventions were aiming at reducing the number of new HIV infections, free treatment, care and support services were rolled-out, and activities were designed and implemented to reduce stigma and discrimination. In many areas the response was very successful, and Thailand is globally considered as "best practice" for HIV prevention and care services.

Thailand's national strategy on HIV/AIDS 2012-2016 acknowledged that successes in prevention – for example the number of new infections declined more than 25% between 2001 and 2009, behaviour change among clients of sex workers (high rates of condom use), and young male adolescents (frequenting sex workers much less than 20 years ago) – have masked a stable HIV prevalence over the last five years among sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs). As a matter of fact, new infections among SWs, MSM, IDUs and among serodiscordant intimate partners account for 94% of new infections in Thailand between 2012 to 2016.

Socio-political, legal and environmental factors still hinder access to prevention (e.g. harm reduction for injecting drug users), treatment and care services (i.e. for non-Thai like unregistered labour migrants). Stigma and discrimination, including gender, reproductive and sexual rights related issues, though reduced, continue to negatively impact on people infected and affected by HIV and AIDS.

The National Strategy set ambitious targets which are fully aligned with (and actually exceed) the 10 targets of the 2011 Political Declaration, and proposes strategies to address issues both as regards HIV prevention, treatment, care and support. While this review is not a review of the National Strategy, it provides the opportunity to critically examine Thailand's journey to the 2015 targets and beyond.

Process

This review builds on a number of formal evaluations and assessments, recommendations from multi-stakeholder meetings, and consultative meetings (see Annex 1).

The multi-stakeholder process for Thailand's AIDS Response Progress Report 2013 was used to review and validate data. Several consultative meetings in March 2013 reviewed the external evaluations of MSM, IDU and SW interventions in Thailand, and made recommendations for a re-design of the programme and its implementation. A study was commissioned to review and analyze information as regards national laws and policies in Thailand and their respective impact of the AIDS response.

The national consultation on Strategic Use of ARVs (August 2012) recommended several multi-stakeholder working groups to assess opportunities for a range of critical programme areas, including HIV counseling and testing, PMTCT B+, treatment as prevention, PrEP, and financial and epidemiological modeling. The groups finalized their draft reports between January and April 2013, and the respective recommendations and findings are included in this report and were discussed at the consultative meeting of the national mid-term review.

A working group coordinated by the National AIDS Management Center prepared a draft of the review document and the which is based on respective reports received from 13 working groups (see annex 2 for list). The report and the tool were reviewed and finalized at the consultative meeting of the national mid-term review on 28 May 2013.

Review

The review is structured along the targets of the 2011 political declaration and includes evidence based main findings, main conclusions and recommendations. The recommendations are ranked according priorities (the top three recommendations being the most important ones), and whenever possible a time-line for completion of the recommended priority actions was given.

A graphic system was used to indicate if the targets were attainable. A *green tick mark* indicates that in all likelihood the target will be reached, even if efforts need to be intensified and/or approaches (programmes) optimized. An *attention sign* indicates that the target will not be reached, except a new approach (programme) is designed and implemented. A *question mark* alerts to the fact that there is not enough data to analyze the specific issue, and to design respective responses.

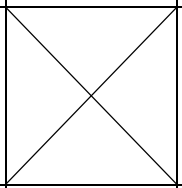
National Consultation

The national consultation on the mid-term review was held on 28 May 2013 (list of participants see annex 3). The draft stock-taking reports were discussed in seven working groups (see annex 4). Specific focus was put on the priority actions, and a consensus was sought for the top three main recommendations for each respective target.

Several cross-cutting priority issues were raised:

- **Political Commitment:** There was consensus that Thailand's capacity and competence across all sectors would allow to 'End AIDS' in the country in the next two decades, if renewed political commitment and leadership provides the needed investment and policy framework.
- **Programmes:** Programmes need to go beyond risk reduction education, commodities distribution, and service referrals to developing and delivering combination implementation approaches that break down historical stovepipes between HIV prevention, care, and treatment services and embrace the evidence supporting the symbiosis of prevention and treatment. Programmes must establish collaborative initiatives that more successfully "seek, test, treat, and retain" individuals facing the greatest HIV infection risks – key populations.
- **New Partnerships:** Re-designed combination prevention and combination treatment responses must go hand-in-hand with new and alternative service delivery systems. Task shifting and task sharing, new service coalitions between public, private and civil society are seen as a pre-condition for successful implementation.
- **Stigma and discrimination**: are still the biggest barriers to services for both key populations and PLHIV. The conceptual move from death sentence to chronic disease management will require a balanced approach as many of the conventional understandings of "chronic" disease do not adequately capture life with HIV for most people.

III. SUMMARY

		Target 1: Thailand can only achieve target 1 if HIV counseling and testing for key populations is scaled-up to 90%, and antiretroviral treatment is used strategically (early treatment initiation independent of CD4 cell count, pre-exposure prophylaxis).
		Target 2: Thailand can only achieve target 2 through expanded quality harm reduction services, including opioid substitution therapy, and needle/syringe programme.
		Target 3: Thailand can be among the first countries in the world to eliminate mother-to-child transmission
		Target 4 Thailand is doing well, but needs to focus on early treatment for key populations and access to services for non-Thai.
		Target 5 Thailand needs urgently to develop national guidelines and implement respective case management.
		Target 6 Continuous effort is needed to provide the needed human and financial resources for prevention, treatment and care both at the national and sub-national level.
		Target 7 Thailand needs to ensure gender sensitive services especially as regards HCT, prevention, treatment and care through appropriate policies and quality controlled implementation.
		Target 8 Thailand needs to design and continuously implement a public campaign to “normalize AIDS” as a chronic medical condition and to address stigma and discrimination.
		Target 9 Not applicable for Thailand
		Target 10 Re-designed HIV/AIDS related services can be an example for Global Health Integration, task shifting and task sharing in new partnerships between public sector, civil society, and private sector.

IV. HLM TARGETS

Target 1

Attainable

HLM: Reduce sexual transmission of HIV by 50% by 2015
Thailand NSP: Reduce sexual transmission of HIV by two-thirds in 2016

Main Findings:

- Main driver of Thailand's present HIV epidemic are infections among MSM. 94% of new HIV infections occur among MSM (41%), sero-discordant couples (32%), sex worker and clients (11%), and injecting drug users (10%).
- 65% of new infections happen in 31 provinces. Bangkok Metropolitan Administration alone accounts for nearly 25% of new HIV infections.
- Condom use (at last sex) among MSM has stabilized at around 86%, and among female sex worker at 94%.
- Coverage of prevention activities for venue based MSM, MSW and FSW is around 53%, 74% and 54% respectively.
- The majority of new HIV infections come from individuals who do not know their HIV status. Uptake into HIV counseling and testing is very low, especially among key populations and young people.
- HIV testing is free for Thai nationals. However, it is not well publicized. Un-insured labour migrants and non-registered Thai have to pay.
- Most outreach activities among key populations are carried out by NGOs and CBOs. 90% of financial resources for prevention programmes for key populations come from external sources (Global Fund).
- There is weak coordination and linkage between different service providers (i.e. NGOs, public sector, private sector).
- Modeling and economic appraisals show substantial prevention benefits of early treatment independent of CD4 cell count. Based on current behaviour variables and response, modeling shows that the targets will not be reached.

Main Conclusions:

Thailand cannot substantially reduce new HIV infections through behaviour change interventions alone which only address risk behaviour. It will need a new generation of combination prevention, which, while maintaining positive behaviour, also includes active recruitment into HIV testing, strategic use of ARV, and adherence support.

Geographic prioritization will facilitate intensified combination prevention and adequate scale of the response.

Thailand will need innovative models of service delivery to recruit and retain the target populations for prevention, treatment and care. These will need to a) create demand for, and actively recruit into HIV testing, b) ease the workload of health service providers (task shifting and task sharing), c) ensure quality assured services tailored to key populations, d) establish new partnerships with the private sector and communities themselves (e.g. private laboratories, pharmacies), and e) can be financed through domestic resources.

Identified Priority Actions:

Action	Time Frame
➢ Re-design combination prevention to maintain positive behaviour and include innovative ways to recruit key populations into HIV testing and early treatment, and retain them in services. This include demand creation through social mobilization and incentive mechanisms for recruitment into HCT, task shifting and task sharing, branding of selected quality services, and the usage of point-of-care testing (same hour results) and diagnosis.	By end September 2013
➢ Increase both human and financial resources to implement at a scale required the re-designed combination prevention	Financial year 2014/2015 and bridge mechanisms for 2013/2014
➢ Intensify programmes in prioritized provinces with a specific focus on Bangkok. The highest priority should be given to MSM interventions.	By October 2013
➢ Establish an adequate system for estimations and incidence projections, monitoring, data collection and use in order to measure achievements of the implementation in the field.	By end of 2013
➢ Maintain availability and accessibility of condoms and voluntary counseling and testing for the low risk population.	Throughout 2013-2016

Target 2

Attainable

HLM: Reduce transmission of HIV among people who inject drugs by 50% by 2015

Thailand NSP: Reduce transmission of HIV among people who inject drugs by two-thirds by 2016

Main Findings:

- Drug use patterns are shifting with a clear trend towards amphetamine type stimulants, and multi drug injecting.
- HIV prevalence among people who inject drugs is consistently high (25% in 2012).
- Law enforcement impacts negatively on the work of NGOs and CBOs with PWID, as peer-educators and outreach workers are sometimes detained, and clients are afraid to contact harm reduction services. However, there are good examples on collaboration between police, NGOs and CBOs which show a positive impact
- Methadone for opioid substitution therapy is covered by Universal Health Coverage (funded by the National Health Security Office), but not for clients of other insurance packages. Even while covered under the universal health coverage, MMT services are not everywhere available.
- Programmes addressing the specific needs of people who inject drugs are primarily externally funded (Global Fund) and implemented by NGOs and CBOs. Coverage of sterile injection equipment distribution is miniscule.
- Based on NCCCDE (order 30/2012), Thailand has introduced screening and treatment criteria based on the level of drug dependency. Translation into implementation is in progress. But there is still inadequate civil society participation. The present compulsory drug detention ("treatment") centers are ineffective in reducing drug dependence.
- Agencies involved in drug related activities are not well coordinated, while the focus of Thai leaders, law enforcement, laws and policies is on abstinence with little understanding of harm reduction.

Main Conclusions:

A reduction of new HIV infections among people who use drugs can only be achieved through a comprehensive harm reduction approach, including needle and syringe programmes and opioid substitution therapy. Global evidence shows that PWID are best reached through peer-networks and civil society groups.

Voluntary, community and evidence-based treatment should be encouraged.

Identified Priority Actions:

Action	Time Frame
➢ A review of current legal provisions, policies and practices including the option of decriminalization of drug use to ensure a) the safeguard of human rights, especially the Right to Health, and b) the provision of voluntary, community based medical treatment, care and support for people who use drugs.	By February 2014
➢ The Government needs to ensure that its national drug policy includes harm reduction as a key component, and that harm reduction is jointly planned, resourced and implemented by concerned government agencies and civil society through a range of evidence-based services and programmes to protect and promote the health of people who inject drugs.	By September 2013
➢ Harm reduction needs a re-design of essential services, including needle and syringe exchange, to include focus on recruitment of PWID into HCT, early ARV treatment, MMT and Hepatitis management.	By September 2013
➢ Empowerment of affected communities to a) lead efforts to reduce drug related harm, b) meaningful participate in policy design and monitoring, c) support community based voluntary treatment and care services, and d) to effectively cooperate with law enforcement, communities, and local authorities.	Throughout 2013-2016

Target 3

Attainable

HLM: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS related maternal deaths

Thailand NSP: Vertical transmission of HIV less than 2%

Main Findings:

- PMTCT service coverage and quality are generally high. 99% of women in ANC are tested for HIV (97% of women without ANC); 94% of pregnant women with HIV receive ARVs (although only 55% for women without ANC; the proportion of HIV-exposed infants receiving ARV prophylaxis is almost universal (99%); and the estimated rate of mother-to-child transmission of HIV is now only 2.7% (decreasing, but still above the national goal of <2%).
- Some PMTCT components are in need of improvement. The proportion of pregnant women attending ANC whose male partner was tested for HIV in the past 12 months remains low at 32%. The proportion of HIV-exposed infants receiving a virological test within 2 months of birth (77%) has been improving annually, but confirmatory tests for those with an initial positive test result are often not provided immediately, thereby delaying a definitive HIV diagnosis and treatment initiation if required. Less than 30% of HIV-infected infants are initiated on ART at <6 months. Access to PMTCT services for non-Thai citizens (including stateless populations and ethnic minorities) remains lower than for Thai citizens due to immigration related and financial concerns.
- Discussions are underway regarding the potential utility of adoption Option B+ to improve clinical outcomes for women with HIV and reduce sexual transmission between serodiscordant couples.
- PMTCT data reporting coverage, while initially more extensive, has declined in recent years (current reporting coverage ≈ 50-60%).

Main Conclusions:

While most aspects of PMTCT service delivery in Thailand are effectively delivered, selected areas require added focus and strengthening including increased ANC coverage for pregnant women with HIV and some non-Thai citizens, improved rates of couples testing and counseling, and improved virological testing rates and procedures for infants exposed to HIV.

Mechanisms to increase the effectiveness of PMTCT service delivery should be explored, including the potential adoption of Option B

Identified Priority Actions:

Action	Time Frame
➢ Increase ANC coverage to 100% for Thai and non-Thai including early ANC, improved efficacy of ARV for PMTCT, and strengthen couple counseling and testing through prioritized action in identified provinces with high transmission rate.	Implementation starting by October 2013
➢ Promote continuing care for women living with HIV and prevent new HIV-infections among sex partners through continuing ARV treatment and increased testing of male partners.	October 2013
➢ Improve EID effectiveness by increasing proportion of HIV-exposed infants receiving first virological test before 2 months of age to over 90%, and provide second confirmatory test as soon as possible for infants with an initial positive test result.	By September 2014
➢ Reduce average age at ART initiation for infants with confirmed HIV infection to <6 months of age through earlier confirmatory diagnosis and treatment preparedness.	By September 2014
➢ Strengthen PMTCT M&E system, including reporting coverage, and data analysis and use.	September 2013

Target 4

Attainable

HLM: Reach 15 million people living with HIV with lifesaving antiretroviral treatment

Thailand NSP: All people living with HIV resident in Thailand receive social protection and access to quality treatment and care
AIDS-related deaths reduced by half

Main Findings:

- Thailand's health insurance systems provide free antiretroviral treatment (ART) for Thai. Since October 2012 services are standardized across the three insurance schemes.
- At present, around 240,000 or 70% of Thai eligible for treatment receive ART. Some of non-Thai (migrants) are receiving ART with support from the GFATM, some are paying with their own money, while the others have no accessed to ART. While the number of people treated with ARVs increased tremendously over the last seven years, human resources in public facilities remained the same.
- Generic ARV drugs are manufactured in Thailand. Only 2 ARV are manufactured under compulsory licensing. Some ARV used for second and the third line regimens are imported from international pharmaceutical companies.
- Death rate of ART clients in 2012 was 10%, and adherence after 12 months is 82% (2012). The mortality rate among non-ART clients is 3 times higher than those with ART.
- Late recruitment into care and initiation of ART remained of concern over the last years. About 50% of people are accessing care and treatment services at CD4 < 100 cells/mm3.
- The proportion of second line ARV regimens increased from 6% in 2009 to 10% in 2012. The cost of second line drugs is about 4 times higher than first line drugs.
- A number of health facilities have very high workload. Task sharing to the local primary health care services has been informally managed by hospitals without a supported policy and management from the Thai MoPH.

Main Conclusions:

Thailand has a robust, well-functioning health system to provide ARV to people in need. Main challenge is to diagnose HIV in an early stage, initiate treatment as soon as possible, and to provide adequate adherence support. This needs to be done in a spirit of task sharing (with civil society, private entities).

Human resource constraints have led to high workload, and stress on service quality. Workload can be reduced, and services can be brought closer to people in need through task shifting and alternative service delivery systems (i.e. community service delivery).

Identified Priority Actions:

Action	Time Frame
➢ Develop a policy on the "Strategic Use of ART" to maximize the prevention benefit of ART, and to reduce AIDS deaths and new HIV infections.	September 2013
➢ Increase accessibility, early recruitment and retention to care and ART, through strategic expansion of HCT and creation of demand among key populations.	October 2013
➢ Operationalize a policy on task shifting, task sharing and increased use of point-of-care testing to strengthen integration of HTC, care, ART, adherence and psychosocial support into health and community systems.	October 2013

Target 5

Attainable

HLM: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

Thailand NSP: TB deaths among people living with HIV reduced by half by 2016

Main Findings:

- Provider-initiated HIV Testing and Counseling (PITC) of TB patients have been integrated into national guidelines and are implemented throughout the country.
- Routine HIV screening is recommended nationally for all registered TB patients; in 2011, the HIV counseling and testing rate among TB patients was 74%. 15% among all those tested were found to be HIV-positive.
- In 2011, it was reported that 36% of all estimated HIV positive incident TB cases received treatment for both TB and HIV, although program coverage based on routine program data indicates that this is over 60%.
- Late initiation of ART and/or in-appropriate clinical management for TB/HIV co-infection has been observed. The TB/HIV death rate at 12 month after registration to care and treatment was 53% and 11% among non-ART and ART clients, respectively.
- TB/HIV coordination, monitoring and supervision is weak and needs to be improved.

Main Conclusions:

While Thailand has made significant progress in managing HIV-TB activities, specifically on HTC among TB patients, death rates from TB among HIV infected patients are high.

Identified Priority Actions:

Action	Time Frame
➢ Initiate ARV treatment independent of CD4 cell for count for PLHIV to reduce the risk of TB infection, and initiate ART in all HIV-TB co-infected patients as quickly as possible to reduce infections and death rates.	By end of 2013
➢ Update national guidelines and improve respective clinical management of all TB	By September 2013
➢ Coordination of respective HIV and TB service providers and monitoring needs to be strengthened and improved at all levels	By July 2014
➢ Integrate recruitment, case finding and case management into re-designed combination prevention programmes	End September 2013

Target 6

Attainable

HLM: Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion on low- and middle-income countries

Thailand NSP: By 2016 increase budget proportion for prevention in priority provinces

Main Findings:

- In 2011, Thailand is financing 83% of the total HIV/AIDS expenditure through domestic funds. 17% come from external sources, mainly the Global Fund. The distribution between prevention activities and treatment and care activities was 13% and 73%, respectively.
- The Global Fund is de facto the main and only funding source for prevention services targeting key affected populations (MSM, SW, PWID) and prevention and care services for non-Thai migrants. The funding support from the Global Fund will end in 2014.
- Due to the decentralization policy, domestic resources are either directly distributed from the national budget to provinces and the sub-national level has to allocate funds to respective priority areas, or the sub-national level has to mobilize resources for HIV prevention activities.
- Although Bangkok contributes around 25% of new HIV infections in Thailand, the central budget allocation for HIV to the Bangkok Metropolitan Authority decreased from 134 million Baht in 2011 to 34 million Baht in 2013.
- A study in 2008 conducted in a province in the Central Region revealed that financial resources for HIV were provided by the Ministry of Public Health (MOPH), National Health Security Office (NHSO), Comptroller General Department and Local Administration Organizations and others at 31%, 20%, 17%, 12%, and 20% respectively.
- A study on HIV expenditures of local government units (LGU) in two provinces in the North and North-East region found that main proportions of budget expenditures between 2006-8 were: administration, infrastructure, education, health, environment, social service, and other at 29%, 19%, 12%, 4%, 2%, 15%, and 19% respectively. The average annual AIDS expenditures were USD 1,300 - 2,700 per LGU. Main expenditures for HIV were the monthly support to people affected by HIV, campaign activities, meeting or group activities and others at 90%, 5%, 2% and 3% respectively.
- Provinces were well aware of the HIV situation, the national strategy and key interventions, but faced difficulties to mobilize resources for programmatic action at an adequate scale for key populations.
- A prevailing negative attitude towards sexuality and key populations are key challenges as regards mobilizing support from local government units and other stakeholders at sub-national level.

Main Conclusions:
At the sub-national level, HIV programming, particularly prevention services for key populations, has a rather low priority and does not receive enough attention to mobilize financial and human resources to meet the response challenges.

A national, pooled financing mechanism, resourced from various sources and centrally managed, could play a strategic role to ensure coverage and focused services for key populations in priority locations.

Identified Priority Actions:

Action	Time Frame
➢ Identify the most appropriate financial mechanism both at the national and sub-national level to resource re-designed combination prevention and care programmes with a specific focus on key populations.	December 2013
➢ Reposition the NHSO AIDS fund to provide financial resources to support HIV related services for key populations.	December 2013
➢ Mobilize locally (both at the national and sub-national level) human and financial resources needed towards an expanded response, including private sector contributions.	Throughout 2013-2016

Target 7

Attainable

HLM: Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

Thailand NSP: Reduce Gender inequalities by half by 2016

Main Findings:

- No recent national survey on Intimate Partner Violence (IPV) exists. The latest study (2003) conducted in Bangkok and in an upper-central province revealed nearly 50% of respondents reporting having experienced physical or sexual violence by their intimate partners.
- Thailand has established "one stop crisis centers" in health facilities to respond to victims of sexual abuse and domestic violence.
- A qualitative study suggested that HIV infection among women in intimate partnerships is caused by their inability to negotiate safer sex with their regular sexual partners.
- The IBBS conducted in 2010 revealed that females who inject drugs used condoms less frequency compared with male PWID.
- Anecdotal evidence exists on violence and abuse of transgender people and MSM; pilot projects are implemented to address violence against male sex worker and transgender people.
- Spending on the enabling environment in achieving the Zero stigma and discrimination goal including gender in the national AIDS Strategy for 2012-2016, accounted for 1.4% of the total AIDS spending in 2011.

Main Conclusions:

There is limited and fragmented information and analysis on gender-based violence both at national and sub-national level.

Identified Priority Actions:

Action	Time Frame
➢ Improve as a matter of urgency research and strategic information related to IPV and access to key HIV related services for women, girls and transgender to inform advocacy and programming.	By July 2014
➢ Ensure gender sensitive services especially as regards HCT, treatment and care through appropriate policies and quality controlled implementation.	By September 2013
➢ Integrate reproductive health needs, and rights of women and girls living with HIV into national policy and associated strategy for reproductive health.	June 2014

Target 8

Attainable

HLM: Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

Thailand NSP: Expand the protective social and legal environment essential for HIV prevention and care

Main Findings:

- Main barriers to access services are the existing laws and policies as regards drug use, sex work, age of consent for HIV testing among young people (18 years), issues related to registration status of non-Thai and access to services.
- There are new draft laws that provide promotion and services to health of the people such as Sexual Opportunity and Equality Promotion Act, People's Participation in Public Policy Act, and People's Participation in Local Administration.
- Stigma and discrimination still exists at the workplace, in educational and health facilities, and as regards confidentiality while accessing social and medical services.
- People in closed settings have very limited access to HIV prevention and care services.
- Acknowledging the need to address stigma, discrimination and violation of fundamental human rights of key populations including PLHIV, Thailand established a sub-committee on 'AIDS rights, Promotion, and Protection' under the National AIDS Committee
- Thailand is at the moment developing a routine monitoring system as regards stigma and discrimination among key populations, including PLHIV with a specific focus on stigma and discrimination in health care settings.

Main Conclusions:

There are still legal and policy barriers to HIV related services which need to be removed as a matter of urgency.

While the magnitude of different types of stigma and discrimination against key populations and PLHIV in Thailand is at the moment not quantifiable, it is a very concrete issue for many people which needs to be addressed in order to scale-up HIV related services.

Identified Priority Actions:

Action	Time Frame
➢ Design and implement continuously a public campaign to "normalize AIDS" as a chronic medical condition and to address stigma and discrimination.	Throughout 2013 to 2016
➢ Implement an information campaign that addresses involuntary testing, and the condition put by some service providers to reveal the sero status in order to receive health services.	Throughout 2013 to 2016
➢ Establish mechanisms to respond to human rights violations and stigma and discrimination, starting in the defined 33 priority provinces.	Throughout 2013 to 2016
➢ Monitor the implementation of the code of conduct.	Throughout 2013 to 2016
➢ Decriminalization of sex work and drug use	

Target 9

Attainable

HLM: Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

Thailand NSP: No specific target

Main Findings:

- A number of HIV related functions and services in Thailand are already fully integrated in respective health and development instruments (e.g. development, health, social support, education, and labour). However, financial and human resources for HIV were gradually decreasing particularly for non-health sectors and civil society organizations at the national and sub-national level. This poses an important challenge to meet the ambitious target of ending AIDS in Thailand.
- The MoPH and partners (AIDS Access, PATH, TNP+ and 29 provinces) have started to work on strengthening and linking community systems, health system (case management) and social protection. However, links to private service providers are still very limited.
- Joint key performance indicators (KPIs) for shared achievements and monitoring across different government entities on HIV have been developed. However, the KPIs on AIDS were withdrawn from the government system last year due to competing priorities and the feeling among decision makers that they are not needed anymore.
- A study on performance of provinces on HIV/AIDS in 2012 found only moderate effectiveness of coordination, integration and linkages of outreach activities done by civil societies, and HIV related government services.

Main Conclusions:

While Thailand has made some progress in integrating HIV related services, issues like fragmentation, coordination and new partnerships need to be addressed at all levels in the future.

Identified Priority Actions:

Action	Time Frame
➢ Re-establish joint KPIs on HIV to facilitate coordination and response across government sectors, and motivate private sector and NGOs to adopt the joint KPIs.	End 2013 Fiscal Year 2013/2014
➢ Ensure allocation of adequate resources for integration of key functions relating to HIV into other non-health sector systems.	Fiscal Year 2014
➢ Strengthen human capacity to perform key functions in an integrated manners	As soon as possible

V. Overview Indicators as of 2012

TARGET 1: Reduce sexual transmission of HIV									
HLM Target	**Reduce sexual transmission of HIV by 50% by 2015**								
National Goal	**Reduce new HIV infections by 2/3 by 2016**								
Targets	**Indicators**		**GARPR**	**UA**	**National target by 2016**	**2009**	**2010**	**2011**	**2012**
General population	1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	●	●		Data not available			
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	●	●		Data not available			
	1.3	Percentage (%) of adult (woman and men) aged 15 - 49 who have had sexual intercourse with more than one partner in the past 12 months	●	●		Data not available			
	1.4	Percentage (%) of adult (woman and men) aged 15-49 who have had more than one sexual partner in the past 12 months who reported the use of a condom during there last sexual intercourse	●	●		Data not available			
	1.5	Percentage (%) of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	●	●		Data not available			
	1.6	Percentage (%) of young people (woman) aged 15-24 who are living with HIV	●	●	**0.33%**	0.58%	0.44%	0.44%	0.40%
Female Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	**80.0%**		50.4%		53.9%
	1.8	Percentage (%) of sex workers reporting the use of a condom with their most recent client	●	●	**95.0%**		95.6%		93.6%
	1.9	Percentage (%) of sex workers who have received an HIV test in the past 12 months and know their results	●	●	**90.0%**		47.8%		55.6%
	1.10	Percentage (%) of sex workers who are living with HIV	●	●	**1.0%**		2.7%		2.2%
Male Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	**80.0%**		61.0%		73.8%
	1.8	Percentage (%) of sex workers reporting the use of a condom with their most recent client	●	●	**95.0%**		88.0%		98.2%
	1.9	Percentage (%) of sex workers who have received an HIV test in the past 12 months and know their results	●	●	**90.0%**		49.0%		52.4%
	1.10	Percentage (%) of sex workers who are living with HIV	●	●	**10.2%**		16.0%		12.2%

TARGET 1: Reduce sexual transmission of HIV									
HLM Target	**Reduce sexual transmission of HIV by 50% by 2015**								
National Goal	**Reduce new HIV infections by 2/3 by 2016**								
Targets	**Indicators**		**GARPR**	**UA**	**National target by 2016**	**2009**	**2010**	**2011**	**2012**
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	●	●	**80.0%**		43.8%		52.6%
	1.12	Percentage (%) men reporting the use of a condom the last time they had anal sex with a male partner	●	●	**95.0%**		80.2%		85.5%
	1.13	Percentage (%) of men who have sex with men that have received an HIV test in the past 12 months and know their results	●	●	**90.0%**		14.9%		25.6%
	1.14	Percentage (%) of men who have sex with men who are living with HIV	●	●	**7.5%**		8.0%		7.1%
Counseling and testing	1.16	Number of women and men aged 15 and older who received HIV testing and counseling in the past 12 months and know their results (including pregnant women)		●				1,054,334	1,146,093
		Number of HIV+		●				22,339	21,907
		Number of women and men aged 15 and older who received HIV testing and counseling in the past 12 months and know their results (excluding pregnant women)		●				307,114	356,816
		Number of HIV+		●				17,464	16,984
Sexually Transmitted Infections	1.17	**Sexually Transmitted Infections (STIs)**							
		1.17.1. Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit		●					91.6%
		1.17.2 Percentage of antenatal care attendees who were positive for syphilis		●					0.1%
		1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment		●					93.1%
		1.17.4 Percentage of sex workers (SWs) with active syphilis	Median	●				0.3%	0.0%
			Mean	●				0.6%	0.5%
		1.17.5 Percentage men who have sex with men (MSM) with active syphilis		●				Data not available	
Reporting Date: 31 May 2013									

TARGET 2: Reduce transmission of HIV among people who inject drugs									
HLM Target	**Reduce transmission of HIV among people who inject drugs by 50% by 2015**								
National Goal	**Reduce new HIV infections by 2/3 by 2016**								
Targets		**Indicators**	**GARPR**	**UA**	**National target by 2016**	**2009***	**2010**	**2011**	**2012**
	2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	●	●	**88**			9.8	11.5
	2.2	Percentage (%) of people who inject drugs who report the use of a condom at last sexual intercourse	●	●	**95.0%**	39.2%	46.0%		49.1%
	2.3	Percentage (%) of people who inject drugs who reported using sterile injecting equipment the last time they injected	●	●	**82.0%**	42.0%	77.7%		80.4%
	2.4	Percentage (%) of people who inject drugs that have received an HIV test in the past 12 months and know their results	●	●	**90.0%**	40.0%	40.7%		43.6%
	2.5	Percentage (%) of people who inject drugs who are living with HIV	●	●	**21.0%**	17.2%	21.9%		25.2%
	2.6	Estimated number of opiate users (injectors and non-injectors) Number of people on Opioid Substitution therapy (OST)							
		2.6.1 Estimated number of opiate users (injectors and non-injectors)		●				Data not available	
		2.6.2 Number of people on opioid substitution therapy (OST)		●			2,201	2612	3,735
	2.7	Number of needle and syringe programme (NSP) sites Number of substitution therapy (OST) sites (WHO)							
		2.7.1 Number of needle and syringe programme (NSP) sites		●		39	49	42	36
		2.7.2 Number of substitution therapy (OST) sites		●		49	Data not available	147	147
	Note: In 2009 indicator no 1-5 from IBBS conducted only in Bangkok and Chiang Mai.								
	Reporting Date: 18 April 2013								

TARGET 3: Eliminate mother-to-child transmission of HIV										
HLM Target	**Eliminate new HIV infections among childrenby 2015 and substantially reduce AIDS-relatedmaternal deaths**									
National Goal	**Vertical transmission of HIV less than 2%**									
Targets	**Indicators**		**GARPR**	**UA**	**National target by 2016**	**2008**	**2009**	**2010**	**2011**	**2012**
	3.1	Percentage(%) of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	●	●	**98.8%**	93.6%	95.0%	94.2%	94.0%	93.8%
	3.2	Percentage % of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	●	●	**90.0%**			75.8%	73.1%	77.2%
	3.3	Estimated percentage (%) of child infections from HIV-infected women delivering in the past 12 months	●	●	**2.0%**			3.8%	3.0%	2.7%
	3.4	Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status		●		99.7%	99.3%	99.5%	99.9%	99.1%
	3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months		●						32.3%
	3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing		●			44.0%			85.6%
	3.7	Percentage of infants born to HIV-infected women receiving antiretroviral prophylaxis to reduce the risk of early /mother to child transmission in the first 6 weeks		●		96.5%	99.3%	99.4%	99.0%	99.2%
	3.8	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.		●						Indicator not relevant
	3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth		●			35.9%		42.0%	52.0%
	3.10	Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit		●						Indicator not relevant
	3.11	Number of pregnant women attending ANC at least once during the reporting period		●				772,772	747,967	783,305
	Reporting Date: 31 May 2013									

Target 4: Anti-Retroviral Treatment									
HLM Target	**Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**								
National Goal	**-All people eligible for treatment and care receive the same standard of services across the respective health insurance schemes -Reduce AIDS-related deaths by 50%**								
Targets	**Indicators**		**GARPR**	**UA**	**National target by 2016**	**2009**	**2010**	**2011**	**2012**
	4.1	Percentage (%) of eligible adults and children currently receiving antiretroviral therapy - (CD4 <200 cell/ml)	●	●	90.0%	75.8%	71.8%	77.0%	
		- (CD4 <350 cell/ml)					59.1%	64.6%	70.0%
	4.2	Percentage (%) of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	●	●	**95.0%**	85.1%	80.7%	83.1%	82.1%
	4.2 b	Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2010)		●			79.8%	79.8%	78.9%
	4.2 c	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2007)		●					NA
	4.3	Number of health facilities that offer antiretroviral therapy (i.e. prescribe and/or provide clinical follow-up)		●		1,014	943	937	949
	4.4	Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months		●				3.1%	3.1%
	4.5	Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis		●			89.0%	89.3%	92.5%
	4.6	**HIV care**							
		4.6.1) Number of adults newly enrolled in pre-antiretroviral therapy (pre-ART) during the reporting period		●					10,646
		4.6.2) Number of adults newly enrolled in HIV care (pre-ART or ART) during the reporting period		●					24,654
Reporting date: 18 April 2013									

Target 5: Reduce tuberculosis deaths in people living with HIV									
HLM Target	Reduce tuberculosis deaths in people living with HIV by 50% by 2015								
National Goal	TB deaths among people living with HIV reduced by half								
Targets	Indicators		GARPR	UA	National target by 2016	2009	2010	2011	2012
	5.1	Percentage (%) of estimated HIV-positive incident TB cases that received treatment for TB and HIV	●	●	50.0%	25.5%	26.1%	36.2%	27.8%
	5.2	Number of health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control (WHO)		●			Data not available	Data not available	Data not available
	5.3	Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))		●			Data not available	Data not available	Data not available
	5.4	Percentage(%) of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit		●			95.0%	Data not available	Data not available
	Note: Indicator 5.1 in 2011 revised from 27.7% to 36.2%								
	Reporting Date 3 1 May 2013								

TARGET 6: Closing the resource gap										
HLM Target	Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion on low- and middle-income countries									
National Goal	By 2016 increase budget proportion for prevention in priority provinces									
Targets	**Indicators**		**GARPR**	**UA**	**National target by 2016**	**2007**	**2008**	**2009**	**2010**	**2011**
	6.1	Total AIDS Spending (million THB)	●			6,728	6,928	7,208	7,733	9,922
	6.2	Total AIDS Spending for prevention program (million THB)	●			950	1,500	987	1,015	1,334
		Percentage of prevention spending out of total AIDS spending			**25.0%**	**14%**	**22%**	**14%**	**13%**	**13%**
	6.3	Total of AIDS spending for prevention program targeting PWID,SW,MSM (million THB)	●			38	24	52	135	271
		Percentage of AIDS spending for prevention program targeting PWID,SW,MSM and PLHIV out of total prevention AIDS spending				**4%**	**2%**	**5%**	**13%**	**20%**
	6.4	Total AIDS spending for M&E, program evaluation and operational researches excluding biomedical and basic science researches(million THB)	●			199	50	67	73	137
		Percentage of M&E, program evaluation and operational researches spending out of total AIDS spending			**5.0%**	**3%**	**1%**	**1%**	**1%**	**1%**
	Reporting Date: 31 May 2013									

Special 2013 GARPR questionnaire

Part A: View of the Government

1) Have you performed population size estimations for key populations?

Key population Size estimation	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a) Men who have sex with men	yes	2012	550,571
b) People who inject drugs	yes	2012	40,300
c) Sex workers	yes	2012	123,530
d) Other key populations, please specify			
which key population in the comment box.			
e) Comments	The size estimation among Migrant was 3.2 -3.7 million (2012)		

2) Are health facilities providing HIV services integrated with other health

Area	Many	Few	None
a) HIV Counseling & Testing with Sexual & Reproductive Health	•		
b) HIV Counseling & Testing and Tuberculosis	•		
c) HIV Counseling & Testing and general outpatient care		•	
d) HIV Counseling & Testing and chronic Non-Communicable Diseases			•
e) ART and Tuberculosis	•		
f) ART and general outpatient care		•	
g) ART and chronic Non-Communicable Diseases			•
h) PMTCT with Antenatal Care/Maternal& Child Health	•		
i) Other comments on HIV integration:			

3) Are there any key policy changes in the AIDS response since early 2012 when you'relast NCPI?

1. National AIDS Strategy

The National AIDS Committee (NAC) has passed a resolution to approve the National AIDS Strategy for 2012-16 (NAS) and the National M&E Plan for the same period. Government has convened orientation meetings for government agencies, Civil Society, and businesses at the central and provincial levels in order to align implementation in accordance with the NAS.

Challenges

The Office of the Public Sector Development Commission (OPDC) has discontinued the Joint KPI system related to HIV prevention for the Fiscal Year 2013. ODPC felt that cross-agency collaboration was already functioning well. However, the Joint KPI for HIV prevention task force still feels the system is necessary to maintain the momentum of inter-sectoral collaboration. Further, this system can serve as a demonstration model of integrated implementation, which may serve as a valuable case study for other countries.

2. Prevention

In August of 2012, a national consultative meeting was convened on the topic of strategic use of ARV. It was concluded that, in order for Thailand to reduce new cases of HIV by two-thirds below the projected total for 2016, it will be necessary to consider use of ART for prevention. The key strategy for this is earlier detection and enrolment in treatment of PLHIV, especially for MSM, sex workers, and PWID. This will involve improvements and expansion of HIV testing, continuous care, development of the role of Civil Society, and increasing the capacity of key target populations to access services. The proposal for policy on the strategic use of ARV has been planned to proceed in 2013.

Thailand has collaborated with the Global Fund (GF) headquarters to conduct evaluations of implementation of HIV prevention among MSM, sex workers and IDU. These evaluations have generated important data for improving measures and implementation plans for projects and activities supported by the GF and Thai government.

Challenges

In 2010, the NAC approved the policy for harm reduction from injection drug use, with a comprehensive package for 10 items of services. The Office of the Narcotics Control Board (ONCB) has also endorsed harm reduction as one intervention option. However, converting these policies into action has been difficult. The Council of State views needle/syringe program as abetting drug use. The NAC has issued guidance to relevant ministries (e.g., Public Health, Justice, Interior, National Police) to consider ways to implement in harmony in the project areas supported by the Global Fund as well as the demonstration sites in Bangkok, Sonkla and Chiang Mai to show how this harmonized implementation can work. The projects are in progress.

3. Treatment, Care and Assistance for PLHIV and Affected Persons

The NHSO has altered the criterion for initiating ART from a CD4 count of 250 to 350 cells/cu.mm. for insured members. The NHSO has also provided budget for improving the system and quality of HIV Counseling and Testing in support of the early detection strategy.

The government has announced the policy to align the three funds which support the cost of ART (NHSO, Social Security, Government Civil Service) so that they all cover the same standard of treatment. There has been a review, improvement and consolidation of data into a single system, beginning on October 1, 2012.

The MOPH has been assigned the task of considering how to provide comprehensive health insurance for cross-border migrant workers and their dependents, so that both registered and non-registered workers are covered, including ART.

4. Stigma and Discrimination

The Sub-committee for the Promotion and Protection of AIDS Rights (under the NAC) has shown strong implementation in the following ways:

- Compilation of data, and convening a seminar(s) to present policy recommendations to the NAC on important issues such as compulsory HIV testing, and impact of policy on drug use as it relates to harm reduction.

- Prepared an implementation plan to reduce stigma and discrimination, including plans for campaigning to promote and protect AIDS rights during 2012-13.

Challenges

Even though the NAC has issued official guidelines on AIDS in the Workplace, which includes the need for both government and private sector employers to respect AIDS rights, and sent a letter to employers by the Chairperson of the NAC, implementation of the guidelines has not been uniform across the country.

Part B: View of Civil Society

During the period of 2011-12 the government has given Civil Society (CS) an opportunity to participate in most of the activities related to the response to AIDS. For example, in 2011 and 2012, CS representatives contributed to the development of the direction and strategies for the National AIDS Strategy (NAS 2012-16), and the national M&E plan. CS agencies took ownership of the AIDS response in certain localities. Nevertheless, there are gaps in CS participation in resolving obstacles related to laws, policies, and the translation of policy into action. The following lists some advances and challenges that remain:

- Announcement of the AIDS policy for a single standard across the three funds, starting the implementation on October 1, 2012;
- The change in the guidelines by the National Health Security Office (NHSO) to cover initiation of ART for PLHIV with CD4 of 350 instead of 200 cells/cu.mm., starting the implementation on October 1, 2012;
- The laws related to drug addicts still criminalize drug use with penalty of imprisonment from six months to three years. This is in contrast to the government's position of viewing drug addiction as a health problem. Thus, this lack of clarity of law and policy inhibits access to services by drug users and some standard outreach activities may even be considered illegal.
- The harm reduction policy has been supported at the prime ministerial level since the International AIDS Conference in 2004. Subsequently, implementing agencies that work with People Who Inject Drugs (PWID) tried to expand to more comprehensive services, including needle and syringe program. However, this aspect of harm reduction met resistance from parts of the government in the implementation areas. Some government agencies felt that needle distribution was a form of promoting drug use. This opinion was endorsed by the Council of State, which further impeded harm reduction. Even though the Department of Disease Control (DDC) of the Ministry of Public Health (MOPH) supports comprehensive harm reduction in principle, it was difficult to implement at the local level. At the same time, SOPs for other interventions such as methadone maintenance therapy (MMT) underwent changes, including who is eligible, steps and procedures, amount of the dosage, take-home supply, etc. Often, these changes did not result in better quality service for PWID and little improvement in their quality of life. The motivation of the PWID support networks declined, in part, possibly due to the apparent policy opposition. External support for these groups declined accordingly.
- Some policies are in conflict with each other, such as the treatment-as-prevention strategy which tries to get people with risk into HIV VCT and, if appropriate, treatment programs. However, there is also the regulation which forbids individuals under age 18 from receiving HIV testing without parental consent. The Thai Medical Council has not yet revised its guidance on this issue since first issuing the parental consent guideline in 1983. Despite this, there is still compulsory HIV testing for nursing students at one private university; those found to be HIV+ are expelled. (A law suit has been filed in that case and is pending.) On May 31, 2012, a national AIDS hotline was launched (#1663) through the cooperation of AIDS ACCESS Foundation, the DDC, the Thai Red Cross AIDS Research Center and the NHSO.
- Stigma and discrimination is still an issue and an impediment to prevention and treatment for many vulnerable populations. Stigma discourages many to exercise their rights to services; others are denied services they have a right to, or have their rights violated. Even to this day, many employers still require HIV testing for job applicants; others do not

provide appropriate services for PLHIV, or try to find ways to fire them. Often, these actions are a result of ignorance of human rights and fair treatment of PLHIV. CS organizations have been the prime movers in campaigning and advocating to combat stigma and discrimination through the Sub-committee for Support and Protection of AIDS Rights (set up by the NAC in 2011). The Foundation for AIDS Rights (FAR) and other CS groups, UNDP, UNAIDS, networks, and agencies which work with PWID or with male sex workers (e.g., SWING) collaborated with the Education Directorate of the National Police Headquarters to develop a training curriculum on AIDS stigma and rights of various groups. The target of the training is to create a critical mass of police officers to spread knowledge and norms with colleagues to improve interactions with vulnerable populations and PLHIV. With support from UNDP and UNAIDS, the TNP+ network and FAR developed guidelines for AIDS rights protection for implementation in seven pilot provinces (Ubon, Srisaket, Chayaphum, Payao, Nan, Nakorn Sawan, and Lopburi). As of 2012, a total of 47 rights-violation grievances had been filed in these provinces.

In the area of prevention, CS has played an important role during 2011-12 in activities supported by the Global Fund (GF), and has reached/conducted activities with affected populations across a wide range. However, it is hard to see how these activities can continue when GF support to Thailand ends.

There have been significant advances in treatment of PLHIV in Thailand. Coverage of ART by the NHSO has encouraged more people to seek HIV testing early, instead of waiting for symptoms to develop. This provides more effective treatment, and also promotes prevention. CS and associated communities can and do play an important role in campaigning and capacity building to promote early HIV VCT and treatment. Government needs to continue to support CS with equipment and supplies for these efforts. However, the government has not kept pace with covering the increasing number of cross-border migrant workers from Myanmar, Cambodia and Lao PDR so that they have health insurance which covers essential HIV/AIDS services.

- The policy advocacy strategy for AIDS under the NAC by creating the AIDS rights sub-committee is an important step forward. However there is a shortage of budget support, especially for communication activities to combat stigma and discrimination against PLHIV and other special populations.

Limitations/Challenges

Support from Political Powers and Leadership: The change of government in 2011 brought in a new leadership team and, accordingly, a new Chairperson of the NAC (the deputy Prime Minister). Because there are multiple deputies, the NAC chairmanship lacked continuity, and this adversely affected advancement of draft policies and strategies (e.g., the “Getting to Zero” strategy).

Improving and Expanding ART for Everyone in Thailand: This is especially important for non-Thai citizens or those without Thai ID cards and who cannot access ART through the NHSO scheme. This is important since the migrant workers and undocumented residents are important human resources for the continued development of the country. It is uncertain whether GF support will continue in this area, and what substitutes sources of funds exist. Cross-border collaboration among Thailand’s neighbors is also an important factor.

VI. ANNEXES

ANNEX 1: List of Evaluation and Assessments

Title	Authors/Implementers	Year of Report completed
Harm Reduction Assessment	Mark Tyndall and Sutayut Osornprasop	August 2011
Evaluation of the national AIDS response in Thailand	ASEAN Institute for Health Development (AIHD), The International Health Policy Program (IHPP), Health Counterparts Consulting and HLSP, UK	November 2011
Monitoring and Evaluation System Strengthening (MESS) Assessment	Institute for Population and Social Research, Mahidol University	March 2012
Situation analysis in support of Global Fund supported programming (Round 10)	Yves Bourny and Nonthathorn Chaiphet for ICF International	December 2012
Cost study of comprehensive HIV Prevention program targeting Most at Risk Populations by promoting Integrated Outreach and Network	Health Intervention and Technology Assessment Program (HITAP)	December 2012
Evaluation of HIV programmes among female sex workers, people who inject drugs and men who have sex with men	International consultants for Institute for Population and Social Research, Mahidol University	December 2012
Evaluation of the national HIV prevention program for key affected populations and prisoners	Institute for Population and Social Research, Mahidol University	March 2013
The way forward of Thailand's HIV/AIDS Programmes after being weaned off from the Global Fund Support	The International Health Policy Program (IHPP),	Presentation: March 2013
Consultations:		
Development Cooperation Seminar on "Harm Reduction and Drug Treatment, a choice, a right or a duty"?	Ministry of Justice and UN Country Team Thailand	April 2012
National consultation on the strategic use of ART	Ministry of Public Health, UN Joint Team on AIDS in Thailand	August 2012
Thailand AIDS Response Progress Report 2013	Ministry of Public Health, multi-stakeholder consensus	March 2013
Stocktaking Exercise 2013	Ministry of Public Health, multi-stakeholder	
National Law and Policy Review Thailand	UNAIDS	May 2013

ANNEX 2: Working Groups to Analyze and Draft Mid-Term Review

- Working Group on Prevention
- Working Group on HIV Counseling and Testing
- Working Group on Treatment and Care
- Working Group on PMTCT
- Working Group on TB-HIV
- Working Group on CABA
- Working Group on Provincial Review
- Working Group on Legal Review
- Working Group on PrEP
- Working Group on Economic Analysis Group
- Working Group on Option PMTCT B+ working group
- Working Group on Service Delivery
- Working Group on Strategic Use of ARV

ANNEX 3: Participant List at National Consultation on 28 May 2013

Thailand's National Consultation of the Mid-Term Review of the HLM Targets
28 May 2013 at Miracle Grand Convention Hotel, Bangkok

Participants

1.	Dr Somsak Akkasilp	Department of Disease Control
2.	Dr Petchsri Sirininund	National AIDS Management Center
3.	Dr Sombat Thanprasersuk	Department of Disease Control
4.	Dr Sumet Ongwandee	Bureau of AIDS, TB and STIs
5.	Dr Taweesap Siraprapasiri	Bureau of AIDS, TB and STIs
6.	Dr Cheewanun Lertpiriyasuwat	Bureau of AIDS, TB and STIs
7.	Dr Montinee Wasantiuppokakorn	Bureau of ADSU, TB and STIs
8.	Ms Jiraporn Yachompu	Bureau of AIDS TB and STIs
9.	Ms Wannarat Makumnert	Bureau of AIDS TB and STIs
10.	Ms Suwanee Maisuwan	Bureau of AIDS TB and STIs
11.	Ms Jittra On-Nom	Bureau of AIDS TB and STIs
12.	Mr Chaisuk Tangwongjunniem	Bureau of AIDS TB and STIs
13.	Dr Chawetsun Namwart	Bureau of TB
14.	Dr Sriprapa Netniyom	Bureau of TB
15.	Ms Nuttisa Booncharoen	Bureau of TB
16.	Mr Sahaparp Poongaysorn	Bureau of Epidemiology
17.	Dr Sarawut Boonsuk	Bureau of Health Promotion, Department of Health
18.	Ms Chailai Lertwanangkul	Bureau of Health Promotion, Department of Health
19.	Ms Areerat Kumdornhun	Bureau of Health Management
20.	Ms Achara Tunyasitti	Bureau of Health Management
21.	Mr Wasitsak Taweewattanaprecha	National Command Center for Drug Elimination
22.	Ms Chaweewan Punjabuss	Tanyaraks Institute
23.	Ms Jumriang Ruengmak	Tanyaraks Institute
24.	Dr Nareerat Pudpong	International Health Policy Programme (IHPP)
25.	Pharmacist Ms Kutnang Tosa-nguan	International Health Policy Programme (IHPP)
26.	Dr Sorakit Pakeecheep	National Health Security Office
27.	Ms Rekawan Lekakanakul	National Health Security Office
28.	Mr Artit Pusam-ang	National Health Security Office
29.	Mr Nattaporn Kongsakunkrai	National Health Security Office
30.	Sen. Col. Karndee Lanparat	Royal Thai Army Medical Department
31.	Maj. Puttachart Puengpibool	Royal Thai Army Medical Department
32.	Commander Ngern Puangnark	Division of Preventive Medicine, Naval Medical Department, Royal Thai Navy
33.	Group Captain Niwat Intrawichien	Naval Medical Department, Royal Thai Navy
34.	Pol. Col. Arun Amornwiriyakul	Narcotics Suppression Division
35.	Pol. Col. Piyamon Suntronpa	Police General Hospital

36.	Pol. Maj. Wanpen Preetiyatorn	Health Promotion Clinic, Royal Thai Police
37.	Mr Soradech Suwan	Social and Economic Advisory Council
38.	Ms. Amarawan Tiwthanom	Development Evaluation and Communication Office Office of the National Economic and Social Development Board (NESDB)
39.	Ms Paphanun Worawatna	Development Evaluation and Communication Office,Office of the National Economic and Social Development Board (NESDB)
40.	Ms. Kanjanarat Jitrjinda	
41.	Ms. Wannapa Lumjiakthes	National Child Protection Committee, Office of the Permanent Secretary, Ministry of Social Development and Human Security
42.	Ms. Apisama Charnsuebsakul	The Comptroller General's Department
43.	Ms. Jaruwan Sakul Udomsak	The Comptroller General's Department
44.	Ms. Rapeepun Watcharangkul	Office of the Permanent Secretary Ministry of Education
45.	Ms Sarankorn Patnanuan	Office of the Higher Education Commission
46.	Ms. Pikul ChaleyPoj	Department of Labour Protection and Welfare, Ministry of Labour
47.	Ms Jitnara Nawarat	Special Prosecutor for Drug related Crime
48.	Pol. Sgt. Jiraporn Boonkarn	Bangkok Metropolitan Administration AIDS Center
49.	Ms Ubonrat Thanarujiwong	Bangkok Metropolitan Administration AIDS Center
50.	Ms Pattranee Phuwaprapachart	Bangkok Metropolitan Administration AIDS Center
51.	Ms Kanokrat Lerttraipob	Bangkok Metropolitan Administration AIDS Center
52.	Ms Wanida Pawaree	Bangkok Metropolitan Administration AIDS Center
53.	Ms. Junya Nuanla-ong	Bangkok Metropolitan Administration AIDS Center
54.	Ms Supojanee Chutidamrong	Office of the Narcotics Control Board
55.	Ms Ketsuda Homsuwan	Office of the Narcotics Control Board
56.	Dr Amornsri Wittawatmongkol	Pediatrics Department, Faculty of Medicine, Siriraj Hospital
57.	Mr Pitthaya Jinawat	Academic and Expert
58.	Ms. Vladanka Andreeva	UNAIDS RST
59.	Ms. Amala Reddy	UNAIDS RST
60.	Dr. Michael Hahn	UNAIDS
61.	Ms. Orawan Bettenhausen	UNAIDS
62.	Dr Patchara Benjarattanaporn	UNAIDS
63.	Mr Sompong Chareonsuk	UNAIDS

64.	Mr. Robert Gass	UNCEF
65.	Ms Nonglak Boonyabhuddi	UNCEF
66.	Dr. Mukta Sharma	WHO
67.	Dr Achara Teeraratkul	TUC
68.	Ms Farida Langkafah	TUC
69.	Ms. Tanada Naiwattanakul	TUC
70.	Ms Somboon Nukai	TUC
71.	Ms. Supatra Nakapew	Thai NGO Coalition on AIDS
72.	Ms Jarunee Siriphan	Foundation for AIDS Rights
73.	Ms Puttinee Gopatta	Foundation for AIDS Rights
74.	Ms Lawan Sarowart	12D Network
75.	Mr Jamrong Paengnonfyang	Sex Worker in Group (SWING)
76.	Ms Ladda Jirawattanaphet	Planned Parenthood Association of Thailand
77.	Mr Somjed Srikanok	Planned Parenthood Association of Thailand
78.	Ms Salee Rattanachot	Planned Parenthood Association of Thailand
79.	Ms Oratai Julsuwannaraks	Planned Parenthood Association of Thailand
80.	Ms Nittaya Promporchuenboon	AIDS Prevention and Control Project
81.	Mr Supoj Tungsereesap	PSI Thailand Foundation
82.	Mr Piyabutr Nakapew	PSI Thailand Foundation
83.	Ms Tongpis Pinyosinwat	Raksthai Foundation
84.	Ms Yenjit Sompoa	Thailand National AIDS Foundation
85.	Ms Wichaksana Huthanon	Disease Control Office 1, Bangkok
86.	Ms Waraporn Kuina	Disease Control Office 2, Saraburi
87.	Mr Sompong Rojrungsasitron	Disease Control Office 3, Chonburi
88.	Ms Panadda Chaichompu	Disease Control Office 5, Nakorn Ratchasrima
89.	Mr Kiattichai Sarnsaweg	Disease Control Office 6, Khonkaen
90.	Mr Sathien Chualee	Disease Control Office 7, Ubonratchathani
91.	Ms Kanaros Jangkum	Disease Control Office 9, Phisanulok
92.	Ms Angkana Teerasawas	Disease Control Office 10, Chiang Mai
93.	Ms Nunthitha Wongsuwan	Health Center 2, Saraburi
94.	Ms Rattana Petchphan	Health Center 3, Chonburi
95.	Ms Jarunee Jaturapornperm	Health Center 4, Rajburi
96.	Ms. Patcharaporn Tosong	Health Center 7, Ubonratchathani
97.	Ms Wanpen Presertsri	Health Center 8, Nakornsawan
98.	Ms. Thanyaporn Khunasombat Dupulo	Provincial Health Office, Lopburi
99.	Pol. Sub. Lt Sarun Yodnin	Pink Monkey Organization, Lopburi
100.	Ms. Yuwadee Sripramarn	Provincial Health Office, Saraburi
101.	Ms Bangon Jemruekjaeng	Samutprakarn Hospital
102.	Mr Teewara Kunawuth	Provincial Health Office, Rayong
103.	Ms Pornnipa Silanond	Provincial Health Office, Samutsakorn
104.	Ms. Sansanee Pattrasriwongchai	Provincial Health Office, Burirum
105.	Ms Naruepak Pichayatanakorn	Provincial Health Office, Srisaket
106.	Ms. Paijit Putthisri	Provincial Health Office, Nakornsawan

107.Ms. Sawakon Prompitak	Sawanpracharaks Hospital
108.Ms. Punyanuch Dejboriboon	Provincial Health Office, Tak
109.Ms Chonlisa Jariyalertsak	Provincial Health Office, Chiang Mai
110.Professor Sanan Wuti	The Church of Christ in Thailand AIDS Ministry
111.Ms Sawanee Punpattanakul	Provincial Health Office, Payao
112.Ms Monta Petchphan	Provincial Health Office, Nakornsrithammaraj
113.Ms Sawanee Rattanadilok na Phuket	Provincial Health Office, Phuket
114.Ms Oranus Yuangthong	Provincial Health Office, Surathani
115.Ms Ying Fundsoiraya	Provincial Health Office, Ranong
116.Mr Charoensuk Chanowanna	Provincial Health Office, Songkla
117.Mr Serm Buathong	Provincial Health Office, Pattalung
118.Ms Parita Kuaykiattikul	National AIDS Management Center
119.Ms Pornthip Kemngern	National AIDS Management Center
120.Ms Busaba Warakamin	National AIDS Management Center

ANNEX 4: List of Working Groups on Targets at National Consultation

- Group 1: Target 1 - Reduce Sexual Transmission
- Group 2: Target 2 - Prevent HIV Among Drug Users
- Group 3: Target 3 - Eliminate New HIV Infection Among Children
- Group 4: Target 4 - Access to Treatment
- Group 5: Target 5 - TB
- Group 6: Target 6 - Resources
  Target 10 - HIV Integration
- Group 7: Target 7 - Gender Inequalities
  Target 8 - Stigma and Discrimination